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COMMENT

Legitimacy for the Florida Midwife: The Midwifery Practice Act

KATHERINE SIMMONS YAGERMAN*

The rite of childbirth once belonged to the mother and her midwife, a companion and attendant interned in the mysteries of human birth. Modern medicine usurped that position, replacing the midwife with the professional physician. The author traces the journey of the midwife to her present status as a legitimate source of obstetrical care and examines the Florida Legislature's recent enactment of the Midwifery Practice Act.

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I. INTRODUCTION

The drama of contemporary childbirth most often occurs in the hospital under the supervision of a physician. Yet, the art and practice of attending women in childbirth was once the exclusive

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province of midwives—women with an expertise founded solely on their experience in undergoing and observing childbirth.¹ The Florida Legislature's enactment of a comprehensive program for the regulation and licensing of lay midwives—the Midwifery Practice Act²—reaffirms the art and tradition of midwifery, acknowledging this practice as a legitimate source of maternity care.

The term "midwife," which means "with-woman,"³ refers to anyone other than a physician who supervises and assists women in labor and childbirth. The State of Florida recognizes two types of midwives: a certified nurse midwife, a registered nurse who has completed advanced specialty training in obstetrics;⁴ and a lay midwife, someone other than a registered nurse or physician who assists women in pregnancy and childbirth.⁵ The Midwifery Practice Act prohibits the practice of lay midwifery without state licensing, replacing an ineffective 1931 statute⁶ that also aimed at licensing midwives, but which had floundered for several years in

1. A. PILLITTERI, *MATERNAL-NEWBORN-CARE OF THE GROWING FAMILY* 28 (1981). The author notes that "[c]hildbirth was so totally women's business that as late as 1522 a Doctor Weitt in England was burned alive for dressing as a woman and observing a delivery." *Id.*

2. 1982 Fla. Laws ch. 82-99 (codified at FLA. STAT. §§ 467.001-.209 (Supp. 1982)).

3. R. WERTZ & D. WERTZ, *LYING-IN, A HISTORY OF CHILDBIRTH IN AMERICA* 6 (1977); see also A. PILLITTERI, *supra* note 1, at 28.

4. FLA. STAT. § 464.012 (1981). Section (4)(b) of the Nurse Practice Act, FLA. STAT. ch. 464 (1981), states that

[t]he nurse midwife may, to the extent authorized by established protocol approved by the medical staff of the health care facility in which midwifery services are performed, perform any or all of the following:

1. Perform superficial minor surgical procedures.
2. Manage patient during labor and delivery to include amniotomy, episiotomy, and repair.
3. Order, initiate, and perform appropriate anesthetic procedures.
4. Perform post partum examination.
5. Order appropriate medications.
6. Provide family-planning services.
7. Manage the medical care of the normal obstetrical patient.

Nurse midwives, as did lay midwives, also supervised pregnancy and childbirth before childbirth became the responsibility of male physicians. See *infra* text accompanying notes 22-26. The respect and predominance of the nurse midwife is increasing, however, as nurse midwives "have stepped again into the part they originally played—that of patient advocate, a person to see that pregnancy, childbirth, and the postpartal period is a rewarding time in life, not one filled with concern and loneliness" A. PILLITTERI, *supra* note 1, at 28. For a discussion of the history of nurse midwifery, see J. LITOFF, *AMERICAN MIDWIVES, 1860 TO THE PRESENT* 122-34 (1978).

5. 1982 Fla. Laws ch. 82-99, § 485.003(2) (codified at FLA. STAT. § 467.003(7) (Supp. 1982)), states that midwife "means any person not less than 18 years of age, other than a licensed physician or certified nurse midwife, who is licensed under this chapter to supervise the delivery of a child." *Id.*

6. FLA. STAT. ch. 485 (1981) (repealed by 1982 Fla. Laws ch. 82-99 § 2).

an uncertain status after having been declared unconstitutional by several lower state courts.⁷

The key difference between the new Act and its 1931 predecessor, however, lies in its recognition of "the need for parents' freedom of choice in the manner of, cost of, and setting for their children's births."⁸ Thus, the new legislation attempts to incorporate lay midwifery into the conventional health-care delivery system and to broaden choice for prospective parents. In contrast, the old law was narrow in scope and purpose, designed only to establish minimal standards of competency for midwives, who in 1931 served mainly the rural poor and black populations,⁹ and was based on the expectation that the number of midwives would decrease as more sophisticated medical resources became available to the poor.¹⁰

An examination of the rich tradition of midwifery in America, the historical climate surrounding the 1931 Act, and finally, recent cultural changes in philosophies of the childbirth experience gives perspective to the Midwifery Practice Act and promotes an appraisal of its elements, its weaknesses, its problems and its potential. This discussion will illustrate how the Midwifery Practice Act takes important, although fledgling, steps toward resolving a long-standing conflict between the midwifery profession and the medical-legal establishment, thus reestablishing this historically oppressed profession as a legitimate and indeed necessary source of obstetrical care.

