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Direct Entry Midwives: Political Factors Shaping Variation in Regulation

By: Gabrielle Shlikas, *Wellesley College*

Introduction and Context

Within the United States, the narrative surrounding the use of midwives focuses heavily on the safety within said field. The rate of home births in the United States is low,¹ yet continues to rise. The rate of home births in 2017 reached 1.61%², up 77% from 2004.³ This rising number has prompted discussion of midwife regulation in relation to the safety of mother and child. With the number of midwife-attended home births⁴ increasing, an analysis of the varying state regulations regarding different types of midwives is necessary.

The current popular and medical discussion in regard to midwives focuses on topics of health and safety outcomes. Multiple articles regarding testimonials about home births gone right⁵ or horrifically

wrong⁶ are prevalent,⁷ as well as articles and studies⁸ weighing the safety⁹ of home births¹⁰ and midwives.¹¹ Bambi Chapman, a resident of Ohio, chose to use a midwife and attempt a homebirth for her second child after a traumatic birth experience with her first child. After delivering the baby, her midwife assured her that everything was normal. Only hours later, her daughter stopped breathing and was unable to be resuscitated by doctors. The coroner informed the family that had her (direct entry) midwife not missed signs of respiratory distress, her child could still be alive.¹² This is only one of countless stories from women who engaged with midwives to assist in their homebirth, only to have something go wrong. It is only later that they learn things that trouble them, such as the lacking regulation of midwives in their states, as well as the

1 Belluck, Pam, "As Home Births Grow in U.S., a New Study Examines the Risks," *New York Times*, December 31, 2015, www.nytimes.com/2015/12/31/health/as-home-births-grow-in-us-a-new-study-examines-the-risks.html.

2 Marian F. MacDorman and Eugene Declercq, "Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017," *Birth: Issues in Perinatal Care* 46, no. 2 (June 2019), <https://doi.org/10.1111/birt.12411>.

3 Ibid.

4 Marit L. Bovbjerg, "Perspectives on Risk: Assessment of Risk Profiles and Outcomes among Women Planning Community Birth in the United States," *Birth* 44, no. 3 (September 2017), <https://doi.org/10.1111/birt.12288>.

5 Madison Park, "Home Births: No Drugs, No Doctors, Lots of Controversy," CNN, August 9, 2010, www.cnn.com/2010/HEALTH/08/09/home.births.debate/index.html.

6 Jen Cutts, "Confession: My Home Birth Sucked," *Today's Parent*, January 19, 2017, www.todayparent.com/pregnancy/confession-my-home-birth-sucked/.

7 The Editors, "The U.S. Needs More Midwives for Better Maternity Care," *Scientific American*, February 1, 2019, www.scientificamerican.com/article/the-u-s-needs-more-midwives-for-better-maternity-care/.

8 Joseph R. Wax et al., "Maternal And Newborn Outcomes in Planned Home Birth vs Planned Hospital Births: A Metaanalysis." *American Journal of Obstetrics & Gynecology* 203, no. 3 (July 2 2010): 243.e1 - 243.e8, <https://doi.org/10.1016/j.ajog.2010.05.028>.

9 Belluck, "As Home Births Grow in U.S., a New Study Examines the Risks."

10 "Home Birth: Know the Pros and Cons," Mayo Clinic, Mayo Foundation for Medical Education and Research, October 13, 2018, www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/home-birth/art-20046878

11 The Editorial Board, "Are Midwives Safer Than Doctors?" *New York Times*, December 15, 2014, www.nytimes.com/2014/12/15/opinion/are-midwives-safer-than-doctors.html.

12 Danielle Friedman, "Home Birth Nightmares: Mothers Share Their Stories," *Daily Beast*, September 9, 2010, www.thedailybeast.com/home-birth-nightmares-mothers-share-their-stories.

fact that their midwife may have attended multiple births where the infant died.¹³ Stories of midwives performing risky births whilst having subpar credentials are recurrent,¹⁴ as well as investigations revealing disregard for state and local regulations regarding midwives and birthing centers.¹⁵ Though the American College of Obstetricians and Gynecologists “believes that hospitals and accredited birth centers are the safest settings for birth,” home births continue to rise today against the traditional advice of medical professionals.¹⁶ “Licensed midwives attending child births at birthing centers or private residences are not health-care professionals,” reads a Sarasota County EMS Handbook, encapsulating a popular opinion within the medical community concerning the status of non-nurse midwives in the medical community.¹⁷

As home births become more common,¹⁸ planned home births are more frequently attended by a direct entry midwife rather than a certified nurse midwife.¹⁹ The discussion surrounding this rise in utilization is focused on safety, as highlighted by the aforementioned articles.

