State Laws and the Practice of Lay Midwifery

IRENE H. BUTTER, PHD, AND BONNIE J. KAY, PHD

Abstract: A national survey was conducted to assess the current status and characteristics of state legislation regulating the practice of lay midwives. As of July 1987, 10 states have prohibitory laws, five states have grandmother clauses authorizing practicing midwives under repealed statutes, five states have enabling laws which are not used, and 10 states explicitly permit lay midwives to practice. In the 21 remaining states, the legal status of midwives is unclear. Much of the enabling legislation restricts midwifery practice often resulting in situations similar to those in states with prohibitory laws. Given the growth of an extensive grassroots movement of lay midwives committed to quality of care, this outcome suggests that 21 states with no legislation may provide better opportunities for midwifery practice than states with enabling laws. (*Am J Public Health* 1988; 78: 1161–1169.)

Introduction

Since 1975, many states have passed laws and regulations governing the practice of lay midwives. "Lay midwife" refers to someone who practices in a home setting and who has been trained in a variety of ways, often not linked to formal programs in educational institutions but including substantial clinical training in apprenticeships. Alternative titles include independent midwife, direct entry midwife, and non-nurse midwife although some do have RN degrees. They are distinguished from certified nurse midwives who are RNs with additional training and certification in midwifery and who usually practice in hospital settings. Some states have revoked legal status of lay midwives, attempting to eliminate their participation in childbirth attendance; other states have passed new types of statutes authorizing and regulating their practice. Both directions are responses to the recent comeback of lay midwives, an occupation which had nearly disappeared from the spectrum of birth practitioners.

Some of the factors which account for the reemergence of lay midwives are: questioning of medical domination of childbirth, demanding the right by childbearing women to choose place of birth and birth practitioner, searching for safe alternatives to hospital births, worrying over escalating childbirth costs, the general shifting of specific services away from hospitals, desiring of more natural and woman-centered childbirth experiences. The reappearance of lay midwives is intimately related to the rising trend of out-of-hospital births and has raised numerous questions of legal, medical, financial, political, as well as social nature.[1–4]

Because states have become increasingly active in the area of law and lay midwifery, the profile of legal status of these midwives becomes quickly outdated. Accordingly, a number of surveys have been conducted in the last several years.[4–8] These surveys vary considerably in scope and content. For example, the first two surveys include laws pertaining to certified nurse-midwives and lay midwives, the third survey concentrates on certified nurse-midwifery with some references to certain aspects of lay midwife regulation, while the last two surveys focus on lay midwifery practice exclusively. Other differences relate to their comprehensiveness in documenting regulatory aspects, degree of legal emphasis, style and presentation of information (comparative/tabular or state-by-state descriptions), and the amount of comparative analysis presented.

In the survey to be reported, we raise the question of whether the recently adopted laws authorizing lay midwifery practice are hostile and restrictive or are legitimizing and facilitative. A related question is whether lay midwives are freer to practice in states which legally authorize them than they are in states without legislation, where their legal status is left unclear. We present a national legislative update on lay midwife regulation current as of January 1987 and more detailed information than previous surveys on the 10 states which currently authorize the practice of lay midwives, particularly with respect to eligibility criteria, scope, and standards of practice.

Methods

Letters requesting information on lay midwifery legislation were sent to a list of contacts in all 50 states and the District of Columbia. Relevant persons or agencies were identified from citations in previous surveys or through referrals in state departments of licensing and/or health, medical and nursing boards and related organizations. Where specific legislation existed, a copy was obtained. Letters were followed by telephone interviews to clarify points or to obtain more detailed information particularly in cases where bills had been introduced in legislatures and action was pending. Data from the 10 states with enabling laws were organized and analyzed as a function of characteristics describing implementation, and the specification of eligibility, scope, standards, and limits of practice of lay midwives.

Results

Legal Status of Lay Midwives

There is considerable diversity in the legal status of lay midwives in different states across the United States. One way of viewing lay midwifery law involves placing states on a continuum ranging from one extreme, namely a prohibitory law, to the opposite extreme of no law whatsoever.

There are a total of 10 states which have prohibitory laws, five states with grandmothering clauses, i.e., authorization of midwives under repealed statutes only, five states and the District of Columbia with enabling statutes on the books without having issued permits or licenses in recent years, and 10 states which explicitly permit and/or regulate the practice of lay midwifery. A residual category is made up of 21 states without statutory legislation pertaining to the practice of lay midwifery. In some of these 21 states, legal status of lay midwives is left unclear while there are others in

From the Department of Public Health Policy and Administration, University of Michigan, School of Public Health. Address reprint requests to Irene H. Butter, PhD, Professor, Department of Public Health Policy and Administration, University of Michigan School of Public Health, Ann Arbor, MI 48109-2029. This paper, submitted to the Journal August 7, 1987, was revised and accepted for publication March 2, 1988.

