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Commentary

Making a Case to Reduce Legal Impediments to Midwifery Practice in the United States

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In December 2014, the British National Institute for Health and Care Excellence (NICE) published updated guidelines for intrapartum care. The guidelines present evidence affirming that low-risk childbirths conducted by midwives yield similarly beneficial clinical results to births delivered by obstetricians (NICE, 2014). This included statistical information about outcomes of midwife-led prenatal and childbirth care, and the increased likelihood of receiving continuous one-to-one care during labor for women cared for by midwives. The recommendations also called for increased access to information about choosing an appropriate birth setting (home, birth center, or hospital), weighing risks and benefits, and making a safe decision consistent with their preferences (NICE, 2014). Those working to update the guidelines stressed the need for autonomy in choices about maternity care providers and birth settings, and ensuring safety for all women and infants during childbirth (Prime, 2014). Despite the NICE report's focus on autonomy, information, and choice, the report was characterized widely by news media outlets as heralding midwifery as the safest method of childbirth for low-risk pregnancies (Prime, 2014). In short, the report was seen as a national endorsement for the merits of midwifery. Under a nationally uniform system of health care, this single step of publishing guidelines recommending safe practices for low-risk births has the potential for sweeping impact on the practice of midwifery, potentially conferring both health and economic benefits.

Here in the United States, however, no such unified path to sweeping change in childbirth care exists; rather, the regulatory, legal, and logistical opportunities and constraints around midwifery practice are many and varied owing to unique governance (state vs. federal jurisdiction) and health care (delivery systems, health insurers, practice models, professional associations, etc.) structures. Perhaps in the U.S. context, the NICE recommendations should be considered more broadly for their value in catalyzing conversation about women's choices and how the broader policy environment and health care system can ensure that an appropriate set of safe care options are available to pregnant women making decisions about their childbirth care.

Legal Climate Facing Midwifery in the United States

It is important to first note that, in the United States, the principles of federalism dictate that midwifery—like the practices of most health care providers—falls within the regulatory power of the individual states. As such, laws concerning midwifery are fragmented and vary dramatically from state to state. Many state laws concerning midwifery serve, for instance, to authorize the practice, provide for statewide licensure for midwives, or define the practice of midwifery as it relates to that of other health care providers within a state. Other statutory and regulatory requirements, however, enacted by state legislatures, promulgated by state regulatory bodies, or derived from the common law of different judiciaries have the effect of reducing a midwife's ability and incentive to practice in many states.

Arguably, laws of the latter type—those aimed at limiting or constraining the scope of midwifery practice—have had more impact on women's options than laws of the former focused on authorizing the practice of midwifery; indeed, midwifery throughout the United States is characterized by substantial legal impediments to practice. These restrictions can take the form of restrictive scope-of-practice laws, and other laws and regulations whose effects are to artificially limit the practice of midwifery. Such laws have historically been implemented and passed on the premise of supporting patient safety by placing limits on midwifery practice, but an abundance of clinical evidence indicates that such restrictions may actually have an opposite effect, denying women access to potentially safe,

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high-quality options for maternity care (Sandall, Soltani, Gates, Shennan, & Devane, 2013; Johantgen, Fountain, Zangaro, Newhouse, Stanik-Hutt, & White, 2012). Although each state's laws are unique, some common limitations on the practice of midwifery include compelled supervision by physicians, requirements that physicians and midwives enter into written practice agreements that limit the midwife's autonomy, and limitations on a Certified Nurse-Midwifes (CNM) prescriptive powers (State of California Department of Consumer Affairs, 2011; 172 Nebraska Admin Code 104, § 005).

States that do not allow CNMS full autonomy in practice use a range of policies that may include 1) requiring physician supervision or contractual practice for CNMs to exercise prescriptive authority, 2) requiring CNMs to have contractual practice agreements with physicians for certain procedures, 3) requiring CNMs to have signed contractual practice agreements with physicians for overall practice, and 4) requiring CNMs to have physician supervision for overall practice. The effect of these laws is to limit the independent scope of practice open to midwives, such that midwives may not be practicing "at the top of their license" and creating potentially duplicative efforts or unnecessary oversight.

