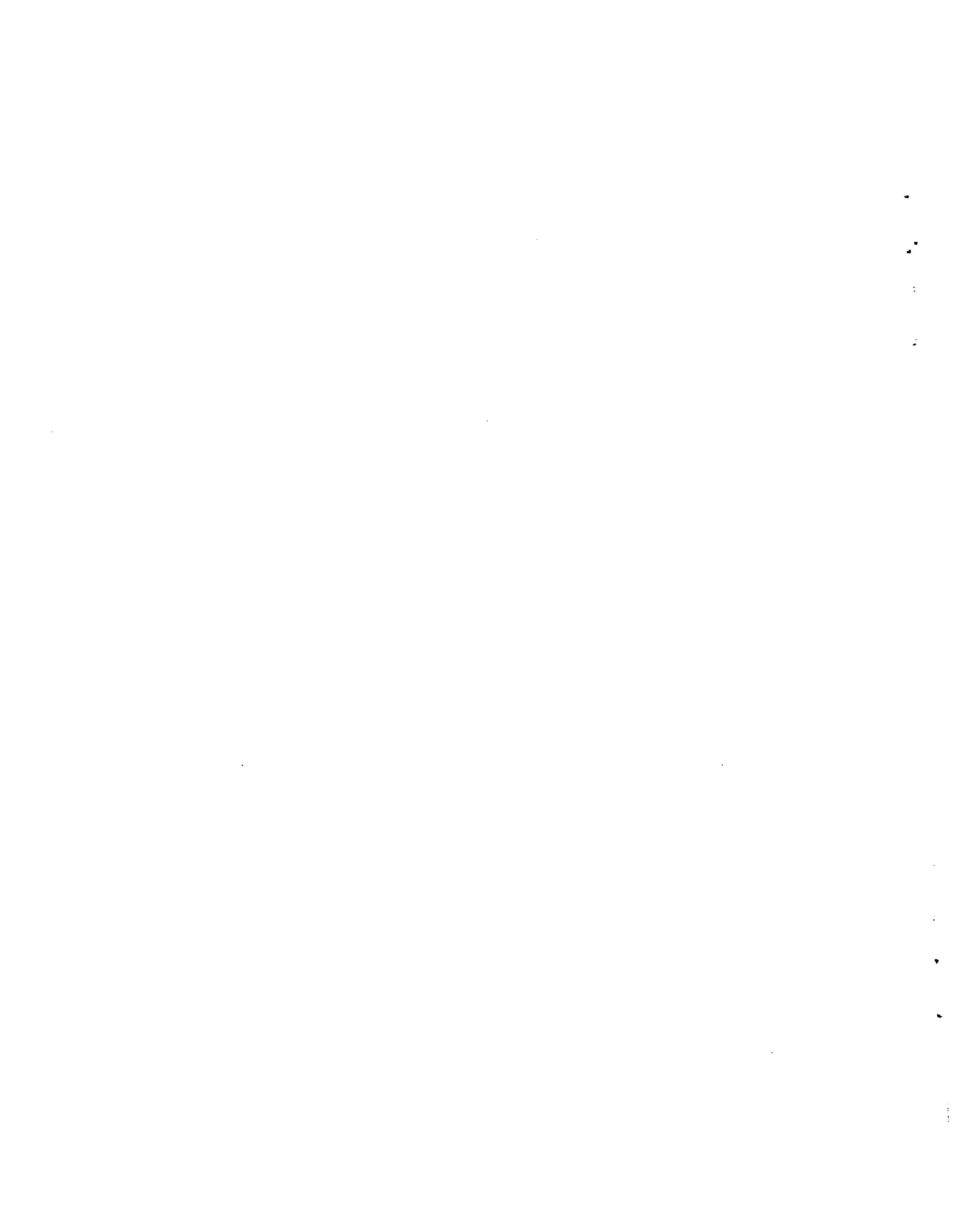
REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

MIDWIFERY STUDY PURSUANT TO HJR 646

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 76

COMMONWEALTH OF VIRGINIA
RICHMOND
2000



JOINT COMMISSION ON HEALTH CARE

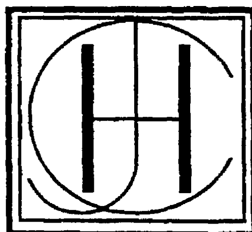
Chairman
The Honorable Kenneth R. Melvin

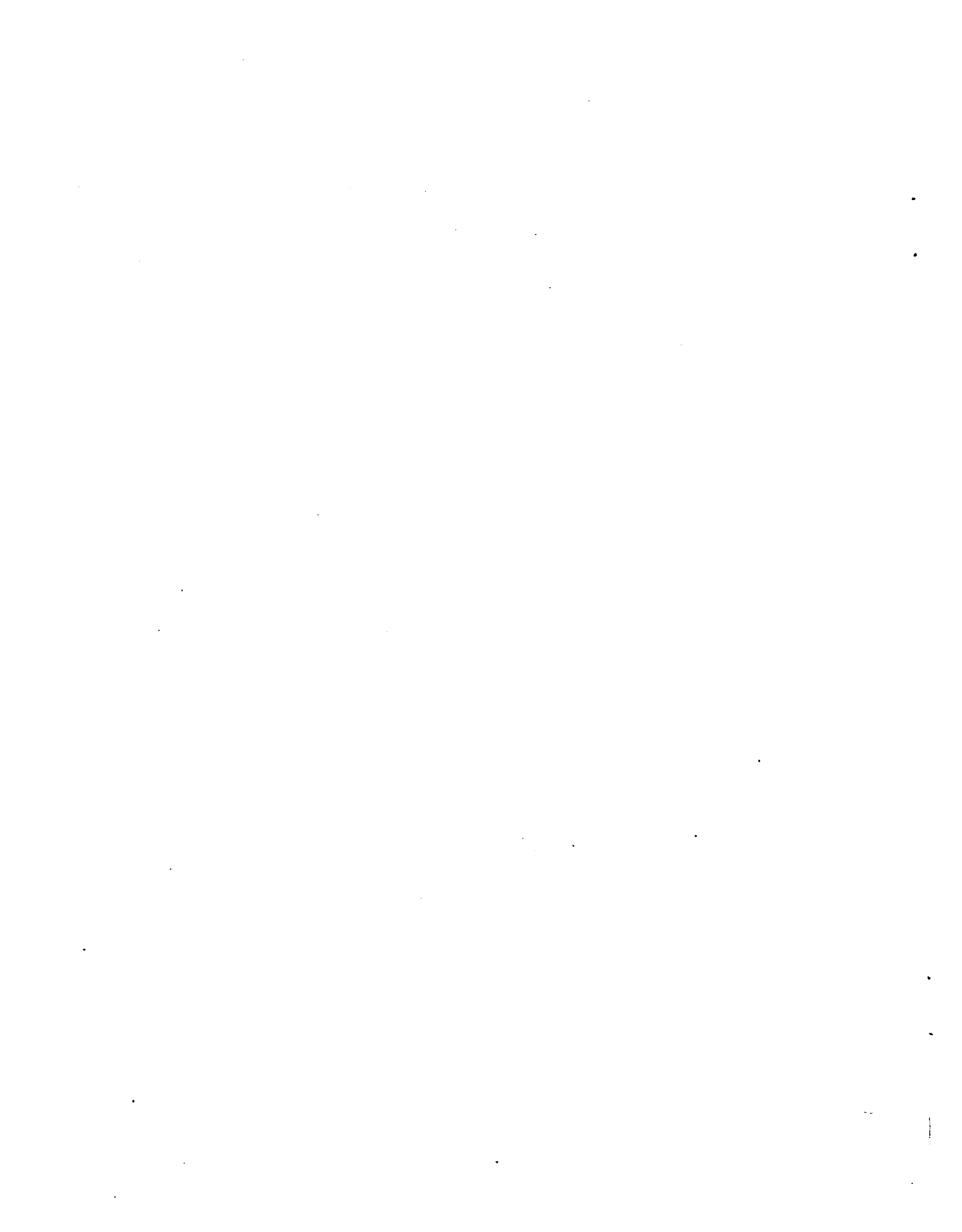
Vice Chairman
The Honorable Jane H. Woods