TABLE 1—Current Legal Status of Lay Midwives by State (1986)

State	No Law; Status Unclear	Has Enabling Law			Has Enabling Law, Unused	Limited To Licenses/Permits Issued under Repealed Statute	Has Prohibiting Law	Comments
		Licensure	Registration	Certification				
Alabama							1976 (Nurse Midwife Law)	State Health Dept. interpreted Nurse Midwife Law as prohibiting the practice of new Lay Midwives. No new certificates have been issued since 1980. In 1985 the last Lay Midwife retired.
Alaska			1985 An Act Relating to the Practice of Midwifery					
Arizona		1957 Licensing and Regulation of Midwifery						
Arkansas		1987 An Act to Authorize the Practice of Midwifery Statewide						A previously existing Law of 1983 limited licensure of lay midwives to a six-county poverty area.
California								
Colorado							1949 1985	Repealed—Enabling legislation Colorado Rev. Stat. 12-36-106. See Wolfson.[4]
Connecticut							1983	Section 9 of 83 Conn. Pub. Acts 441 repealed Conn. Gen. Stat. 20–75 to 86 which had authorized examination and licensing of Lay Midwives by State Department of Health. See Wolfson.[4]
Delaware						(1978)	1978 Board of Health rules and regulations pertaining to Midwifery	Lay Midwives grandmothered and permitted under certain circumstances.
District of Columbia					1981			See Wolfson.[4]
Florida		1984 Midwifery Practice Act						
Georgia					1980			"Practice of Midwifery", part of official code of Georgia, regulations originated 1968; updated 1980.
Hawaii							1976 (Revised 1984)	Title 11—Chapter 141: "Midwives"
Idaho	X							
Illinois						(1965)	X	Licensing of midwives came under medical practice act, practice act repealed 1965; those practicing could continue, no new licenses issued.

which case law rules so that practice is either permitted or prohibited by judicial interpretation or by Attorney General opinion (Table 1). For example, in Indiana (1984), Iowa (1978), Kansas (1978), and Maine (1977) practice is prohibited either as a result of judicial interpretation of a court case or by a specific AG opinion, but no prohibitory law exists. Three states have had judicial interpretations or AG opinions which support midwifery practice: Massachusetts (1985), Nevada (1982), and Oregon (1977). In the remaining states, midwives may or may not be practicing , but if they do, it is outside of the regulatory auspices of state government. In at least four additional states, Missouri, Wisconsin, Wyoming, and Massachusetts, bills pertaining to state regulation have recently been introduced in the legislature, but as of January 1987 have not been adopted.

In sum, there are only 10 states in which the practice of lay midwifery is clearly legal; in 10 other states it is clearly illegal, and in the remaining 30 states and the District of Columbia, it is legally ambiguous.

There does not appear to be a distinct geographic pattern in the distribution of states defining lay midwifery as clearly legal or clearly illegal (Figure 1). While seven of the 10 states with enabling legislation are in the south or southwest, the remaining three are in the far northwest or northeast. Those with clearly prohibitory laws are scattered, as are those without any legislation.

As shown in Table 1, almost all of the 10 states where midwifery is clearly legal adopted this legislation since 1980. The exception is Arizona whose current law was passed in 1957 although regulations were updated and revised in 1982. States with enabling laws on the books but no permits or licenses recently issued by-and-large enacted the legislation

TABLE 1—Continued

State	No Law; Status Unclear	Has Enabling Law			Has Enabling Law, Unused	Limited To Licenses/Permits Issued under Repealed Statute	Has Prohibiting Law	Comments
		Licensure	Registration	Certification				
Indiana	X							Practice prohibited by judicial interpretation. *Smith v. State Ind CT App.* 1984. See Wolfson.[4]
Iowa	X							Practice prohibited by 1978 AG opinion. See Wolfson.[4]
Kansas	X							Practice prohibited by 1978 AG opinion. See Wolfson.[4]
Kentucky						(1983)	1983	"902 KAR 4.010 Law Midwifery" replaced more liberal regulations issued in 1975.
Louisiana		1984 Midwife Practitioners Act						
Maine	X							Practice prohibited by 1977 AG opinion stating that practice of Midwives constitutes practice of nursing. See Wolfson.[4]
Maryland							1984	Title 10, Dept. of Health & Mental Hygiene, Subtitle 27 10.27.05. Regulations governing the practice of midwives, limits the practice to RNs; supersedes more liberal regulations which allowed LMWs since 1954.
Massachusetts	X							Practice is permitted by judicial interpretation. *Leigh v. Board of Registration in Nursing* (1985). See Wolfson.[4]
Michigan	X							Practice is permitted by judicial interpretation, *People v. Hildy* (1939). See Wolfson.[4]
Minnesota					1982			Licensure administered by Board of Medical Examiners; no applicants for some time.
Mississippi					1985			Dept. of Health stopped issuing permits to LMW in 1985 but this does not prohibit them from continuing to practice.
Missouri	X							Midwives are not licensed but they are permitted to practice. Legislation to regulate the practice has been introduced in the past two legislative sessions.
Montana	X							
Nebraska	X							See Wolfson.[4]
Nevada	X							Permitted by judicial interpretation of *Pierce v. Douglas County District Attorney* (1982). See Wolfson.[4]
New Hampshire				1981 Lay Midwifery (Chapter 326-D)				

