Jordan Priest – Midwifery: Expanding Maternal Healthcare Options in the U.S.

The practices of midwives in the United States and the United Kingdom are legally regulated. Each nation has enacted differing laws and policies governing requisite training, licensure, and allowable practices. In the U.S., laws regulating midwifery vary by state and by the level of educational attainment needed versus apprenticed skills. The U.K. has a longer history of developing and implementing policies to oversee midwifery. The U.K.’s Nursing and Midwifery Council (NMC) is the single regulatory body, with consistent licensing policies and jurisdiction over each of the countries that comprise the U.K. (NMC 3). In 2015-16, 50% of births in England were attended by midwives (Stephenson 1), compared to the 2014 statistic of only 8% of total births in the U.S. (American College of Nurse-Midwives). The U.K.’s more extensive use of midwives and centralized regulatory authority can inform the disparate midwifery licensing and regulatory environment in the U.S., which could help expand maternal care options for more U.S. women, while maintaining safety standards. Both nations need to increase and diversify the midwifery education pipeline to engage students of color, from multi-cultural backgrounds, to change the faces of the current white female dominated profession and the patients they serve.

The U.S. has three midwife categories, each with different qualifications and regulating policies. A Certified Nurse Practitioner (CNP) is an academically credentialed nurse who has gone on to specialize in midwifery (Hermer 325). By contrast a direct entry nurse may have an eclectic background. Some direct entry midwives have medical training, however, most receive their training and education through experience and apprenticeship (Hermer 325). Direct entry midwives are not legal in all U.S. states (Hermer 325). Certified professional midwives (CPM), are also regulated by individual states, but not all states have this certification. Certification is
granted through the North American Registry of Midwives (NARM). CPMs are allowed in 30 states, 11 states have emerging legislation to legalize midwives, 4 states are formulating legislation, and 5 states have pro-midwives advocacy groups and are on the path to enabling legislation. In the 20 states where CPMs are yet to be legally recognized, illegal practices are subject to criminal charges (NARM).

With the states having the regulatory authority over midwifery, policies vary widely. The climate for accepting midwifery is not always favorable. Several states restrict women from receiving care from a midwife. The majority of OB/GYNs consider a homebirth to be more dangerous than a hospital birth (Harmon 119). This widely held doctor viewpoint has significantly influenced policy makers, which has contributed to some states enacting laws obstructing the practice of midwives. The statistics however, reveal something different. Infants born in hospitals have a higher rate of disease and infection (Harmon 119). Women who give birth in hospitals also have a higher chance of undergoing surgical procedures such as C-sections, which may not be necessary for their circumstances (Harmon 119). It is also important to note that midwives are selective and careful with the patients they accept (Harmon 117). Midwives will not accept women who have a history of high blood pressure or a family medical history of problems with childbirth (Harmon 117). Most states have laws and policies that require the midwife to transfer care in the event of emergency, as well as having emergency plans in place during labor (Harmon 117). These policies attempt to alleviate problems that are out of the midwife’s scope. However, many U.S. doctors’ opinions towards midwives and homebirths have remained unchanged and continue to be unfavorable (Harmon 117). This is likely because doctors are immersed in disease focused medical training and most treat pregnancy as an illness (Hermer 331). OB/GYNs also expect complications and are poised with
interventional treatments, even though pregnancy complications only occur in 10 percent of pregnancies (Hermer 331). By contrast, the foundational philosophy of midwives is pregnancy and birth are normal and natural (Hermer 331). They keep the mother at the center of focus and control, caring for her needs, including her emotional state. They also extend care and support to the mother following birth (Hermer 331).