There are multiple types of midwives under different definitions depending on state regulations.²⁰

Certified nurse midwives are women who are midwives and nurses, whereas direct entry or certified practicing midwives are women who do not have nursing or medical degrees.²¹ Certified nurse midwives vary less across states because they are required to have a nursing degree from either an accredited nurse midwife school or a traditional nursing program. An RN seeking to become a certified nurse midwife may become one with midwife training yet remains at the level of an RN. While the certified nurse midwife regulations vary across states, certified nurse midwives primarily work in professional settings and are legal in all 50 states.²²

Legislation varies from state to state regarding the certification and privileges afforded to direct entry midwives. Direct entry midwives are the most variably regulated²³ state to state. They are banned in four states, regulated in 32, and completely unregulated in 14 states.²⁴

The same direct entry midwife can practice with no license in West Virginia,²⁵ is prohibited from practicing in Georgia,²⁶ and is required to have a license to practice in Texas.²⁷ This raises the question as to why there is such a large divergence across states.

13 Ibid.

14 Neil Vigdor, “Unlicensed Nebraska Midwife Is Arrested in Newborn’s Death After Home Delivery,” *New York Times*, July 6, 2019, www.nytimes.com/2019/07/06/us/nebraska-midwife.html.

15 Emily Le Coz, Josh Salman, and Lucille Sherman, “Attempted Out-of-Hospital Birth Takes Tragic Turn for New Parents,” *Sarasota Herald-Tribune*, February 17, 2019, www.heraldtribune.com/news/20190222/attempted-out-of-hospital-birth-takes-tragic-turn-for-new-parents/1.

16 “Planned Home Birth,” ACOG, April 2017, www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Planned-Home-Birth.

17 Le Coz, Salman, and Sherman, “Attempted Out-of-Hospital Birth Takes Tragic Turn for New Parents.”

18 Melissa Cheyney, “Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009,” *Journal of Midwifery & Women’s Health* 59, no. 1 (January 20, 2014), <https://doi.org/10.1111/jmwh.12172>.

19 “Planned Home Birth,” ACOG.

20 “Types of Midwives,” Midwives Alliance of North America, [https://mana.org/about-midwives/types-of-midwife#:~:text=The%20most%20common%20types%20of,and%20Certified%20Midwives%20\(CM\)](https://mana.org/about-midwives/types-of-midwife#:~:text=The%20most%20common%20types%20of,and%20Certified%20Midwives%20(CM).). For general purposes and this paper, I will be using the Midwives Alliance of North America (MANA) definitions regarding the different classifications of midwives.

21 Ibid.

22 Ibid.

23 “State By State,” Midwives Alliance of North America, mana.org/about-midwives/state-by-state.

24 Ibid.

25 Ibid.

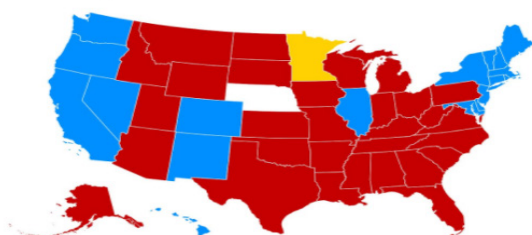
26 Ibid.

27 Ibid.

This paper will examine the political forces that have shaped the regulations in Georgia, West Virginia, and Texas since they are all states that vote reliably conservative in elections, and are all in the general south of the United States. The South as a case study is intriguing due to its varying stances on reproductive healthcare. The goal was to find out how states generally perceived to be “anti-choice” would monitor and regulate their birth industry.²⁸

First, this paper will delve into what the various regulations are in each state, if there are any pres-

LEGISLATIVE CONTROL
 ■ Democrat ■ Republican ■ Divided



Source: National Conference of State Legislatures

ent at all. Then, it will work backwards, constructing a timeline of how the current landscape came to be. Once the facts have been established, the differences and similarities witnessed in each state will be analyzed.