(continued)

since 1980. Only New Jersey's law was passed slightly earlier, in 1978. Of the five states which repealed enabling legislation but allow grandmothering of praticing lay midwives, three passed this legislation recently. The two states which shifted to grandmothering earlier are Delaware (1978) and Illinois (1965). Of the 10 states which enacted legislation prohibiting lay midwifery practice, four did so recently and the others anywhere from 1949 to 1976. California had the earliest prohibitory law passed in 1949. Thus very few of the laws predate the 1970s and most of them appeared in the 1980s.

We now turn attention to the specific nature of enabling statutes governing the practice of midwifery in the 10 states were it is clearly legal. Our aim is to examine how facilitative or restrictive these statutes are and how much variation exists in current state regulation of lay midwives.

Characteristics of Enabling Legislation

Contemporary lay midwifery statutes have selected features not found in older and more traditional pratice acts which regulate the practice of members of mainstream health occupations. The legal basis for regulation of occupations is the police power of states which provides for the general welfare, health, and safety of its citizens. Of the various forms of state regulation, licensure is generally found to be more stringent than registration or certification because licensure laws define eligibility criteria, scope, responsibilities, and duties for practice more strictly with the purpose of controlling occupational entry. Whereas licensure is a mechanism used only by government agencies to regulate occupations, certification and registration are processes used by governmental or private organizations to recognize persons

TABLE 1—Continued

State	No Law; Status Unclear	Has Enabling Law			Has Enabling Law, Unused	Limited To Licenses/Permits Issued under Repealed Statute	Has Prohibiting Law	Comments
		Licensure	Registration	Certification				
New Jersey					1978			No new licenses have been granted since 1971.
New Mexico			1982					Practice is regulated by Public Health code. Regulations were passed in 1982.
New York	X							There is no law prohibiting but practice is prohibited by interpretation of CNM regulations that state anyone can attend birth but, but they cannot accept compensation unless they are CNM or MD. (Personal communication: K. Buckley)
North Carolina							1983—An Act to Regulate the Practice of Midwives	As of 1985 there were no permitted Lay Midwives practicing in North Carolina. 1983 legislation states that any person who on Oct. 1, 1983 had been a practicing Midwife in NC for more than 10 years may continue. State is not aware of anyone meeting this criterion. (Personal communication: Ronald Levine 3/4/86)
North Dakota	X							
Ohio	X							Cannot call yourself a Midwife unless you are a nurse but nothing in the law prohibits practice of Midwifery. Those who practice Midwifery who are not nurses call themselves birth attendants. (Personal communication: Vivian Goode 12/17/86)
Oklahoma	X							There is no law prohibiting the practice. Lay Midwives do deliver in the state. (Personal communication: Kathryn Nimmo 7/13/86)
Oregon	X							State Board of Nursing is aware of practicing Lay Midwives in the state but no regulations exist regarding that practice. (Personal communication: Mary Amdall-Thompson 4/7/86). Practice is permitted by AG opinion 1977. See Wolfson.[4]
Pennsylvania							1968	Practice is prohibited by the Medical Practice Act regulations which allow admission to an examination for licensure to practice Midwifery only to registered nurses.

who meet specified standards for entry and practice, entitling the holder to use a particular occupational title. In this paper, all three forms of regulation discussed are "statutory regulation."

Of the 10 states whose enabling legislation is actively in use, Arizona, Arkansas, Florida, Louisiana, and Washington specify licensure for practicing midwives; Alaska, New Mexico, Texas, and South Carolina use registration; and New Hampshire requires certification. A review of the laws and regulations of these 10 states finds, contrary to general belief, that midwifery statutes labeled as licensing acts are not necessarily more restrictive than the laws which require registration or certification. In only one state, New Hampshire, is regulation voluntary, i.e., a midwife can practice legally without being certified. In the remaining states, licensure, registration, or identification is mandatory.

