South Dakota Legislative Research Council

Issue Memorandum 97-14

LAY MIDWIFERY:

A REASONABLE ALTERNATIVE?

Background

Direct-entry midwives, also known as lay midwives, traditional midwives, or independent midwives, are not required to be nurses, and their qualifications may be established by formal education or by apprenticeship. Direct-entry midwives practice independently from physicians and will attend births at home.

South Dakota currently licenses certified nurse-midwives and regulates their practice under SDCL 36-9A. Certified nurse-midwives are registered nurses who have additional formal training in midwifery, pass a national examination, and are jointly certified by the Board of Nursing and the Board of Medical and Osteopathic Examiners. They practice under the supervision of a licensed physician and attend births in a hospital.

The number of South Dakota citizens desiring to have babies delivered at home by a direct-entry midwife has been the impetus for legislation[1] introduced in the 1995, 1996, and 1997 sessions.

The legislation attempted in the first year to provide for the regulation of direct-entry midwives under a Board of Certified Midwives in the Department of Commerce and Regulation. The bill would have required applicants for licensure to meet specified requirements for education and experience, to take an examination, and to be trained in cardiopulmonary resuscitation of adults and infants. The bill enumerated the areas in which the board could adopt rules, including the obtaining of informed consent and the reporting of vital information.

The legislation introduced in 1996 would have permitted the practice of independent midwifery in this state. The bill defined the practice of independent midwifery and excluded practices that are included in the practice of medicine. The bill stated that the practice of midwifery was not the practice of medicine, nursing, counseling, or any other profession licensed pursuant to Title 36 of the South Dakota Codified Laws.

The bill introduced this year simply affirmed the right of a parent to have a traditional independent midwife present at the birth of a child and defined a traditional independent midwife.

None of the legislation received sufficient legislative support in any of the three years to pass out of the committee in the house of origin.

The Issues in South Dakota

Proponents of the legislation believe that childbirth is a natural phenomenon that under normal circumstances can safely occur at home and that it is not analogous to a sickness or disease to be treated through the practice of medicine. They believe that home birth is a safe, cost-effective, and psychologically satisfying way for birth to occur. They believe that they have a right to determine the setting for the birth of their children and to decide who is to attend the birth. Most of the proponents are parents. Others include lay midwives who would be willing to attend home births in this state and a medical statistician, Dr. David Stewart[2].

Dr. Stewart is executive director of the International Association of Parents and Professionals for Safe Alternatives in Childbirth--NAPSAC International. He is a medical statistician with special training in obstetrics and is a certified childbirth educator. He testified by telephone conference before the House Health and Human Services Committee as a proponent of 1997 HB 1303.

Opponents believe that the normal care of mothers and babies before, at, and after childbirth is the practice of medicine and that the health and safety of mothers and children require that the birth occur in a hospital setting. South Dakota's statutes reflect this position. The language in SDCL 36-9A-13 specifically delegates to certified nurse-midwives (CNMs) the prenatal and postpartum care of the mother-baby unit and the management and direction of the birth as medical functions. Many health insurers support this position by denying payment for home births. Opponents of the legislation allowing direct-entry midwifery include the South Dakota Board of Nursing, The South Dakota Nurses Association, the South Dakota Medical Association, and certified nurse-midwives.

Statistical Perspectives

Births attended by midwives, whether nurse-midwives or direct-entry midwives, are rare, and home births are even more rare.

The National Center for Health Statistics, Centers for Disease Control, reported in 1991[3] that in 1989 there were 11,383 (.28 percent) planned home births attended by midwives out of 4,040,958 total births. Of these births, one-third were attended by nurse-midwives.

Births attended by midwives have increased over the last twenty years. Although the number of such births remains low as a percent of all births, the trend is upward. The Metropolitan Life Insurance Company reported[4] that in 1994 there were 218,466 births attended by midwives in the United States, seven times more than the 29,413 births attended by midwives in 1975. The percent of all births attended by midwives rose from 0.9 percent in 1975 to 5.5 percent in 1994. Most of the births attended by midwives were attended by certified nurse-midwives (CNMs) and occurred in hospitals. Six percent of these births, 13,108, were attended by other midwives, and these births are increasingly occurring outside hospitals.

Regulation of Direct-Entry Midwives in Other States

The national organization of certified nurse-midwives, the American College of Nurse-Midwives (ACNM), lists[5] twenty-two states which regulate or permit the practice of direct-entry midwives: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Kentucky, Louisiana, Minnesota, Montana, New Hampshire, New Jersey, New York, New Mexico, Oregon,

Pennsylvania (permitted by case law), Rhode Island, South Carolina, Texas, and Washington. According to the ACNM, the practice of direct-entry midwives is not allowed in Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Nevada, North Dakota, Ohio, South Dakota, Vermont, West Virginia, and Wisconsin.