A Brief History of Regulation: **West Virginia, Georgia, Texas** **West Virginia**

Within the state of West Virginia, certified nurse midwives are regulated by the state,²⁹ but no

similar regulations exists for direct entry midwives.³⁰

The 1925 West Virginia Code mandated that no one besides a doctor could practice midwifery without being licensed. The license could be issued to anyone over twenty-one years old who was able to read and write, who demonstrated adequate cleanliness habits, and who had either a physician’s statement verifying knowledge, or a diploma from a midwifery school.³¹

This code was restructured in 1973 when the American College of Nurse Midwives standards for nurse midwives were advocated for by Delegate Queen, who sponsored a bill to adopt the College’s standards in state law. The bill would bring the state up to federal standards and thus make them eligible for more funding for maternal programs in the state.³² As of 2012, only 40 certified nurse midwives were working in West Virginia;³³ though as of December 2019, only four were found practicing within the state.³⁴

In light of this puzzling situation regarding direct entry midwives, correspondence was established with midwife organizations in the area. In reaching out to West Virginia Friends of Midwives, contact was made with a member, Ms. N,³⁵ a certified nurse midwife who is a member of the Midwives Alliance of West Virginia as well.

The first inquiry to Ms. N was in regard to her feelings on the lack of regulation within her state. Her response was surprising. “We have members who have worked on [direct entry midwife] licensure at least 3 different times (in the 1990s, and twice in the late 2000s/early 2010s),” she wrote, illustrating that midwives and their organizations are in favor of state regulation, rather than ambivalent. She went on to reveal that she was personally involved in two efforts to lobby for legislation, and was rebuffed when her

28 Carter Sherman, “48 State Legislatures are Now Under Single-Party Control. That Hasn’t Happened since 1914,” Vice, December 12, 2018, www.vice.com/en_us/article/vbaxnb/48-state-legislatures-are-now-under-single-party-control-that-hasnt-happened-since-1914.

29 “Online Midwifery Schools Offering CNM Masters Degrees in West Virginia,” How to Become a Nurse Midwife, www.midwifeschooling.com/west-virginia/.

30 “State By State,” Midwives Alliance of North America.

31 Uriah Barnes, *Barnes’ West Virginia Statutes, 1925 : Fully Annotated : Containing Laws of 1923 and 1925* (Charleston: Tribune Printing Co., 1925), 609.

32 Ervin S. Queen, Telephone interview by author, May 7, 1989.

33 “Online Midwifery Schools Offering CNM Masters Degrees in West Virginia.”

34 Ibid. I utilized the same search process cited in the article that claimed 40 midwives in 2012.

35 A pseudonym is used for privacy’s sake.

organization attempted to submit a “sunrise application.”³⁶ The answer received to the sunrise application explained that licensing would not be taken up as an issue regarding direct entry midwives as “there were not enough [direct entry midwives] in [West Virginia] to justify a new regulatory process.”³⁷ This placed direct entry midwives in an undesirable position, as they were unable to attract more direct entry midwives due to the lack of clear regulations and oversight, with a legislature that was unwilling to proceed until a larger population was witnessed.

Ms. N assured that West Virginia is not a “wild west” for the few direct entry midwives in practice. Midwife organizations and fellow midwives hold each other accountable and set internal quality controls.

One possibility is that a small population has caused a lack of legislation. In 2015, HB 2829³⁸ was introduced in the West Virginia State Legislature. This bill would have imposed minimal regulation and would only require reporting, not licensing. Be that as it may, it failed to pass.

In search of more information on this bill, HB 2829, three of the original four co-sponsors that still serve in the West Virginia State Legislature were contacted, though as of the publication of this paper no response has been received.