Arkansas was the only state with geographic limits on midwifery practice, so that licensure of lay midwives was confined to counties with 32.5 per cent of the population below poverty. A new law, effective July 1987, expanded availability of licensure to midwives residing anywhere in the state. Another type of restrictiveness is found in Florida where a ceiling is placed on the number of lay midwives that can be licensed. Provisions in the statutes of remaining states do not appear to have further strings attached. But the development of midwifery legislation is currently in a great

TABLE 1—Continued

State	No Law; Status Unclear	Has Enabling Law: Licensure	Has Enabling Law: Registration	Has Enabling Law: Certification	Has Enabling Law, Unused	Limited To Licenses/Permits Issued under Repealed Statute	Has Prohibiting Law	Comments
Rhode Island						1982		Rules & regulations for licensing of Midwives as amended in 1982 limit licensing to registered nurses. There is one Lay Midwife licensed via a grandmother clause of those regulations.
South Carolina			1981					General public health law regulates practice of Midwifery. Regulations were established in 1981.
South Dakota	X							
Tennessee	X							Midwifery is explicitly excluded from the statutory definition of medicine. Also it was ruled that Midwifery is not practice of nursing in *Legget v. TN Board of Nursing* (1980). See Wolfson.[4]
Texas			1983 Lay Midwifery Law					Annual identification with county clerk required along with submission of verified identification form.
Utah	X							State task force has been formed to examine practice of Midwifery.
Vermont	X							There is no law prohibiting or enabling the practice. Midwives do practice and are self-regulating. Vermont Midwives Alliance are in the process of creating a certification process. Also State Health Dept. is completing a study of birth outcomes of midwife-attended births. A bill to regulate midwives may come out of that study. (Personal communication: Catra Kindar)
Virginia						1985		Since 1977 new licenses to practice have been limited to registered nurses. (Article 4, Midwives)
Washington		1981 Licensed Midwife Law						
West Virginia							1973 H.B. No 718 Article 15-Midwives	
Wisconsin							1953	A law which authorized the practice of Midwifery was repealed from the Medical Practice Act in 1953. Legislation to legalize the practice has been introduced in the last 2 sessions.
Wyoming	X							No law enabling or prohibiting. Legislative activity to regulate the practice is expected to be introduced this year.

AG = Attorney General
LMW = Licensed Midwives
CNM = Certified Nurse Midwife

deal of flux; in New Mexico, legislators are contemplating a switch from registration to licensure and South Carolina is pursuing deregulation.

In eight of the 10 states, regulation and monitoring are implemented by the department of public health or its equivalent. This is in contrast to the conventional situation in which health occupations have their own regulatory board, consisting of members of their own occupation, and where licensure is administered by a department of licensure and regulation. In Louisiana, midwifery is regulated by the Board of Medical Examiners and in Washington state midwifery regulation is housed in the Department of Licensing.

Another relatively unique characteristic of the midwifery statutes is the creation in each of the 10 states of a Midwifery Advisory Committee, Board, or Council for the purpose of overseeing the administration and recommending modifications of the regulatory scheme. Suggestions are solicited from Midwifery Advisory Boards on such topics as

