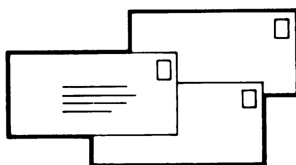

# Letters to the Editor

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*Letters should be submitted in duplicate, double-spaced (including references), and should not exceed 400 words.*

## Professional Midwifery

We applaud Irene Butter and Bonnie Kay for their thorough description and analysis of state laws regulating "lay midwifery" practice in the US.[1] Indeed, this patchwork array of state statutes, with diverse and sometimes inconsistent regulations, serves as one of the major obstacles to the development of midwifery as a viable health profession in the US. This inconsistency adversely affects the practice of certified nurse-midwives as well as the midwives discussed in Butter and Kay's study.

We would, however, take exception to the term "lay midwife," as defined by Butter and Kay. It does not apply to midwives such as those licensed in Washington State who have completed an accredited education program whose requirements meet or exceed international standards for midwifery education[2] and who are licensed to practice midwifery with a scope not dissimilar from the state's certified nurse-midwives. To use the word "lay"—defined by Webster's as "not of or from a particular profession" and whose common usage connotes "untrained"—does a disservice to a group of health care providers striving for professional recognition.

Furthermore, enacting "enabling" legislation (as it is referred to in this paper) to allow for the practice of midwifery is not solely an issue of providing home birth services to a small minority of families. While home birth is an important issue in itself, the legitimization and increased utilization of midwives should be viewed in the larger context of improving access to care, improving the quality of care, and reducing the cost of care at a time when these are pressing public health problems. That midwives can provide some solutions to these problems has been suggested by reports from the White House Conference on Child Health and Protection of 1930[3] to the Institute of Medicine's 1985 report Preventing Low Birthweight.[4]

For such legislation to be truly "enabling" it will have to address some of the formidable barriers that currently stand in the way of full practice, even for state licensed midwives: lack of (affordable) malpractice insurance, inability to obtain hospital privileges, incomplete reimbursement from third party payers and excessive restrictions on the scope of practice. With such legal remedies, and with health policymakers as facilitators, professional midwifery has the potential to be an efficient, cost-effective way of providing quality maternity care, in all settings, to the families of this country.

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## Opportunities for Lay Midwifery Practice

A recent article concluded that legislation enabling midwifery practice was restrictive of such practice and that better opportunities for lay midwifery practice would be found in states with no legislation.[1] This conclusion was based only on the fact that the enabling legislation contained certain restrictions which were presumed to limit or discourage practice. I found this conclusion somewhat surprising in view of the fact that Washington State, which has enabling legislation, ranks in the top 10 states with respect to the proportion of births delivered by midwives in nonhospital settings.[2] According to a recent study,[3] the majority of these deliveries are by midwives licensed under the Washington State enabling law. I examined data from a national publication[2] to calculate the per cent of deliveries attended by lay midwives in each state, using midwife-nonhospital deliveries as a surrogate measure of lay midwifery. The state data were then grouped by legislative status area. The results are as follows:

| | Per Cent of Deliveries in Midwife-Nonhospital Group | | |
|---|---|---|---|
| Legislative Status[1] | Median | Mean | Range |
| No law | 0.20 | 0.49 | 0.00–2.22 |
| Enabling Law | 0.88 | 0.87 | 0.06–1.86 |
| Enabling Law—Unused | 0.10 | 0.12 | 0.01–0.29 |
| Grandmothering Only | 0.17 | 0.44 | 0.06–1.50 |
| Prohibitory Law | 0.09 | 0.19 | 0.01–0.60 |

As the data ranges show, there is a great deal of overlap in rates between the five groups. Obviously, legislative status is not a good distinguishing variable to use in this case. It is also noteworthy that the two "no law" states with the highest percentage of midwife-nonhospital deliveries (Oregon and Nevada) have no direct enabling legislation, but have had legal opinions supportive of lay midwife practice.[1]

This comparison is undoubtedly flawed. It is very likely that lay midwives are not reported as birth attendants in states where lay midwifery is prohibited by law and thus the percentages may be artificially low for these states. Another shortcoming is a lack of comparability between states in terms of what constitutes a "lay midwife" and/or a "non-hospital" delivery. How-

ever, errors introduced by definitional differences may be randomly distributed among the various legislative status groups and thus balance out. Furthermore, even restricting Washington State to the narrowest possible definition of lay midwifery (home delivery by a licensed midwife), it still ranks twelfth in the country in "lay midwife" deliveries compared to other states; some of the other states are likely to have more inclusive definitions.