The bill would have added an official definition of direct entry midwives to the West Virginia Code, and imposed reporting on those operating as direct entry midwives. The bill would have required direct entry midwives to self-report to the Bureau of Public Health in West Virginia statistics about their involvement in different situations regarding birth annual-

ly. These situations included the number of clients, number of stillbirths, number of hospital transfers, and more.³⁹

The bill, introduced in the House of the West Virginia Legislature in 2015, passed through the House easily, and was then introduced in the Senate. With no floor votes or readings, the bill was referred to committee and was never reexamined.⁴⁰

Georgia

In Georgia, it is functionally illegal to be a practicing direct entry midwife.⁴¹ There is a framework in place for midwife licensure, though licenses are only issued to individuals with nursing degrees. This makes direct entry midwives and certified midwives nonexistent in the state of Georgia,⁴² whereas certified nurse midwives are allowed and can get licensure through the Georgia state government.⁴³

This lack of licensure is enshrined in the law. The Georgia Code reads, “In order to become eligible for a certificate of authority to practice midwifery, applicants shall attend classes and satisfactorily complete courses of instruction therein to be prescribed by the department and shall pass an examination covering such courses.”⁴⁴ The state has interpreted this statute to mean that nursing school is required, among other things, to be a certified midwife. Thus, the state does not grant licenses to those who do not have nursing degrees, only giving the classification of midwife to certified nurse midwives. Since its 1955 iteration, the Official Code of Georgia has included language regarding the licensure of midwives.⁴⁵

There is advocacy on the ground in Georgia in reaction to the lack of licensure for non-nurse

36 “Sunrise Provisions for Occupational Licensing: A Review,” Institute for Public Policy: Harry S Truman School of Public Affairs, 2016, static1.squarespace.com/static/545815dce4b0d75692c341a8/t/58923a44cd0f6884a009b2af/1485978181624/Sunrise+Provisions+for+Occupational+Licensing+DRAFT+11.15.16+%281%29.pdf.

37 Ibid.

38 H.B. 2829, Sess. of 2015 (W.Va. 2015), https://www.wvlegislature.gov/bill_status/bills_history.cfm?INPUT=2829&year=2015&sessiontype=RS.

39 Ibid.

40 Ibid.

41 “State by State.”

42 “Citizens for Midwifery,” Status of Midwives and Midwifery, cfmidwifery.org/states/states.aspx?ST=GA.

43 “Online Midwifery Schools Offering CNM Masters Degrees in Georgia,” Midwife Schooling, www.midwifeschooling.com/georgia/.

44 O.C.G.A. § 31-26-2.

45 Ibid.

midwives in the state. Groups like the Georgia Birth Advocacy Coalition⁴⁶ lobby for legislation to allow for the licensure of direct entry midwives, using the narrative of safety. They posit that certified nurse midwives rarely work outside of hospitals and therefore do not serve the community in the same way that direct entry midwives would.

This on the grounds advocacy seems to have had some impact, as a bill, HB 717, was introduced in March of 2019 to the House of the Georgia Legislature with the purpose of amending the state code to allow for the certification of direct entry midwives. HB 717 was placed into the hopper with six co-sponsors. Specifically, the bill would:

Amend Title 31 of the O.C.G.A., relating to health, so as to repeal in its entirety Chapter 26, relating to the practice of midwifery; to amend Title 43 of the O.C.G.A., relating to professions and businesses, so as to provide for the licensure and regulation of midwives; to provide for definitions; to provide for the creation of the Advisory Board for Licensed Midwives; to provide for its membership and duties; to provide for licensure requirements; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.⁴⁷

The bill was given a first read on the floor and assigned to the regulated industries committee on April second. It was reassigned to the health and human services committee on April second, as well.⁴⁸ No further action was taken on the bill, as the Georgia General Assembly is only in session from January to April. A Senate version of the bill was introduced in the 2019 legislative session, but failed to garner a second floor reading. SB 267 had two co-sponsors, and was also introduced in April, when it was assigned to

committee and made no further progress.⁴⁹ The lack of action taken on the bills renders them essentially moot. To be considered, they would need to be reintroduced in the next session. The bill was introduced so late in the session as to make it virtually impossible for it to get a second floor reading, let alone be passed.⁵⁰

Despite the bill only being in the general assembly for a week, the bill garnered local media attention. With a familiar framing, an article in the *Augusta Chronicle* opened with the death of a child during birth under midwife care.⁵¹ The author reports on the death of Asa Joy Cruz, who was delivered after two and a half days of labor in her parents' home under midwife care rather than in a hospital. The midwife overseeing the birth was certified with the North America Registry of Midwives, but did not possess a license in Georgia, as she does not have a nursing degree. The article, critical of non-nurse midwives, still lobbies the state to pass HB 717 and impose regulations on direct entry midwives, rather than allowing them to operate in the shadows.

