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Midwifery in Illinois: The Need for Independence

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I. INTRODUCTION

Midwives are, in most instances, as capable as obstetricians at natal care, yet midwives are negatively affected by physicians' broad scope of practice[1] as it provides them with exclusive control over the practice of medicine.[2] States create health profession acts, which serve to legitimize various professions, define their scope of practice, and create boards to continue regulating as the profession grows.[3] Through the use of scope of practice standards and punishments for their violations, health professionals are able to claim particular practices as their own.[4] In Illinois, a person is practicing medicine if he diagnoses, treats, recommends or prescribes for, or operates upon an individual for the relief or cure of any condition or ailment, whether it is mental or physical.[5] Furthermore, if he holds himself

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1. *See* Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 89-90 (1996). Scope of practice refers to the legislatively defined areas within which various professionals may engage in their trade. *See* Barbara J. Safriet 2, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 303 (2002).

2. *Id.* at 306. The Tenth Amendment of the United States Constitution reserves powers not delegated to the federal government by the Constitution, or prohibited by it to the states, to the states. U.S. CONST. amend. X. Among the powers that states receive under the Tenth Amendment is the police power, which provides states with the ability to regulate for the protection of their citizen's health, safety, morals, and welfare. Cohen, *supra* note 1, at 87.

3. *See* Patrick M. Callahan, *Power Allocations and Professional Hierarchy in the Illinois Health Care System*, 13 DEPAUL J. HEALTH CARE L. 217, 220 (2010).

4. Callahan, *supra* note 3, at 219.

5. 225 ILL. COMP. STAT. ANN. 60/49 (2013). "Holding oneself out to the public" includes attaching the title, abbreviation, or any other word to their name indicating that he

out to the public as having the knowledge, skill, or ability to engage in any of the aforementioned acts, he is practicing medicine.[6] This definition is overly inclusive. Because only physicians are allowed to practice medicine,[7] the over-inclusiveness creates a discrepancy between the knowledge and abilities of non-physicians and their legal authority.[8] This discrepancy leaves midwives in Illinois to either forego the safe practice of midwifery or risk sanctions for illegally practicing medicine.[9] These power allocations also affect patients by limiting their healthcare experiences, opportunities, and access to other groups of practitioners.[10] For the aforementioned reasons, Illinois should allow direct entry midwives (DEMs) and certified nurses midwives (CNMs) to practice independently of physicians.

This article will provide a brief history of midwifery in the United States. Then this article will look specifically at Illinois' current scope of practice laws and its limitations on the practice of midwifery and compare its laws to those of the state of Washington, which has nearly opposite legislation.[11] Next, the article will discuss how the limitations on midwifery increases the cost of birthing care, decreases access to birthing care, and denies mothers

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or she is a medical professional, and maintaining an office to examine or treat those in need of a medical professional. *See Id.*

6. 225 ILL. COMP. STAT. ANN. 60/49 (2013). "Holding oneself out to the public" includes attaching the title, abbreviation, or any other word to their name indicating that he or she is a medical professional, and maintaining an office to examine or treat those in need of a medical professional. *See Id.*

7. Safriet, *supra* note 1, at 306.

8. *See Id.* at 315.

9. *Id.* at 305.

10. Callahan, *supra* note 3, at 220.

11. Washington's Businesses and Professions provision specifically addresses the practice of midwifery and gives midwives a large scope of practice, whereas Illinois' Medical Practice Act does not allow DEMs to practice at all, and provides CNMs with only a limited scope of practice. *See* WASH. REV. CODE tit. 18 (2013); *Cf.* 225 ILL. COMP. STAT. ANN. 60 (2013). Furthermore, Washington was the first state to grant DEMs true autonomy. Suzanne Suarez, *Midwifery is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315, 357 (1993).

the full range of birthing options. This article will suggest that DEMs and CNMs are as capable as obstetricians at natal care and will conclude that Illinois should allow DEMs and CNMs to practice independently of physicians. Lastly, this article will suggest that the best way for Illinois to extend midwives' scope of practice in good conscious is to follow in Washington's footsteps and enact independent education statutes for midwives. By enacting independent educational standards similar to those in Washington, Illinois will be able to experience the benefits of midwifery while maintaining its interest in regulating for the health, safety, and welfare of its citizens.