I conclude that there is no evidence of lower lay midwife use rates for states with enabling legislation. This issue can have significant ramifications for the midwives and for states considering enabling legislation. Thus, more data with comparable definitions are needed before any conclusion can be drawn about the impact of legislation on opportunities for midwives. In particular, it would be very useful to see if Washington State's experience of proportionately high lay midwife deliveries is shared by other states with enabling legislation.

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## Response from Drs. Butter and Kay

In response to Dr. Starzyk's letter we wish to emphasize the following:

1) The National Center for Health Statistics data do not distinguish between lay midwife and certified nurse midwife out-of-hospital deliveries. Thus, using "midwife-nonhospital deliveries" as a measure of lay midwife deliveries is not valid. For example, this category would include midwife-supervised deliveries at birthing centers. Few, if any, lay midwives work in these settings.

2) Nine of the 10 states with enabling legislation require that the midwife have physician back-up. The 10th state requires that the midwife inform her clients on a disclosure form whether or not she has physician back-up. Physicians are often unwilling to enter into these relationships with lay midwives because of restrictions on home birth specified in their malpractice insurance policies. This has posed a restriction for midwives who want to establish such relationships regardless of the state in which they work. Specifying physician back-up in a law, given current malpractice policies, is inherently restrictive.

3) Nine out of 10 states specify the type of client lay midwives are permitted to work with. Four specify "low risk" cases only as determined by a physician. Two state "low risk" clients only, except when no physician is available in an emergency. The other three limit clients to "low risk" and provide definitions of "low risk." Reliance on physicians for an evaluation presumes their willingness to work with lay midwives. Refer to #2 above. These data are available from us on request.

4) We refer Dr. Starzyk to the last paragraph in our paper where we suggest that enabling legislation can be a mixed blessing. There is disagreement among midwives about the pros and cons of legal recognition. The issue is complex. Whether in the future the advantages (however defined) outweigh the disadvantages or vice versa depends on other changes emerging in the dominant health care system as well. In any event, we concur with Dr. Starzyk about the importance of the above issues and the desirability of further discussion.

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## Comments from Taffel at NCHS

Dr. Starzyk errs in using National Center for Health Statistics figures on midwife-nonhospital deliveries as a surrogate for deliveries by lay midwives. A number of freestanding birthing centers (e.g., the Maternity Center Association of New York City), where deliveries are by certified nurse-midwives, are included in the NCHS out-of-hospital category. According to a recent survey of nurse-midwifery practice in the United States, 14 per cent of certified nurse-midwives conduct deliveries in private homes and 12 per cent in non-hospital birth centers. The proportion of nurse-midwives who deliver babies in non-hospital settings varied by 20-fold among states.[1,2]

At this time, many state birth certificates do not make the distinction between lay and certified nurse-midwife deliveries. Hence, it is not possible to determine from NCHS data what proportion of midwife out-of-hospital deliveries are by law midwives or how this proportion varies from state to state. This problem will be corrected beginning in 1989 with the implementation of the revised US Standard Certificate of Live Birth, which distinguishes between lay and certified nurse-midwives, and separately identifies freestanding birthing centers.

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## Smokeless Tobacco: Less Seen at 1988 World Series

We were interested in observing longer range effects of anti-smokeless tobacco use activism on displays of smokeless tobacco use in the televised 1988 World Series. We did this in response to Dr. Rhys Jones' observations of the 1986 World Series.[1] He observed much display of use just subsequent to the initiation of several anti-smokeless tobacco activities and policy. In our replication study, we observed all five games and established inter-rater agreement of independent observations made from the time of the national anthem until the last out. Observations included number of times players or coaches made explicit shows of gum (a signal that players were not using smokeless tobacco or at least were hiding it in their mouths), number of spitting events that occurred, or any show of smokeless tobacco or smokeless tobacco packaging. Inter-rater agreement was $r=.94$ across categories and mean ratings