II. A BRIEF HISTORY OF AMERICAN MIDWIFERY

Controversy over the legitimacy of midwives began in the early part of this century, fostering debate over the "midwife problem" in nearly every part of the United States.¹¹ The view that

7. See *infra* text accompanying notes 75-82.

8. FLA. STAT. § 467.002 (Supp. 1982).

9. See *infra* text accompanying notes 45-50. See generally Midwifery Files, Florida State Archives, Bureau of Archives and Records Management, Tallahassee, Florida 32304 [hereinafter cited as Midwifery Files].

10. J. Graves, The Midwife Program in Florida (undated report), Midwifery Files, State Board of Health, *supra* note 9 [hereinafter cited as Graves].

11. Kobrin, *The American Midwife Controversy: A Crisis of Professionalization*, 40 BULL. HIST. MED. 350, 351 (1966).

Kobrin describes this period (the early 1900's) as a "contest" between "the increasingly self-conscious obstetrical specialist" and the midwife. *Id.* at 350. Obstetricians at this time were also struggling for acceptance; they faced "both medical and non-medical competition and an almost insuperable economic problem; the level of even the best obstetrical work was almost more of a hindrance than a help." *Id.* See also J. LITOFF, *supra* note 4, at 57.

midwives were a "problem" arose from a complex of social and economic developments in the health care field,¹² and was intensified by ignorance of the history and function of the midwife in American society.

Midwives had been an important element of American life since colonial times, as early settlers brought the traditional English customs and practices of midwifery to the new world.¹³ In early America a cluster of female friends and relatives usually gathered around a laboring woman to provide moral support and, when necessary, intervened to ease a difficult birth.¹⁴ In addition, the newly-delivered woman could expect the midwife to care for her and assume her domestic responsibilities during the "lying-in period," a period of several weeks following the birth.¹⁵

Midwives did not receive any formal training; instead, they learned their skills from attending births and sharing a fund of common knowledge from more experienced midwives.¹⁶ Midwives performed their services in all strata of society, for although they charged fees for their skills, licensing conditions often required them to attend the poor regardless of ability to pay.¹⁷ Many communities encouraged the availability of midwives by placing them on the public payroll or providing them with free housing.¹⁸

The midwife performed social as well as medical duties; she often acted as a type of civil servant, reporting birth statistics to the authorities and baptizing infants in emergency situations.¹⁹ From time to time, the midwife testified in court concerning the gestational age of a newborn in cases of suspected fornication, the name of a child's father in bastardy cases (under the premise that the mother may have revealed the name during labor), and the physical condition of a woman accused of a crime (if pregnant, the

12. See *infra* text accompanying notes 34-38.

13. R. WERTZ & D. WERTZ, *supra* note 3, at 1. For more than 150 years, the custom and practice of midwifery prevailed in America. *Id.*

14. *Id.* at 4, 6. The author characterizes this ritual as "social childbirth," where neighbors and friends made birth "a social event for a coterie of women, whom the husband often assembled." *Id.* at 4.

15. *Id.*

16. One historian notes that midwives were probably selected informally through "networks of women who had aided one another in birth and were distinguished by such intangibles as manual dexterity, sensitivity, and luck." *Id.* at 6.

17. In 1716 a New York City ordinance requiring licensing of midwives commanded that the midwife "help any woman in labor, whether poor or rich; that in time of necessity she will not forsake the poor woman and go to the rich" *Id.* at 7.

18. *Id.* at 8.

19. *Id.* at 7.

convicted woman would not be executed).²⁰ In short, "the colonists accorded midwives considerable authority about women's physical condition, trusted them to speak knowledgeably and reliably, and treated midwives as if they were servants of the moral and civil order of the state."²¹

Around the time of the American Revolution, men returning from European medical study began to practice midwifery.²² Knowledge acquired from French studies of the birth process and English experimentation with instruments made these male midwives eager to practice a new form of midwifery which emphasized intervention, usually involving the use of crude forceps to ease the course of difficult births.²³

During the nineteenth century these male midwives began to establish their dominance in the practice of midwifery, associating themselves with the branch of medicine known as "regular" or "heroic" medicine.²⁴ This philosophy of medicine relied on the use of harsh therapeutics to purge the body of its impurities. Regular medicine is generally considered as the forerunner of today's modern form of medical practice, identified with the American Medical Association ("AMA").²⁵ But male dominance of a traditionally female practice did not occur without friction. These "regular" doctors practicing obstetrics had to overcome the widespread female aversion to examination and treatment of their bodies by a male physician,²⁶ as well as the perception that childbirth was a natural process not requiring a physician's attendance, before they could acquire the status and acceptance eventually associated with their profession.