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Stanley C. Walker
The Honorable Thomas G. Baker, Jr.
The Honorable Robert H. Brink
The Honorable John J. Davies, III
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Claude A. Allen

Executive Director
Patrick W. Finnerty





Preface

House Joint Resolution (HJR) 646 was approved by the 1999 General Assembly. HJR 646 directed the Joint Commission on Health Care to examine "the advisability of legalizing the practice of direct-entry midwifery in the Commonwealth." Specifically, the Joint Commission on Health Care was directed to examine (i) advantages and disadvantages of legalizing direct-entry midwifery, (ii) experiences of other states that have legalized direct-entry midwifery, (iii) options for effectively regulating the practice of direct-entry midwifery to ensure, to the extent possible, the health and safety of women and infants receiving direct-entry midwifery services, and (iv) other issues as may seem appropriate.

A copy of HJR 646 is attached at Appendix A.

Based on our research and analysis during this review, we concluded the following:

- The "midwifery model of care", according to the Midwives Alliance of North America, defines pregnancy and birth as normal, non-medical, life events.

- Virginia law allows the practice of midwifery by certified nurse-midwives, subject to the supervision of a physician, and subject to joint regulation by the Board of Medicine and the Board of Nursing.

- A direct-entry midwife is educated through self-study or some other program distinct from the discipline of nursing, and practices primarily in non-hospital settings.

- Only those direct-entry midwives who were permitted by the Virginia Department of Health prior to 1977 are legally allowed to practice.

- There is evidence to suggest that the illegal practice of direct-entry midwifery is occurring in Virginia.

- Thirty states and the District of Columbia allow the practice of direct-entry midwifery, but only 18 of those states actively regulate the practice.

- Regulatory qualifications for practice in other states can include some or all of the following: educational requirements, clinical experience, CPR certification, standardized examination requirements, and a professional credential.

- Among states that regulate direct-entry midwifery, required supervision by a physician is uncommon but required back-up by a physician or a certified nurse-midwife is fairly typical.

- For low-risk, planned at-home births attended by a well-trained direct-entry midwife, it is difficult to identify literature that empirically demonstrates such an undertaking is more risky than other types of birth settings.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 23-24.

A Midwifery Subcommittee was established to review the issue of legalizing direct-entry midwifery. The Midwifery Subcommittee held three meetings at which testimony was received from interested parties. In addition, three public hearings were held across the state (Northern Virginia, Tidewater, and Southwest Virginia). The staff briefing on this issue comprises the body of this report. Following a presentation of the briefing to the Joint Commission, public comments were solicited. A summary of the public comments is attached at Appendix B.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank all those persons who provided information and testified before the Joint Commission on Health Care's Midwifery Subcommittee.

Patrick W. Finnerty
Executive Director

December, 1999

TABLE OF CONTENTS

I. AUTHORITY FOR THE STUDY 1

II. OVERVIEW OF MIDWIFERY IN VIRGINIA 1

III. APPROACHES IN OTHER STATES 11

IV. POLICY OPTIONS 23

V. APPENDICES

Appendix A: House Joint Resolution 646

Appendix B: Summary of Public Comments

I.
Authority for the Study

House Joint Resolution (HJR) 646 was approved by the 1999 General Assembly. HJR 646 directed the Joint Commission on Health Care to examine "the advisability of legalizing the practice of direct-entry midwifery in the Commonwealth." Specifically, the Joint Commission on Health Care was directed to examine (i) advantages and disadvantages of legalizing direct-entry midwifery, (ii) experiences of other states that have legalized direct-entry midwifery, (iii) options for effectively regulating the practice of direct-entry midwifery to ensure, to the extent possible, the health and safety of women and infants receiving direct-entry midwifery services, and (iv) other issues as may seem appropriate.

This report is divided into four sections. Section II discusses midwifery in Virginia. Section III discusses approaches in other states to midwifery. Section IV presents policy options for the Joint Commission on Health Care to consider regarding midwifery.

II.
Overview of Midwifery in Virginia

Direct-entry Midwives Have a Variety of Backgrounds

The term direct-entry midwife, as used in this report, means a person who provides midwifery services but does not have formal training in nursing. According to the Midwives Alliance of North America (MANA),

> A Direct-Entry Midwife is an independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A Direct-Entry Midwife is trained to provide the Midwifery Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out- of-hospital settings.

Direct-entry midwives are sometimes also referred to as lay midwives, community midwives, traditional midwives, or domiciliary midwives (though the later term could also refer to a nurse midwife who delivers babies in a home setting). It is noted that the term direct-entry midwife potentially encompasses individuals with a wide variety of professional and educational experiences.

Certified Nurse-Midwives Are Advanced Practice Nurses

A certified nurse-midwife is an advanced practice nurse who has (i) licensure as a registered nurse, (ii) professional certification as a Certified Nurse Midwife, and (iii) formal educational training usually leading to the bachelor of science in nursing (BSN) or, increasingly, the master of science in nursing (MSN) degree. According to the American College of Nurse-midwives (ACNM),

> Certified Nurse-midwives (CNMs) are registered nurses (RNs) who have graduated from a nurse-midwifery education program accredited by the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA) and have passed a national certification examination to receive the professional designation of certified nurse-midwife. Nurse-midwives have been practicing in the U.S. since the 1920s.

Prior to 1977, Midwives Were Permitted by the Department of Health

Prior to 1977, the Virginia Department of Health (VDH) was responsible for permitting midwives. The regulations in effect at that time required that applicants for a permit to practice midwifery:

- present letters of reference from each of two local practicing physicians who personally knows the candidate,
- observe and assist with ten or more hospital deliveries,
- pass a physical examination,
- conform with acceptable moral reputation and adhere to high standards for personal cleanliness, neatness, and demeanor.

In addition to these requirements, beginning July 1, 1974, "applicants for a midwife permit must be a registered nurse in good standing and a graduate of a school of midwifery accredited by the American College of Nurse Midwifery." This provision effectively prevented "direct entry" midwives from receiving a permit in Virginia as of July 1, 1974. While the term "nurse midwife" was not used in the regulations, these regulations appear to have restricted the practice of midwifery to nurse midwives as of 1974.

Since 1977 Only Certified Nurse-Midwives and "Grandfathered" Lay Midwives Have Been Permitted in Virginia

