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

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

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

CONCLUSIONS

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

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

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

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

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

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

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

PART III

DIRECTORY OF INFORMATION BY STATES AND JURISDICTIONS

ALABAMA

Legal Status

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

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

Legislation and Sources

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

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

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

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

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

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

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

ACNM Affiliation

Chapter 9, Region V

Key Source for Legislation Information

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

ALASKA

Legal Status

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

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

Legislation and Sources

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

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

Qualifications for Practice

Under consideration by the State Boards of Nursing and Medicine.

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

ACNM Affiliation

Chapter 26, Region VI

Key Source for Legislation Information

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

ARIZONA

Legal Status

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

1. Registration in Arizona as a professional nurse.

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

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Hospital
Davis-Monthan Air Force Base
Tucson, Arizona 85707

Maricopa County Hospital
2601 E. Roosevelt
Phoenix, Arizona 85006

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

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

ACNM Affiliation

Chapter 21, Region VI

Key Source for Legislation Information

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

ARKANSAS

Legal Status

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

None specific to nurse-midwifery.

Application for Licensure

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

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

Arkansas State Medical Board
212 Jackson Street
Harrisburg, Arkansas 72432

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 20, Region V

Key Source for Legislation Information

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

CALIFORNIA

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

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

St. Luke's Hospital
San Francisco, California 94110

Watts Health Foundation
Los Angeles, California 90059

ACNM Affiliation

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

Key Source for Legislation Information

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

COLORADO

Legal Status

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

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

Legislation and Sources

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

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

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

Qualifications for Practice

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

Application for Licensure

None at present.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

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

CONNECTICUT

Legal Status

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

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

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

Legislation and Sources

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

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

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

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

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

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

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

Qualifications for Practice

Under the nursing statutes:

1. Licensure as a professional nurse registered in Connecticut.

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

Under the Public Health Code for Midwifery:

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

2. Good moral character.

3. Connecticut residence.

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

Limitations to Practice

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

Application for Licensure

Under the Public Health Code for Midwifery:

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

Agencies Employing for Full Clinical Practice

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

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

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

Hill Health Center
428 Columbus Avenue
New Haven, Connecticut 06519

Yale Health Plan
17 Hillhouse Avenue
New Haven, Connecticut 06511

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

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

ACNM Affiliation

Chapter 2, Region I

Key Source for Legislation Information

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

DELAWARE

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

Under the health code, applicants must:

1. Be at least 21 years of age;

2. Possess sufficient experience in the practice of midwifery;

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

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

5. Renew license annually on August 1.

Application for Licensure

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

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

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

DISTRICT OF COLUMBIA

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

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

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

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

Agencies Employing for Full Clinical Practice

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

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

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

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

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

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

FLORIDA

Legal Status

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

Legislation and Sources

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

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

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

Qualifications for Practice

1. Licensure as a professional nurse in Florida.

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Bethesda Memorial Hospital
Boynton Beach, Florida

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

Elgin Air Force Base Hospital
Valparaiso, Florida 32542

MacDill Air Force Base Hospital
Tampa, Florida 33608

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

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

ACNM Affiliation

Chapter 8, Region V

Key Source for Legislation Information

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

GEORGIA

Legal Status

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

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

Legislation and Sources

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

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

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

Qualifications for Practice

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

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

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

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Archibald Memorial Hospital
with Thomas County
Thomasville, Georgia

Dr. S. Gatewood
Americus, Georgia

Glynn-Brunswick Memorial Hospital
Brunswick, Georgia 31520

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

ACNM Affiliation

Chapter 9A, Region V

Key Source for Legislation Information

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

GUAM

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

1. Qualification as a graduate nurse.

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Naval Regional Medical Center

Seventh Day Adventist Clinic (affiliated with Guam Memorial Hospital)

ACNM Affiliation

Region VI

Key Source for Legislation Information

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

HAWAII

Legal Status

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

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

Legislation and Sources

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

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

Qualifications for Practice

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

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

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

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

Limitations to Practice

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Region VI

Key Source for Legislation Information

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

IDAHO

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

1. Licensure as a registered nurse in Idaho.

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

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

ILLINOIS

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

The INA statement requires that a nurse-midwife be:

1. Graduated from an approved school of professional nursing;

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

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

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

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

ACNM Affiliation

Chapter 15, Region IV

Key Source for Legislation Information

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

INDIANA

Legal Status

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

Legislation and Sources

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

Qualifications for Practice

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 14, Region IV

Key Source for Legislation Information

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

IOWA

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

Under the physician assistants act:

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

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

Application for Licensure

Under the physician assistants act:

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

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 17, Region IV

Key Source for Legislation Information

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

KANSAS

Legal Status

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

Legislation and Sources

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

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

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

Qualifications for Practice

None.

Limitations to Practice

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 19, Region IV

Key Source for Legislation Information

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

KENTUCKY

Legal Status

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

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

Legislation and Sources

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

2. Kentucky Revised Statutes 211.090, 211.180.

Qualifications for Practice

1. Licensure as a registered nurse in Kentucky.

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

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

4. Annual renewal of licenses.

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Appalachian Regional Hospital
Hazard, Kentucky 41701

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

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

Frontier Nursing Service
Wendover, Kentucky 41775

Ireland Army Hospital
Fort Knox, Kentucky 40121

Lake Cumberland District Health Department
Somerset, Kentucky 42501

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

J. Myron Lord, MD
Frankfort, Kentucky 40601

Morehead Clinic
Morehead, Kentucky 40351

University of Kentucky Medical Center
Lexington, Kentucky 40506

ACNM Affiliation

Chapter 10, Region III

Key Source for Legislation Information

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

LOUISIANA

Legal Status

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

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

Legislation and Sources

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

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

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

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

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

Qualifications for Practice

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

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

ACNM Affiliation

Chapter 9, Region V

Key Source for Legislation Information

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

MAINE

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

1. Licensure as a Registered Nurse in Maine.

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

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Maine Medical Center
22 Bramhall Street
Portland, Maine 04102

ACNM Affiliation

Chapter 1, Region I

Key Source for Legislation Information

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

MARYLAND

Legal Status

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

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

Legislation and Sources

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

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

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

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

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

Qualifications for Practice

Under the lay midwife laws, applicants shall:

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

2. Be able to read and write English;

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

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

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

6. Renew license biennually.

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Baltimore City Hospital
Baltimore, Maryland 21224

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

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

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

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

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

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

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

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

MASSACHUSETTS

Legal Status

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

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

Legislation and Sources

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

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

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

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 1, Region I

MISSISSIPPI

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

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

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

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Delta Community Hospital and Health Center
Mound Bayou, Mississippi 38762

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

South Washington County Hospital
Hollandale, Mississippi 38748

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

ACNM Affiliation

Chapter 9, Region V

Key Source for Legislation Information

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

MISSOURI

Legal Status

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

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

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

1. Licensed as a registered nurse in Missouri.

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

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

ACNM Affiliation

Chapter 19, Region IV

Key Source for Legislation Information

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

MONTANA

Legal Status

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

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

Legislation and Sources

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

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

Qualifications for Practice

1. Licensure as a registered nurse in Montana.

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

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

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

NEBRASKA

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Ehrling Berquist Hospital
Offatt Air Force Base
Omaha, Nebraska 68113

ACNM Affiliation

Chapter 17, Region IV

Key Source for Legislation Information

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

NEVADA

Legal Status

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

Legislation and Sources

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

Qualifications for Practice

Being developed by the State Board of Nursing.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

Nellis Air Force Base Hospital
Las Vegas, Nevada 89101

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

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

NEW HAMPSHIRE

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

1. Licensure as a registered nurse in New Hampshire.

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

ACNM Affiliation

Chapter 1, Region I

Key Source for Legislation Information

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

NEW JERSEY

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

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

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

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

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

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

North Hudson Hospital
Weehawken, New Jersey 07087

ACNM Affiliation

Chapter 4, Region II

Key Source for Legislation Information

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

NEW MEXICO

Legal Status

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

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

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

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

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

Legislation and Sources

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

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

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

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

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

Qualifications for Practice

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

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

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

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

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

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

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

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Kirtland Air Force Base Hospital
Albuquerque, New Mexico 87110

Indian Health Service Hospital
Shiprock, New Mexico 87420

ACNM Affiliation

Chapter 21, Region VI

Key Source for Legislation Information

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

NEW YORK

Legal Status

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

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

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

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Albany Medical Center
Department of Obstetrics
Albany, New York 12208

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

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

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

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

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

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

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

Elmhurst Hospital
Queens, New York 11203

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

Gouverneur Hospital
9 Gouverneur Slip
New York, New York 10002

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

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

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

Lenox Hill Hospital
New York, New York 10021

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

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

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

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

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

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

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

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

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

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

University of Rochester Medical Center
Rochester, New York 14627

ACNM Affiliation

Chapter 4, Region II

Key Source for Legislation Information

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

NORTH CAROLINA

Legal Status

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

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

ACNM Affiliation

Chapter 7, Region V

Key Source for Legislation Information

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

NORTH DAKOTA

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

None.

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 20, Region V

Key Source for Legislation Information

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

OREGON

Legal Status

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

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

Legislation and Sources

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

Qualifications for Practice

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

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

PENNSYLVANIA

Legal Status

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

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

Legislation and Sources

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

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

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

Qualifications for Practice

1. Licensure as a professional nurse.

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

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

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

or

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Booth Maternity Center
6051 Overbrook Avenue
Philadelphia, Pennsylvania 19131

McKeesport Hospital
1500 Fifth Avenue
McKeesport, Pennsylvania 15132

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

ACNM Affiliation

Chapter 5, Region III

Key Source for Legislation Information

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

PUERTO RICO

Legal Status

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

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

Legislation and Sources

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

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

Qualifications for Practice

1. License to practice nursing in Puerto Rico.

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

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

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

ACNM Affiliation

Chapter 27, Region II

Key Source for Legislation Information

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

RHODE ISLAND

Legal Status

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

Legislation and Sources

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

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

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 2, Region I

Key Source for Legislation Information

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

SOUTH CAROLINA

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

1. Licensure as a registered nurse in South Carolina.

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

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

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

ACNM Affiliation

Chapter 7, Region V

Key Source for Legislation Information

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

SOUTH DAKOTA

Legal Status

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

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

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

Legislation and Sources

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

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

Qualifications for Practice

1. Licensure as a professional nurse.

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

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Public Health Service Hospital
Pine Ridge, South Dakota 57770

ACNM Affiliation

Chapter 16, Region V

Key Source for Legislation Information

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

TENNESSEE

Legal Status

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

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

Legislation and Sources

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

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

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

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

Qualifications for Practice

Currently being developed.