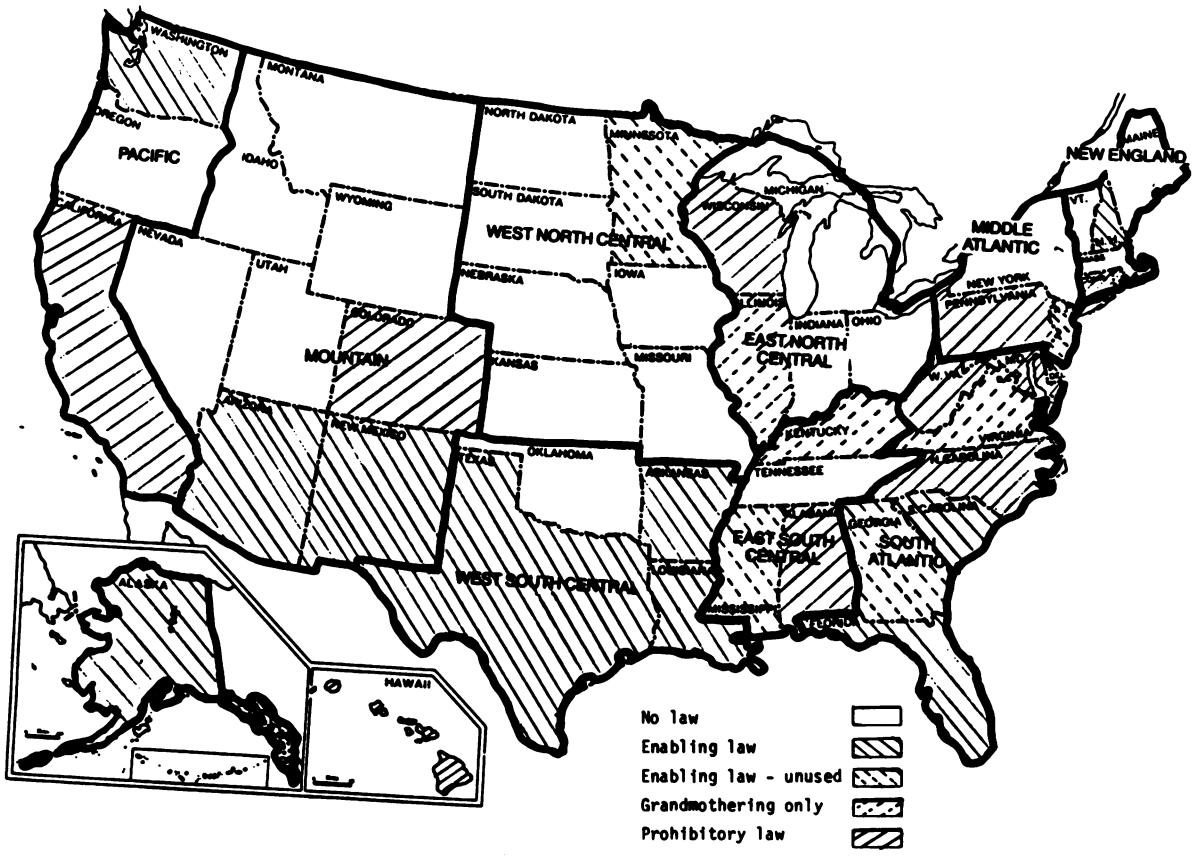

FIGURE 1—Geographic Distribution of State Legislative Status of Midwifery

examinations, peer review, standards of practice, and continuing education. The composition of these advisory committees is quite similar from state to state, consisting of a licensed obstetrician, one licensed practicing physician, one certified nurse-midwife, two to three lay midwives, and one public member, who shall have no financial interest in the rendering of health services. To date, there is not a great deal of information available on how these advisory committees function in practice and on how important their role is now or will become in the future. Potentially, these committees could play an innovative role in that they are multi-disciplinary and may provide a broader perspective that would lend openness and flexibility to the regulatory process. Of special interest is the fact that even in Louisiana, where midwives are licensed by the Board of Medical Examiners, a Licensed Midwife Practitioner Advisory Committee has been created.

Seven of the 10 states make reference to "Lay Midwife" as part of the title, sometimes prefaced by the terms "licensed," "registered', or "certified." Two other states, Arizona and Washington, use the title of "Licensed Midwife", and in Louisiana the Act specifies "Licensed Midwife Practitioners." Nevertheless, requirements for licensure, registration, and certification are not insignificant in most states.[3] The State of Washington, for example, requires three years of training in an approved program, and most other states define training requirements with varying degrees of specificity. With the exception of Texas, all states require a qualifying examination and a certain amount of clinical experience for licensure, registration, or certification. Thus the title of "lay" midwife provides a distorted impression of the actual qualifications these practitioners have.

Most states require fees for application, examination, and renewal of licenses, permits, or certificates. Fees are quite modest and should not represent a financial barrier to practice. They commonly range from $25-$50 for application and renewal with Florida and Washington at the extreme charging examination fees as high as $150. Renewal of licensure or registration is annual in all states except Florida and New Mexico where is it biennial.

Eligibility and Qualifications for Practice

Only three of the 10 states specify age minima: 18 years in Alaska and 21 years in Louisiana and Washington. Seven out of 10 states require a high school diploma or equivalent. Six states require midwives to obtain cardiopulmonary resuscitation (CPR) certification and three states have health status requirements, a negative TB test, Rubella immunization or a certification of good physical and mental health. Arizona and Texas are the only states without any miscellaneous eligibility requirements.

In Texas, however, midwives are required to identify themselves in December of each year to the county clerk of the county in which they reside or practice, and at that time, midwives must submit a detailed, verified identification form.

With the exception of Texas, the laws in all 10 states make some reference to both clinical experience and cognitive requirements. The clinical experience requirements encompass prenatal, natal, and postnatal care, and in most states, these are spelled out in some detail, e.g., the minimum number of client contacts required in each category. The minimum ranges from 60–100 visits or caring for 15–50 women during the prenatal period and caring for between 15–

50 women during intrapartum and postpartum stages. Among other requirements to become a licensed midwife in Washington, one must care for 50 women from the prenatal phase through the birth and the early postpartum period. Most other states require pregnancy care experience, including birthing and postnatal care, for 15–25 women.