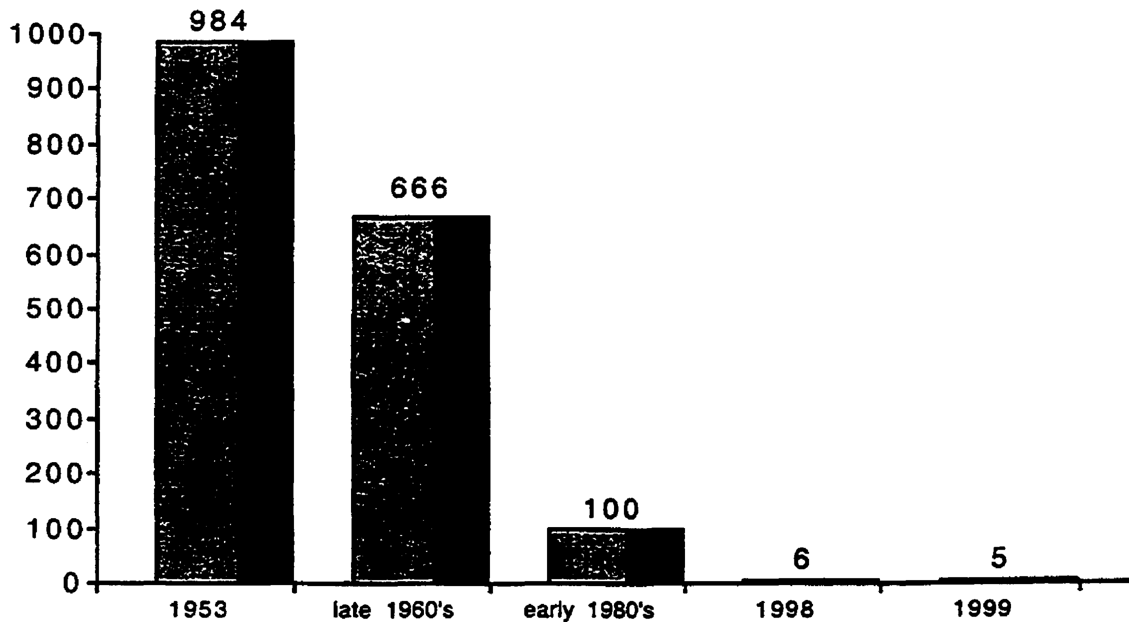
The 1976 General Assembly enacted legislation which limited practice by lay midwives to those midwives who were permitted by the Department of Health prior to January 1, 1977. In addition, certified nurse-midwives were permitted to practice, with certain restrictions. Certified nurse-midwives were and are considered in Virginia law and regulation to be a type of nurse practitioner, jointly regulated by the Boards of Medicine and Nursing.

Current Virginia law regarding midwives defines a midwife in § 32.1-145 of the *Code of Virginia* as "Any person who, for compensation, assists in delivery and postnatal care by affirmative act or conduct immediately prior and subsequent to the labor attendant to childbirth in conjunction with or in lieu of a member of the medical profession shall be deemed a midwife and to be practicing midwifery." Section 32.1-146 of the *Code of Virginia* states that "No person shall practice midwifery unless such person is registered and possesses a permit to practice midwifery as provided for in this section. Any person who fulfills such requirements to practice midwifery as the Board may, by regulation, promulgate shall be eligible for a permit. Upon registration and qualification, the permit shall be issued without charge by an official of the Department designated by the Commissioner and countersigned by the director of the local health department." However, § 32.1-147 of the *Code of Virginia* states that "The provisions of this article shall apply only to midwives who are not registered nurses and who are registered and permitted to practice pursuant to this article prior to January 1, 1977. All subsequent licensure for midwifery shall be limited to registered nurses who are trained as nurse-midwives pursuant to regulations jointly promulgated by the Board of Nursing and the Board of Medicine under the authority of §54.1-2901. Subject to the regulations of the State Board of Health, the permits of midwives who are not registered nurses and who have been previously licensed under this article shall be renewed on a biennial basis."

One Permitted Midwife Continues to Practice in Virginia

According to staff at the Virginia Department of Health, there are currently five direct entry midwives registered to practice in the Commonwealth. Of these five, one is apparently living out of state, several are retired, and only one is actively practicing. Figure 1 shows the number of permitted midwives in Virginia over time. As can be seen from Figure 1, the number of permitted midwives has decreased from nearly a thousand in the 1950's to five today (again, only one of these midwives is actively practicing).

Figure 1
Number of Permitted Midwives in Virginia

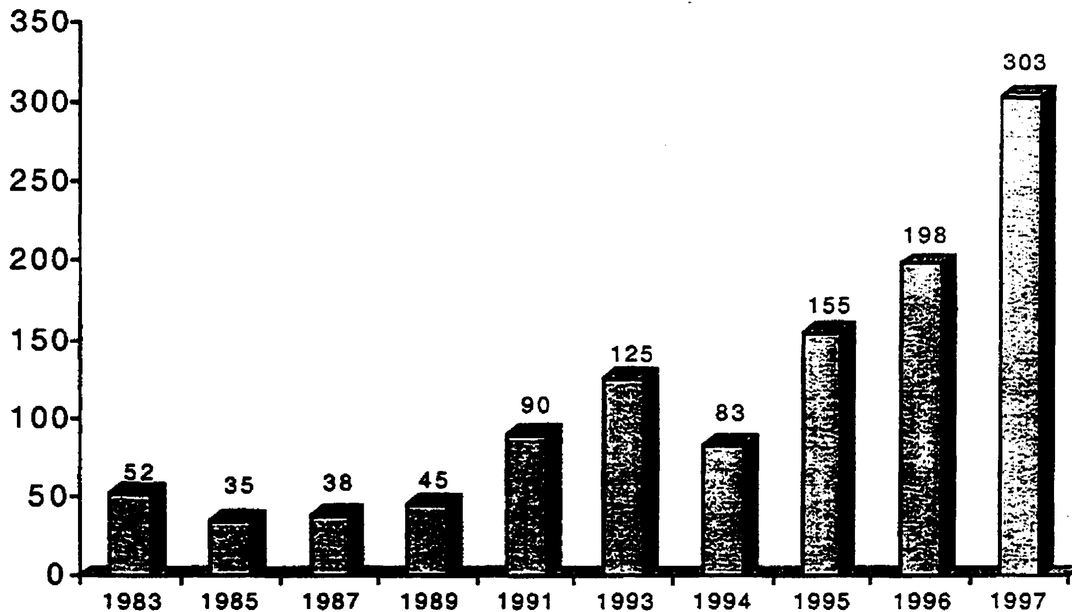


Source: Virginia Department of Health, Center for Health Statistics

While there are only five permitted midwives practicing in Virginia, it appears that there is a certain number of midwives who are practicing in Virginia without being permitted. In fact, as the number of permitted midwives has continued to decrease since the early 1980's, the number of

deliveries attributed to the "other midwife" (non-nurse midwife) category in the Department of Health's birth certificate data has increased. Figure 2 shows the number of births attended by the "other midwife" category.

Figure 2
Virginia Births Attended by Other Midwives: 1983-1997



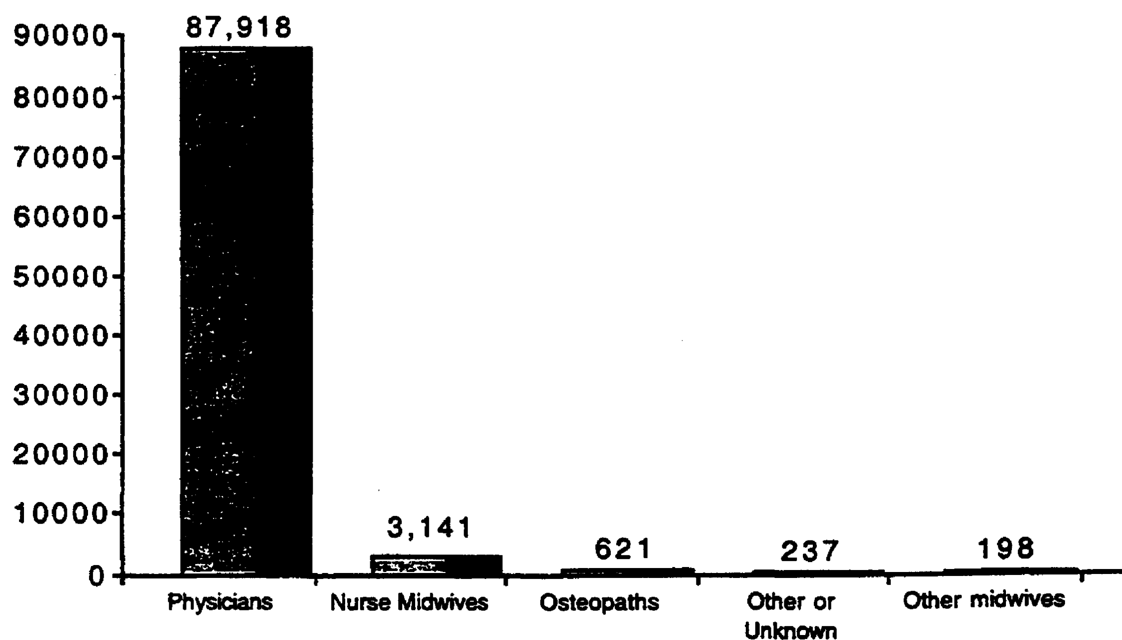
Source: Virginia Department of Health, Center for Health Statistics