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Halston Valley Community Hospital
Kingsport, Tennessee 37662

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

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

ACNM Affiliation

Chapter 10, Region V

Key Source for Legislation Information

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

TEXAS

Legal Status

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

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

Legislation and Sources

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

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

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

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

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

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

Qualifications for Practice

None specified.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

Sheppard Air Force Base Hospital
Wichita Falls, Texas 76306

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

ACNM Affiliation

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

Key Source for Legislation Information

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

UTAH

Legal Status

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

Legislation and Sources

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

Qualifications for Practice

1. Licensure as a registered nurse in Utah.

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

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

UTAH (continued)

Application for Licensure

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

Agencies Employing for Full Clinical Practice

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

Hospital
Hill Air Force Base
Ogden, Utah 84406

Uintah County Hospital
Vernal, Utah 84078

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

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

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

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

VERMONT

Legal Status

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

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

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

Legislation and Sources

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

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

Qualifications for Practice

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

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

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

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

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

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

ACNM Affiliation

Chapter 1, Region I

Key Source for Legislation Information

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

VIRGINIA

Legal Status

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

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

Legislation and Sources

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

Qualifications for Practice

1. Registration as a professional nurse in Virginia.

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

3. Age 18-65.

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

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

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

7. Renewal of permit every two years.

Application for Licensure

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

Agencies Employing for Full Clinical Practice

Hospital
Langley Air Force Base
Virginia 23365

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

ACNM Affiliation

Chapter 6, Region III

Key Source for Legislation Information

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

VIRGIN ISLANDS

Legal Status

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

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

Legislation and Sources

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

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

Qualifications for Practice

1. High school education or equivalency.

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

3. Good character and good physical and mental health.

4. Payment of a $10.00 fee.

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

Application for Licensure

Executive Director
Board of Nurse-Midwife Examiners
U.S. Virgin Islands
c/o Charles Harwood Memorial Hospital
Christiansted, St. Croix, U.S. Virgin Islands 00802

Agencies Employing for Full Clinical Practice

Virgin Islands Health Department at:

Charles Harwood Memorial Hospital
Christiansted, St. Croix, U.S. Virgin Islands 00802

Knud Hausen Memorial Hospital
Charlotte Amalie, St. Thomas
U.S. Virgin Islands 00801

ACNM Affiliation

Chapter 28, Region II

Key Source for Legislation Information

Theolinda Hewitt, CNM
P.O. Box 305
Christiansted, St. Croix
U.S. Virgin Islands 00802

WASHINGTON

Legal Status

Although there are no legal restrictions to the practice of nurse-midwifery, only one nurse-midwife is practicing fully in the state of Washington. A 1917 lay midwife act (1) is still in effect despite attempts at repeal since 1971.

The state's nurse practice act (2), revised in 1973, provides for extended nursing practice in areas recognized jointly by the nursing and medical professions and regulated by the State Board of Nursing. Rules and regulations for advanced registered nurses and specialized registered nurses have recently been promulgated by the Board (3). Also, the physician assistants act (4) would appear to cover the practice of nurse-midwifery.

Legislation and Sources

1. Revised Code of Washington, Chapter 18.50, Midwifery, Sections 50.010 to 50.900. 1917.

2. Revised Code of Washington, Laws of 1973, Law Regulating the Practice of Registered Nursing, Chapter 133, Sections 18.88.010 to 18.88.285.

3. Board of Nursing Rules and Regulations, WAC 308-120-190 to 250. February, 1975.

4. Revised Code of Washington, Chapter 18.71A, Physicians' Assistants, Sections 18.71A.010 to 18.71A.0o0. 1971.

Qualifications for Practice

Under the nurse practice act:

1. Licensure as a professional nurse;

2. Others as determined by the Board of Nursing.

Under the lay midwife act:

1. Passing of an examination and payment of a $15.00 fee.

2. Certificate or diploma from a school of midwifery having an approved program;

or

3. Certificate or diploma from a foreign institution of equal requirement, conferring the right to practice in that country;

4. Endorsement by a physician licensed in the state of Washington.

The physician assistants act does not provide for licensure. The State Board of Medical Examiners is authorized to adopt rules and regulations fixing the qualifications for persons who may be employed as physician assistants.

Limitations to Practice

Licensure under the lay midwife act prohibits the nurse-midwife from prescribing any drug or medicine, except some household remedy, after the birth of the infant.

Physician assistants may practice only after authorization by the Board of Medical Examiners and only to the extent permitted by the Board.

Application for Licensure

Under the Nurse Practice Act:
Executive Secretary
Washington State Board of Nursing
Department 77180
P.O. Box 649
Olympia, Washington 98501

Under the lay midwife act:
Administrator
Division of Professional Licensing
Fifth and Sylvester
71000 Capital Center Building
P.O. Box 649
Olympia, Washington 98501

Under the physician assistants act:
Division of Professional Licensing
Fifth and Sylvester
71000 Capital Center Building
P.O. Box 649
Olympia, Washington 98501

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 23, Region VI

Key Source for Legislation Information

Tamara Cyr Baker, CNM
205C North 63rd Avenue
Yakima, Washington 98902

WEST VIRGINIA

Legal Status

Certified nurse-midwives are practicing fully and are licensed under a recently enacted nurse-midwifery practice act (1) which is derived from a 1931 lay midwife law. Under the new act, the few lay midwives holding licenses on July 1, 1973 were permitted to continue practicing in accordance with the former law, but authority for licensing midwives was transferred from the state's Board of Health to the Board of Examiners for Registered Nurses.

Legislation and Sources

1. Code of West Virginia, Chapter 30, Article 15, Midwives, Sections 30-15-1 to 30-15-8, 1973.

Qualifications for Practice

1. Registration as a professional nurse in West Virginia.

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

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

Application for Licensure

West Virginia Board of Examiners for Registered Nurses
Building 3, Room 416
1800 Washington Street, East
Charleston, West Virginia 25305

Agencies Employing for Full Clinical Practice

A.R. Jacobson, MD
P.O. Box 50
Beckley, West Virginia 25801

ACNM Affiliation

Chapter 11, Region III

Key Source for Legislation Information

Nancy Schnell, CNM
1250 Dorsey Avenue
Morgantown, West Virginia 26505

WISCONSIN

Legal Status

Nurse-midwives are not permitted to practice fully in the state at this time, according to the 1973 Wisconsin Attorney General's interpretation of statutes concerning midwifery and medical practice (1). However, the state's nurse practice act (2) does not specify any conditions which would prohibit the practice of midwifery.

In 1953, sections of the state's statutes referring to licensure of midwives were repealed, but a "grandfather clause" included in statutes pertaining to the state's Medical Examining Board permitted lay midwives already licensed to continue practicing under the old laws and subject to "other provisions" in the Board Statutes (3). In 1955, the state's Attorney General had interpreted that statute to mean that in effect no person other than a licensed physician could practice midwifery, although according to the more recent interpretation, it is not clear from the law that the legislature intended to exclude all persons except physicians from practicing midwifery, and therefore new legislation would be required (1).

Legislation and Sources

1. Letter from the Attorney General of the State of Wisconsin directed to the Secretary, Medical Examining Board, March 5, 1973, referring to 44-0-AG-94 (1955).

2. Wisconsin Statutes, Chapter 441, Division of Nurses.

3. Wisconsin Statutes, Chapter 448, Medical Examining Board, Section 448.20, 1953.

Qualifications for Practice

None.

Application for Licensure

None.

Agencies Employing for Full Clinical Practice

None known.

ACNM Affiliation

Chapter 16, Region IV

Key Source for Legislation Information

Anita H. Grand, CNM
Maternal and Child Health Consultant
State Division of Health
P.O. Box 309
Madison, Wisconsin 53701

WYOMING

Legal Status

One nurse-midwife is licensed to practice midwifery in accordance with the state's medical practice act (1). Although the law was not designed for nurse-midwifery practice, it is not restrictive, and the state's Nursing Practice Act is likewise permissive (2). Although no nurse-midwives are practicing fully, some physicians in the state have expressed interest in starting nurse-midwifery services.

Legislation and Sources

1. Wyoming Statutes-1957, Chapter 33, Physicians and Surgeons, Section 33-339, Practitioners of Obstetrics and Midwifery.

2. State of Wyoming Nursing Practice Act, Sections 33-280 through 33-291, Wyoming Statutes, 1957.

Qualifications for Practice

1. Graduation from a midwifery program.
2. Passing of an examination by the state's Board of Medical Examiners.

Application for Licensure

Executive Secretary
Board of Medical Examiners
State Office Building West
Cheyenne, Wyoming 82001

Agencies Employing for Full Clinical Practice

None at present.

ACNM Affiliation

Chapter 22, Region VI

Key Source for Legislation Information

Karol A. McRorie, CNM
1202 East Fifth Avenue
Cheyenne, Wyoming 82001

APPENDIX A

PHILOSOPHY OF THE AMERICAN COLLEGE OF NURSE-MIDWIVES

The Philosophy of the American College of Nurse-Midwives is based on the belief that

- Every childbearing family has a right to a safe, satisfying experience with respect for human dignity and worth; for variety in cultural forms; and for the parents' right to self-determination.
- Comprehensive maternity care, including educational and emotional support as well as management of physical care throughout the childbearing years, is a major means for intercession into, and improvement and maintenance of, the health of the nation's families. Comprehensive maternity care is most effectively and efficiently delivered by interdependent health disciplines.
- Nurse-midwifery is an interdependent health discipline focusing on the family and exhibiting responsibility for insuring that its practitioners are provided with excellence in preparation and that those practitioners demonstrate professional behavior in keeping with these stated beliefs.

Adopted 1972

APPENDIX B

ACNM STATEMENT OF QUALIFICATIONS, STANDARDS, AND FUNCTIONS

Qualifications for the Practice of Nurse-Midwifery

1. Certification by the American College of Nurse-Midwives.
   a. Active licensure as a registered nurse in one of the 50 states or Territories including the District of Columbia.
   b. Completion of a nurse-midwifery educational program approved by the American College of Nurse-Midwives.
2. Compliance with legal requirements of the jurisdiction in which nurse-midwifery practice will occur.

Standards for the Practice of Nurse-Midwifery

Nurse-midwifery practice

1. Strives to provide continuity of care to the woman and her family during the maternity cycle, continuing interconceptionally throughout the childbearing years;
2. Fosters the delivery of safe and satisfying care;
3. Recognizes that childbearing is a family experience and encourages the active involvement of family members in care;
4. Upholds the right to self-determination of consumers within the boundaries of safe care;
5. Focuses on health and growth as developmental processes during the reproductive years;
6. Stimulates community awareness and responsiveness to the needs for delivery of quality family-centered care;
7. Occurs interdependently within a health care delivery system;
8. Occurs within a formal written alliance with an obstetrician, or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist;
9. Exists within a framework of medically approved protocols;
10. Occurs within the realm of professional competence;
11. Requires opportunities for continuing professional growth and development;
12. Includes an on-going process of evaluation.