II. HISTORY OF MIDWIFERY IN THE UNITED STATES

Midwives were the primary birth attendants in the United States until the early twentieth century.[12] During this time, childbirth was considered a social event.[13] Throughout the pregnancy, midwives provided prenatal care, health screenings, and information on birthing and newborn care, while building trust with the expecting mother in order to maintain a safe, anxiety-free environment.[14] Friends and family gathered during the delivery, and the midwife provided the mother with practical and emotional delivery support.[15] Today, the early twentieth century midwives would be considered DEMs, midwives that typically practice in the home setting.[16] As the twentieth century progressed, childbirth changed from a communal

12. Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813, 815 (1994).

13. Rachel P. Berland, *Introducing Patient Scope of Care: Psychologists, Psychiatrists, and the Privilege to Prescribe Drugs*, 6 ST. LOUIS U.J. HEALTH L. & POL'Y 425, 435 (2013).

14. *Id.* at 819.

15. *Id.*

16. Hafner-Eaton, *supra* note 12, at 816. DEMs can gain experience though clinical training, apprenticeships, or formal training. *Id.* at 815.

event into a medical event.[17] Obstetricians' newfound social, cultural, and legal authority, along with technological advancements, made them become more distant from their patients.[18] The practice of medicine was extended to include the birth process, and pregnancy came to be interpreted as intrinsically dangerous, requiring physician intervention.[19]

In 1925, the profession of nurse-midwifery was created as a compromise between obstetricians and DEMs.[20] As a result of this compromise, CNMs are permitted to practice in all fifty states.[21] After earning a nursing degree, CNMs obtain further education in gynecology and obstetrics to receive the necessary certification to attend deliveries without physician supervision.[22] Although CNMs are permitted to practice in all fifty states, they typically only practice in hospitals under the direct supervision and control of physicians.[23] This restriction is due to various statutory limitations placed on CNMs.[24]

DEMs, on the other hand, primarily practice in the home setting.[25] Traditionally, most DEMs gained experience in birthing through self-education or apprenticeships and clinical training.[26] However, in 1994, professional associations of DEMs created the National American Registry of Midwives (NARM), an education and certification agency, with the goal

17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.* at 820.
21. Benjamin G. Chojnacki, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 J.L. & HEALTH 45, 49 (2010).
22. Berland, *supra* note 13, at 435.
23. Stacey A. Tovino, J.D., *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 69 (2004).
24. *Id.* Hospitals are also cautious to grant midwives privileges for fear that physicians will go on strike, which has happened in the past when osteopaths were granted hospital privileges. Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273, 1279 (1996).
25. Hafner-Eaton, *supra* note 12, at 815.
26. *Id.*

of re-introducing DEMs as an birthing attendant option by standardizing licensure and scope of practice requirements.[27] In order to receive certification through the NARM, a midwife must attend an accredited formal midwifery program, or attend forty births and complete seventy-five prenatal exams, twenty newborn exams and forty postpartum exams, all with the direct oversight of a clinical instructor, show proficiency in all required skills, and pass the certification exam.[28] By putting these standards in place, the NARM has legitimized the practice of midwifery in some states.[29]

III. ADVANTAGES OF MIDWIFERY

One of the major justifications for giving physicians the broad authority over the practice of medicine is to protect patients and ensure that they receive the highest quality of care.[30] However, evidence suggests that midwives are just as, if not more than, qualified as physicians are to attend to low to moderate-risk childbirth.[31] Both in the home and hospital setting, midwife-attended births have lower morbidity and mortality rates than births attended by physicians.[32] Independent midwives perform approximately seventy-five percent of all births in all European countries, and all of those countries have lower infant mortality rates than the United States.[33] Washington's Department of Social and Health Services found that women under the care of midwives were less likely to give birth to an underweight baby than women who did not receive prenatal care from

27. Berland, *supra* note 13, at 439.
28. Sarah Anne Stover, *Born by the Woman, Caught by the Midwife: The Case for Legalizing Direct-Entry Midwifery in All Fifty States*, 21 HEALTH MATRIX 307, 325-26 (2011).
29. *See* Berland, *supra* note 13, at 439-440; *see* Stover, *supra* note 28, at 318, 326.
30. Callahan, *supra* note 3, at 219.
31. Hafner-Eaton, *supra* note 12, at 813.
32. *Id.* at 818.
33. Hafner-Eaton, *supra* note 12, at 815.

midwives.[34]

Midwives perform well with high-risk patients as well.[35] When complications arise in pregnancy and childbirth that require the aid of a physician, midwives promptly transfer the patient.[36] According to a study that followed 5,418 women in the care of midwives, the midwives transferred around twelve percent of their patients to hospitals due to failure to progress during delivery and pain relief.[37] This study indicates that midwives, like physicians, recognize when a complication arises during pregnancy, and are willing to give up control when necessary. Midwifery is a safe practice, and Illinois would not risk the safety of its citizens by supporting it.