The Joint Commission on Health Care's 1998 issue brief on midwifery estimated, based on anecdotal information and interviews, that there may be 20 to 30 practicing lay midwives in Virginia. This number is impossible to verify empirically, though subsequent interviews have indicated that the 1998 estimate may be too high. Nevertheless, at a minimum, it appears that approximately 275 deliveries in Virginia in 1997 can be attributed to un-permitted direct entry midwives (the one legally practicing permitted midwife delivered approximately 20 infants). The actual number of deliveries by direct entry midwives may be higher, as it is possible that some of the deliveries in the "other attendant" or "unknown" category were delivered by direct entry midwives. Clearly, the current legal status of direct entry midwifery creates an disincentive for a family in registering a birth to highlight that the birth was attended by a direct entry midwife.

Physicians Deliver the Great Majority of Infants in the Commonwealth

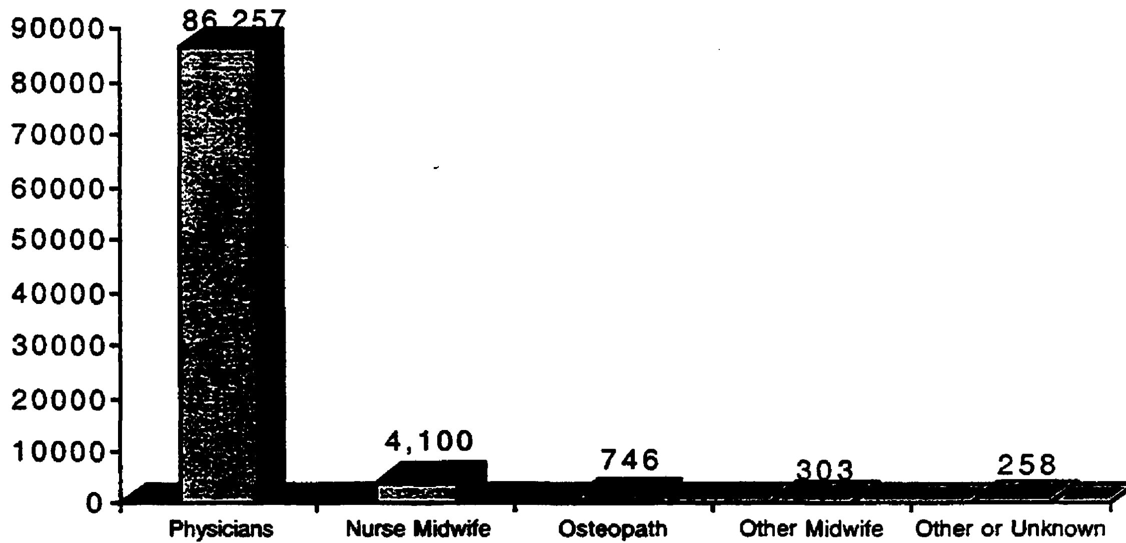
While the number of deliveries by direct entry midwives is increasing, according to data provided by the Virginia Department of Health, the vast majority of births in Virginia for both 1996 and 1997 (the two most recently available years) were attended by physicians (Figures 3 and 4). Nurse midwives were the second most common type of attendant. The number of births attended by nurse midwives has risen sharply since 1983 (Figure 5).

Figure 3
1996 Virginia Births by Type of Attendant



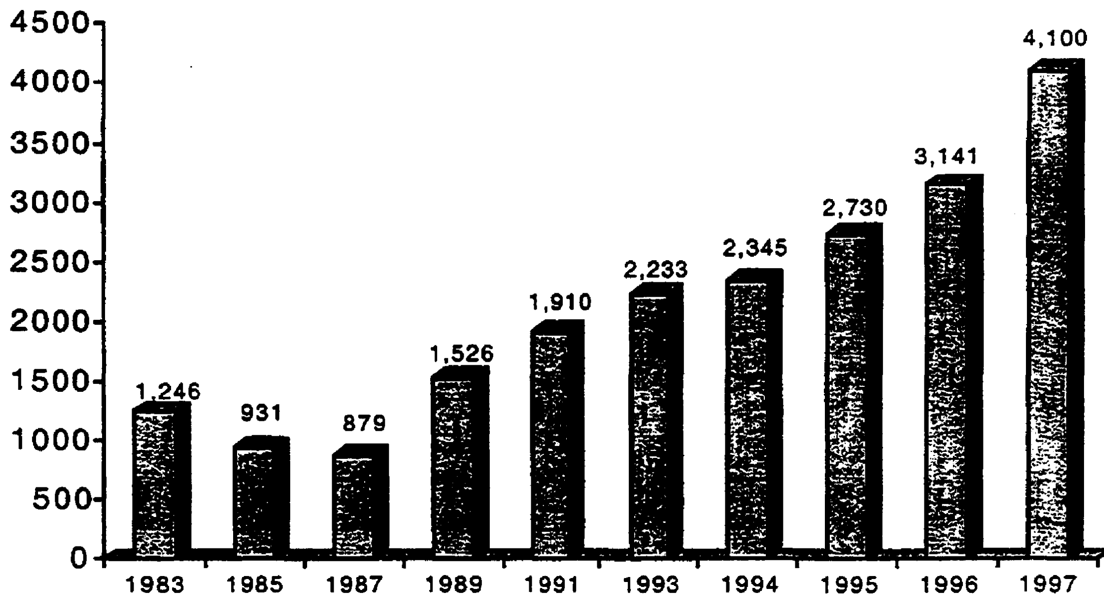
Source: Virginia Department of Health, Center for Health Statistics

Figure 4
1997 Virginia Births by Type of Attendant



Source: Virginia Department of Health, Center for Health Statistics

Figure 5
Virginia Births Attended by Nurse Midwives: 1983-1997



Source: Virginia Department of Health, Center for Health Statistics

Most Speakers at Public Hearings Supported Legalization of Direct Entry Midwifery

As was noted in the Joint Commission on Health Care's 1998 issue brief regarding midwifery, the question of legalization of direct entry midwifery is one where consensus will be difficult to achieve among the interested parties. To further solicit public comment from interested parties, the Joint Commission on Health Care's Midwifery Subcommittee held three public hearings during July 1999. On July 19, 1999 public hearings were held in Dublin, Virginia (at New River Valley Community College) and in Fairfax, Virginia (at George Mason University). On July 20, 1999 a public hearing was held in Newport News, Virginia (at Christopher Newport University).

At the public hearing in Dublin, 36 people attended, of whom 12 spoke. All spoke in favor of legalization of direct entry midwifery in some form. At the public hearing in Fairfax, there were 26 speakers. Of these, 24 spoke in favor of legalization of direct entry midwifery. Two obstetricians who spoke indicated the need for physician supervision if direct entry midwifery were legalized. Approximately 80 people attended the public hearing in Newport News. Of these, 25 spoke, all of whom were in favor of legalization of direct entry midwifery.

In total, of the 63 speakers at the three public hearings, 61 spoke in favor of direct entry midwifery being legalized. These speakers included mothers and fathers whose children had been attended by direct entry midwives, Virginia's only legally practicing direct entry midwife, certified nurse-midwives, and representatives of organizations supportive of direct entry midwifery. These organizations included: Virginia Birthing Freedom, Families for Natural Birth and Health Care, and the Commonwealth Midwives Alliance.