20. *Id.* at 7-8. Midwives serving these special "woes of matrons" also rendered their opinions on suspicious deaths of women. *Id.*

21. *Id.* at 8.

22. *Id.* at 29.

23. *Id.* For a comparison of interventionist techniques and traditional midwife methods, see Bogdan, *Care or Cure? Childbirth Practices in Nineteenth Century America*, 4 FEMINIST STUD. 92 (1978).

Forceps became a popular accessory for the nineteenth century physician attending a delivery. "The use of forceps was taught in nineteenth-century medical schools by lecture, and experience with forceps typically came after graduation. . . . Pelvic tearing was common; the tears were rarely sutured and often became the source of chronic complaints." *Id.* at 96.

24. This form of medicine was characterized by the use of drastic measures to bring about cure, and thus earned the label "heroic" medicine. Practitioners thought that the more severe the impact on the body, the more certain the cure. B. EHRENREICH & D. ENGLISH, *FOR HER OWN GOOD, 150 YEARS OF THE EXPERTS' ADVICE TO WOMEN* 42 (1978).

25. *Id.*

26. J. LITOFF, *supra* note 4, at 10-11.

The ascent of science as a new ideology in the latter part of the nineteenth century promoted the acceptance of this form of medical practice. Regular medicine, encumbered by accusations of commercialism,²⁷ had faced serious competition from other groups of practitioners—midwives, osteopaths and folk healers. The development of a medicine founded in science dissipated the earlier distrust of the regulars;²⁸ the objectivity and disinterestedness of science gave it “great moral force in the mind of the public.”²⁹

The practice of medicine founded on scientific principles also promoted a shift from home birth to hospital birth. The focus of the scientific approach on the body's natural processes, rather than on the person as a whole,³⁰ included a desire to control the process of birth by applying the scientific method, a method which could only be applied through hospitalization.

The development of technology that was compatible only with the hospital setting further established the hospitals as the best place for births. And, because obstetricians believed that intervention was necessary in most deliveries,³¹ birth in a hospital equipped with this sophisticated technology was viewed as safer and less painful for the delivering mother.

Thus, by the time the “midwife problem” became a subject of debates in the early twentieth century, doctors had already gained acceptance among the middle and upper classes. In fact, most midwives practiced primarily among the rural and immigrant populations.³² Yet, despite her economic insignificance “the future of the midwife was fiercely debated within the pages of [the major American medical journals].”³³ A thorough explanation for this antago-

27. Popular recognition of the commercialism of regular medicine tainted its image in the public eyes. R. EHRENREICH & D. ENGLISH, *supra* note 24, at 62. According to these commentators, “[s]cience was the transcendent force to which the doctors looked to lift medicine out of the mire of commercialism and gird it against its foes.” *Id.* at 63. See also J. LITOFF, *supra* note 4, at 10-11.

28. For a discussion of the AMA's powerful role in the promotion of scientific remedies and scientific medical practice, see Comment, *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 938, 959, 963 (1954).

29. B. EHRENREICH & D. ENGLISH, *supra* note 24, at 68.

30. R. WERTZ & D. WERTZ, *supra* note 3, at 136. The authors describe this approach: “It was the process that interested the doctor; it was curing the ‘diseased’ process or aiding the ‘difficult’ process that gave him satisfaction and status.” *Id.*

31. Kobrin, *supra* note 11, at 353. Obstetricians based their belief in intervention on the theory that pregnancy was not a normal physiological condition. *Id.*

32. J. LITOFF, *supra* note 4, at 27; see *supra* note 9. For a personalized account of a nurse-midwife's experience treating a poor, black and rural community, see S. SIMPSON, *SISTER STELLA'S BABIES - DAYS IN THE PRACTICE OF A NURSE MIDWIFE* (1978).