Functions for the Practice of Nurse-Midwifery

The nurse-midwife

1. Assumes responsibility for the management and complete care of the essentially healthy woman and newborn related to the childbearing processes;
2. Develops with the woman an appropriate plan of care attentive to her interrelated needs;
3. Participates in individual and group counseling and teaching throughout the childbearing processes;
4. Manages, through mutual agreement and collaboration with the physician, that part of care of medically complicated women which is appropriate to the skills and knowledge of nurse-midwives.
5. Collaborates with other health professionals in the delivery and evaluation of health care;
6. Assesses own professional abilities and functions within identified capabilities;
7. Assumes responsibility for own self-determination within the boundaries of professional practice;
8. Maintains and promotes professional practice in concert with current trends;
9. Utilizes Standards for Evaluation of Nurse-Midwifery Procedural Functions in development and evaluation of practice (Addendum 1).
10. Promotes the preparation of nurse-midwifery students;
11. Assists with the education of other health care personnel;
12. Supports the philosophy and official policies of the American College of Nurse-Midwives.

Accepted 1975

ADDENDUM 1

Standards for Evaluation of Nurse-Midwifery Procedural Functions

The following guidelines were adopted by the Executive Board of the American College of Nurse-Midwives as a way of approaching the clinical practice of the nurse-midwife. Practice is continually evolving and it varies depending upon the institution and the demands for service within each setting. Because of this, the nurse-midwife may frequently be in a position of having to evaluate a new function for possible inclusion into her practice. This need for evaluation may be stimulated by the obstetrician, the demands of the patient or community, pressure from other groups, or desires of the nurse-midwife herself. In any case, the answer as to the worth and safety of a new procedure for inclusion into nurse-midwifery may not be clear.

No one of these guidelines can stand alone. It is only by employing each of them and then surveying the whole that an accurate feeling for the safety and suitability of the procedure for nurse-midwifery practice can be obtained. Guidelines help to direct but they do not necessarily guarantee that the direction will be completely clear. Systematic review of new procedures will help to assure that the statements on qualifications, standards and functions are up to date.

1. The procedure assists the nurse-midwife in managing the care of the normal childbearing woman and infant.
   a. It does not conflict with the basic philosophy of nurse-midwifery as outlined by the ACNM and with that outlined by the nurse-midwifery service.
   b. The procedure can be done competently by the nurse-midwife, i.e., the practitioner has obtained sound theory and supervised clinical experience from qualified faculty.
   c. The nurse-midwife is prepared to handle possible complications from the procedure until help arrives.

2. The procedure is within accepted obstetrical practice within the institution.
   a. It is presently an established procedure.
   b. It is a new procedure that is being instituted by the obstetric service.

3. The procedure fills a demonstrated need.
   a. There is consumer demand.
   b. Within the obstetric team it is appropriate that the nurse-midwife carry out the procedure.
   c. The nurse-midwife feels the procedure will contribute to the provision of optimal care.

4. The procedure is evaluated in the literature and/or in practice.
   a. The literature has been reviewed with both indications and contraindications identified.
   b. There is consideration of what other institutions and other nurse-midwives are doing.

5. The procedure is within legal limits.

6. There is an on-going plan for the evaluation of the procedure.
   a. The plan is filed with the Clinical Practice Committee at the time of initiation of the procedure.
   b. Progress reports are periodically submitted to the Clinical Practice Committee.

The Committee requests that if a nurse-midwifery service or a nurse-midwife intends to initiate a new procedure, the Clinical Practice Committee be notified. This will enable the Committee to record changes in practice throughout the United States and will also facilitate the dissemination of information of nurse-midwifery practice. It is hoped that periodic reports to the Committee will be made which are evaluative and in summary form. The collection of this type of data is important to the development of nurse-midwifery and will provide a resource for other services which may be considering the initiation of the same procedures.

Accepted January 27, 1972

APPENDIX C

ACNM POSITION STATEMENT ON NURSE-MIDWIFERY LEGISLATION

Preamble

The patterns of health laws in the United States vary widely and are changing rapidly. The complexity of this situation presents a barrier to the optimal growth and development of nurse-midwifery due to serious ambiguities in the legal base for practice. The American College of Nurse-Midwives (ACNM) has received increasing demands from the public and from professional organizations for recommendations on legislation. The following position statement is a result of the desire of ACNM to respond to these demands.

Beliefs

The ACNM believes that accessibility to comprehensive care is the right of all persons. Certified nurse-midwives have demonstrated that they are capable of making significant contributions in provision of this care. The ACNM believes that legislation which regulates the practice of the profession of nurse-midwifery should be so designed that it promotes and protects the health and welfare of the public. To achieve these objectives nurse-midwives must collaborate with other groups which share their primary concern of quality maternal and infant health care for all population groups.

Statement

A nurse-midwife who is currently certified by ACNM is qualified to practice nurse-midwifery throughout the United States and its jurisdictions.

The American College of Nurse-Midwives, as the recognized authority governing nurse-midwifery practice, is responsible for

- Certification of nurse-midwives;
- Establishment of qualifications, standards, and functions for the practice of nurse-midwifery;
- Approval of nurse-midwifery educational programs;
- Development of guidelines for nurse-midwifery services;
- Development of guidelines for continuing education of nurse-midwives.

Separate statutory recognition is recommended as the basis for nurse-midwifery practice. To the extent possible, this legislation should be uniform throughout the United States and its jurisdictions. Until such legislation is enacted, nurse-midwives may practice under a variety of legal arrangements.

Nurse-midwives should be involved in the policy making process of those regulatory bodies which administer and/or influence the practice of nurse-midwifery. Nurse-midwives who act in these capacities should be representative of and accountable to the practicing nurse-midwives within their respective areas.

Information and consultation on legislation pertaining to nurse-midwifery is available through the American College of Nurse-Midwives.

This statement was prepared by the ACNM Legislation Committee based upon recommendations from participants in the ACNM Workshop on the Legal Status of Nurse-Midwifery, held in Cincinnati, Ohio, June 14-15, 1974. Approved by Board of Directors, July 30, 1974.

APPENDIX D

ACNM LEGISLATION COMMITTEE GUIDELINES FOR ESTABLISHING NURSE-MIDWIFERY PRACTICE

Step I.

Send for and read the actual documents which pertain to nurse-midwifery practice in your state. These are

1. Nurse Practice Act;
2. Medical Practice Act;
3. Legislation specifically mentioning midwifery or nurse-midwifery;
4. Existing joint policy statements of groups such as American Nurses Association, American College of Obstetricians and Gynecologists, medical societies, etc. relating to the practice of nurse-midwifery;
5. Existing statement by the Attorney General or by any single professional organization;
6. Any other documents felt to be relevant by the Department of Health.

Step II.

If there is no specific statement prohibiting the practice of nurse-midwifery in the medical practice act, nurse-midwifery practice may be established according to the guidelines set up by the American College of Nurse-Midwives.

Step iii.

Any specific parts of nurse-midwifery which are forbidden by the law (Example: Only a doctor may perform minor surgical procedures, e.g., episiotomies) should be written up as a clinical practice experiment and formally studied. Statistics should be carefully kept.

Step IV.

When a body of practice has been established with accurate statistics as a visible reflection of its existence, a statement may be sought from the Attorney General concerning the limits and extent of this practice. Such a statement should be sought via joint participation of official groups. (This statement does not have the force of law but is increasing evidence in favor of nurse-midwifery practice.)

Step V.

A joint policy statement on nurse-midwifery practice may be sought from the state nurses association, state hospital association and the state medical society. This would also provide guidelines and a visible approval of practice.

At this time the Legislation Committee does not suggest any changes in the laws unless they are completely restrictive to the practice of nurse-midwifery.

Note: These guidelines were developed by the Legislation Committee in 1971. They are in the process of revision.
Further information may be obtained from the American College of Nurse-Midwives.

APPENDIX E

UPDATE OF TABLE 5 ON PAGE 13

PATTERNS OF LEGISLATION AND ACTUAL PRACTICE OF NURSE-MIDWIFERY IN THE UNITED STATES

I. States and jurisdictions with specific recognition of nurse-midwifery in legislative statutes or official regulations:

A. CNM's practicing fully:

Alabama	Florida	Massachusetts	North Carolina	South Carolina
Alaska	Guam	Mississippi	Ohio	Utah
Arizona	Hawaii	New Hampshire	Oregon	Virgin Islands
California	Indiana	New Jersey	Pennsylvania	Virginia
Colorado	Kentucky	New Mexico	Puerto Rico	Washington
Connecticut	Maryland	New York	Rhode Island	West Virginia
				Wisconsin

B. CNM's not practicing fully:

Delaware	Idaho	Michigan	Montana*	South Dakota*

II. States with permissive laws, but no specific recognition of nurse-midwifery:

A. CNM's practicing fully:

Arkansas	Illinois	Minnesota	Texas
District of Columbia	Louisiana	Missouri	Vermont
Georgia	Maine	Tennessee	Wyoming

B. CNM's not practicing fully:

Iowa	North Dakota*	Oklahoma
Nebraska	Nevada	

III. States with restrictive interpretation of laws and no CNM's practicing fully:

Kansas

* Exception: Nurse-Midwives practice in federal governmental hospitals

Prepared by the Legislation Committee of the American College of Nurse-Midwives

July, 1980

APPENDIX F

UPDATE OF TABLE 7 ON PAGE 15

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

Licensure Specific to Nurse-Midwifery

Alabama	Maryland	Oregon
Alaska	Massachusetts	Pennsylvania
Arizona	Michigan	Puerto Rico
California	Mississippi	Rhode Island
Connecticut (a)	Montana	South Carolina
Delaware	New Hampshire	South Dakota
Florida	New Jersey	Utah
Guam	New Mexico	Virginia
Hawaii	New York	Virgin Islands
Indiana	North Carolina	Washington
Kentucky	Ohio	West Virginia

Specific Qualifications, other than State Licensure, for Nurse-Midwifery

District of Columbia	Maine
Georgia	Vermont
Illinois	

Legal Provisions for Lay Midwives May Apply

Louisiana	Minnesota	Texas (b)

Legal Provisions for Physician Assistants May Apply

Connecticut (a)	Iowa

(a) Nurse-Midwives have a legal option to qualify for practice under statutes applicable to one or more practitioners of midwifery.
(b) Laws do not specify qualifications for practice.