Texas

In the state of Texas, direct entry midwives are extremely regulated and well documented.⁵² The state government keeps a thorough record of licenses awarded to midwives, and lists copious amounts of information on their website.⁵³ The Department of Health and Human Services' website has data online about the number of direct entry midwives licensed each year and in which county they operate from 2008 on, with data from previous years available upon request. One can also check the license of any practicing midwife to verify their history and certification.⁵⁴

The history of midwifery in Texas has been long documented. In 1924, a State Bureau of Child

46 "Midwife Licensure," Georgia Birth Advocacy Coalition, georgiabirth.org/midwife-licensure.

47 H.B. 717, Sess. of 2015 (Ga. 2019-2020), https://openstates.org/ga/bills/2019_20/HB717/.

48 Ibid.

49 Ibid.

50 I could not get in contact with any of the co-sponsors of the bill to procure any firsthand information.

51 "Editorial: Midwife Licenses Pose Certifiable Problems," *Augusta Chronicle*, September 30, 2019, www.augustachronicle.com/opinion/20190930/editorial-midwife-licenses-pose-certifiable-problems.

52 "State By State."

53 "County Supply and Distribution Tables - Direct Entry Midwives," Texas Department of State Health Services, www.dshs.texas.gov/chs/hprc/DEM-lnk.shtm./datamart/login.do.

54 "Online Licensing Services," Texas Department of Licensing and Regulation, vo.licensing.tdlr.texas.gov.

Hygiene survey estimated that there were around 4,000 midwives practicing within the state.⁵⁵ The midwife tradition is traced back to indigenous Native American people and immigrant women who typically served rural populations. Anyone deemed a midwife was regulated under the Sheppard-Towner Maternity and Infancy Protection Act of 1921, which set in place the requirement of hygiene training.⁵⁶ The act expired in 1929 without being renewed. As hospital births gained prominence, the tradition of utilizing midwives was carried on by Latina and indigenous women.

In 1974, midwives established midwife associations for both nurse and lay/direct entry midwives. In 1985, midwives had a resurgence, and the Baylor School of Medicine began to train midwives in a program, the first of its kind in Texas.⁵⁷ In 1983, the first regulation of lay/direct entry midwives was introduced: the Lay Midwife Act.⁵⁸ This arose out of concern for the lack of regulation with non-nurse midwives, as they were attending a higher number of births.⁵⁹ In 2015, the statutes were codified into the Texas Occupations Code.⁶⁰ The act was then changed to take oversight of midwives from a Texas Midwifery Board, thus giving the authority to the Texas Department of Licensing and Regulation.⁶¹ Before the Texas Midwifery Board was dissolved and transferred, it came under sunset review in the original legislation.⁶² With the review coming in the 2005-2006 legislative sessions, the Texas Medical Association weighed in on the practice of direct entry midwives in the state.

The Medical Association shared concerns over the role of direct entry midwives in Texas. “Direct-entry midwives’ education is inadequate to ensure the safety of mothers and newborns under these

circumstances,” writes the Texas Medical Association, highlighting the fact that midwives are “not medical professionals,” nor doctors. The Texas Medical Board had serious concerns about the structuring of the legislation and how direct entry midwives are monitored. They asked that the

Texas Medical Association (1) work for Texas midwifery rules that specify protocols and standards to be used by practicing direct-entry midwives, including clear standards for the delineation of findings that preclude a woman’s or newborn’s condition as being classified as normal; (2) push for all direct-entry midwife-assisted pregnancies that are either transferred/referred for emergency care or have adverse outcomes be reported by the midwife to a midwifery advisory body and the case reviewed by a committee that includes at least one physician; (3) support legislation that requires formal informed consent from clients that clarifies the distinction between direct-entry midwives and certified nurse midwives; and (4) oppose Medicaid reimbursement for direct-entry midwives.⁶³

The Texas Medical Association published this request during the initial review of the Texas Midwifery Board, and the suggestions were taken into consideration when the act came up for renewal in the Texas General Assembly. Direct entry midwives are now required to obtain informed consent from patients, highlighting what skills they have and clarifying that they are not, in fact, doctors or nurses.⁶⁴

55 Megan Seaholm, “Midwifery,” *The Handbook of Texas Online*, Texas State Historical Association, June 15, 2010, tshaonline.org/handbook/online/articles/sim02.

56 Ibid.

57 Ibid.

58 Texas Department of Licensing and Regulation, *Midwives: Texas Midwifery Basic Information and Instructor Manual* (Austin: TDLR, April 2018), www.tdlr.texas.gov/midwives/forms/MID005.pdf.

59 Seaholm, “Midwifery.”

60 Texas Department of Licensing and Regulation, “Midwives.”

61 Ibid.

62 Realini, Janet, “Direct-Entry Midwives’ Scope of Practice: Report of Committee on Maternal and Perinatal Health,” (Austin: Texas Medical Association, 2006). www.texmed.org/Template.aspx?id=4878.

63 Ibid.

64 Texas Department of Licensing and Regulation, “Midwives.”

Analysis & Observations

When analyzing the layout of these three different states in regards to how they regulate direct entry midwives, no clear cut pattern begins to emerge as to why each state has taken the route it has. There is no course defining factor that changed Georgia from a state that wholeheartedly embraced direct entry midwives into one that bans them. There is no focusing event that defines these southern states, only a history⁶⁵ of doing what was done in the past, with minor adjustments. This is born out in the conclusions when states do attempt to change their laws regarding direct entry midwives.

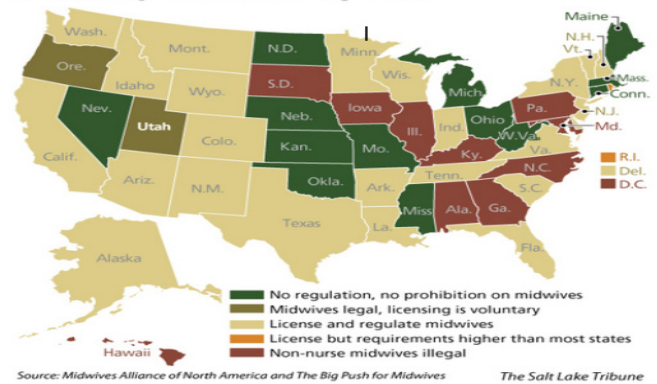
HB 2829 failed in the West Virginia House of Representatives despite the fact that it would have imposed no regulations, just an impetus on direct entry midwives to report to the state some statistics about their operations. They have no licensure or requirements, and yet even this bill failed to pass the state legislature.

The same can be seen regarding HB 717 in Georgia. The bill would have changed the status regarding direct entry midwives from unacknowledged by the state to allowing for a regulatory process that would allow them to operate legally in Georgia. The bill, despite having numerous co-sponsors in the Georgia House and Senate, failed.

So why has Texas, a state similar in its representative philosophy and make, succeeded in enacting such a robust regulatory system where Georgia and West Virginia have failed? It is hypothesized that the answer lies in the entrenchment of the current process regarding midwives, a lack of focusing events, and a lack of a substantial base pushing for change.

The history of midwifery in Texas is especially strong due to the prominence of immigrant and indigenous women, as well as the rural nature of the state. Due to these factors, midwives flourished in a time before there were even any classifications for them. In 1924, a state survey found that 4,000 midwives were practicing within the state of Texas,⁶⁶ a number that is unheard of today. Midwives, in all their current classification, are counted and regulated in Texas today because they always have been. There is no coalition arguing for a lack of licensure for them, and very few

Midwife policies state by state



circumstances that could lead to this group forming. With no fight for a repeal of the regulations in Texas, the current regulations stand.

Whereas the “let things stand” philosophy can help to explain Texas’ policies, it can also help to explain the policies in West Virginia. As gleaned from people on the ground, there is a willingness to accept and lobby for change from the direct entry and nurse midwives on the ground, and yet not enough interest on the part of legislature and state regulators. This creates a feedback loop that prevents any progress from being made. The state refuses to regulate direct entry midwives, therefore discouraging them from establishing a practice in a state that refuses to differentiate or legitimize them. The state then refuses to regulate on the basis that there is not enough of a demand. It is an easy path to take no action. With a lack of true focusing events or a surge in the direct entry midwife population, it is not likely that anything will change on the ground in the near future.

Whereas Texas and West Virginia are cases that can be surmised with the concepts of entrenchment and inaction being easier than action, Georgia presents a unique challenge. With Georgia, change is needed from governmental structure to allow direct entry midwives to practice at all. Despite there being multiple co-sponsors in the House and Senate in the Georgia General Assembly, the bill was presented so late as to make it virtually impossible for it to be passed in either house. This signifies that there is either a strong enough lobby that pushed legislators to act, possibly leading to real change, or that a powerful

65 Erin Alberty, “Legal Problems Sent Midwife to Utah, Where Another Baby Died,” *Salt Lake Tribune*, September 23, 2017, archive.sltrib.com/article.php?id=56739550&itype=cmsid.

66 Seaholm.

special interest or focusing event pushed legislators to act immediately, despite the lateness in the legislative period. Special interests like medical associations and boards being against furthering midwives recognition can be viewed as a cause of the stall in Georgia. Ground roots interest may come from the fact that the board of nurses that issues midwives licenses in Georgia was granted the power to levy 500 dollar fines on those who claim to be midwives without having a nursing degree.⁶⁷ This enflamed the debate in Georgia over direct entry and certified midwives, who (in general) hold animosity toward the nurse midwives who struggle less with state recognition. The lack of substantive action in Georgia can be attributed to the on the ground tension between nurse and non-nurse midwives.

The influence of strong anti-direct entry midwife lobbies may have prompted the legislators to introduce the bill so late, as well. In filing the legislation, representatives can take back to their constituents that they did *something*, while simultaneously ensuring that the bill never makes any real progress to appease the medical lobby/direct entry midwife detractors.

Whereas the Georgia Department of Public Health is against issuing licenses to non-nurse midwives,⁶⁸ Representative Buddy Carter (GA-1) introduced the BABIES act in Congress in 2019, which would provide funding for birthing centers following the “birth center model of midwifery-led care.”⁶⁹ This back and forth between state and federal legislators, nurse midwives, and non-nurse midwives illustrates that this issue is under scrutiny in Georgia and will continue to be fought. Overall, the topic of safety is one that continues to be focused on, and this is one reason the debate in Georgia is ongoing. No representative wants to be held responsible for legalizing non-nurse midwives if/when a child dies or a mistake happens in their care. At the same time, advocates argue for the positive outcomes that direct entry midwives deliver statistically, and that their legalization would help with the shortage of medical professionals dealing with birthing issues in areas of the state.

Despite the current debates, the midwives have yet to prevail, in part due to their lack of organization and political capital. Midwife organizations can be found in Georgia, yet these women are not doctors or nurses, and more often than not do not have the connections that being a medical professional provides.

In contrast, a look at why Texas allows strong regulation despite the fact that medical associations are against direct entry midwives is necessary. It can be argued that it is for the same reasons insurance companies adapted to The Affordable Care Act: the regulation of midwives was happening, so instead of continuing to fight, they got into the business of shaping the standards and legislation. Overall, direct entry midwives do not have the hospital and medical lobbies behind them. In fact, these strong lobbies are against the legalization of direct entry midwives in the state. Direct entry midwives in Georgia are fighting a larger, more well-funded interest group, making progress slow and difficult.

The situations being faced by midwives in the states of Georgia and West Virginia are the ones most compelling, as they illustrate groups asking the government for regulation, and being denied. A change in the system being denied is a situation that is applicable to varying situations regarding healthcare. Whereas policy changes regarding long term care or other healthcare reforms usually require tax increases, the legalization of midwives does not require funding, begging the question if a perceptive path forward for midwives is a ballot initiative approach in places like Georgia.

Implications

Overall, these case studies illustrate how pervasive the philosophy of “if it is not broken, do not fix it” is statewide within United States politics and government. There is no compelling evidence in Texas that would indicate that — had it not established regulation early in its state history - it would not be identical to West Virginia: without guidelines and with no plans for implementation. Likely, the only state

67 Jim Manley and Caleb Trotter, “Call the Midwife - but Not If You Live in Georgia,” The Hill, December 26, 2019, thehill.com/opinion/healthcare/474216-call-the-midwife-but-not-if-you-live-in-georgia.

68 Georgia Department of Public Health, *Notice of Proposed Rulemaking*, Atlanta, GA: Department of Public Health, September 11, 2015. dph.georgia.gov/sites/dph.georgia.gov/files/1338_001.pdf.

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with potential for change anytime soon is Georgia, which exemplifies how conflict and debate can lead to change.

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