All states except one require the candidate to pass a qualifying written, oral, and/or practical examination. In Texas, an examination is offered but not required. In some but not all states areas covered include: nutrition, biology, anatomy, physiology, social and behavioral sciences, human fetal growth and development, etc. Specifications of how one acquires the necessary knowledge is generally flexible since a number of options are available. These include self-study, apprenticeships, formal courses of study like those offered in Florida and Washington for midwives specifically or training programs incorporated into existing community colleges, as proposed in Arizona.[9] As an attempt to assure continuing competency midwifery statutes, analogous to those of other health occupations, six states specify between 10–20 hours of continuing education annually as a condition of licensure/certification/registration renewal.

Scope, Standards, and Limits of Practice

In contrast to other aspects of the laws, for most states the scope of midwifery practice is defined in great detail, frequently specifying the number and timing of required consultations with physicians and listing the conditions for which an MD must be consulted. Six states require at least one examination of a potential client by a physician during the prenatal period as well as consultations with physicians for a list of intrapartum conditions. For postpartum care, emphasis is placed on the number of hours the midwife must remain with her client and the length of the period over which the mother and infant would be evaluated. All states but Washington specify that newborn care lies within the scope of midwifery practice and either recommend that a physician be consulted or list the conditions which require physician consultation. Fundamental to these scope-of-practice definitions is the availability of physicians willing to cooperate with lay midwives and ready to be called in for consultation.

In addition to specifying what midwives are not allowed to do, the statutes also define duties and requirements. For example, most of the states have reporting requirements for birth certificates, mortality/morbidity reports, and monthly, quarterly or semi-annual case summaries. The requirements of informed consent forms from mother or both parents in eight states represent a feature not common in practice acts of other health occupations. This aspect may reflect the influence of health consumer and women's health movements in their efforts to promote knowledge sharing and demystifying the birth process. Informed consent of a substantive nature and the spelling out of potential risks would appear to be mutually beneficial for midwives and clients.

Eight states require a pre-arranged agreement for physician backup, implying that a written plan is needed to assure cooperation by physician and hospital in case of emergency. The usual pattern in the statues is one where the physician backup requirement goes hand-in-hand with an emergency transport plan. In the event that physicians are either unavailable or unwilling to form these working agreements with midwives, the scope and standard of practice stipulations would be seriously jeopardized or, alternatively, midwives would be preempted from practice.

All states stipulate that midwives confine their practice to low-risk pregnant women. One state defines low risk as "normal and uncomplicated," four states require low risk to be determined by physical risk assessment and evaluation, and the statutes of three states provide a list of conditions that would prohibit the midwife from accepting the client.

When it comes to what midwives are and are not allowed to do in the realm of medications and operative procedures, the relevant sections of the statutes are quite detailed and very specific. Administering drugs and use of invasive procedures are generally prohibited except in emergencies. Specific drugs are permitted under physician auspices or explicitly defined conditions. Performance and repair of episiotomies and the repair of lacerations are permitted in seven states. The use of artificial or forcible means during delivery or correcting fetal presentation is prohibited in eight and five states respectively.

Discussion

At present, the only meaningful statistic describing the midwife's role pertains to out-of-hospital births.[10] It is not clear how complete these data are, but according to the most recent estimate for out-of-hospital births, they comprised 1 per cent of all births in 1984 and, of these, midwives attended over 74 per cent or approximately 28,000 births. While this clearly does not point toward growth matching earlier times when midwives attended as many as 50 per cent of all births in the US, it does represent a small yet persistently desired birth option. In the past two decades, the raison d'etre of lay midwifery practice has been to respond to this expressed desire for birth alternatives by childbearing women. Given this purpose, lay midwives have formed regional, state, and national networks as vehicles for sharing a common philosophy of birth and for developing a style of practice which is woman-centered and in stark contrast to mainstream obstetrics.[15] One response to these recently organized manifestations of lay midwifery has been statutory changes across the country which are the focus of this paper. The picture which emerges is one of great diversity. Ten states have declared the practice of lay midwifery clearly illegal. In many more states legal status is left ambiguous or has been described as "legality by default."[11] Most of this paper concentrates on the 10 states with statutes that define midwifery as clearly legal.

The 10 states which constitute the main focus of our study include five states with licensure, four with registration, and one with certification. Although it is generally perceived that licensure, registration, and certification represent different levels of restrictiveness, in the case of lay midwifery the demarcation between them seems to be less sharply drawn. In New Hampshire, certification is voluntary, and it is not illegal for an uncertified midwife to practice. In the other nine states it is mandatory for lay midwives to obtain licensure or registration. While Texas seems to be the state with the most lenient statute because eligibility, educational, or training requirements are not stipulated, the fact that lay midwives must register annually with the county clerk, coupled with a disclosure form and other reporting forms than are mandated could mean that this statute is potentially as restrictive as others in restraining midwifery practice at the local level. Much hinges on implementation of the rules and regulations in each state, and we did not attempt to collect information in this area.