A more detailed summary of comments made at the public hearings was provided at the August 6, 1999 Midwifery Subcommittee meeting.

Virginia Chapter of the American College of Certified Nurse Midwives Supports Legalization of Direct Entry Midwifery

The Virginia Chapter of the American College of Nurse Midwives presented at two of the three public hearings a statement in favor of legalization of direct entry midwifery. This statement indicated "In order to protect the public and increase access to health care, the American College of Certified Nurse Midwives, Virginia Chapter supports regulation

of direct entry midwifery through licensure. Licensure should require certification by examination through the North American Registry of Midwives or the American College of Certified Nurse Midwives."

In addition, the Virginia Council of Nurse Practitioners endorsed a new category of licensure for direct entry midwives under the Department of Health Professions. The Council recommended that direct-entry midwives should be tested and certified by either the North American Registry of Midwives or the American College of Nurse-Midwives Certification Council and should be required to practice using collaborative management with referral to a licensed practitioner as appropriate. Finally, the Council recommended that the Virginia Birth-Related Neurological Injury fund be modified to allow participation by direct-entry midwives.

Physician Groups Oppose Legalization of Direct Entry Midwifery

The Medical Society of Virginia and the American College of Obstetricians and Gynecologists (ACOG) oppose legalization of direct entry midwifery. The Virginia Chapter of ACOG reiterated the ACOG statement of policy on home delivery, which dates to 1979. This statement is:

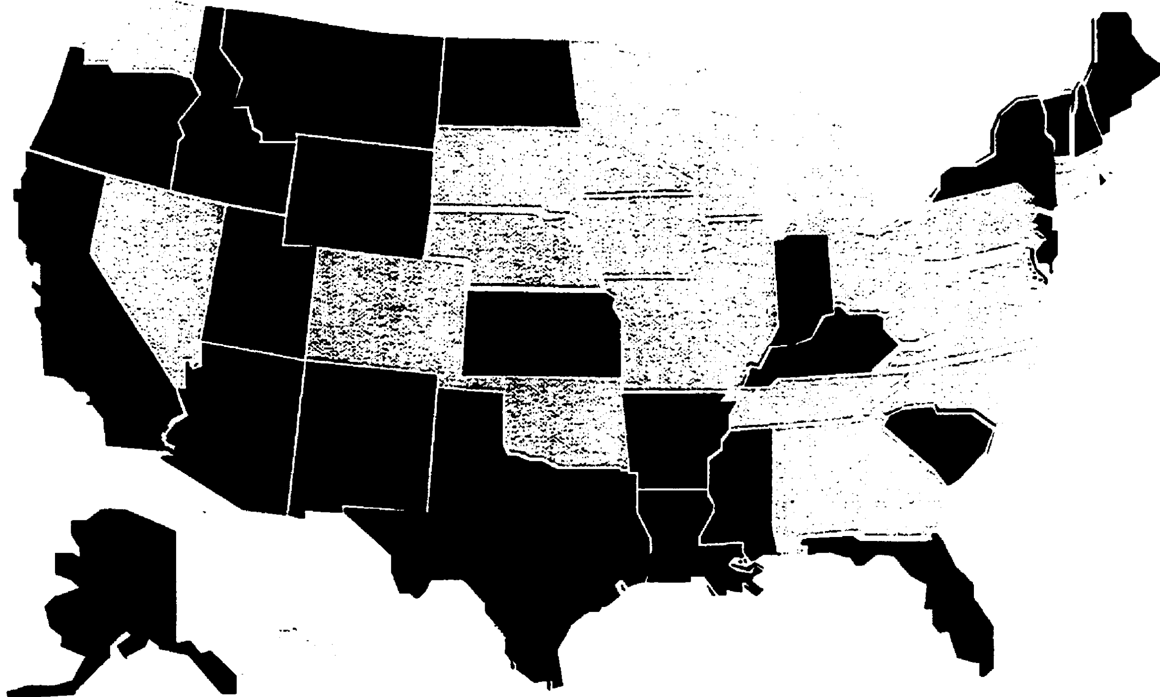
> Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation.
>
> We support those actions that improve the experience of the family while continuing to provide the mother and her infant with accepted standards of safety available only in hospitals which conform to standards as outlined by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

III.
Approaches in Other States

As the Joint Commission on Health Care's 1998 issue brief on midwifery noted, there is a wide variation among other states in terms of regulation of direct entry midwifery. This chapter provides more detailed information about other states. The information is based on a telephone survey of other states, conducted by JCHC staff as well as secondary data sources.

A total of 30 states and the District of Columbia explicitly allow the practice of direct entry midwifery. These states are shown in Figure 5. As Figure 5 reflects, states in New England, the Mountain West, Southwest, and deep South are the most likely to explicitly allow the practice of direct entry midwifery. However, not all of the states that allow the practice of direct entry midwifery actively regulate the practice. Figure 6 details the regulatory approaches used in the states allowing the practice of direct entry midwifery.

Figure 6
States Allowing the Practice of Direct Entry (Lay) Midwifery (States Shaded in Black Allow Direct Entry Midwifery)



Source: JCHC telephone survey of state long-term care ombudsman.

Figure 6
Provisions Regarding Direct Entry Midwifery in States Allowing the Practice of Direct Entry Midwifery

State	Requirements for Becoming a Midwife	Regulatory Agency?	Legally Practicing Midwives?
Alaska	Requirements include completion of an accepted course of study including clinical experience (minimum of 30 labor and deliveries).	Board of Certified Direct Entry Midwives	16
Arizona	Requirements include completion of college-level courses or equivalent in seven core subjects), successful completion of an apprenticeship program including clinical experience, successful completion of the NARM exam (score of 80 percent or better on all parts of the examination).	Department of Health Services	42 (27 actively practicing)
Arkansas	Requirements include completion of high school diploma or equivalent, certification in adult and infant CPR, clinical experience (including 30 labor and deliveries).	Department of Health	24
California	Direct entry midwives must have a supervising physician; must complete a three-year, post-secondary midwifery education program accredited by an organization recognized by the U.S. Department of Education, or successful completion of another midwifery education program approved by the board; successful completion of an exam equivalent to the American College of Nurse Midwives Exam, successful completion of a licensing exam (may receive credit by examination for previous educational and clinical experience).	Medical Board of California	104

State	Requirements for Becoming a Midwife	Regulatory Agency?	Legally Practicing Midwives?
Colorado	Direct entry midwives must complete a state examination (NARM exam is not accepted). Must complete training approved by the director; must be the primary birth attendant for at least 30 births (as well as completing other clinical experience requirements); must be certified for adult and infant CPR.	State Dept. of Regulatory Agencies, Midwives Registration Division	33
Connecticut	The practice of direct entry midwifery appears to be legal but unregulated.	not regulated	unknown
Delaware	Direct entry midwives must be 21 years old, submit a sworn statement of moral and physical fitness, submit evidence of experience and training acceptable to the Board, and must submit evidence of an alliance with a physician licensed in Delaware and certified by ACOG. The area of practice is limited to populations which are medically underserved or have religious beliefs opposed to medical treatment.	State Board of Health	1
Florida	Direct entry midwives must have an emergency back up provider (physician or nurse-midwife), must have a high school diploma or equivalent, must have demonstrated competencies in communication and computation, must have graduated from an approved training program, must successfully complete the NARM examination.	Department of Health	80 (some are inactive)
Idaho	The practice of direct entry midwifery is legal in some circumstances but not regulated	not regulated	unknown