April, 1980

APPENDIX G

UPDATE OF TABLE 8 ON PAGE 17

REGULATORY AUTHORITY FOR NURSE-MIDWIFERY BY STATES AND JURISDICTIONS

State Board of Health (or equivalent)

Connecticut (a)
Delaware
Florida (b)
Hawaii
New York
New Mexico
Rhode Island

State Board of Medicine (or equivalent)

Guam
Indiana
New Jersey
Ohio
Pennsylvania
Puerto Rico

State Board of Nursing (or equivalent)

Alabama
Alaska
Arizona
California
Florida
Kentucky
Maryland
Massachusetts
Michigan
Mississippi
Montana
Oregon
South Carolina
South Dakota
Washington
West Virginia

Joint Commission of State Boards

Idaho
New Hampshire
North Carolina
Virginia

Other Agencies

Utah — Department of Business Regulation, Committee of Certified Nurse-Midwifery
Virgin Islands — Board of Nurse-Midwife Examiners

(a) Authority for control is ambiguous.
(b) Registration required.

April, 1980

APPENDIX H

SPECIFIC RECOGNITION OF CERTIFIED NURSE-MIDWIVES IN LAWS OF STATES AND JURISDICTIONS

Statutory Recognition with or without Regulatory Recognition

Alabama
California
Colorado
Kentucky
Maryland
Massachusetts
Michigan
Montana
New York
Ohio
Utah
Virginia
West Virginia

Regulatory Recognition Only

Alaska
Arizona
Connecticut
Delaware
Florida
Hawaii
Idaho
Indiana
Mississippi
New Hampshire
New Jersey
New Mexico
North Carolina
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Washington

Prepared by the Legislation Committee of the American College of Nurse-Midwives.

January, 1980

MIDWIFERY OUTSIDE OF THE NURSING PROFESSION: THE CURRENT DEBATE IN WASHINGTON

HEALTH POLICY ANALYSIS PROGRAM
SCHOOL OF PUBLIC HEALTH AND COMMUNITY MEDICINE
UNIVERSITY OF WASHINGTON

MIDWIFERY OUTSIDE OF THE NURSING PROFESSION:

THE CURRENT DEBATE IN WASHINGTON

Health Policy Analysis Program
RD-37
School of Public Health and Community Medicine
University of Washington
Seattle, Washington 98195
(206) 543-3522

October, 1980

Other publications:

Health Maintenance Organizations: An Analysis of Policy Issues for Washington State, 1974

Organization of State Health Functions: An Analysis of Policy Issues for Washington,* 1974

The Next Step . . . Designation of a Washington "State Agency" Under P.L. 93-641,* 1975

The Guidebook to Personal Health Care in Washington, 1975

Certificate of Need in Washington: An Examination of Federal Regulations and State Options for Change,* 1975

The Malpractice Issue in Washington, 1975

Looking to Classification: Uniform Standards for Health Insurance in Washington, 1976

Public Health in Washington: The Current System and Future Options, 1978

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Long-Term Care for the Elderly in Washington, 1978

The Yellow Pages: A Directory of Health Data Resources in Washington State, 1978

Surgical Second Opinion Programs in Perspective, 1978

The State Board of Health: Roles and Options, 1978

In-Home Services for the Elderly and Disabled in Washington State, 1979

The Commission Approach to Nursing Home Reimbursement in Washington: In Pursuit of a Reasonable Price, 1979

Clinical Laboratory Services Improvement: Options for Washington State, 1979

Available from Health Policy Analysis Program
University of Washington
RD-37
Seattle, Washington 98195

Also available:

Closed Claim Actuarial Study of Medical Malpractice in the State of Washington (Booz, Allen Consulting Actuaries), 1977

*Out of print

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TABLE OF CONTENTS

PREFACE

The Health Policy Analysis Program (HPAP) is a cooperative undertaking of the executive and legislative branches of Washington State and the University of Washington's School of Public Health and Community Medicine.

The purpose of the Program is to provide independent research and analysis services to the State's public decision-makers who have responsibility for health care policies and programs.

Assignments undertaken by the Program represent the priorities and concerns of the public officials. The selection process for work assignments is the responsibility of the HPAP Advisory Committee which includes representatives of the

- Washington State House of Representatives
- Washington State Senate
- Department of Social and Health Services
- Washington State Hospital Commission
- School of Public Health and Community Medicine

The Program is funded by Washington State and is housed in the Department of Health Services of the School of Public Health and Community Medicine.

During the period of this report the staff of the Health Policy Analysis Program included:

Thomas W. Bice, Director
Charles T. Heaney, Research Associate*
Laurence Costa, Research Associate
Amy Malter, Research Assistant*
Sandra Lee, Research Assistant
Ruth Marie Fish, Secretary

October, 1980
*Principal authors

SUMMARY OBSERVATIONS

1. Concern over the adequacy of the state's 1917 midwifery statute is a product of (1) the recent appearance of candidates who have successfully fulfilled the requirements for licensure, (2) activities of midwifery advocates in the areas of legislation and education, and (3) a small, but noticable increase in out-of-hospital births.

2. Since 1975, sixteen individuals have been licensed as midwives in this state. Nine of them were trained abroad (see pp. 5-6).

3. In 1978, a midwifery school was established in Seattle. Five of its graduates have been licensed as midwives (see pp. 9-10).

4. Between 1970 and 1979, the percentage of out-of-hospital births in Washington rose from 0.6 percent to 2.6 percent. The absolute numbers, however, are relatively small--approximateiy 1,600 out of 50,000 births in 1978. The great majority of these births (approximately 80 percent) are attended by licensed practitioners, including licensed midwives (see pp. 11-16).

5. Midwifery is an integral component of maternity services in Europe. It is viewed in terms of (1) normal pregnancy, (2) a broad scope of practice, (3) a variety of practice settings, and (4) a profession distinct from nursing (see pp. 19-22).

6. The European consensus seems to be that while some nursing skills are necessary to the practice of midwifery, one need not first be a nurse in order to be a competent midwife (see p. 22).

13. In framing a new statute, the membership of the designated credentialing authority will be crucial to establishing the credibility of the midwifery regulatory process (and midwifery itself) in the minds of the public and the professional community (see pp. 67-69).

14. Of the various duties usually assigned to an occupational credentialing body, the determination of educational requirements and the approval of training programs will be the most important under a new midwifery statute (see p. 69).

15. In the absence of a general consensus on midwifery and professional organizations that could be entrusted to develop reasonable educational standards, the task of approving programs may best be performed by the credentialing body constituted under a new statute (see pp. 57,69).

16. Whether a midwifery credentialing body should have ultimate decision-making authority or should be advisory to state government depends on the perceived need for public accountability (see pp. 70-73).

17. Continuing education, re-examination, and peer review are mechanisms for promoting continued competence over the course of a practitioner's career. Since the relationship between these activities and quality of care is unclear, discretion is important in devising a reasonable set of requirements (see pp. 73-76).

18. In deciding how dependent or independent midwives should be in their association with physicians, important considerations are the level of training and the scope of practice (see pp. 77-81).

19. Midwives may be allowed to use certain basic obstetrical medications without being granted prescriptive authority. At issue is the difference between the "dispensing" and the "administering" of legend drugs (see pp. 83-85).

7. While the European experience can offer useful guidelines, caution must be exercised in applying European standards to midwifery practice in this country. Because midwifery is neither well established nor well accepted in the United States, a flexible policy perspective would appear desirable (see pp. 24-25).

8. While midwifery, in general, is very limited and highly controversial, nurse-midwives have, to date, received the greatest degree of recognition (see pp. 29-32).

9. Outside of nursing, midwifery has been limited by the lack of (1) organized leadership and educational activities, (2) favorable state regulatory policy, and (3) clear relationships with, and acceptance by, other health professionals (see pp. 32-36).

10. In revising the current statute, the legislature may wish to consider three approaches: (1) deferring action, (2) revising the existing statute, and(3) combining in a single statute a regulatory program for nurse-midwives and midwives independent of nursing (see pp. 41-45).

11. The critical elements of any new midwifery statute will be (1) the scope of practice, (2) training requirements, (3) the credentialing process, and (4) the degree of independence vis-a-vis other practitioners. The definition of scope of practice will largely govern decisions regarding the other three factors. In general, the broader the scope of practice, the more rigorous should be the other requirements (see pp. 45-47).

12. In view of current developments in occupational regulation, the state may wish to consider certification or registration as an alternative to licensure. All three can be used to require the same standards of education and practice (see pp. 61-66).

INTRODUCTION

Toward the latter part of 1979, the Health Policy Analysis Program Advisory Committee requested that a study be undertaken on the subject of midwifery and, in particular, midwifery outside of the nursing profession. Specifically, HPAP was asked to examine the principal issues that will have to be resolved in developing new legislation that would supplant the state's existing midwifery statute enacted in 1917. This law does not require nurse training as a prerequisite to licensure as a midwife.

As will be discussed more fully in Chapter 1, there are essentially three developments that have prompted public officials in this state to take an interest in devising a new midwifery statute. The first is the reactivation of the 1917 provisions which had lain dormant for decades. This was brought on by the recent appearance of a number of individuals whose credentials enabled them to fulfill the requirements for licensure under the existing law. Second, midwifery advocates have raised the visibility of this issue through legislative activity and the establishment of a midwifery school, the graduates of which are eligible to sit for the state licensing examination. Finally, there has been concern over the rise in out-of-hospital births, especially those attended by unlicensed or otherwise unqualified individuals. As a result, the legislature has made some preliminary efforts to assess the adequacy of the existing midwifery statute and its relevance to maternity services in this state.

Underscoring these local developments, however, is what appears to be a widespread and growing interest in midwifery generally as a valuable resource in the delivery of obstetric services. An integral and predominant feature of maternity care in most developed countries, indeed throughout the world, midwifery virtually disappeared in the United States following the emergence of hospital-based, medical obstetrics in the mid-1900s. That midwives are once again becoming active is a consequence of many factors. Important among these are the women's movement, the professional and political activities of midwives, and the ongoing controversy surrounding the efficacy of standard birth practices and their relationship to psychological needs as well as physical safety. To the extent that it has occurred, the revival of midwifery has been helped greatly by the willingness of many individuals and organizations to overcome fear, prejudice, and inertia in order to give expression to a branch of maternal and child care long considered taboo in this country.

Modern midwifery has been marked by the emergence of several groups of practitioners. First there are nurse-midwives, registered nurses who have undertaken advanced training and have passed a uniform, national certifying examination administered by the American College of Nurse Midwives. The practice of these "certified nurse-midwives" (CNMs) is governed in almost all states either by statute or by regulation issued by established professional licensing bodies, generally boards of nursing or medical examiners. While nurse-midwives have gained the high regard of the professional community and the public wherever they have been allowed to apply their skills, their acceptance by the medical community is by no means universal, nor has it been quickly and easily forthcoming.