By allowing physicians the exclusive power to independently attend to births, Illinois is driving up the cost of birthing care.[38] Midwives are able to charge less than physicians for their services because they have lower training costs and receive lower salaries.[39] The salary of an obstetrician is about ten times that of a CNM.[40] Physicians also tend to order more costly tests, use higher cost treatments, and prescribe more drugs than midwives.[41] This discrepancy exists because obstetricians primarily focus on treating

34. *Benefits of Midwifery go Beyond Money Saved*, THE OLYMPIAN (Feb. 2, 2010), http://www.theolympian.com/2010/02/02/1123262/missing-headline-for-02oedits.html.

35. Andrews, *supra* note 39, at 1284. One study found that when midwives attended high-risk patients the outcomes were as good as those of lower risk patients seen by physicians. *Id*.

36. Andrews, *supra* note 24, at 1286.

37. Stover, *supra* note 28, at 328.

38. *See* Callahan, *supra* note 3, at 219.

39. Andrews, *supra* note 24, at 1279.

40. *Id.*

41. *Id.* at 1285. The negative effects of a physician's intervention during labor typically causes the need for another intervention. Hafner-Eaton, *supra* note 12, at 817. For example, epidurals are usually given to control pain, but they often slow labor, causing a "failure-to-progress" and a need for a cesarean section delivery. *Id.* In Washington, physicians order nearly twice as many cesareans as midwives. Olympian, *supra* note 34. Cesareans can cause hemorrhages, infections, and maternal morbidity. Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX 325, 343 (2003).

problems that arise during pregnancy, causing them to treat all pregnancies as high-risk.[42] In contrast, midwives typically view childbirth as a normal process unless a problem arises.[43] Under midwives' view, the mother that delivers the baby is the primary decision-maker, not the midwife.[44]

Despite fewer tests and drugs, when midwives and physicians care for similar patients, midwives' patients faired just as well as those of the physicians.[45] Without insurance, the average cost of physician-attended birth in the United States is between $8,000 and $13,000, while the average cost of a midwife-attended home birth is between $2,000 and $3,000.[46] Based on those figures, if the United States followed in the footsteps of Europe, where midwives attend over seventy-five percent of births, it could save over $8.5 billion a year.[47] In Washington, the Department of Health found that the cost of a midwife-attended birth was $1,000, while the average cost of a physician-attended birth was $3,800.[48] The Department went on to state that Washington would save $2.7 million over just two years by utilizing more midwife-attended births.[49] By allowing midwives to practice independently, Illinois could reduce the cost of birthing care.[50]

In addition, if Illinois granted midwives the authority to practice independently, access to prenatal, natal, and postnatal care would increase,

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42. Stover, *supra* note 28, at 319. High-risk patients are often low income, uninsured, or underinsured. Andrews, *supra* note 24, at 1284. These women often present a "greater risk for obstetric complications because of the relative nutritional and psychosocial deprivation of poverty." *Id.*

43. Stover, *supra* note 28, at 320.

44. *Id.*

45. Andrews, *supra* note 24, at 1285.

46. *FAQ - Answers to Frequent Questions about Homebirth and Midwives*, NEW MOON MIDWIFERY, http://newmoonmidwifery.com/faq/ (last visited Dec. 3, 2013).

47. Hafner-Eaton, *supra* note 12, at 831.

48. Olympian, *supra* note 34.

49. *Id.*

50. *See* Callahan, *supra* note 3, at 219. Reducing the cost of birthing care would allow low-income women who previously did not obtain care because they could not afford care to be able to pay for it. *Id*.

especially in rural and low-income areas.[51] Over 1.5 million of the 12.8 million Illinoisans live in rural areas, and the average per capita income is nearly $10,000 lower than that of urban areas.[52] Across the United States, CNMs provide care in rural and low-income areas at higher rates than obstetrician-gynecologists.[53] CNMS are the only primary healthcare providers available in some rural areas in the country.[54] While only ten percent of obstetrician-gynecologists provided care in high-poverty areas, nineteen percent of CNMs provided care in high poverty areas.[55] Midwives serve rural and low-income areas at a higher percentage than physicians, providing affordable care to women who otherwise might not receive any. In 2011, CNMs and DEMs attended 309,514 births, about eight percent of the total births in the United States.[56] About 700 women have home births in Illinois every year.[57] Allowing midwives to practice independently in Illinois could increase the amount of home births and provide those living in rural areas with cheaper, alternative birthing care. In 2009, the Center for Disease Control (CDC) found that home births not attended by a physician or a midwife had an infant mortality rate of 16.56 per 1000 births, while home births attended by CNMs and DEMs had an infant mortality rate of