State	Requirements for Becoming a Midwife	Regulatory Agency?	Legally Practicing Midwives?
Indiana	The practice of direct entry midwifery appears to be legal under the 1993 Medical Practice Act, though this matter is not settled in the courts. The practice is not regulated.	not regulated	unknown
Kansas	A 1996 Kansas Supreme Court ruling held that lay midwifery is not the practice of either medicine or nursing and therefore is not prohibited by state law. Lay midwives must have a backup arrangement with a licensed physician.	not regulated	not regulated
Louisiana	Direct entry midwives must be 21 years of age, certified in CPR, submit four recommendations (one must be from a physician or nurse midwife and one must be from a licensed midwife), must complete required clinical experience (including at least 15 live births), must demonstrate competency in biology, must complete the NARM examination.	State Board of Medical Examiners	14
Maine	The practice of direct entry midwifery appears to be legal but unregulated.	not regulated	unknown
Massachusetts	The practice of direct entry midwifery appears to be legal but unregulated based on a 1985 court ruling that the mere practice of midwifery does not constitute the practice of medicine.	not regulated	unknown
Minnesota	Direct entry midwives must hold the CPM credential or equivalent as determined by the Board, must be certified in CPR, must complete clinical experience including 20 births, must have a diploma from an approved educational institution or have completed an apprenticeship.	Minnesota Board of Medical Practice	none practicing legally as statute took effect 7/1/99 (some midwives are practicing without licensure at present)

State	Requirements for Becoming a Midwife	Regulatory Agency?	Legally Practicing Midwives?
Mississippi	The practice of direct entry midwifery is legal per a 1991 Attorney General's opinion but not regulated.	not regulated	unknown
Montana	Direct entry midwives must have a high school diploma or equivalent, must be certified in infant and adult CPR, must have clinical experience (including at least 25 births), must pass the NARM exam.	Board of Alternative Health Care	16
New Hampshire	The practice of direct entry midwifery is currently allowed but not regulated at present; proposed new rules would require passing the NARM exam and a short examination on state law.	Department of Health and Human Services has authority to regulate direct entry midwifery but has not done so yet (new rules have been proposed)	10
New Jersey	Direct entry midwives must pass a state examination, must have a diploma from an approved midwifery school or maternity hospital (schools must have a program of at least 1,800 hours of instruction over not less than nine months), must have a "common school" education or equivalent	State Board of Medical Examiners	unknown
New Mexico	Direct entry midwives must be a CPM (and complete a state-approved exam) or complete the NARM examination, must complete a required educational course (similar to NARM requirements), must be certified in CPR and IV therapy.	Department of Health and Department of Maternal Health	100
New York	Direct entry midwives must complete educational requirements as established by the state (requirements are similar to those for nurse midwives), must pass the licensing examination, must have a high school diploma or equivalent	Board on Midwifery	Unknown

State	Requirements for Becoming a Midwife	Regulatory Agency?	Legally Practicing Midwives?
North Dakota	The practice of direct entry midwifery is not prohibited but not regulated	not regulated	unknown
Oregon	Direct entry midwives must have a backup physician, undergo peer review, have documented clinical experience , must be certified in infant and adult CPR, must complete the NARM examination	Health Licensing Office	36
Tennessee	The practice of direct entry midwifery is legal but not regulated.	not regulated	unknown
Texas	Direct entry midwives must complete NARM core competencies, must be certified in adult and infant CPR, must be training in collection of newborn screening specimens (or have an arrangement with someone who is)	Texas Midwifery Board and Board of Health	166
Utah	not explicitly prohibited	not regulated	unknown
Vermont	appears to be legal but unregulated	not regulated	unknown
Washington	Direct entry midwives must successfully complete the NARM exam and must graduate from an approved school of midwifery.	Department of Health	110
Wyoming	practice of direct entry midwifery is legal but not regulated	not regulated	unknown

States Regulating the Practice of Direct Entry Midwifery Have a Variety of Requirements

As illustrated in Figure 6, states that regulate direct entry midwifery have a variety of requirements for becoming a direct entry midwife. The most typical of these requirements are:

- certification in adult and infant CPR,

- hands-on clinical experience (for example assisting in a given number of deliveries or providing prenatal care for a given number of women), and
- passing an examination (most typically the examination administered by the North American Registry of Midwives (NARM).

Some states also require midwives to have professional certification, either as a certified professional midwife (CPM) or Certified Midwife (CM). The next section explains these two types of certification.

Direct-entry Midwives Can Become Certified Professional Midwives

Some direct-entry midwives have received a credential as a Certified Professional Midwife or CPM. According to the Midwives Alliance of North America (MANA),

> [a] Certified Professional Midwife is an independent practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the Midwifery Model of Care. The NARM certification process recognizes multiple routes of entry into midwifery and includes verification of knowledge and skills and the successful completion of both a Written Examination and a Skills Assessment. The CPM credential requires training in out-of-hospital births.

As noted in Figure 6, a number of states require passing the NARM exam as part of the process for becoming a direct entry midwife.

Certified Nurse-Midwives Are Advanced Practice Nurses

A certified nurse-midwife is an advanced practice nurse who has (i) licensure as a registered nurse, (ii) professional certification as a Certified Nurse Midwife, and (iii) formal educational training usually leading to the bachelor of science in nursing (BSN) or, increasingly, the master of science in nursing (MSN) degree. According to the American College of Nurse-midwives (ACNM),

> Certified Nurse-midwives (CNMs) are registered nurses (RNs) who have graduated from a nurse-midwifery education program accredited by the American College of

Nurse-Midwives (ACNM) Division of Accreditation (DOA) and have passed a national certification examination to receive the professional designation of certified nurse-midwife. Nurse-midwives have been practicing in the U.S. since the 1920s.

ACNM Now Offers Certification to Direct-entry Midwives

While the membership of the ACNM has traditionally centered on registered nurses, the organization has recently become interested in certifying direct-entry midwives. To this end, it has created the Certified Midwife credential. New York is one state that has initiated a formal program to train direct-entry midwives to become Certified Midwives. According to ACNM:

> Certified midwives (CMs) are individuals who have or receive a background in a health related field other than nursing and graduate from a midwifery education program accredited by the ACNM DOA. Graduates of an ACNM accredited midwifery education program take the same national certification examination as CNMs but receive the professional designation certified midwife. The ACNM Certification Council, Inc, (ACC) administers the national certification examination for CNMs and CMs. The certification for individuals who pass the ACC national exam after January 1996 will expire after eight years and will require re-certification to maintain the professional designation.

It is noted that the effort by the ACNM to certify direct-entry midwives has not been without controversy. Some members of the ACNM apparently feel that the organization should remain focused on nurse-midwives. The governing body of the ACNM is currently considering a resolution to change the name of the organization to the American College of Midwives, reflecting a viewpoint of some members of the organization that it should represent both direct-entry midwives and nurse-midwives.

Conversely, some direct-entry midwives and some organizations representing direct-entry midwives have expressed concern about legislative efforts in some states to require the CM credential for direct-entry midwives, preferring the CPM credential. One particular point of contention has been the ACNM's requirement that persons receiving the

CM credential have an undergraduate degree in some discipline (not necessarily nursing). The CPM credential does not have this requirement.

Physician Supervision Requirements for Direct Entry Midwives Vary by State

Most states that allow the practice of direct entry midwifery do not require that direct-entry midwives be supervised by a physician. Two states that do have such a requirement are Louisiana and California. However, it is more common for a state to require a direct-entry midwife to have some type of back-up arrangements with a physician in the event a physician's services are necessary to protect the health of the mother or the baby.

Literature on Direct Entry Midwifery, While Limited, Suggests that Direct Entry Midwifery Has Generally Favorable Birth Outcomes

Direct entry midwifery has been the subject of a number of studies, though most have been limited to a single state or parts of a state. However, JCHC staff were unable to find any studies that indicate that direct entry midwifery is demonstrably less safe than other types of maternity care if the direct entry midwife is well-trained. In 1989, the *New England Journal of Medicine* published a study by Rooks et. al. of outcomes of care from birthing centers, where most (80.6 percent) of the 11,814 births studied were delivered by certified nurse-midwives though some of the births were attended by direct-entry midwives. The study concluded that "birth centers offer a safe and acceptable alternative to hospital confinement for selected pregnant women, particularly those who have previously had children, and that such care leads to relatively few cesarean sections" (New England Journal of Medicine 1989; 321: 1804-1811).