33. J. LITOFF, *supra* note 4, at 57.

nism to midwives is beyond the scope of this comment.³⁴ Historians and other commentators have attributed the conflict to a clash of ideology,³⁵ economic competition³⁶ and class struggle.³⁷

Whatever the underlying forces may have been, certain identifiable events contributed to the rejection of midwifery as a legitimate source of obstetrical care. By 1910, regular medicine had become the standard-setting force in the health care field. In addition, national concern about recently-publicized high infant and maternal death rates in the United States spurred many state health authorities to focus on improvement of obstetrical services.³⁸ Midwives, now far outside the sphere of legitimate medicine, received a large share of the blame for this national problem. As they became the focus of debate, they also became a target for elimination in many states.³⁹

III. THE ORIGINS OF FLORIDA'S REGULATORY LAW

Florida also experienced furor over the "midwife problem" during this period, a furor exacerbated by the fact that Florida possessed the highest maternal and infant death rates of the states.⁴⁰

Although the state legislature initially refrained from addressing the midwife issue statutorily,⁴¹ regulation of midwives occurred

34. For a variety of theories discussing the historical antagonism to the midwifery practice, see B. EHRENREICH & D. ENGLISH, *supra* note 23; Kobrin, *supra* note 11.

35. Kobrin attributes this antagonism to the "two fundamentally different approaches to the process of childbirth, based on opposite views of its naturalness." Kobrin, *supra* note 11, at 353.

36. J. LITOFF, *supra* note 4, at 48-50. Many obstetricians viewed midwives, osteopaths and other competitors as invading the legitimate field of medicine and depriving licensed physicians of fees. Kobrin, *supra* note 11, at 358.

37. B. EHRENREICH & D. ENGLISH, *WITCHES, MIDWIVES AND NURSES, A HISTORY OF WOMEN HEALERS* 4 (1973). These authors view the "takeover" of health care by male professionals as a result of a political struggle fueled by sexism and classism. The new medicine, reserved for society's elite, excluded women, who were the "people's doctors." *Id.*

38. J. LITOFF, *supra* note 4, at 48-50.

39. See *infra* text accompanying notes 40-47.

40. Letter from Mrs. William L. Wilson, President, Florida Federation of Women's Clubs, to Governor Doyle E. Carlton (Jan. 11, 1932) (located in Gov. Doyle E. Carlton, Records, Administrative Correspondence, 1924-32, Board of Health File, Florida State Archives, Bureau of Archives and Records Management, Tallahassee, Florida) [hereinafter cited as Wilson Letter]. See also Address by Joyce Ely, State Supervisor of Midwives (1933) (available in Essays on Midwifery 1931-1946) (unpublished materials) (Midwifery Files, *supra* note 9) [hereinafter cited as Ely Address].

41. One of the earliest references to midwives in state records was made by Dr. Porter, a Florida Health Officer, in 1914. Ely Address, *supra* note 40. In a State Board of Health Report, Dr. Porter mentioned a statement made by Dr. Jacobs, President of the American

informally under the Bureau of Child Hygiene and Public Health Nursing created in 1918 as a branch of the State Board of Health.⁴² The Bureau sponsored classes for midwives, issued obstetrical kits containing silver nitrate for application to newborns' eyes, and published an instruction manual. In 1924 the Bureau began to issue certificates of fitness to midwives participating in the program.⁴³ The federal government also provided support, contributing funds under the Sheppard-Towner Maternity and Infant Protection Act of 1921.⁴⁴

Despite the positive aspects of these programs, the attitude of public health officials toward the midwife was one of condescension, rooted in the belief exhibited by most officials that the majority of midwives, especially the "problem" midwives, were black.⁴⁵

Medical Association in 1914, suggesting that midwives should be educated rather than suppressed. *Id.*

42. The Florida Federation of Women's Clubs was apparently the motivating force behind the formation of the Bureau. Wilson Letter, *supra* note 40.

43. Ely Address, *supra* note 40. The midwives, and others, came to refer to these unofficial certificates as licenses. Hanson & Blachly, *Present Status of Midwifery in Florida*, 25 S. MED. J. 1252, 1253 (1932). There seems to have been some confusion in 1909 concerning state licensure of midwives. See letter from "Assistant State Health Officer" to Isabella Maynor (Sept. 9, 1909) (letter answering inquiry about midwifery license) (in Midwifery Files, *supra* note 9). One individual, inquiring about a system of licensing for midwives, described how "every little while some old midwife writes that she has lost her license or burned it" A reply stated that "there never was any licensing of midwives" in Florida, theorizing that physicians had given "the old grannies in their families" a certificate stating that "they were capable and could be trusted." Memoranda from H.B. and J. YL P., letterhead of State Board of Health (undated) (in Midwifery Files, State Board of Health, *supra* note 9). Perhaps the state legislature likewise became confused as to the licensing situation for midwives; in 1927, it passed a law requiring the registration of "every license to practice medicine, osteopathy, chiropractic, naturopathy, midwifery and every other medical and/or material method of the practice of the healing art . . . before the licensee begins practice thereunder" 1927 Fla. Laws ch. 12005 (amended by 1931 Fla. Laws ch. 14760 and repealed prior to the 1941 codification of Florida Laws).