51. *See Id.*

52. RURAL ASSISTANCE CTR., http://www.raconline.org/states/illinois/ (last visited Nov. 16, 2013).

53. Mary Beck, *Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. REV. 951, 956 (1995).

54. *Id.*

55. *Id.* In addition, eighty-nine percent of CNMs reported serving low-income women, about eighty percent reported serving uninsured women; twenty-one percent of CNMS indicated that around ninety percent of their patients lived in high-risk areas, and thirteen percent indicated that all of their patients lived in high-risk areas. *Id.*

56. *Fact Sheet: Essential Facts about Midwives*, AM. COLL. OF NURSE-MIDWIVES, http://www.midwife.org/Essential-Facts-about-Midwives (last updated July 2013).

57. Rachel Wells, *Home Birth Bill Takes a Baby Step for Midwives*, ILLINOIS TIMES (Mar. 10, 2011), http://illinoistimes.com/article-8430-home-birth-bill-takes-a-baby-step-for-midwives.html.

2.81 per 1000 births.[58] If Illinois wants to protect women by providing the safest home birth possible, it should allow DEMs and CNMs to practice independently.

By not allowing midwives to practice independent of physicians, Illinois is denying expecting mothers a full range of care.[59] The birth location may be as important as the birth attendant to expectant mothers.[60] While only one percent of women in the U.S. reported giving birth at home, a study found that over twenty percent of mothers would have preferred this option.[61] This figure may be attributed to the fact that the home can provide emotional security.[62] The result of this study suggests that if midwifery were made more available, more women would choose it as their birthing option. The familiar setting of the home makes the patient feel safer than a hospital filled with equipment she may be unfamiliar with.[63] Childbirth can be one of the most intimate and important experiences for a family, and midwives provide their patients more control over the birthing process than physicians.[64] According to a government ordered study of midwifery in the United States, none of the patients in CNM-attended births preferred a physician, but some of the patients in an obstetrician-attended birth would

58. CDC Wonder, *Linked Birth / Infant Death Records, 2007-2009 Results*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://wonder.cdc.gov/lbd-current.html (last visited Dec. 3, 2013) (click agree, in section 4, select 'not in hospital' as birthplace, and 'other' as medical attendant, and then click submit. Reset form and select 'CNM' and 'other midwife' as medical attendant).

59. Stover, *supra* note 28, at 311.

60. "For many, choosing to deliver away from the hospital is a choice that reflects spiritual, religious, political, and feminist beliefs." Chojnacki, *supra* note 21, at 51.

61. Stover, *supra* note 28, at 308.

62. Hafner-Eaton, *supra* note 12, at 823.

63. *Id.* Added stress and anxiety during pregnancy can cause preterm births, lower birth weights, miscarriage, temperamental problems and lower attention spans in the infant, and delayed mental and emotional development. Katrina C. Johnson, Ph.D., *The Effects of Maternal Stress and Anxiety During Pregnancy*, EMORY U., http://www.psychiatry.emory.edu/PROGRAMS/GADrug/feature_articles.html (last visited Nov. 13, 2013).

64. Andrews, *supra* note 24, at 1280.

have preferred a midwife.[65] This study suggests that the women who choose midwifery are more satisfied with their birthing experience than women who choose to have a physician as their birth attendant.