In addition to nurse-midwives, many other persons have begun to attend births. Because these individuals vary widely in their training, experience, and competence, meaningful categorization is difficult. In the debate over maternity services, however, they are commonly referred to as "lay" or "empirical" midwives. They appear to be educated, urban, middle class women serving their peers. They contrast greatly with the "granny" midwives of earlier generations, who were largely the uneducated poor practicing among the uneducated poor in rural areas and in the immigrant communities of the larger metropolitan centers.

Unlike the nurse-midwives, these other practitioners are viewed by many in the health establishment generally, and the medical profession in particular, as not having a place in modern maternity care. Also unlike nurse-midwives, whose training standards and codes of professional practice are well established, midwifery outside of nursing does not yet have a strong professional and educational foundation. Moreover, few states have attempted to provide a regulatory framework for this group of practitioners. Most states either have no statutes relating to midwives or--as is the case in Washington--have laws enacted in the early 1900s that have little relevance to modern standards of obstetrical care. Only a few states have taken steps to recognize and regulate the activities of those persons providing birth services outside of the established health professions.

This inquiry is intended to examine the major policy questions that will have to be addressed by the legislature in any deliberations on the regulation of midwives outside of the nursing profession. In the politics of maternity care, this issue is often highly charged with emotion and divisiveness, and it is for this reason that the HPAP Advisory Committee thought that a dispassionate and practical analysis would be especially useful.

Chapter I will focus on the specific concerns that have given rise to the current interest in midwifery on the part of public officials in this state. The second chapter provides an overview of midwifery in the United States and in other developed countries, addressing such issues as its history, training requirements, and regulation. Chapters III-VIII will examine the major policy questions. Our concluding remarks and general observations are set out in Chapter IX.

Chapter I

THE STATE'S INTEREST IN MIDWIFERY

The discussion of midwifery legislation that is currently taking place in Washington is a consequence of recent activity under the state's current licensure statute, the strategies adopted by midwifery proponents, and the increase in out-of-hospital births. This chapter provides an overview of these developments.

Washington's Midwifery Statute

At the present time, state law provides for the licensure of midwives under the terms of legislation enacted in 1917 (see Appendix A). In general, the law requires that examinations be administered by the state Department of Licensing. Applicants for licensure must be graduates of legally recognized schools of midwifery, domestic or foreign, in which the program of training is of at least fourteen months' duration. The regulations indicate the subject areas to be covered by the initial licensing examination and permit examination on other topics to be required from time to time as circumstances warrant. Presumably, this latter provision was intended to allow midwives to be tested on new developments in maternity care that are relevant to their practice. The law requires midwives to secure the services of a physician when abnormal symptoms appear in mother or infant and to conform to state public health and vital statistics reporting requirements. Midwives are prohibited from prescribing medications and are limited to the use of "household remedy" after birth.

Prior to 1975 there is no record of anyone having been licensed under the midwifery provisions. This is hardly surprising given the short lived fate of the one or two midwifery schools that existed in this country during the first half of the century.[1] In the latter months of 1974, however, a Danish midwife applied for licensure. With no precedent or experience to go on, the Department of Licensing--with some hesitation--activated the administrative machinery and prepared an examination with the assistance of an outside medical consultant. In March of 1975, the first license was granted under the state's midwifery statute. Since then, fifteen other persons have obtained licenses. Eight have been foreign-trained midwives, most of whom had undergone basic nurse training. Five were graduates of the recently established Seattle Midwifery School (see p. 10). Two others, a physician's assistant and a registered nurse, did not undergo midwifery training per se. However, they were deemed eligible by the Department to sit for the examination on the basis of their having special education and clinical experience in maternal and child health care. As of this writing (August 1980) two persons have applied to take the licensing examination to be given in January 1981. Six students midway through the training program at the Seattle Midwifery School will be eligible for licensure upon graduation.

Since activating the midwifery regulatory process in 1975, the Department of Licensing has adopted several practices in an attempt to reconcile the provisions of an outdated statute with contemporary circumstances and expectations. Between 1975 and 1979, for example, the Department used a single medical consultant to devise examination on a one-by-one basis as applicants presented themselves. Examinations are presently held in January and July. Their format and content are determined by an informally constituted professional advisory group consisting of physicians, certified nurse-midwives, and licensed

midwives. Whereas the earlier applicants for licensure had strong midwifery credentials from abroad, the eligibility of some of the more recent applicants has not been quite so clear-cut. When in doubt, therefore, the Department now seeks legal advice on whether an applicant is properly qualified. There is also some discussion in the Department on including the professional advisory group (mentioned above) in revising applications for licensure.[2]

It appears that the Department of Licensing has acted cautiously and with good judgment in administering the provisions of the midwifery statute.

Pressure for Change from Midwifery Advocates

The trend toward out-of-hospital births, the presence of licensed midwives, and the status of the current midwifery statute are well known to those whose business or inclination it is to keep abreast of such matters. That midwifery licensure has become a public policy issue is, in part, a consequence of the active steps taken in recent years by the supporters of midwifery in the areas of legislation and training.

In mid-1977, the Washington State Midwifery Council (WSMC) approached the Committee on Social and Health Services of the state House of Representatives with a view toward revising the 1917 statute. Formed in 1977, the WSMC represents persons interested in midwifery, home birth, and other childbirth alternatives. Between November 1977 and March 1979 there were several public hearings on various legislative proposals favored by the WSMC. The provisions of these early proposals were extremely controversial. They included such topics as prescriptive drug authority, hospital admitting privileges, mandatory insurance coverage, and apprenticeship training.

A "compromise bill" was put before the House committee in late 1979. Under House Bill #2713 (see Appendix B), the Director of Licensing was empowered to promulgate standards for accrediting training programs (Section 6), develop and administer licensing examinations (Sections 6 and 7), provide for the maintenance of continued professional competence (Section 4), take disciplinary measures, and to act in other matters relating to professional licensure. The Director was to be assisted in these duties by a Midwifery Advisory Committee (Section 3) composed of professionals and consumers. With respect to scope of practice issues, the bill did not provide for the more general prescriptive drug authority as did the earlier proposals. It did, however, grant midwives the authority to "acquire and administer" three categories of drugs deemed necessary to basic midwifery practice--eye prophylaxis, anti-hemorrhagics, and local anesthetics (Section 7). The use of anesthetics implied the authority to suture or to perform and repair episiotomies, or both, although these functions were not explicitly mentioned in the bill.

Following a public hearing in January 1980, H.B. #2713 failed to win enough support to be moved out of committee for consideration by the House. Supporters of the bill emphasized its advantages in terms of greater freedom of choice for parents, more competition in the health industry which would probably lower the costs of care to consumers and third-party insurers, and a lessening of the amount of inappropriate medical intervention which would both lower costs and improve the quality of maternity services. The bill was opposed by the medical community, in general, and the obstetricians, in particular, who argued against the necessity for a midwifery licensure law and expressed a definite preference for nurse-midwives. The physicians contended that the health sector had made much progress in responding to demands for modified birth practice and that there was now sufficient diversity among practitioners and settings to

meet the needs of most individuals. The nursing profession, including nurse-midwives, took a neutral stance, stating that should the legislature see fit to continue the practice of midwifery, the standards for education and training should be consistent with standards recognized in the developed countries of Europe (see p. 22).

Concern was expressed about the bill's vagueness on scope of practice, accreditation of training programs, measurement of continued competence, and membership of the midwifery advisory committee. It is thought that another licensure proposal will be developed for consideration during the 1981 legislative session.

In addition to working through legislative channels, midwifery advocates have pursued other courses in pressing for a favorable reappraisal of the state's licensure statute. About the time the WSMC began discussions with state lawmakers in 1977, it was also decided that several useful purposes would be served by establishing a midwifery training program. Without a formal program, it would be extremely difficult for in-state residents wishing to become midwives to satisfy the educational requirements under the current or any future licensure statute. Indeed, several lay midwives who were active at the Fremont Women's Clinic Birth Collective in 1977 were denied permission to take a licensing exam as they had not undergone an organized course of instruction. As we have seen, the first seven persons to obtain licenses in this state between 1975 and 1979 had all received their training abroad. Moreover, since the approximately ten midwifery programs in the U.S. are not standardized, there was no assurance that any of them would meet the standards of present or future licensure laws in Washington.

A second objective of establishing an educational program was to demonstrate the potential for competence, an issue that

would surely surface in any legislative deliberations on midwifery licensure.

Finally, it was hoped that the existence of a school would add visibility and momentum to the efforts to re-establish midwifery as an option in childbirth in Washington.[4]

Following some fruitless discussions with representatives of one of Seattle's community colleges, the lay midwives from the Fremont Birth Collective mentioned above decided to develop a training program on their own initiative. The Seattle Midwifery School began operation in May, 1978. The present course of study includes approximately 350 hours of classroom instruction and a clinical component drawing mainly on the School's home birth services and its relationships with several of Seattle's publicly funded community clinics. To date, the School has not been able to negotiate supervised clinical rotations for its students in area hospitals. However, preceptorships with private physicians are being established, and current admission policies give preference to applicants who are able to arrange supervised preceptorships prior to starting the course of study at the school. In general, the period of training lasts from two to three years, depending on the time taken to complete the clinical requirements.[5]

Out-of-Hospital Births and Birth Attendants

In recent years, modern obstetrical care, as practiced in hospitals, has come under increasing scrutiny as both parents and professionals have raised serious questions as to the necessity, efficacy, safety, dignity, and cost of institutional maternity care. Critics charge that hospital obstetrics have become highly impersonal, that many of the routine practices are more for the convenience of medical and hospital staffs than for the health and safety of mothers and infants, and that some of these practices may even be harmful. At issue here are such items as the separation of mothers and babies, exclusion of family members from the birth environment, routine enemas, shaving, and IV's, multiple and unsupportive attendants, use of

analgesics, the predominance of the lithotomy position for birth (back flat with knees drawn up), restriction on food intake and mobility, and routine episiotomy.[6] Advocates for change contend that parents can and should have more control over these more discretionary aspects of maternity care.