Midwives practice a non-interventionist approach to pregnancy and childbirth. This includes a less prominent use of technology such as ultrasounds and sonograms. This results in midwife attended births costing considerably less than in hospital births (Harmon 118). The World Health Organization (WHO) has supported midwifery as a safe and cost efficient medical practice. Despite this endorsement by the WHO, the U.S. still outlaws direct entry midwives (Harmon 118). Many American insurance plans do not provide coverage for homebirths and despite the ACA requirement for Medicaid plans to cover the option of a midwife attended birth and the choice of a freestanding state-licensed birthing center, access to coverage for low income women to deliver at home differs in states (healthinsurance.org). The Midwives Alliance of North America (MANA) argues for the right of all women to have the option to employ a midwife and deliver their child at home by citing the precedence established in Roe v. Wade, which affirmed women’s freedom to make reproductive health decisions. MANA believes a woman’s right to make her own reproductive decisions must be extended to the right to choose a homebirth and a midwife’s care (Harmon 118). The California Supreme Court case, Bowland v. Municipal Court, occurred a few months following the U.S. Supreme Court decision in Roe v. Wade (Corcoran 665). The California Supreme Court decision in the Bowland case did not extend the constitutional right to privacy that mandates protection of decisions pertaining to abortion, childrearing, marriage, and contraception, but instead determined Roe did not extend to
“protect a woman’s choice of the manner and circumstances in which her baby is born and required those who assist in childbirth have valid licenses” (Harmon 125).” The Bowland decision found the state could intervene in deciding who was at a woman’s birth, because it occurred in the third trimester of her pregnancy (Corcoran 665). The midwifery advocates were very distressed by the decision and argued this wrong interpretation of Roe was to criminalize direct-entry midwives and prevent choice of care (Harmon 125).

Some scholars have argued that laws which outlaw direct-entry midwives actually have negative impacts on the profession, by deterring further training and access. Corcoran argues laws to prohibit direct entry midwives, which are designed to help protect women, in reality can have the opposite effect. She argues that women seeking a homebirth in states where direct-entry midwives are outlawed may still have the homebirth, but riskily without assistance of a midwife (Corcoran 666). This can cause severe harm to mother and the baby, which could be avoided with an attending midwife (Corcoran 666). Unlicensed midwives may delay in referring a complication they cannot handle for fear of getting caught. Several states where direct-entry midwives are decriminalized still have laws in place that require training and education that surpass the standards established by the NARM (Corcoran 667). New Mexico recognizes the legality of direct-entry midwives and surpasses the NARM recommendations by mandating all direct-entry midwives complete one formal year of training (Corcoran 667).

Fast forward to the September 1, 2000 amendment to the California Licensed Midwifery Practice Act of 1993 (SB-1479), which effectively reversed a portion of Bowland. The amendment codified a woman’s birth choice by acknowledging a woman’s right to choose includes not only her right to terminate a pregnancy, but her right to choose the setting and manner of the birth and to select who is the attending professional (Harmon 129). However, a
certified or licensed requirement to lawfully practice midwifery in California still stands (Harmon 126).

Certified Nurse-Midwives (CNMs) are allowed to practice in all 50 states, with most working in a hospital setting, usually under a physician. Unfortunately, the hospital demand for CNMs greatly impacts the availability of certified nurse midwives to attend homebirths and restricts access for pregnant women to employ certified nurse midwives (Harmon 120). In some states, as discussed earlier, CNMs are the only ones that practice legally, with lay midwives and professional midwives being declared illegal, potentially facing criminal charges (Harmon 120). The penalty for practicing midwifery without a license in the U.S. varies per individual state laws. For example, in North Carolina it is a misdemeanor, usually resulting in arrest, charge, and a fine. Section 2521 of the California Business and Professions Code, makes unlicensed practicing of midwifery a misdemeanor (Harmon 126). Midwife manslaughter cases are uncommon, however in early 2000, an Orange County, California former midwife named Lori Jensen was charged with contributing to the death of an infant, a felony under California law (Harmon 127). Jensen pleaded guilty to the charge and was the first successful California criminal prosecution of a licensed midwife (Harmon 128). According to Harmon, criminally charging and prosecuting medical practitioners is increasing and midwives are not exempt (Harmon 128).