In the remaining states, the status of regulation is unclear. In some states, midwives are allowed to practice, not because they are regulated, but because they are specifically exempted from a state's medical practice act or because the practice of midwifery is not considered to be the practice of medicine and the practice of midwifery is not within the scope of the state's medical practice act.

In most states, certified nurse-midwives are regulated as advanced practice nurses by boards of nursing or joint boards of nursing and medical practice while direct-entry midwives, if they are regulated at all, are regulated by a department of health or by a separate professional licensing board.

The Midwives Alliance of North America (MANA), the national organization of direct-entry midwives, analyzes the legal status of direct-entry midwives in more detail. A chart containing MANA's state-by-state analysis is attached to this memorandum.

Recent Legislation in Other States

Washington, Alaska, Colorado, and Florida[6] have recently revised or enacted their statutes on midwifery. Colorado and Florida specifically note the need in their states for the independent practice of midwifery. They all register, certify, or license direct-entry midwives and set standards for education and experience. They all require an examination, such as the nationally recognized examination of the North American Registry of Midwives (NARM). Three of the four require the use of an informed consent and Washington requires a form that is used to inform the patient of the midwife's qualifications.

Florida Governor Lawton Chiles in a letter sent to hospitals[7] urged their cooperation in working with direct-entry midwives and stated as a goal of the Healthy Start initiative that fifty percent of low-risk pregnant women in Florida receive care by midwives by the year 2000.

Pros and Cons

Persons who advocate allowing the practice of independent direct-entry midwives want the freedom to choose where their babies are to be born and who should deliver them. They believe that the attendance of a midwife at a normal, low-risk home birth offers them a low-cost alternative to a hospital setting. A midwife gives more personal care to the mother than a busy obstetrician who may or may not be present at a birth. A midwife uses fewer drugs than an obstetrician and intervenes less in the birth process, resulting in fewer Cesarean sections and fewer infant deaths. The risk of infection for a mother and her baby are actually less at home than at a hospital.

Persons who oppose independent midwifery believe that the health and safety of baby and mother are paramount, and they believe that a hospital setting is necessary for childbirth. They think that a home is not a safe environment and emphasize the things that can go wrong at a home birth. They feel that midwives do not refer emergencies soon enough. They question the credentials of midwives and refuse to work with them.

Conclusion

Some states are beginning to recognize that certified direct-entry midwives can be part of a health care team that complements maternity care without threatening either obstetricians or certified nurse-midwives. Hard data on which to base decisions about the independent practice of direct-entry midwifery are lacking, but with the renewed interest in independent midwifery and the recent legislation in other states allowing practice by certified direct-entry midwives, states will be able to gather the statistics that support the position of either the pros or the cons. Legislators will then be able to decide the issue on the basis of facts.

Given the nature of the opposition, it will be difficult to pass midwifery legislation in South Dakota. Until the state policy makers can see, and have proven to them, the value of a safe and low-cost alternative to current methods of delivering childbirth services, the pros may continue to see their legislation defeated.

Endnotes

1. 1995 HB 1303, An Act to provide for the regulation of direct-entry midwives; 1996 HB 1246, An Act to permit the practice of independent midwifery; and 1997 HB 1154, An Act to affirm the right of a parent to have a traditional independent midwife present at the birth of a child.

2. Dr. David Stewart has degrees in mathematics and physics and a Ph.D. from the University of Missouri at Rolla, 1971. He testified as a proponent of HB 1303 by telephone conference on February 14, 1997.

3. Cited by Suzanne Hope Suarez in "Midwifery is Not the Practice of Medicine," *Yale Journal of Law and Feminism*, Spring 1993, Vol. 5, No. 2, p. 315.

4. MetLife Statistical Bulletin Recap: Births Attended by Midwives, Metropolitan Life Insurance Company, 1997.

5. American College of Nurse-Midwives. *Nurse Midwifery Today: A Handbook of State Legislation.* Revised edition, 1995.

6. Alaska: AS 08.65.010 et seq. (1992); Colorado: Colo. Rev. Stat. §§ 12-37-101 et seq. (1993); Florida: Fla. Stat. §§ 467.001 et seq. (1994); Washington: Wash. Rev. Code Ann. §§ 18.50.003 et seq. (1991).

7. Letter from Lawton Chiles, Governor of Florida, dated November 8, 1996.

This issue memorandum was written by Rosemary Quigley, Administrative Rules Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.