What gains have been achieved by midwives in the 10 states which define their status as clearly legal? In what ways

have the statutes enhanced and facilitated midwifery practice? And in what ways are these laws inhibitory and restrictive? After reviewing the material presented in previous sections there is little doubt that what we have called enabling legislation offers some advantages but also disadvantages to lay midwives.

While the main purpose of state regulation of health occupations is protection of consumers (by establishing minimum standards of competency), the impact of the types of regulation here presented can be considered anti-competitive. Cognitive and experiential prerequisites for entry into an occupation can serve to restrict the number of practitioners who qualify for practice. Although entry criteria (eligibility, cognitive/experiential requirements, and fees) are not prohibitive, attributes of state regulations which define the boundaries of practice, prohibit use of drugs, and require collaboration and backup by physicians are potentially inhibitory or hostile to lay midwifery. Having to depend on physicians to define which clients are low risk and experiencing normal pregnancies can be used as a device to restrict clientele, and having to rely on physician willingness to cooperate, consult, and provide support when complications arise or emergencies occur limits autonomy and can stifle the practice of lay midwives.

The example of Arizona illustrates one possible consequence of a statutorily defined physician-dependent relationship. Administrative rules of Arizona's midwifery law require physician consultation and support. Since September 1985, two major insurance companies providing malpractice insurance to Arizona physicians have prohibited their insured physicians to backup uninsured licensed midwives. At the same time, it has become increasingly difficult for Arizona midwives to maintain the malpractice insurance which their former insurance company either canceled or rendered nonrenewable. As a result, Arizona licensed midwives face a dilemma: the law requires physician backup, but physicians are prohibited (by their insurance companies) to backup midwives without malpractice insurance (insurance which is no longer available to them.)[12] Are Arizona's licensed midwives better off than midwives in states where their practice, while not prohibited, remains unregulated?

Midwifery regulation is placed under authority of the medical board in one state (Louisiana) and in all other states under a committee or board constituted of a majority of non-midwives. Will this advisory committee recommend standards, rules, and regulations facilitative and supportive to midwifery practice or is the committee more likely to view midwifery as a competitive threat to be curbed and confined rather than protected and enhanced?

Among the benefits associated with state authorized practice are the following: the statutes provide midwives with legal status; they are granted the privilege to practice as distinguished from unlicensed/unregistered midwives; the credential obtained through licensure/registration/certification creates an image of public legitimacy and professional respectability, in the context of the dominant health system; and under these laws midwives would be protected from possible criminal prosecution, incarceration, and fines if sued for unsuccessful pregnancy outcomes. Of these three benefits, the last (protection from criminal prosecution) is the most important because it cannot be obtained in any way other than state recognition. Legal status, the first benefit listed above, may be one of several factors underlying availability of malpractice insurance for lay midwives. Of course, malpractice insurance would have to be affordable to be of any use. The combination of legal status and malpractice insurance would make lay midwives less liable, less vulnerable, and provide them with a greater sense of security.

A professional respectability and an enhanced professional image can be achieved outside the realm of state regulation. There has been a growing grassroots movement among lay midwives in this country seeking to establish a system of standard setting and monitoring. This movement consists of at least two factions: those midwives seeking recognition and credibility from within because they view themselves outside of the mainstream health care system; and those midwives who view state regulation as inevitable, and want to be prepared for and participate in the conglomerate of interest groups that will take part in structuring and influencing the laws governing practice of midwifery. Whether lay midwives see themselves within, at the periphery, or outside the dominant health delivery system, they are striving toward establishment of a system of voluntary certification or registration with a national examination for entry level competence,[13] the development of standards of practice through a mechanism of peer review, and protocols which specify guidelines and routines for midwifery care.[14,15]

The overriding collective concern here is one of professional responsibility, accountability, and respectibility. While it is probably true that lay midwife groups in the 10 "clearly legal" states endorsed the legislation in its formative stages, it is also true that currently lay midwives seek to protect and promote their occupation and to assure further development of midwifery practice outside the realm of state legislation. This grassroot movement, strongly committed to the well-being of clients, is actively asserting itself nationally through the Midwife Alliance of North America (MANA), incorporated in 1982 and with several regional divisions and on the state level as well. Midwife groups in some individual states have been active in developing their own certification programs. While midwife groups worry about the risk that underqualified practitioners could injure the reputation of their occupation, and even though they have made a commitment to monitor each other's practices, they are not likely to exclude anyone from practice on grounds unrelated to competence. It is on these grounds that monitoring and standard setting by lay midwives groups in states without midwifery statutes may be more enhancing for lay midwives than practice in the 10 states with so-called enabling laws which are constrictive and stultifying. While there are clearly some tradeoffs between state regulated and legally unrecognized practice of midwifery, the future of midwives may be fostered most by those states in which legal status remains unclear.