Unlike the U.S., where midwifery regulations vary significantly by state, the U.K. has adopted several pieces of legislation that uniformly impact the practice and profession of midwifery. The U.K. legal history regulating midwives originated over a century ago with the Midwives Act of 1902, which was the first piece of legislation to address the practice of illegal midwives. The main purpose of the act was to establish a statutory body governing midwives,
which was the Central Midwives Board (CMB). The CMB was given the authority to draft rules, appoint midwife examiners, decide where exams were administered, and publish an annual “Roll of Midwives” listing newly accredited midwives. Most recently the Nursing and Midwifery Order 2001, referred to as “The Order,” was enacted in April 2002, which established the Nursing & Midwifery Council (NMC) as the statutorily created body with regulatory authority over the practices of midwives in the U.K. (Jones and Jenkins 34). The NMC is responsible for conducting trainings, setting standards and evaluating performance. The NMC handles any misconduct violations alleged against certified midwives (Jones and Jenkins 34). Under law, all midwives must have their certification reviewed and revalidated, which is required every 3 years following initial registry as a midwife. This is an effort to assure midwives stay current in their knowledge and continue to practice safely and effectively (Jones and Jenkins 34).

Professionally trained midwives must also follow The Code: The Professional Standards of Practice and Behavior of Nurses and Midwives, often referred to in short hand as “The Code” (NMC 11). When practicing in the U.K., midwives need to take into consideration their scope of practice, which encompasses their skills, training and education designed to prepare them to handle certain situations and cases (NMC 8). The Code mandates midwives do not practice outside their scope of practice (NMC 8). This means midwives cannot take on cases that surpass their competency and skills (NMC 8). This concept of scope of practice reaches beyond only possessing the title midwife, but also to matching midwives and cases, to assure midwives are qualified for the cases they undertake (NMC 8). Midwives have limited prescriptive authority, which includes pharmacy medications, also known in the U.S. as over-the-counter medications, plus some limited prescription medications (NMC 13). Midwives can administer drugs to some named individuals that follow the midwife supply orders (MSO). The prescribing power of select
medicines and drugs is limited to midwives who have also attained medical education in nursing (NMC 13).

Midwives in the U.K. must comply with a mandatory indemnity agreement, which assesses the responsibilities and risks involved with their practice (NMC 9). The indemnity agreement shall cover the full scope of their practice, in case an incident occurs. All midwives employed by the National Health Service have indemnity insurance provided (NMC 9). However, self-employed midwives and midwives employed by a company as a contractor need to find their own indemnity insurance (NMC 9). Commercial providers, as well as other organizations, provide indemnity insurance policies for midwives practicing independently or as contractors to purchase. It is vital that midwives understand the importance of indemnity insurance and have coverage that protects the full scope of their practice (NMC 9).

The Code further requires midwives to abide by certain protocols, which include practicing safely, effectively, with a patient-oriented focus, with professionalism, all while engendering trust (NMC 11). A professional duty of candor was legally established by the NMC, in coalition with the General Medical Council. It requires midwives have complete honesty with their patients (NMC 11). They must resolve to have full transparency, especially if something goes wrong during childbirth (NMC 11). This policy also applies to pregnant women who work with other midwives, physicians, healthcare organizations, and any other entity or person a midwife may work with (NMC 11). When a midwife is under review or investigation, she/he/they must act with openness and honesty, providing a full recount of what happened. Midwives are responsible for fostering an environment that promotes honesty and truth, while refraining from collusion with colleagues to promote dishonesty (NMC 11). A midwife is further
prohibited from obstructing a colleague or patient from reporting an incident, which is a form of dishonesty and negates openness (NMC 11).

Most recently, the NMC requested review of the current midwifery regulations in 2015, looking for clarification and the removal of what it perceived as redundant supervision tiers. Legislation, based on their request, was passed in 2016 and went into effect this year (2017). The new legislation affirms the NMC’s regulatory authority as described in paragraphs above, but it places non-statutory responsibility on improving the quality of midwife services on the employers and providers (NMC, Legislative Update, April 2017). Clarifying the non-statutory responsibility of the midwife employers and providers to improve service quality is perhaps in response to growing expressed concerns and recent surveying.