One focused study of direct-entry midwifery care from 1992 (often referred to as the "Farm Study") examined pregnancy outcomes in 1,707 pregnant women cared for by direct-entry midwives in rural Tennessee and compared these outcomes with 1980 data on physician attended hospital deliveries (Duran, AM, *American Journal of Public Health,* March, 1992, 82(3): 450-453). This study found that "under certain circumstances, home births attended by lay midwives can be accomplished as safely as, and with less intervention than, physician-attended hospital deliveries." A study in Washington state found comparably favorable outcomes for licensed midwives when compared with nurse-midwives and physicians (Holt and Myers, Birth. Sep. 1994,

21(3): 141-148). One legislative study that examined the relative safety of direct-entry midwives was conducted in Ohio during 1996-1997. This study, conducted by the Direct-entry Midwifery Study Council created by Senate Bill 154, recommended that Ohio recognize direct-entry midwives and develop means for regulating them.

Other studies that examine the safety of direct entry midwifery include Mehl et. al. (1977) who examined home births by five delivery services, including two consisting of direct entry midwives in California. Birth outcomes for all groups examined in this study, including the direct-entry midwives, were more favorable than California state averages. A 1980 study published in the *Journal of the American Medical Association* found that planned home deliveries attended by direct-entry midwives were significantly safer than either planned home births without a midwife or unplanned home births (Burnett, etl. all, Vol. 244, No. 24, 2741-2745). A 1983 study in the *American Journal of Public Health* examined births attended by direct-entry midwives in Arizona and found that "Arizona's experience illustrates that home births can be a safe alternative for low-risk pregnancies if they are attended by an adequately trained practitioner, even if that practitioner is not a physician. Arizona's experience also illustrates the difficulty in maintaining standards of care in a political climate of deregulation (Sullivan and Beeman, Vol. 73, No. 6, pp. 641-645). A 1985 study in the *Journal of the American Medical Association* concluded that planned home births, including those attended by direct-entry midwives, compare favorably in terms of birth outcomes with other delivery settings. The study also found that unplanned home births had demonstrably less favorable outcomes than other delivery settings.

It must be emphasized that states vary in their regulations (if any) for direct-entry midwives and that it therefore is difficult to extrapolate results from one state to the nation as a whole. However, for low-risk, planned at-home births attended by a well-trained direct entry midwife, it is difficult to identify literature that empirically demonstrates such an undertaking is more risky than other types of birth settings.

Advantages and Disadvantages of Legalizing the Practice of Direct Entry Midwifery

The advantages and disadvantages of legalizing direct entry midwifery are impossible to quantify with any precision. The following empirical observations, however, can be made:

- at least 275 births occurred in 1997 that were attended by direct entry midwives who are not authorized to practice legally in Virginia;

- the number of births certified as being attended by "other midwives" has increased from 35 in 1985 to 303 in 1997 (some of the total for each year includes births attended by lay midwives permitted before 1977 and therefore legally authorized to practice);

- the number of births attended by other midwives has increased while the number of legally authorized practitioners has decreased, suggesting that the increased demand is being met by midwives not legally allowed to practice;

- prosecution of midwives for practicing direct entry midwifery is not common (one case is pending in Stafford County).

A more subjective observation is that current state law provides a disincentive for persons receiving direct entry midwifery services to seek medical attention when such attention is warranted. It should be noted that the practice of direct entry midwifery is currently illegal, but the receipt of such services is not. Nevertheless, the current illegal status of direct entry midwifery could delay persons from seeking medical attention for a mother and her baby when necessary, when the desirable public policy goal would be to have such services sought as quickly as possible. A further subjective observation is that parents who chose direct entry midwifery services appear to be highly motivated to do so, and it is unclear that the desire to seek such services is influenced significantly, if at all, by the legal status of direct entry midwifery.

It should be further noted that the public policy decision against the practice of direct entry midwifery during the 1976 session of the General Assembly was clouded by the General Assembly's decision to grandfather existing practitioners. There is one direct entry midwife still legally and actively practicing today as she has been since 1972, with the full impirateur of the state. Therefore, it is difficult to cogently argue that the public policy position of the state is that direct entry midwifery is patently unsafe. If this were the case, then there would have been no justification for the grandfathering provisions included in 1976.

IV.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care. It is noted that, in some cases, these options are mutually exclusive.

Option I: **Take No Action.**

Option II: **Introduce legislation legalizing the practice of direct- entry midwifery by individuals who meet the following requirements: (i) a passing score on the examination administered by the North American Registry of Midwives or the American College of Nurse-Midwives Certification Council, (ii) current certification in adult or infant CPR, (iii) a high school diploma or equivalent, (iv) clinical experience and education sufficient to meet the requirements of the North American Registry of Midwives for certification as a Certified Professional Midwife (CPM). This legislation should also include provisions for referral to a licensed physician or certified nurse-midwife when appropriate. The General Assembly may wish to include a sunset provision on this legislation, with an enactment clause requiring the Department of Health to study the safety of direct entry midwifery services provided in the Commonwealth and make recommendations to the Governor and General Assembly regarding reenactment of the statute prior to the expiration of the sunset date.**

Option III: **Introduce legislation removing any legal prohibitions on the practice of direct entry midwifery provided that direct entry midwives have all patients sign informed consent forms to be developed by the Virginia Department of Health that clearly state direct entry midwives are neither licensed nor regulated by the Commonwealth of Virginia.**

Option IV: **Introduce legislation directing the Board of Nursing and the Board of Medicine to jointly promulgate regulations within 280 days for legalizing the practice of direct entry midwifery by qualified individuals.**

Option V: Introduce legislation directing the Board of Health to promulgate regulations within 280 days for legalizing the practice of direct entry midwifery by qualified individuals.

APPENDIX A

HOUSE JOINT RESOLUTION NO. 646

Directing the Joint Commission on Health Care, with the assistance of the Department of Health Professions and the State Department of Health, to examine the advisability of legalizing the practice of direct-entry midwifery in the Commonwealth.

Agreed to by the House of Delegates, February 8, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, direct-entry midwives are not currently allowed to practice in Virginia unless registered with the State Department of Health prior to 1977; and

WHEREAS, only six direct-entry midwives are currently registered under these statutory provisions, most of whom are not actively practicing; and

WHEREAS, some direct-entry midwives are currently practicing in Virginia outside of state law; and

WHEREAS, most states currently permit the practice of direct-entry midwifery in some form; and

WHEREAS, significant variation exists among states that have legalized direct-entry midwifery regarding whether and how the practice is regulated; and

WHEREAS, notwithstanding the prohibition on the practice of direct-entry midwifery in the Code of Virginia, at least 199 births in Virginia during 1996 were attended by direct-entry midwives; and

WHEREAS, access to competent care is important in both in-hospital a[illegible] of-hospital birth settings; and

WHEREAS, at the request of the House Rules Committee, the Joint [illegible] on Health Care recently completed a study on issues regarding mi[illegible] issues originally raised by Senate Joint Resolution No. 196 (1998[illegible]

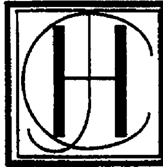
WHEREAS, further study is necessary to examine the experiences [illegible] states that have legalized direct-entry midwifery as well as to furth[illegible] scientific studies on birth outcomes in different settings; now, there[illegible]

RESOLVED by the House of Delegates, the Senate concurring, T[illegible] Commission on Health Care, with the assistance of the Departme[illegible] Professions and the State Department of Health, be directed to e[illegible] advisability of legalizing the practice of direct-entry midwifery in t[illegible] Commonwealth. The study shall include, but not be limited to, a[illegible]

advantages and disadvantages of legalizing direct-entry midwifery, (ii) experiences of other states that have legalized direct-entry midwifery, (iii) options for effectively regulating the practice of direct-entry midwifery to ensure, to the extent possible, the health and safety of women and infants receiving direct-entry midwifery services, and (iv) other issues as may seem appropriate.