In addition to these scope of practice laws, there are varying considerations for different categories of midwives, including CNMs, Certified Midwives (CMs), Certified Professional Midwives (CPMs), and Direct Entry Midwives (DEMs; Johnson, 2011). For instance, CMs, a newer certification to midwifery, are not yet reflected in all state statutory or regulatory structures and are only authorized to practice in five states. Not all states recognize the CPM credential that requires knowledge of and experience in out-of-hospital settings, and many CPMs attend births in women's homes or in out-of-hospital birth centers. Only 11 states provide DEMs with Medicaid reimbursement (Midwives Alliance of North America, 2011). Many other states have failed to pass legislation that would mandate that private insurers reimburse midwives for services rendered (American College of Nurse-Midwives, 2014c). Other barriers include the ability and propensity for hospitals to deny admitting privileges to midwives and the high cost of professional liability insurance for midwives, as well as restrictions on practice that may be imposed by malpractice insurers, lack of or limited midwife representation in administration and among medical staff leadership, reticence by private health insurers to contract directly with midwives or reimburse them for the full range of services they are authorized to provide under applicable state laws or regulations, and pervasive false sentiment that midwifery poses dangers to both mother and child (American College of Nurse-Midwives, 2014b; Bushman, 2014; Johnson, 2011).

Other laws specify a narrow range of services that can be provided by midwives. For example, they may be allowed to provide prenatal, intranatal, and postnatal care, implicitly denying them the chance to provide general primary care for women, gynecological care, family planning, or other services included within the American College of Nurse Midwifery's model scope of practice (American College of Nurse-Midwives, 2014a). Moreover, the majority of states either altogether forbid or refuse to recognize direct entry midwifery; this means that, in the states where it is not an actual crime, the risk of litigation can limit the practice of midwifery to mere "baby catching" (Midwives Alliance of North America, 2011).

In large part, state regulations to restrict the practice of midwives arose out of a desire to place the profession under oversight to ensure public confidence and safety from the prevailing, and false, perception that midwifery was not a legitimate clinical practice. However, the evolution of the profession of midwifery and the understanding of the public at large has changed. Patients today have more rights, responsibilities, and greater health literacy than the population in the 1920s, when state governments first imposed the type of licensure requirements on midwives that were intended to drive out practitioners who could pose a danger to an unwitting public (Declercq, Paine, Simmes, & DeJoseph, 1998). However, the time has come, in light of clear evidence supporting the benefits of the midwifery model of care as well as the economic hardships facing the health care system, to revisit these policies that govern the role midwifery in the U.S. health care system.

Empirical Evidence in Support of Increasing Midwifery

Despite historical fears about the dangers of incompetent practitioners of midwifery, studies of the actual practice of midwifery and its effectiveness over the last few decades show quite the opposite: midwifery is not only competently practiced, it is perhaps the most competent maternity care model available. There is a growing body of evidence supporting increased access to midwifery as a means toward individual-level and population-level benefits in terms of clinical, psychosocial, and financial outcomes (Sandall et al., 2013). Since the late 1990s, studies have consistently shown that low-risk women who receive care from midwives experience comparable—and sometimes better outcomes—than women who receive care from physicians (Johantgen et al., 2012; MacDorman & Singh, 1998; Renfrew et al., 2014; Sandall et al., 2013). Furthermore, globally, studies have projected a reduction in infant mortality rates in countries that implemented plans to make major commitments to increasing midwifery practice (Homer et al., 2014). There is also some evidence that midwives can produce similar rates of positive outcomes to doctors in hospital settings for more complicated births (Homer et al., 2014).

On top of the clinical evidence, there is the potential for greater efficiency when similar or superior quality of care can be produced using fewer financial resources. Women who receive midwife-led care have a reduced need for higher priced physician time, higher priced obstetric procedures, longer hospital stays, and all the attendant staff resources unnecessarily spent on low-risk births (Cawthon, 2013; Sandall et al., 2013). Although the social cost of bad birth outcomes is to be avoided at all costs, it seems that the United States, despite leading the world in health care spending, has not figured out how to spend wisely enough to eliminate this risk. Indeed, in 2010, the U.S. infant mortality rate was 6.1 infant deaths per 1,000 live births, and the United States ranked 26th in infant mortality among Organisation for Economic Co-operation and Development countries (MacDorman, Matthews, Mohangoo, & Zeitlin, 2014). The estimated costs of approximately 4 million annual U.S. births is well over $50 billion, potentially rising as high as $66 billion in 2013 (National Partnership for Women & Families, 2015). It is nearly universally acknowledged that the U.S. health care system is overburdened by costs. The need to find innovative ways to create value within the U.S. health care system was a primary motivation behind the passage of the Affordable Care Act and continues to dominate business decisions and policy discussions as clinicians, administrators, researchers, and policymakers look for new ways to improve the economic efficiency of the health care system while maintaining high standards for access and quality (Robinson, & Smith, 2008).