The U.K.’s National Health Service (NHS) constitution legally establishes that midwives must exhibit the qualities of respect and dignity, which are considered crucial, as pregnant women and women during birth are in vulnerable positions (Hall and Mitchell 9). The International Confederation of Midwifery also distinguishes respect as a guiding principle for the midwifery profession (Hall and Mitchell 9). Responding educators to Drs. Hall and Mitchell’s recent survey of “Lead Midwives in Education in the U.K.,” indicated teaching respect and dignity were top priorities, however, findings demonstrated an inconsistency in these values’ incorporation into curricula, which resulted in disparity on the emphasis on the values of dignity and respect in midwifery education. Hall and Mitchell’s studies further revealed many women in the U.K. reported they had not received care encompassing respect and dignity from their midwives (9). Further reports indicated that some midwives lacked emotional support and compassion, while some women reported being treated with a rude attitude. It was suggested these attitudes and behaviors were due in part to the heavy case load midwives were carrying, as
well as the burn out factor (Hall and Mitchell 10). The recent significant increase in nurses and midwives leaving the U.K. profession support their findings. In 2016/17, 29,434 nurses and midwives left the register, which translates to 45% more UK registrants left than joined the registry last year (Siddique 1). Many blamed workplace pressures, salary caps, and concerns over Brexit (Siddique 1). Unions have asserted a 3,500 midwife shortage in England alone (Siddique 1).

Both the U.S. and the U.K. face shortages in health care professionals trained to support maternal health and need to increase the numbers and diversity of students entering the fields. Midwifery remains dominated by white females and does not reflect the growing multi-cultural populations in each nation. The ethnic/racial compilation of midwives in the U.S. has continued to lack diversity over the past two decades, with 90 percent of membership to the American College of Nurse-Midwives (ACNM) comprised of white members (Serbin and Donnelly). Only about 7 percent of ACNM midwives identify as persons of color (Serbin and Donnelly). Only 5.8 percent of midwives seeking recertification identify as a person of color. Fortunately, there has been a recent surge in diversity within the midwifery profession, with 14.5 percent of CNMs seeking first time certification through the ACNM identifying as women of color (Serbin and Donnelly). Despite the recent increase, lack of diversity persists in the U.S. midwifery profession. (Serbin and Donnelly). The U.S. has a growing ethnically diverse population, with only 62.2 percent of the population in 2014 identifying as non-Hispanic white. In 2044, it is estimated the percentage of people of color in the U.S. will outnumber the percentage of Caucasians. The midwifery profession must strive to build its membership to reflect the changing demographics of the U.S. population, so it can better serve in all communities with cultural competencies and authenticity. (Serbin and Donnelly). The importance of understanding issues
of race is critical to the midwife profession, because women of color more frequently die from childbirth or lose the life of their child (Serbin and Donnelly).

The U.K.’s midwifery profession remains equally dominated by white women, despite an early legal effort. The U.K. enacted the Sex Discrimination Act of 1975, which was applied to the midwifery profession (Jones and Jenkins 29). The act allowed for men to train and become midwives, which previously had been only available to women. The profession, however, did not welcome men with the law’s passage. The Royal College of Midwives continued to prohibit men’s acceptance until 1983. In Hall and Mitchell’s “Survey of Lead Midwifery Educators,” instructors expressed the value of eliminating discrimination against race, sexual orientation, class, culture and belief towards both those admitted into the midwifery profession and to those patients midwives serve (10). Yet, males represent only 0.6% midwives in the U.K. (10).