Parents and a growing number of professionals are also voicing serious concern over aspects of medical obstetrical management of labor and delivery. The emphasis here is on aggressive management and excessive intervention. Many are particularly alarmed about the routine application of high technology in the absence of medical indication or in situations where its benefits have not been firmly established through rigorous scientific experimentation. There is presently much controversy centering on the long term effects of obstetric medications, electronic fetal monitoring, elective induction of labor, the cesarean section rate (which doubled between 1971 and 1976), the routine use of forceps, oxytocin challenge tests (a prenatal screening test), and other practices.[7]

A result of this controversy is that hospital obstetrics has come to be viewed by many as insensitive to human and personal needs and overly obsessed with pathology and the use of sophisticated equipment. Since the early 1970s, a small but growing number of parents have sought and received maternity care outside of hospitals---in the home, in practitioner offices and clinics, and more recently, in specially designed free-standing birth centers. After steadily falling over the past several decades, the percentage of U.S. births occurring outside of hospitals has risen from a low point of 0.6% in 1970 to 1.5% in 1977, as can be seen in Table 1. The trend in Washington has been somewhat more pronounced than in the nation (see Table 2) with out-of-hospital births rising from 0.6% to 2.5% during the same period. Again, it must be emphasized that the absolute number of these births is still quite small compared with total births. In 1979, for example, the figures were approximately 1,600 and 60,000 respectively.

Table 1

Percent Distribution of Live Births by Attendant and by Place of Delivery: United States Selected Years 1940-1977

Year	Physician in hospital	Not in hospital	
		Physician	Midwife, other, and not specified
1940	55.8	35.0	9.3
1950	88.0	7.1	5.0
1960	96.6	1.2	2.2
1970	99.4	0.1	0.5
1971	99.1	0.3	0.6
1972	99.2	0.2	0.5
1973	99.3	0.2	0.5
1974	99.2	0.3	0.5
1975	98.7	0.4	0.9
1976	98.6	0.4	1.0
1977	98.5	0.4	1.1

Source: Vital Statistics of the United States, Volume I, Natality. U.S. Department of Health and Human Services, National Center for Health Statistics. Published annually.

Table 2

Percentage of Live Births by Place of Occurrence Washington, 1970-79

Year	Hospital[1]	Maternity[2] home	Private residence	Other and not stated	Total not in hospital
1970	99.4	0.2	0.3	0.1	0.6
1971	99.1	0.1	0.6	0.2	0.9
1972	99.0	-	0.7	0.3	1.0
1973	98.2	-	0.8	1.0	1.8
1974	98.8	-	0.8	0.4	1.2
1975	98.4	-	0.8	0.8	1.6
1976	97.0	-	1.0	1.0	2.0
1977	97.5	-	1.2	1.3[3]	2.5
1978	97.3	-	1.2	1.5[3]	2.7
1979	97.4	-	1.2	1.4	2.6

1. Includes federal and non-federal facilities.
2. No longer in existence, these facilities (licensed under 18.46 RCW) served (a) unwed mothers and (b) rural areas. As of April 1980, childbirth centers are licensed under 18.46 RCW, as amended.
3. Includes a small number of births (less than 13) that were listed as "born on arrival" and that represent less than .05% of total live births.

Source: Vital Statistics Summary: Washington State, Department of Social and Health Services, Center for Health Statistics. Published annually.

To varying degrees, many hospitals have responded to demands for change by altering their policies and procedures. These modifications have ranged from simply permitting husbands into the delivery room to the creation of separate family-centered maternity units staffed by nurse-midwives where parents can have a substantial voice in how they wish their birth experience to proceed.[8] In this state, for example, a recent University of Washington survey indicated that in the near future approximately 65 percent of the state's hospitals intend to establish combined labor-delivery rooms or some other alternative birth arrangements within the hospital.[9] It is still much too early to assess the impact--if any--that these changes in hospital obstetrical practices will have on the prevalence of births outside of hospitals.

In the ongoing debate over the future of maternity services in this country, perhaps the most divisive issue is that of home birth. The rule rather than the exception at the beginning of this century, home birth became insignificant in the mid-1900s as the philosophy and practice of modern medical obstetrics moved childbirth into the hospital. There has been a small increase in home births in recent years. Despite a common perception that this occurred due to the activities of counter-culture types, religious sects, and other fringe groups, the available evidence indicates that the primary interest in birth at home is coming from urban, middle class individuals who are seeking greater flexibility and control of their birth experiences than are allowed in hospitals or other institutional settings.[10]

Since it represents a radical departure from the current norms of obstetrical practice and since there has been little substantive research on the subject, the controversy over home birth has been based as much on emotion and ideology as on reason and objectivity.

Our own assessment inclines us toward the view that home birth is neither safe nor hazardous in and of itself. Rather,

it appears more reasonable to suggest that the outcome of childbirth at home will be largely dependent on the conditions under which it takes place. While information is admittedly limited, the experience in this country and elsewhere indicates that home birth can be a viable option in maternity under certain conditions. These includes the careful selection of cases to include only low-risk pregnancies, a high level of parental responsibility and maturity, a suitable home environment, the management of the pregnancy by a skilled practitioner, and the ready availability of consultation and support services to handle the complications and emergencies that are bound to arise despite the best of selection procedures. If these principles are allowed to prevail, it is likely that planned home birth will be shown to be a childbirth alternative well within the bounds of acceptable standards of public health and safety.[11]

The interest of public officials in the rising number of out-of-hospital births in this state has had to do with the qualifications of those attending these births. There has been some concern that parents wanting to give birth outside of the hospital setting are turning to practitioners who may not have the knowledge and skills necessary to ensure a high standard of care. The available data, however, do not indicate a major problem. As portrayed in Table 3, birth certificate information supplied by the Department of Social and Health Services revealed that, in 1978, about 80 percent of births occurring outside of hospitals were attended by licensed practitioners. The 20 percent that were not took place mainly in the home, accounting for 41 percent of the births in that setting.

Describing the unlicensed attendant group is difficult owing to the substantial number of births in the "Father/Midwife" group. This designation was apparently used by fathers where the birth certificate asked for information as to the type of attendant.

Table 3

Out-of-Hospital Births By Place and By Attendant - Numbers (Percentages)

Washington, 1978

Attendants	Home	Birth Center	Chiro.-Naturo. Office	Misc. Other	En Route	Unknown	Attendant Totals
Licensed							
Physician	186 (23.4)	450 (63.1)		18 (66.7)	86 (81.9)	2 (40.0)	742
Osteopath	18 (2.3)	43 (6.0)		4 (14.8)	4 (3.8)	-	69
Naturopath	29 (3.6)	11 (1.5)	15 (93.7)	-	-	-	55
Cert.-Nurse Midwife	48 (6.0)	196 (27.5)	-	1 (3.7)	-	-	245
Licensed Midwife	182 (22.9)	11 (1.5)	-	-	-	-	193
Emergency Med. Team	5 (.6)	-	-	-	1 (1.0)	-	6
Subtotals	468 (58.8)	711 (99.7)	15 (93.7)	23 (85.2)	91 (86.7)	2 (40.0)	1,310 (79.0)
Unlicensed							
Father-Midwife	208 (26.1)	-	-	2 (7.4)	3 (2.8)	1 (20.0)	214
Father	21 (2.6)	-	-	1 (3.7)	-	-	22
Relative	26 (3.3)	-	-	1 (3.7)	-	2 (40.0)	29
Lay Midwife	61 (7.7)	2 (.3)	1 (6.3)	-	11 (10.5)	-	75
Unknown	12 (1.5)	-	-	-	-	-	12
Subtotals	328 (41.2)	2 (.3)	1 (6.3)	4 (14.8)	14 (13.3)	3 (60.0)	352 (21.0)
TOTALS	796 (100)	713 (100)	16 (100)	27 (100)	105 (100)	5 (100)	1,662 (100)

It is possible that this terminology was intended to mean "father acting as midwife." However, in view of the large number involved it seems plausible to suggest that lay midwives may have attended some of these births and that the fathers signed the birth certificates in order to protect their chosen practitioners from possible legal or other reprisals. This same rationale, of course, may also apply to the other categories of unlicensed attendants. If this is indeed the case, then the 75 births attributed to unlicensed lay midwives in Table 3 may be substantially understated.

It appears that in this state there are opportunities for parents wanting an out-of-hospital birth experience to receive the services of qualified practitioners. While physicians and nurse-midwives predominate in birth centers, the presence of licensed midwives has increased the availability of competent practitioners to those desiring home birth. Were it not for the availability in this state of a variety of properly licensed practitioners willing to respond to the demand for non-traditional maternity services, it is indeed likely that many more births would come under the care of persons who may not possess qualifications necessary for a high standard of service. For example, in Oregon where there is no regulatory provision for the practice of midwifery outside of nursing, only about 60 percent of non-hospital births are attended by licensed practitioners compared with 80 percent in Washington. With respect to home birth, the comparable figures are 43 percent and 60 percent respectively.[12]

The state can indeed be said to have an interest in the outcome of birth. The mismanagement of pregnancy can result--although this is a rare occurrence--in death. More significantly, inadequate or inappropriate supervision can have untoward effects which are not readily detectable at birth, but which can have serious

long term effects on growth and development. Efforts to safeguard mothers and infants against incompetent birth attendants, therefore, are a legitimate activity of government, and it is in this context that the current debate over midwifery must be viewed.

Chapter II

MIDWIFERY: AN OVERVIEW

Throughout history, every society has sought to provide assistance to mothers during childbirth. Traditionally, this task has fallen to the midwives, female birth attendants who, with little or no training, gave aid and comfort to women in labor. Even today in many parts of the world, particularly in undeveloped countries, these traditional midwives are the principal source of maternal care. It has been estimated that, worldwide, two-thirds of births occur without the assistance of a trained attendant.[13]

Modern times, however, have also witnessed the emergence of trained professional midwives capable of rendering a wide spectrum of services in keeping with generally accepted standards of obstetrical care. While professional midwifery, whether combined with or separate from nursing, is now being cautiously regarded in the U.S., it is a firmly established and well accepted component of maternal and child health services in most developed countries, particularly in Europe. This is an extremely important distinction that should be recognized when considering what should be the proper stance toward the regulation of midwifery in this country.

As policymakers in this state and elsewhere contemplate their response to public demands for changes in maternity care, perhaps the experience of other developed countries might hold some useful lessons. This chapter will focus on the perceptions and practices of professional midwifery in Europe.

An American perspective is also a necessary part of this discussion. Midwives, be they trained or untrained, their practice legal or illegal, have always been active in this country.

Widely practiced in the early 1900s, midwifery diminished sharply toward mid-century with the advent of modern medical obstetrics and is beginning to appear again, albeit for different reasons and in a different form. This evolution will also be discussed.