IV. A COMPARISON BETWEEN ILLINOIS AND WASHINGTON

Currently, forty-one states permit DEMs to practice through licensure, registration and certification, judicial or statutory interpretation, or lack of affirmative regulations expressly prohibiting DEMs to practice.[66] Illinois is one of the nine states, as well as the District of Columbia, that prohibit direct-entry midwifery.[67] While Illinois does not have a statute expressly prohibiting DEMs from practicing midwifery, the practice is still illegal in the state because it falls outside the definition of practicing medicine.[68] The director of the Illinois Department of Professional Regulation brings charges against those who engage in midwifery without a license, and Illinois courts have upheld these charges and subsequent convictions.[69]

Alternatively, the state of Washington's Businesses and Professions provision specifically addresses midwifery, setting out definitions and educational requirements.[70] Washington's secretary has the authority to grant licenses and a midwifery advisory committee advises and makes recommendations to the secretary regarding education, required

65. *Id.*

66. Stover, *supra* note 28, at 310.

67. Hermer, *supra* note 41, at 356. The Illinois Medical Practice Act of 1987 defines a "physician" as a person licensed under the act to practice medicine in all of its branches. 225 ILL. COMP. STAT. 60/2 (2013). Section two of the act states, "No person shall practice medicine, or any of its branches, or treat human ailments without the use of drugs and without operative surgery, without a valid, existing license to do so. . ." 225 ILL. COMP. STAT. 60/3 (2013). Physicians may collaborate with CNMs, but in order to do so the physician must provide the actual delivery service. 225 ILL. COMP. STAT. 60/54.5 (2013). First time violations of the act are considered Class A Misdemeanors, while subsequent violations are considered Class 3 Felonies. 225 ILL. COMP. STAT. 60/59 (2013).

68. *See* 225 ILL. COMP. STAT. ANN. 60/49 (2013).

69. *See, e.g.*, People ex rel. Sherman v. Cryns, 786 N.E.2d 139, 161 (Ill. 2003).

70. *See* WASH. REV. CODE tit. 18 (2013).

examinations, and peer review.[71] In order to practice midwifery in Washington, an individual must obtain a certificate or diploma from an accredited midwifery program, receive three years of training, including the study of basic nursing skills, meet all educational requirements, observe fifty women in the intrapartum period,[72] and attend to the care of at least fifty women in each of the prenatal, intrapartum, and early postpartum periods."[73] The midwives are then tested to ensure they have the scientific and practical knowledge and ability to practice midwifery.[74] All the requirements and regulations Washington has in place appear to have the common goal of protecting women who choose midwifery as a birthing option. Enacting education standards similar to those of Washington is one way in which Illinois and its citizens can experience the benefits of midwifery. Washington mothers who use midwives experience decreased cost of care, increased access to care, alternative birthing options, and increased safety.[75] Washington is able to maintain its interest in guarding the health and safety of its residents who utilize midwifery because of its strict educational requirements on the profession.

V. CONCLUSION

Illinois needs to expand midwives' scope of practice because the established benefits outweigh any kind of hypothetical disadvantage.

71. WASH. REV. CODE § 18.50.020 (2013); WASH. REV. CODE § 18.50.150 (2013).

72. The intrapartum period is the when the woman is in labor.

73. WASH. REV. CODE § 18.50.040 (2013). The minimum educational requirements include the study of "obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breast feeding; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization, and aseptic technique; and such other requirements prescribed by rule." *Id.*

74. WASH. REV. CODE § 18.50.060 (2013).

75. Olympian, *supra* note 34.

Enacting independent education standards similar to those of Washington is one method in which Illinois can protect the health and safety of its citizens while providing them with the benefits of midwifery. Currently, Illinois law prevents DEMs from practicing within the state,[76] and CNMs from practicing without the supervision of a physician.[77] Midwives have proven that they are capable of performing deliveries as safely, if not safer than, physicians, yet they are not given the authority indicative of their ability.[78] Illinois has the power to create the educational standards needed by midwives to practice within the state.[79] If Illinois does not accept the NARM standards, or those of other midwifery associations and programs, it should enact its own educational standards as Washington has done.[80] Washington's educational standards require those practicing midwifery to complete training and coursework in a variety of different fields.[81] To further protect its citizens, Washington also statutorily imposes a duty on midwives to consult a physician when there are deviations from normal childbirth.[82] Illinois should follow in Washington's footsteps because using statutorily-imposed education standards to regulate midwifery, rather than limiting or excluding the practice, can provide Illinois with the benefits of midwifery – decreased costs, increased access, and safe alternative birthing options – while maintaining its interest in protecting its citizens.

76. *See* Hermer, *supra* note 41, at 356.
77. 225 ILL. COMP. STAT. 60/54.5 (2013).
78. *See* Safriet, *supra* note 1, at 307-08; Hafner-Eaton, *supra* note 12, at 813.
79. *See* Cohen, *supra* note 1, at 87.
80. WASH. REV. CODE § 18.50.040 (2013).
81. *Id.*
82. WASH. REV. CODE § 18.50.010 (2013).