Further U.K. legal efforts include the Equity Act of 2010 (Griffith, et al. 60). This Act consolidated laws on race, gender and disability, while expanding protections against discrimination based on sexual orientation, religion and age. Discrimination is illegal in employment relationships, the exchange of goods and services, and interactions among public bodies. This act has and will be applied to the regulation of midwifery. Midwives cannot select or deny patients on the grounds of ethnicity, sexual orientation or religion.

Putting laws into practice does not always occur with the same intent as they were passed, perhaps more so when a profession is so singularly dominated by one demographic. A case involving midwife supervisors who imposed their own beliefs upon a patient was heard by the U.K. Supreme Court in the 2014 case, Greater Glasgow Health Board v. Doogan and another. The case involved two midwives employed by the National Health Service (NHS) as Labour Ward Co-coordinators. (Medical Law International Case Review 246) They were
responsible for admitting patients, overseeing midwives and finding ways to support midwives. These two co-coordinators claimed conscientious objection based on their belief in the official position of the Catholic Church that life begins at the moment of conception. The two cited conscientious objection as articulated in 4(1) of the Abortion Act of 1967, as the legal foundation to exclude them from having to oversee abortions performed by other midwives (247). They brought judicial review against the NHS, because they claimed their complaints were not taken seriously. A lower court ruled with in favor of Doogan, however, the Health Board appealed the case to the U.K. Supreme Court. Lady Hale was the only Supreme Court judge to provide a judgement. Lady Hale ruled on the side of the Health Service, with four other justices in agreement. Refusing to provide and oversee a legal abortion was considered by the Supreme Court to be a human rights violation of the patient’s right to be free from discrimination. Article 9 of the European Convention on Human Rights (ECHR) was cited as rationale (Medical Law International 253).

As we compare the use of midwifery in both countries, it is clear the U.S. could benefit from uniformity in regulations governing midwifery. Standardization of training, certification and reciprocity of licensure could help grow the pipeline of skilled and licensed midwife practitioners. The U.K.’s current NHS policies assess pregnant women’s risk factors and give low risk birth mothers the choice, from their first medical visit, to choose a midwife or homebirth with a midwife attending (Hollowell 2), with 100% insurance coverage of all options. The policies in Scotland, Wales and Northern Ireland may vary somewhat, but all allow U.K. women to decide their birthing location, fully covered by NHS. Midwifery is and has been fully incorporated into U.K.’s obstetric practice and culture, unlike in the U.S. where midwifery remains an outlier. The U.S. must debunk the cultural stereotypes that plague midwifery as
unskilled and unsafe. In England, about 79 percent of women live in a 30-minute proximity to a midwife and an obstetrics unit (Hollowell 2). Additionally, 41 percent of women were granted the option to receive care by a midwife (Hollowell 2). Eighteen percent of women were granted the choice of having a homebirth, with only about 2 percent of women actually deciding to have homebirths in England (Hollowell 2). With the increase in England’s hospital births, there has been an increase in the number of C-section deliveries, aligning with the research that midwife attended births are less likely to end in C-section (Hollowell 2). The U.S. could benefit from adopting the U.K.’s initial risk assessment protocol, which proactively offers midwifery as a birth planning option in the initial prenatal visits. What was most glaring in my midwifery research is white women are the midwives and their patients accessing midwifery services are also predominantly white women. We must bring an intersectional lens to expanding midwifery as a safe and viable birthing choice to all populations in the U.S. Education institutions, training providers and the medical community must develop outreach, recruitment and scholarships to underrepresented populations to bring them into their educational pathways to licensure. When there are trained providers from diverse communities, they are best positioned to serve with language and cultural authenticity and to engender trust. Our immigrant and impoverished communities often lack pre-natal care and midwives should be a cost effective way to provide access to care in underserved communities. Midwives can be the highly skilled, cost effective extenders of maternal medical care, but it will require more advocacy within the OB/GYN medical community itself. We need OB/GYN champions to join in leading this effort for birthing choice.
Work Cited


The UK Supreme Court. *Greater Glasgow Health Board (Appellant) v Doogan and Another (Respondents) Scotland*. 17 Dec. 2014.