The Joint Commission shall report its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B



JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: MIDWIFERY STUDY (HJR 646)

Individuals/Organizations Submitting Comments

A total of 192 individuals and organizations submitted comments in response to the HJR 646 report.

Policy Options

Option I: **Take No Action.**

Option II: **Introduce legislation legalizing the practice of direct-entry midwifery by individuals who meet the following requirements: (i) a passing score on the examination administered by the North American Registry of Midwives or the American College of Nurse-Midwives Certification Council, (ii) current certification in adult or infant CPR, (iii) a high school diploma or equivalent, (iv) clinical experience and education sufficient to meet the requirements of the North American Registry of Midwives for certification as a Certified Professional Midwife (CPM). This legislation should also include provisions for referral to a licensed physician or certified nurse-midwife when appropriate. The General Assembly may wish to include a sunset provision on this legislation, with an enactment clause requiring the Department of Health to study the safety of direct-entry**

midwifery services provided in the Commonwealth and make recommendations to the Governor and General Assembly regarding reenactment of the statute prior to the expiration of the sunset date.

Option III: **Introduce legislation removing any legal prohibitions on the practice of direct-entry midwifery provided that direct-entry midwives have all patients sign informed consent forms to be developed by the Virginia Department of Health that clearly state direct-entry midwives are neither licensed nor regulated by the Commonwealth of Virginia.**

Option IV: **Introduce legislation directing the Board of Nursing and the Board of Medicine to jointly promulgate regulations within 280 days for legalizing the practice of direct-entry midwifery by qualified individuals.**

Option V: **Introduce legislation directing the Board of Health to promulgate regulations within 280 days for legalizing the practice of direct-entry midwifery by qualified individuals.**

Overall Summary of Comments

A total of 183 commenters expressed support for Option II, that midwives meet the CPM credential. Of the 183 comments, 33 commented in opposition to the sunset statute, 20 suggested a two to three-year window to allow practicing midwives to phase-in to the CPM credential as outlined by NARM, and seven expressed support for Options II and V. Three comments were in support of Option I. One commenter stated support for Option III. Five comments received did not support any of the options. In addition, three commenters expressed concern about the validity and accuracy of data presented by the Virginia Department of Health concerning such issues as differences between the types of midwives and the health

outcomes of home-births versus hospital births. Following the public comments period, the Joint Commission also received a petition signed by 124 citizens requesting "the General Assembly to decriminalize the practice of home-based midwifery. This includes legalizing the Certified Professional Midwife (CPM)." Due to the extensive number of comments received, it is not possible to list all of the individuals who submitted comments, particularly those who expressed support for Option II. What follows below are the individuals that expressed support for Options I or III, or who expressed support for Option II provided that the option is modified, or who did not express support for any of the options contained in the issue brief.

Summary of Individual Comments

Freeda Lynn Cathcart

Ms. Cathcart recommended that the General Assembly agree to a resolution affirming "the inherent value of midwifery." The resolution should state that "midwifery is not the practice of medicine but a community health service." According to Ms. Cathcart, "once the midwifery model of care has a healthy environment to flourish in then we should be able to track a significant decrease in maternal and perinatal morbidity rates."

Citizens for Midwifery, Inc.

Susan Hodges, President, recommended the following revisions to Option II: (1) the legislation should establish that midwifery is an autonomous profession; (2) provisions for referral to a licensed physician or certified nurse-midwife would be appropriate as a recommendation in rules and regulations, but not as a requirement in the statute unless licensed physicians and certified nurse-midwives also would be legally required to accept such referrals; (3) follow the lead of Minnesota's new midwifery law which would make the regulation voluntary for the first few years, giving additional direct-entry midwives the opportunity to become CPMs; and (4) do not include a sunset provision.

Susan V. Mead, Ph.D.

Susan V. Mead urged the Joint Commission to "consider a new option, (other than those in the report) that would fully legalize midwifery..." Dr. Mead also stated that "Virginia's law must explicitly guarantee that midwifery will be appropriately recognized as an autonomous profession..."

The Medical Society of Virginia (MSV)

Lawrence E. Blanchard, M.D., President, expressed strong support for Option I. Dr. Blanchard stated that "it is the belief of the MSV that optimal maternity care must be directed by a qualified physician. Under this policy, MSV fully recognizes that patients can access care through certified nurse midwives, under physician supervision, to completely manage an uncomplicated pregnancy. On the contrary though, direct entry midwives do not have the skills or training of certified nurse midwives. We do not believe that any perceived benefits to be gained by allowing direct entry midwives to practice would outweigh the risks or the potentially significant compromises to patient care and safety."

Lois Smith

Lois Smith stated, "I do not support any of the options. I want the right as a consumer to choose the midwife of my choice and the government out of my bedroom."

Virginia Birthing Freedom

Stephen L. Cochran, Founder, stated that forced to choose, he would select Option I and suggested that "the Commission should draft a more detailed and coherent set of options."

Virginia Chapter American College of Nurse-Midwives (ACNM)

Judith S. Castleman, R.N., stated that ACNM supports regulation of direct entry midwifery through *licensure* as described in Option II. They also support the provisions for the training and education of

direct entry midwives as outlined in Option II. Additionally, they expressed support for the practice of direct entry midwifery occurring within a health care system that provides for consultation, collaborative management and referral with a licensed practitioner, as indicated by the health status of the client. They felt it would also be appropriate to apply this same standard to certified nurse-midwives. They suggested that it would be necessary to alter the current physician supervision language in order to accomplish this. Further, it was their opinion that a sunset clause is not necessary.

Virginia National Organizations for Women

Connie Hannah, President, expressed support for Option III. However, she suggested changing Option III to read as: "Introduce legislation removing any legal prohibitions on the practice of direct entry midwifery. Provide funding through the VDH to create regional Childbirth Task Forces to educate the public so that informed choices can be made. The Commonwealth recommends that direct entry midwives have their clients sign informed consent forms available through their local branch of the VDH."

Virginia Obstetrical and Gynecological Society

Fred Mecklenburg, M.D., President, and Robert L. Vermillion, M.D., Chairman, expressed strong support for Option I. They stated that "this position is in keeping with the ACOG policy on home delivery...We stand by the acceptable standards of birthing safety available only in hospitals as outlined in the "Guidelines for Perinatal Care" which is a joint effort by ACOG and the American Academy of Pediatrics. It is by these standards that we strive to fulfill maternal and infant safety and care."

Arthur and Evelyn S. Webster

Arthur and Evelyn S. Webster commented that neither Option I nor Option II were acceptable. Further, they stated that "Option II may be considered a compromise by some but will not insure that the kind of care that we desire would be available at the consumer level." They suggested that an acceptable bill must: "(1) decriminalize midwifery now, (2) allow for collaboration with

physicians without requiring supervision of midwives, and (3) protect our consumer rights, that we may receive the healthcare of our choice."

JOINT COMMISSION ON HEALTH CARE

Executive Director

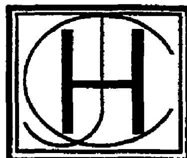
Patrick W. Finnerty

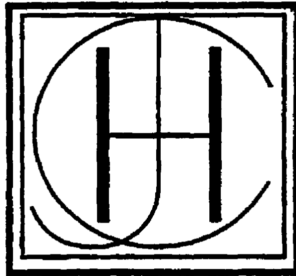
Senior Health Policy Analysts

Joseph J. Hilbert
William L. Murray, Ph.D.
E. Kim Snead

Office Manager

Mamie V. White





Joint Commission on Health Care
Old City Hall
1001 East Broad Street
Suite 115
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm