Midwifery in Texas:

Safety, Regulation and Need

The Association of Texas Midwives

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Version 1.0

This version of *Midwifery in Texas: Safety, Regulation and Need* reflects, with only slight modification of format, research done by Kathy Rateliff at the request of the Association of Texas Midwives (ATM). Kathy conducted her research under contractual agreement with ATM, and this document is the result of the compilation of her research. Plans are being made for a subsequent edition of this document, which will feature expansion of content and standardization of the annotation and citation schemes currently employed.

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This research was compiled by Kathy Rateliff on behalf of the Association of Texas Midwives.
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Midwifery has always been legal in Texas, although not always regulated. Prior to 1989, the law did not require much more than having midwives identify themselves by registering with the county clerk. In 1989, the Midwifery Act was amended to include mandatory basic and continuing education requirements which took effect in September, 1993. In 1993, The Midwifery Act was further amended to provide investigative authority to the Midwifery Board. The most recent amendments occurred in September, 1997 when new rules were written to assist the Midwifery Board in implementing the law through disciplinary actions which could include removal of documentation and administrative penalties. [1]

Safety and Regulation

Birth and death information from the Texas Department of Health for 1990 - 2000 indicate that birth with midwives in Texas has always been a statistically safer option than birth with either a medical doctor or doctor of osteopathy. State maternal mortality rates for all kinds of birth attendants has been under 0.2/1000 since 1977.[2] With midwifery assisted births, infant death rates for 1990-2000 have never exceeded 3/1,000. Births performed by either an MD or a DO have always been at least twice as high as the published rate for midwives.

The following table lists the infant mortality rate of midwives, CMNs, MDs and DOs for 1990 - 2000.

Infant Mortality Rate by Attendant Type 3
Rate per 1,000 live births

Year	Midwife	CNM	MD	DO
1990	3.0	3.0	7.6	7.7
1991	3.0	2.1	7.3	7.6
1992	2.3	2.8	7.5	7.7
1993	1.8	3.3	7.3	6.1
1994	1.7	4.5	6.8	6.4
1995	2.1	2.5	6.5	4.7
1996	1.1	3.1	6.3	4.0
1997	2.8	2.6	6.1	5.0
1998	1.7	2.4	5.7	6.5
1999	1.2	3.6	6.0	5.9
2000	0.3	1.9	5.5	4.7

As one can clearly tell, except for 1991, midwives in Texas have had the lowest infant mortality rate of any attendant type from 1990 - 2000. The source table for this information

also indicates that midwives in Texas had lower cesarean rates than all other provider types, with rates typically under 2/1,000. Cesarean rates for both MDs and DOs were consistently higher than 200/1,000 from 1991-2000.[3]

Regulation of midwives and detailed rules for practice in the Midwifery Act does not account for the comparably lower infant mortality rate. In fact, all levels of infant mortality decreased some since 1990 and maternal mortality rates remained at 0.1/1000.[2]

Documentation and identification records of midwives from The Texas Department of Health Midwifery Programs do, however, indicate that the numbers of legally practicing midwives have steadily decreased since the passage of the 1989 Lay Midwifery Act. In 1989, there were 604 identified midwives practicing in Texas,[5] 14,474 births attended by midwives and others, with almost 9000 of these births taking place outside of the hospital.[4] (Bureau of Vital Statistics {BVS} Table 2 report for "Resident Births by Attendant and Place of Delivery Texas, 1966-2000" does not differentiate between midwives and all other non-physician attended birth or between home births and all other forms of out-of-hospital birth sites. BVS statistics from 1990-2000 are broken down by attendant: Medical Doctor, DO, CNM, Midwife, Other and Unknown.) In 1993 when new education and restriction laws took effect, the number of midwives fell to 262,[5] with 12,682 births attended by midwives or others and 5,871 of these births occurred outside of the hospital.[4] In 1997 when the most recent changes took effect, there were 217 documented midwives,[5] 3,549 midwife assisted births,[4] and 3,825 births were listed as out-of-hospital.[3] The last available tabulated year for birth and death statistics from the BVS is 2000 and indicates that the 182 documented midwives[5] assisted in 3,910 births[3] and 3,360 births took place outside a hospital setting.[4]

Home birth and midwife-assisted births in Texas are typical of safety results documented across the world. Medical research for over a decade has concluded that home birth safety statistics are at least as good, if not better than hospital birth statistics. These statistics are true even when some studies looked at midwife-attended, out-of-hospital births which could be classified more high risk than current midwifery standards allow and those births which include unplanned out-of-hospital births.[6, 7, 8]

Current educational requirements for new midwives in Texas includes both academic study from a variety of medical, midwifery and other authoritative sources and clinical, hands-on, apprentice-modeled training. Certification in both CPR and Neonatal Resuscitation (NNR) are also required in order to practice legally. Standards for education and midwifery practice are consistent with those contained in the MANA Core Competencies.[9] Continued documentation as a midwife requires annual continuing education hours, current CPR and NNR certification, and annual application with fees submitted to the Texas Department of Health Midwifery Program. The Midwifery Program is overseen by The Texas Midwifery Board.

The Midwifery Board is currently working to revise the rules which govern the practice of midwifery in Texas. The Rules Revision Committee has been involved in the process by

recommending standards which are consistent with current Texas law, exhibit practice guidelines which have proven to insure safe midwife-assisted deliveries in home and birth center, and which offer the consumer real choice in care. The Rules Revision Committee consists of Midwifery Board members, practicing midwives and CNMs, members of medical stake holder groups, and consumer members.

A comparison of the current working draft of proposed midwifery rules from the Rules Revision Committee to conclusions on safe midwifery practice in medical literature, indicates that the proposed rules are consistent with standards proven safe for planned home births attended by trained midwives.[10, 11, 12, 13, 14, 15, 16] Those evidence-based standards are also consistent with the definition of midwifery care found in The Midwifery Act: "the practice by a midwife of giving the necessary supervision, care, and advise to a woman during normal pregnancy, labor and the postpartum period; conduction a normal delivery of a child; and providing newborn care."[17, 18]

Need

A question often asked about home birth and/or midwifery as a birthing option is, "With the current number of hospitals and obstetricians, is there a need for out-of-hospital births and midwives?" The current available research says, Yes!" and the reason are many.

Cost Savings

Research demonstrates that midwifery is more cost-effective[22] than the current medical model of hospital birth, even when transport to a hospital during or following labor is needed. This includes birth in a free-standing birth center[19] or birthing at home.[20] Cost for a home birth attended by a qualified midwife in the US is generally 68% less than an uncomplicated vaginal delivery in a hospital. Part of the reason for this cost-effectiveness is the lower incidence of interventions and procedures during pregnancy, birth and the postpartum period done to women and their newborns.[20]

Estimates of annual savings to insurance companies, government medical programs, and consumers ranges in the hundreds of billions of dollars. Most importantly, this savings could come with no decrease in safety in maternal or neonatal mortality or morbidity. Much of this savings would come by eliminating procedures with little or no proven ability to improve safety and by utilizing midwives more.[20, 21, 22] In fact, much of the technology that would be limited or eliminated would be done by following guidelines published in Guide to Effective Care in Pregnancy and Childbirth[23] and the World Health Organization's Care in Normal Birth: a Practical Guide.[24]

Evidence-Based Practice

A Guide to Effective Care in Pregnancy and Childbirth is a compilation of the best international evidence-based research regarding the care of pregnant women and their babies. The Synopsis contains six tables classifying basic elements of care during pregnancy and childbirth according to their effectiveness and potential to benefit or harm. The six tables are:

Table 1: Beneficial forms of care

Table 2: Forms of care likely to be beneficial

Table 3: Forms of care with a trade-off between beneficial and adverse effects

Table 4: Forms of care of unknown effectiveness

Table 5: Forms of care unlikely to be beneficial

Table 6: Forms of care likely to be ineffective or harmful

It is interesting to note that many of the elements which carry the best clinical evidence of efficacy and benefit are also components of the Midwifery Model of Care.[25, 26, 27, 28, 29] Some components of the Midwifery Model of Care which are also included in either Table 1 or 2 in the Guide to Effective Care include: seeing pregnancy as a normal rather than a medical condition, respecting the right of a woman to choose her birth companions, respecting a woman's right to choose her place of birth, informed consent and refusal in all matters, nutritional education, healthy life-style changes when needed (stop smoking, alcohol moderation, appropriate treatments for medical problems that do not harm the baby), support of the mother (physically, emotionally, psychologically), social support provided to the mother/family, midwifery care for low risk women, continuity of care, prenatal education, accurate risk assessment, competent and individual care based on each woman's need, interventions only when there is a demonstrated need, external cephalic versions for breech or transverse lie at term, continuous support during labor, freedom of movement and position choice in labor and birth, positional changes for fetal distress in labor, use of non-medicinal methods to deal with pain in labor (positional changes, counter-pressure, superficial heat or cold, touch and massage, focus and distraction, music and audio-analgesia, etc.), delivery at term, vaginal delivery whenever possible, perineal guarding, VBAC if previous cesarean was low transverse, birth attendant with neonatal resuscitation skills, breastfeeding support and education, early mother-infant contact, rooming-in, support for postpartum depression, and grief support for parents who loose a baby.

The Right to Choose

The September 1999 version of the Midwifery Act states the following: "The legislature finds: 1) a parent has the responsibility and right to give birth where and with whom the parent chooses."[30] Further, the Royal College of Midwives positional paper on Home birth states: "Childbearing women are nearly always competent adults and therefore have every right to decide to give birth in their own homes (the exceptions to this are women prisoners and women who have been declared by the courts to lack the mental capacity to consent to

medical treatment) (RCM, 1998)."[12] Both of these statements highlight the importance of individual choice in pregnancy and childbirth.

Indeed, evidence-based research concludes that self-determination may positively or negatively affect health and the effectiveness of treatment.[31] "Choice itself (allowing women to choose home or hospital birth) may influence levels of anxiety and apprehension and thereby also the outcome of maternity care."[32] Therefore, respect for a woman's choice in birth location and attendant may be crucial in helping her to have the safest birth possible.

Research by Davies et al entitled "Prospective regional study of planned home births spotlights the issue of the woman's right to choose and attitude of other caregivers when she makes a choice contrary to the one they want.[33] The study included 251 women who requested home birth in 1993. "Two thirds of the women (in the study) thought they had not been offered any option about place of birth."

"Some women seem to believe that it is mandatory to have a general practitioner's approval before they can proceed with home delivery, but only one third of women who commented had been given any option about place of birth by their general practitioner. One woman tried 12 different doctors and could not find one prepared to provide intrapartum care; she continued to search even though she had already had one home birth without a general practitioner present."

"Women whose formal requests for a home birth were noted had obstacles placed in their way. Though women wanted the support of their general practitioner, only a minority had a doctor who thought their request was appropriate. For most women it was never a proffered option."[33]

Table 3 from this study looks at the reasons women in this study chose a home birth. Reasons prior to delivery included: more in control, prefer to be at home, more natural, partner more involved, less intervention, less stress for baby, no need to leave other children, safer at home, and no transport worries. Reasons expressed after delivery included: relaxed, in control, natural, non-clinical, peaceful, calm, private, joyful celebration, confident, welcome for baby at home, and safer at home.

A home birth study from Scotland also reported some interesting comments regarding choice.

"The proportion of home births in Scotland in 1994 was small (0.7%), but for those mothers the provision of this service was very important. Despite some difficulty in achieving home birth and despite pockets of professional antagonism, those mothers who achieved their wishes were very satisfied with the experience. The maternal outcomes for the home birth group were as good, if not better than their hospital birth counterparts. The group transferred to hospital had slightly less good outcomes than the mothers who were able to stay at home, but as 65% of them achieved a normal birth it would appear that the midwives erred on the side of caution. The neonatal outcomes were good on the whole, but

the lower birth weight and increased resuscitation in the transferred group was a reflection of the reasons for transfer. Overall, all the mothers, irrespective of the place of birth, expressed satisfaction with their care, but it was more pronounced in those whose choice had been home birth and who had been able to have a home birth." [34]

A small 1992 study by Wright comparing 22 births at home to 23 hospital births also focuses on choice:

"All mothers in this study were multiparous except one in each group. All the pregnancies were wanted and all the women had help at home. Many women felt that they had had no choice about the place of birth, and had merely complied with what they saw as the existing system of hospital births. There had been no discussion on the subject with health care workers. While those having hospital deliveries talked about perceived risks and safety, those who had home births identified specific reasons for their choice and retrospectively emphasized the fulfilling and satisfying process. Both groups felt their choice had been right for them. For the majority delivering at home, their decision had been determined by a previous unexpected home birth which had been a good experience. The perceived lack of choice raises important questions about the way in which information is given to women in pregnancy." [35]

The British Medical Journal Clinical review series on the ABC of ...includes a review entitled "ABC of labour care Place of Birth. Objectives of good labour care include : providing a safe outcome with a minimum of avoidable complication and making birth a satisfying experience. Reasons for choosing home birth were noted as: avoidance of unnecessary intervention 31%; more relaxed and in control in familiar surroundings 25%; previous home birth 11%; wish to be in a familiar setting to aid relaxation 10%; fear of hospital 10%; and a continuing relationship with the midwife 4%. Reasons for choosing a hospital setting were safety 84% and previous hospital birth 6%. A definition of "Women centred care: states, "In whatever setting birth takes place, every effort should be made to ensure that the woman is made to feel physically and psychologically as comfortable as possible. She should perceive herself to be in control of what is happening and be able to make decisions about her care, having had full discussions with the professionals involved." [36]

Demographic patterns of women who choose home birth are typically older than the average childbearing woman, having higher parity, more likely to be married, predominately white, middle class, have a healthier lifestyle as evidenced by smaller percentages of smokers and drinkers, more likely to breastfeed and do so for longer periods of time, more motivated to take an active role in their care and more likely to start prenatal care later. One US study population of home birth mothers had less formal education [37], but other US study populations showed mothers have more formal education or more equally split [38, 39. 40, 41, 42] which is more typical of international home birth populations. [43]

Women who have had or attempted a home birth are more likely to say that they were happy with the experience and would choose a home birth in subsequent pregnancies. [44]

This fact creates a two-fold concern in Texas. First, with a significant decrease in the number of documented midwives available to attend births, women may choose to birth unassisted if they cannot find a legal attendant. Secondly, if home birth lost it's legal status or severely restricted the number of women who qualify as low risk, a significant number of women would still choose to birth at home and might choose to do so unattended. [6, 7, 14, 16, 33, 37] These two factors could lead to less safe conditions at home births.

It is important to maintain a level of safety by practicing at a level determined safe by evidence-based research. It is also important to encourage and support a population of qualified birth attendants who are experienced in home birth conditions so that those women who choose to birth at home can do so safely.

A Shortage of Attendants

A national news story during the week of July 21-27, 2002 reported that many obstetricians are leaving the field due to the high cost of malpractice insurance, and many Family Practice and General Practitioner Doctors have stopped doing births for the same reason . The story noted that malpractice premiums for OBs have increased by 500% or more over the last 10 years. Additionally, the last ten years has witnessed the closing of many small hospitals and medical practices for economic reasons. As noted earlier, the number of legal midwives in Texas has also declined.

Support of midwifery as a reasonable alternative for low risk women would help to insure that all women who need prenatal care can find care. Requiring insurance companies, HMOs, PPOs, and Medicaid to cover midwifery assisted births at birth centers and at home for low risk women would allow more women who desire this option to afford it. Extending payment reimbursement or coverage would not increase medical birth costs; it would actually lower the annual costs now covered due to the high numbers of doctor-attended hospital births to low risk women.

Increase in Options

July 5, 2001, The New England Journal of Medicine published an article on the safety of VBACs. [45] This article led many hospitals to issue policies banning VBACs in their facility. Despite several articles refuting the conclusions of study, [46, 47] VBACs continue to be out of reach of many women. More women are turning to midwives and out-of-hospital births to achieve the VBAC they desire. VBACs are more likely to succeed and less dangerous at home because labor induction, especially with prostaglandins, is not recommended or desired in a home setting.

Additional options sought by women but not found in many hospitals are water births, freedom to ambulate and choose labor and birth positions, freedom to eat and drink in labor, freedom to invite whomever they choose to attend the birth, freedom from having the newborn removed from the presence of the mother in the absence of medical need, freedom from unwanted strangers intruding during the birth, freedom to video record the birth and

freedom from unwanted and unneeded medical interventions. Midwives in a home birth setting can and often do easily accommodate these options, creating a more satisfactory birth.

The Journal of Health Politics, Policy and Law addressed the issue of home birth in December, 1994. The following comments seemed to be most pertinent to this issue:

"Reviewing the full spectrum of literature from the United States and abroad, we present a Constitutional medical-legal analysis of whether home birth with direct-entry midwives is in fact a safe alternative to physician-attended hospital births, and whether there is a legal basis for allowing alternative health policy choices in such an important yet personal family matter as childbirth. The literature shows that low- to moderate-risk home births attended by direct-entry midwives are at least as safe as hospital births attended by either physicians or midwives. The policy ramifications include important changes in state regulation of medical and alternative health personnel, the allowance of the home as a medically acceptable and legal birth setting, and reimbursement of this lower-cost option through private and public health insurers."[48]

Conclusion

Home birth and midwife-assisted deliveries are here to stay. Multiple medical research studies affirm the safety of these choices for low risk women. The evidence-based care commonly used in most midwifery practices increase the safety factor and often increase the satisfaction women have with their birth. Current education requirements and both current and proposed midwifery rules in Texas provide a foundation that will ensure safe midwifery care for women and their babies.

Women who choose midwifery care have the right to choose where and with whom they deliver. They also have the right to full knowledge of benefits and risks of available options in pregnancy, childbirth and parenting and the right to determine what options they will consent to or refuse. Because women who choose home birth are generally more motivated to take an active part in their care, more educated regarding options, and healthier than most women choosing a hospital birth, their pregnancies and birth generally remain low risk.

Future needs include: required coverage and/or reimbursement for midwifery care in or out of hospital, education of pregnant women regarding the availability of midwife-assisted birthing and home birth, better cooperation and collaboration between midwives and the medical community when women need transfer of care or medical consults, and support of the midwifery community as a valid option for low risk women.

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