International Perspectives

The recognition and regulation of midwifery has a long history in the developed countries of Europe, dating back several hundred years in Great Britain and Sweden, for example.[14] Throughout much of Europe, the laws regulating midwifery, the educational system in which it was taught, and the professional associations that represented and governed it were largely in place at the turn of this century. As such, professional midwifery in Europe preceded the birth of modern obstetrics and was presented and incorporated into the health systems of the various nations. The respectability and acceptance which this chronology assured is conveyed in the opening paragraph of a recent report of the Council of Europe which stated:

> From time immemorial, the midwife has played an important part in obstetric care. In recent decades, others have come to work beside her in this field, such as the general practitioner and the specialist, the hospital nurse and the district nurse, the physiotherapist and the dietician.[15]

In addition to holding midwifery in high regard, international health agencies view its professional scope of responsibility in rather broad terms. In 1966 the World Health Organization declared:

> A midwife is a person who is qualified to practice midwifery. She is trained to give the necessary care and advice to women during pregnancy, labour and the postnatal period, and to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor, and to carry out emergency measures in the absence

> of medical help. She may practise in hospitals, health units or domiciliary services. In any one of these situations she has an important task in health education within the family and the community. In some countries, her work extends into the fields of gynaecology, family planning and child care.[16]

A similar definition of midwifery was adopted in 1972 by a joint working party of the International Federation of Gynecology and Obstetrics and the International Confederation of Midwives:

> A Midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and had acquired the requisite qualificiations to be registered and/or legally licensed to practise midwifery.
>
> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the new born and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
>
> She has an important task in health counselling and education, not only for patients but also within the family and community. The work should involve ante-natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care.
>
> She may practice in hospitals, clinics, health units, domiciliary conditions or any other service.[17]

When examining the concept and practice of midwifery as they exist in Europe, several general impressions stand out.

First, <u>the primary focus of midwifery is the medically uncomplicated, or normal, pregnancy</u>. There is a recognition of the difference between the abnormal and the normal aspects of pregnancy and a belief that midwives are most appropriate in dealing with the latter. As the Council of Europe report stated:

> "The obstetrician is, because of his training, pre-eminently qualified in the pathological aspects of obstetrics, whereas the midwife is best equipped to deal with the physiological aspects, i.e., for normal obstetrics."[18]

A noted Dutch obstetrician put it another way when he said the midwife is the "specialist in normal obstetrics" and that "People who have studied for more than ten years at a university are not suited to sit down for hours watching a natural process taking place as a routine."[19]

A second observation is that in many European countries, the laws and regulations governing midwifery provide for a broad scope of practice. Midwives are allowed to perform prenatal screening, to manage normal deliveries on their own responsibility, including the use of certain medications and minor surgical procedures, to provide postnatal and neonatal care, and, more recently, to be involved in certain family planning activities and gynecological care.

The breadth of midwifery as it is perceived in Europe is illustrated by the recommendation of a joint working party of obstetricians and midwives and public officials that met in Copenhagen in 1969. With respect to the scope of practice, the working party agreed that:

> All midwives should receive training in every aspects of prenatal care and the recognition of abnormalities. Having received such training they should be permitted to conduct prenatal care on their own responsibility.
>
> The responsibility for the conduct of normal labour falls within the province of every midwife.
>
> A midwife should be responsible for the postnatal care of the mother for a minimum period of ten (10) days. In some countries this may be extended to the full postnatal period of six (6) to eight (8) weeks.
>
> A midwife should be responsible for the care of the newborn baby for a minimum period of ten (10) days. After this period further care would depend on the facilities available.

> A midwife should be taught the general principles of family planning. In some circumstances she may be encouraged to assist in clinics and can have a valuable role in motivating patients to seek advice on family planning.
>
> A midwife should be so trained that she can detect and differentiate between the normal and the abnormal. If any abnormality occurs, it is her responsibility to call medical aid.[20]

Third, midwives are considered capable of practicing in hospitals, in clinics, in maternity centers, and in the home. The presence of a midwife in these settings is well accepted by professionals and patients alike.

Fourth, midwifery is viewed as a profession separate and distinct from nursing. Even where midwifery education and nursing education are combined to one extent or another, midwifery is regulated under separate statutory and administrative authorities.

Finally, on the issue of educational preparation, the European consensus seems to be that while some nursing skills are useful and necessary in the practice of midwifery, one need not first be a nurse in order to be a competent midwife. For example, the joint working party mentioned above made the following recommendations which appear to encourage flexibility.

> A student should have 12 years' general education before starting midwifery training.
>
> The age for entry should be at least 18 years.
>
> The minimum period of midwifery training should be three years, one year of which should be allocated to nursing training. If a candidate is already a general trained nurse, she may take midwifery training in two years.
>
> The hours of theoretical instruction should occupy a minimum of 1/3 (one-third) of the total training time.
>
> In addition to teaching in obstetrics and neontal paediatrics, the syllabus should include some instruction in basic sciences,

> parentcraft, preparation for childbirth, community care, analgesia, epidemiology, certain aspects of gynaecology and family planning.
>
> During training a student midwife should undertake the care of not less than 50 women in the prenatal period, 50 women during the course of labour and 50 women in the early post-natal period.
>
> No specified number of domicilary confinements should be required but experience in the care of mother and baby at home is advisable.[21]

In practice, countries adopt a variety of approaches. In France, Denmark, and The Netherlands, midwifery training is entirely separate from nursing education. In others, there are two paths of entry into midwifery. Students can enter training directly (i.e., without a nursing background) or, in the case of qualified nurses, there is a specialized training course of lesser duration than the basic midwifery program. This dual pathway approach is found in Germany, England and Wales, and Belgium. Here again, nurse training is not a prerequisite to midwifery, though it is allowed for. In Norway, Sweden, and Scotland, only fully qualified nurses may enter into midwifery training programs.

Generally speaking, where midwifery education is independent of nursing, training programs are two or three (mostly three) years. Where nurses are allowed to take advanced training in midwifery, the programs last from one to two years. To be considered for entry into the training programs, applicants must generally possess a secondary school education, and the minimum age limits range from eighteen to twenty-one.[22]

While there may be valid arguments both for and against the combination of midwifery and nursing, the European experience suggests that both approaches can work well--either separately or side by side--and that each nation must decide which alternatives best meet its needs.[23]

While the principles which have been described here are generally accepted, countries must vary to take account of their political, economic, and cultural heritage. While the European Economic Community is presently trying to devise some minimum professional standards that would be applicable to all member countries, differences will clearly remain, and the need for them is recognized.[24]

Although the European experience offers useful guidelines and perspectives, some caution must be exercised in applying the European model to midwifery practice in America. As mentioned earlier, midwifery has a long history in Europe, reaching back several hundred years, and it is now an established profession. Midwives, furthermore, attend the great majority of births in Great Britain, Germany, Sweden, Denmark, and The Netherlands.[25]

Midwifery in Europe enjoys the high regard of government. In the Federal Republic of Germany, for example, a midwife is required by law to be present at every birth.[26] Many European midwifery schools are directly supported by government. Another factor to be borne in mind is that, in Europe, public policy decisions affecting midwifery are made at the national level. Therefore, any changes in educational requirements or practice patterns are implemented simultaneously and uniformly throughout any given country.

Finally, as regards the important matter of services financing, the various European national health insurance schemes pay for the services of midwives whether they are salaried employees (as most are) or independent practitioners working on a fee-for-service basis. In The Netherlands, for example, where about half of the births take place at home, national insurance pays the family for the cost of birth at home only if it is managed by a midwife. Families wanting a physician present must bear the costs themselves, unless they have private insurance which recognizes physician attendance in the home.[27]

In most of Europe, professional midwives--be they nurses or not--are a distinct and integral component of the medical care system. They account for the majority of births, have ready access to all specialty and back-up services, and enjoy the respect and support of the professional community, the public, and the government. There is little question of European physicians refusing to cooperative with midwives at any stage in the care of a pregnant woman. There is little question of hospitals refusing to accept midwives either as employees or as independent, community-based practitioners. And there is little question of health insurance programs, public or private, refusing to pay for the services of midwives.

As will be described below, these conditions do not apply in the United States, where midwifery practice--both in and outside of nursing--is extremely limited and highly controversial. Therefore, while the conditions that govern the practice of midwifery in Europe may provide useful direction to the current debate in Washington, it does not seem appropriate to apply them rigidly at this time. Modern European midwifery has evolved gradually over many decades, whereas its ultimate place in the United States will not be determined for many years. Under these circumstances, it may be prudent for state policymakers to allow a reasonable level of flexibility in the formulation of regulatory policy, so that midwifery develops in a manner that best responds to prevailing medical, societal, and political attitudes and conditions. To impose, without alteration, the European standards for the training and credentialing might be to insist on uniformity at a time when the public interest might be better served in the long run by permitting diversity and versatility.

Midwifery in the United States

In contrast to the European experience, midwifery has been largely excluded from modern maternity in this country. This occurred for the same reasons that ensured midwifery's success abroad. Whereas professional regulation was firmly established in Europe at the turn of the century, it was only beginning to develop here. Furthermore, while such activities were national in scope overseas, professional regulatory matters in the U.S. were left to the states to deal with individually as they deemed necessary. Consequently, about thirty-four states enacted laws for the control of midwives, all having varying provisions and levels of restrictiveness. Even local health departments adopted their own measures to govern the activities of midwives.[28] These early state and local measures constituted the "granny midwife laws" frequently referred to in the debate on midwifery outside of nursing.

Unlike in Europe, American midwives in the early 1900s had no professional associations or educational systems upon which to build and maintain professional standards and recognition. There were only three formal midwifery school in the U.S. in the early 1900s.[29] Training programs were mounted by many local health departments in certain parts of the country (with some support from the federal Children's Bureau during the 1920s). These efforts depended highly on local finances and initiatives which varied widely.[30]

That midwifery failed to mature in the early part of this century is also owing to ethnic considerations. In contrast to the common language and common heritage shared by midwives in foreign countries, midwives in America had tremendously diverse backgrounds. They were found largely among the poor black population in the South and the various immigrant groups that settled in the major metropolitan areas.[31]

These regulatory, professional, and demographic patterns were significant limitations on midwifery's ability to attain professional stature and respect. As one observer stated, "The

more localistic and diversified the system of legitimization and control of midwives, the less likely would there be internal visibility and a drive for professionalism and institutionalization, i.e., the less likely the development of midwifery as a viable institution."[32]

Of equal, if not greater, importance to the virtual disappearance of midwifery in the first half of this century were the unfavorable view of midwives on the part of the medical profession. The early medical literature gave much emphasis to the "midwife problem" although the term was never clearly defined.[33] Midwives were characterized as being "full of arrogance and superstition," "filthy and ignorant," "a relic of barbarism" and even "un-American."[34] It appears that many doctors viewed midwives as being largely responsible for this country's high maternal mortality rate in the early 1900s.