NOTE: A set of detailed tables describing provisions in the laws of 10 states with enabling legislation, including eligibility requirements, qualifications and training, scope, standards, and limits of practice can be obtained from the authors by request.

ACKNOWLEDGMENTS

The authors would like to express their appreciation to Helen Edwards for her assistance in the preparation of information presented in the tables.

REFERENCES

1. Yankauer A: The valley of the shadow of birth (editorial). Am J Public Health 1983; 73:635–638.
2. DeVries R: The content for control: Regulating new and expanding health occupations. Am J Public Health 1986; 76:1147–1150.
3. Evenson D: Midwives: Survival of an ancient profession. Women's Rights Law Reporter 1982; 7:313–330.

4. Wolfson C: Midwives and home birth: Social, medical, and legal perspectives. Hastings Law J 1986; 37:909–967.
5. Throne LJ, Hanson LP: Midwifery laws in the United States. Women & Health 1981; 6:7–27.
6. Sallomi P, Pallow A, O'Mara McMahon P: Midwifery and the law. Mothering 1981; 21:1–22.
7. Cohn SD, Cuddihy N, Kraus N, Austen TS: Legislation and nurse-midwifery practice in the USA. J Nurse Midwifery 1984; 29(2):57–174.
8. Stickels BJ: Lay Midwifery Regulation 1986 (mimeographed). New Mexico Health and Environment Department, Santa Fe, NM.
9. Sullivan D, Weitz R: Obstacles to the practice of licensed lay midwifery. Soc Sci Med 1984; 19(11):1189–1196.
10. National Center for Health Statistics: Advance Report of Final Natality Statistics, 1984. Hyattsville, MD: NCHS, 1986; 35(4):24.
11. DeVries R: Regulating birth: Midwives, medicine, and the law. Philadelphia: Temple University Press, 1985.
12. Steinbring J, Hodson M: Midwives in Arizona struggle with malpractice crisis. MANA News 1986; 3(6):1–4.
13. North American Registry of Midwives Proposal. MANA News 1987; 4(4): 2–3.
15. Gerritsen L: Protocols for midwives—What, why and how. MANA News 1987; 4(4):(Suppl).
14. Glass S: Standards & Practice Report on Peer Review. MANA News 1987; 4(4):(Suppl).
15. Kay B, Butter I, Chang D, Houlihan K: Women's health and social change: The case of lay midwives. Int J Health Serv 1988; 18(1):223–236.

US Health Care Personnel Numbers Increasing, says DHHS

Despite a drop in the number of persons entering health profession schools, the number of health care personnel continues to increase and to exceed the growth rate of the United States population, according to a new report to Congress. *The Sixth Report to the President and Congress on the Status of Health Personnel in the United States* makes the following statements and projections:

- Approximately 355,000 students were enrolled in schools of medicine, dentistry, podiatry, optometry, pharmacy, veterinary medicine, registered nursing, and public health in the 1985–86 academic year. Overall the number of students training for careers in these disciplines has declined somewhat since the early 1980s and the number of applicants declined considerably. The drop in applicants was particularly rapid and steep in dentistry, declining 64 per cent from a high of 15,734 in the 1975–76 school year to 5,724 in 1986–87.
- Projections indicate that the number of health care personnel will continue to grow through the end of this century but, in most disciplines, at a slower rate. Increases are expected to range from 9 per cent for dentists to 80 per cent for osteopathic physicians between the years 1986 and 2000. The US population is growing about 6 per cent a year.
- The aggregate supply of most health professions is expected to be in rough balance with requirements at least through the end of this century. The aggregate physician supply, however, is expected to exceed overall requirements.
- All states and most areas of the country have shared in the increase in the number of health care personnel. However, approximately 13 million people, about 5 per cent of the US population, remain underserved in the nation's primary care health manpower shortage areas.
- Continued increases in the supply of health care personnel are expected to improve access for some areas. But population and economic factors may remain unfavorable for the establishment of health care practices in many rural and urban poverty areas, which are likely to remain short of adequate health care.
- Currently there is an increased demand for registered nurses in hospitals along with problems of recruitment and retention. Data also indicate chronic deficits of skilled nursing personnel in nursing homes. Although the aggregate supply of and requirements for nurses are expected to be in rough balance for the remainder of this century and the early years of the 21st century, it is expected that requirements will exceed the available supply by the second decade of the 21st century. The supply of baccalaureate and higher degree nurses is expected to fall short of the requirements throughout the projection period.

The Sixth Report to the President and Congress on the Status of Health Personnel in the United States is one of a series of biennial reports required by the Public Health Service Act and prepared by the Health Resources and Services Administration, David N. Sundwall, MD, administrator. For further information about the report, contact Frank Sis, US Public Health Service, 301/443-3377.