When the evidence was examined, however, the connection did not hold. In a 1933 report on maternal mortality in New York City, the New York Academy of Medicine concluded that:

> . . . contrary to the generally accepted opinion, the midwife is an acceptable attendant for properly selected cases of labor and delivery. . . and that her results are as good as those obtained by the physician under what are justly regarded as comparable circumstances and for comparable cases.[35]

The Academy also reported that the midwives more commonly attended, with "better than average" results, the poor and foreign born, ". . . a group of women whose childbearing as a group is more hazardous than average. . ."[36]

At about this time, a White House Conference on Child Health and Protection (presided over by prominent medical and obstetrical leaders) gathered information on maternal mortality and on the performance of midwives from various parts of the country. The Conference concluded that "The high maternal mortality rate in this country is a reflection on the training and education of

the personnel responsible for furnishing maternity care."[37] In other words, the high death rate was the product of a generally poor standard of obstetrical care and not the result of the activities of any particular group.

Referring to the reports on midwifery practice, the Conference report stated:

> . . . statistics show very favorable maternal mortality rates in the practice of midwives, in general, and remarkably low rates for the mothers attended by trained and supervised midwives.[38]

Despite these findings and the recognition given to the important contributions of European midwives, the medical leadership of the time saw no permanent role for midwives in the development of modern obsteric services. The prevailing view was that maternity services should be based in hospitals and should be supervised by qualified physicians assisted by trained nurses, a strategy which, in the words of the conference report, ". . . leaves the midwife out of the ultimate scheme." The hope was that physicians and nurses working together could " . . . supplant the European midwifery system to the advantage of both mother and infant, and to all concerned."[39]

In the short run, of course, the midwife had to be accepted and dealt with, as she was the only source of care in many parts of the country, ". . . where topography, race, social, and economic situations made it impossible to replace her at the present time or even in the immediate future."[40] The Conference, therefore, recommended that training opportunities be made available to midwives at the local level and that local health authorities develop standards for licensure and education.[41]

The scenario envisaged at the White House Conference is, in large part, an accurate portrayal of what took place in the first part of the century. Births moved from the home to the hospital maternity units staffed by physicians and nurses. Where state and local health authorities acted at all, they adopted widely

divergent measures for the control and supervision of midwives. The end result was that the proportion of births attended by midwives fell from about fifty percent in 1900[42] to about one percent in 1950 (see Table 1, p. 12).

In the latter half of this century, midwifery has begun to make a small but noticeable reappearance in the U.S. This has come about as a result of developments in the nursing profession, the women's movement, and the concerns of parents and professionals about the quality and costs of maternity services as presently organized.

Whereas midwifery once flourished mainly among the poor and the geographically isolated, it is now emerging among the urban middle classes. Among present-day midwives, some are nurses; others are not. In this latter group, some midwives have legal recognition in the states where they practice (as in Washington), while others practice outside of the law or where the law has been silent. In neither case do they play a major role in the delivery of maternity care as do their European counterparts.

Certified Nurse-Midwives

To date, the greatest degree of recognition has been given to certified nurse-midwives (CNM), registered nurses who have taken from eight months to two years of advanced training at one of the approximately twenty-four university-affiliated programs accredited by the American College of Nurse-Midwives.

Nurse-midwifery first appeared in this country in 1925 with the establishment of the Frontier Nursing Service, which employed British-trained nurse-midwives to serve poverty-stricken, rural areas in Kentucky.[43] In 1931, six years later, the Maternity Center Association initiated the first nurse-midwifery education program in New York City in order to meet the needs of families that did not have access to basic maternity care.[44]

Nurse-midwifery has developed slowly but steadily. The American College of Nurse-Midwives was founded in 1955. Nurse-midwives achieved a large measure of professional recognition in 1971, when the College issued a joint statement on maternity care, together with the American College of Obstetricians and Gynecologists and the Nurses Association of the American College of Obstricians and Gynecologists. The statement declared that as part of a ". . . health team . . . directed by a qualified obstrician," nurse-midwives ". . . may assume responsibility for the complete care and management of uncomplicated maternity patients."[45] The team concept is interpreted broadly so as to allow a variety of working arrangements and either direct or indirect medical supervision. In all cases, however, the understanding is that obstetrical consultation must be available and that there must be a written signed agreement (or protocol) defining the nurse-midwife's scope of activities and referral and consultation policies.[46]

While there has been much activity around the country in support of nurse-midwifery, it is as yet only a very small element in American maternity care. A 1976 survey indicated that there were about one thousand nurse-midwives in the United States, slightly more than half of whom were involved in clinical practice. Of this latter group, eighty-four percent managed deliveries. In 1976, it was estimated that nurse-midwives accounted for only one percent of the births in this country.[47]

Nurse-midwives in clinical practice work in a variety of settings. The largest single group (about forty-six percent) work in hospitals. Public health agencies account for fourteen percent and another thirteen percent are in private practice with physicians. Nurse-midwives also practice in the U.S. military and in prepaid health plans. About ten percent practice in maternity services operated predominantly by nurse-midwives; these services are mostly in hospitals but may be organized by nurse-midwives in private practice outside of hospitals.[48]

Few nurse-midwives are, in fact, active clinically in community-based practice. Of the 548 who managed deliveries in 1976-77, only 43 (about 8 percent) did so in non-hospital settings.[49]

While the training and orientation of nurse-midwives are geared toward the exercise of independent judgment, there are limits on their level of independence. Not only are they closely bound to physicians in a professional sense, as illustrated by the "team concept" and "written protocols" mentioned above, but also many state laws and regulations describe the relationship between the physician and the nurse-midwife as supervisory.[50]

The association with physicians, both at the official level and in clinical practice situations, has unquestionably served nurse-midwifery well in terms of professional status and work opportunities. Indeed, given the medical community's historical opposition to midwives, the formal ties to physicians were probably a reasonable and necessary step toward securing a foothold in the health system. Increasingly, however, there is some concern among nurse-midwives that their dependence on medical approval, together with their hospital-based training, prevents them from responding to the growing demand for non-traditional maternity services.[51]

Clearly, the development of nurse-midwifery will depend largely on prevailing medical attitudes and preferences at the local level. Although nurse-midwives have consistently demonstrated their ability to deliver a high standard of care since the early days of the Frontier Nursing Service,[52] their acceptance by physicians varies widely from state to state. In Washington, for example, nurse-midwives provide a full range of clinical services both in and out of hospitals under the regulatory authority of the State Board of Nursing. To date, there has been no major conflict with organized medicine. In New Jersey, regulations governing nurse midwifery practice have been the subject of a prolonged dispute between the Board

of Nursing and the Board of Medical Examiners. At issue have been such questions as whether nurse-midwives should be allowed to perform episiotomies (something for which they are trained) and whether they should be allowed to practice outside of hospitals (something for which there is growing precedent around the country).[53]

In general, the level of harmony and cooperation between physicians and nurse-midwives will be heavily influenced by the potential for economic and professional rivalry between the two groups. It is clear that the early physician supporters of nurse-midwifery envisaged it as appropriate in a hospital setting, requiring medical supervision, and occurring in circumstances that did not permit competition for patients.[54] To the extent that nurse-midwives demand and obtain more autonomy, the potential for conflict with physicians will increase.

The ultimate impact of nurse-midwifery on maternity services will depend not only on physician attitudes but will also be a function of consumer demand, the reimbursement policies of third-party insurers (public and private), the legislative and administrative decisions of state and federal government, and the pressure brought to bear by nurse-midwives themselves.

Midwifery Outside of Nursing

That nurse-midwifery has made noticeable advances over the past ten years is a consequence of effective leadership, organization, educational and professional status, patient acceptance, government support, and--from time to time--spirited debate and political activism. The same cannot be said for midwifery outside of the nursing profession.

In one sense, the two branches of midwifery can be said to share a common history in that both have their origins in unconventional attempts to meet perceived gaps in the provision of maternity care. In the case of nurse-midwifery, the focus

was on the economically disadvantaged and geographically isolated. Outside of nursing, midwifery has grown in response to recent demands for alternatives to obstetrical services as provided by physicians in hospitals. Furthermore, our inquiries among the two groups in this state and elsewhere have revealed frequent expressions of a common purpose and philosophy and an interest in forming closer working relationships. Along these lines, within the American College of Nurse-Midwives there has been ongoing debate over the possibility of an alliance with non-nurse-midwives.[55] Nevertheless, there are several important differences between these groups of practitioners.

Whereas the acceptance of nurse-midwives has grown steadily, those wishing to offer maternity services outside of nursing have experienced considerable difficulty in obtaining recognition and legitimacy. These individuals have had no educational or professional base from which they could achieve respectability and status. Although there are about ten training programs in the country, the limited information that could be gathered suggests that, for the most part, they are loosely organized and vary widely in their sponsorship, structure, teaching orientation, and stability. Moreover, none is accredited or otherwise endorsed by a public or private body that could speak authoritatively on the quality of instruction provided. As to an organized leadership component, no such element exists. At present, there are independent advocacy groups (the Washington State Midwifery Council, for example) that have formed in some states to disseminate information and press for favorable legislation and regulatory policies. Should midwifery outside of nursing gain momentum in the states, it is probable that a nationally-based association will be formed. Perhaps at some point nurse-midwives and their non-nurse counterparts will combine under one umbrella organization as they did overseas with the creation of the International Confederation of Midwives. In the near future, however, the forces advocating the practice of midwifery independent of nursing are likely to retain a local focus.

Another factor hindering the development of midwifery separate from nursing is that few states have taken positive steps to respond to this recent phenomenon. Most states have either repealed or administratively deactivated the midwifery laws of the early 1900s. At one point, approximately thirty-four states had explicit provisions. A 1976 survey indicated that this number had fallen to sixteen.[56] Since then, more states have discontinued midwifery regulatory authorities. At present, only eleven states have statutes or regulations permitting the practice of midwifery independent of nurse-midwifery. These states are Arizona, Connecticut, Florida, Minnesota, Missisippi, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, and Washington.

In addition to explicit regulatory provisions, the legitimacy of midwifery has been established by different means in other states. In Oregon, a recent opinion of the state attorney general held that midwifery independent of nursing is within the scope of the law so long as it excludes the performance of episiotomies or the use of medications.[57] In some states the courts have recognized midwifery as separate from nursing. In others, they have concluded that childbirth is a natural function and hence that midwifery does not constitute the practice of medicine.[58]

While the majority of state midwifery provisions are remnants of the early 1900s, in three instances (Arizona, New Mexico, and Rhode Island) they represent recent attempts by state governments to deal with the reality of midwifery outside of the established maternity care system. In each case, action was initiated by a state health department and involves a qualifying examination, case reports by midwives, and oversight by a professional advisory committee (see Appendixes C, D, and E). Arizona's program was the first to be established--in February, 1978--and state officials have reported a generally favorable experience in terms of safety factors and workability of the program.[59]