44. Sheppard-Towner Maternity and Infant Protection Act, ch. 135, 42 Stat. 224 (repealed by Act of Jan. 22, 1927, ch. 53, § 2, 44 Stat. 1024). See Ely Address, *supra* note 40, at 2. The Sheppard-Towner Act provided federal funds for midwife training and regulation for states which elected to participate. In 1923, Dr. Anna E. Rude, Director of the Maternal and Infant Hygiene Section of the United States Children's Bureau, reported that money available through the Act "had enabled thirty-one states 'to attack the long neglected problem of midwife practice.'" J. LITOFF, *supra* note 4, at 140 (citing Rude, *The Midwife Problem in the United States*, 8 J. AM. MED. A. 989-90 (1923)).

45. Ely Address, *supra* note 40, at 4, 5; Graves, *supra* note 10, at 1; Notes of David K. Fulton (undated) (apparently written in preparation for authoring a book describing the history of midwives in Florida) (available in Essays on Midwifery 1931-1946) (unpublished materials) (in Midwifery Files, State Board of Health, *supra* note 9). One prominent physician in 1931 noted that "before obstetricians in air planes [sic] became a reality," the "black mummies" aided white women in childbirth. Report of Dr. Lucille Blachly (1931) (available in Essays on Midwifery 1931-1946) (unpublished materials) (in Midwifery Files, State Board

One influential Florida physician wrote, "Their [the 'black mam-mies'] elimination as midwives must come"⁴⁶ Others urged less severe objectives. Recognizing the impossibility of immediately replacing midwives with physicians and hospital services, the "control" and education of midwives became central themes, although the long-term goal of elimination was implicit in their views.⁴⁷ At least one state health official articulated a goal of replacing "the old illiterate midwife by [sic] the 'nurse mid-wife'"⁴⁸ Nevertheless, midwives were deemed a "problem" and a "menace," and were held responsible for Florida's high infant and maternal death rates,⁴⁹ despite health officials' admissions that, statistically, midwives experienced fewer incidents of maternal and infant deaths than did physicians.⁵⁰

An atmosphere of disrespect for the practice of midwifery and an expectation of its eventual disappearance prevailed when the Florida Legislature finally decided to address the midwife "problem." In 1931, the legislature passed a law requiring licensure and state supervision of midwives.⁵¹ Although little official legislative history is available,⁵² one observer reported that "the State Health Officer and interested individuals, the Medical Association, the Womans Club [sic]" prompted its passage.⁵³

Certain national and state events of 1930 and 1931 explain the

of Health, *supra* note 9) [hereinafter cited as Blachly Report]. By 1931, most of the white population had access to physician care, leaving midwives to treat the black segment of society. Actual registration statistics from 1931 indicate that there were 157 white midwives and 990 black midwives ("mammies"). Hanson and Blachly, *supra* note, 43 at 1253.

46. See Blachly Report, *supra* note 45, at 1.

47. See Ely Address, *supra* note 40.

48. Graves, *supra* note 10, at 7. Part of the program of eliminating at least the older and less educable midwives included the ceremonial issuance to them of a certificate of "Honorable Discharge" in return for a written promise to cease practice. *Id.* at 3. The objective was to avoid "hurting the old midwife's feelings," *id.*, and to give them "due regard for their standing with their own people." Blachly Report, *supra* note 45, at 1.

49. Ely Address, *supra* note 40, at 3; Graves, *supra* note 10.

50. Ely Address, *supra* note 40, at 6 (reference by Henry Hanson, Chief Health Officer, State Board of Health, made in discussion following address). See also Kobrin, *supra* note 22, at 353.

51. Midwifery Act, 1931 Fla. Laws ch. 14760.

52. Committee reports are nonexistent. One state representative who voted against the Act went on record as opposing regulation in view of "a large number of poor people in the State living in remote rural sections, who would be placed at a disadvantage." Statement by Representative C.N. Horne, FLA. H.R. JOUR., 1931 Reg. Sess. at 985. Representative Horne continued: "I vote no for them, and do so reluctantly, as I desire at all times to better general health conditions, and hope the day will soon come whereby no mother will have but the best care in the blessed estate of motherhood." *Id.*

53. Ely Address, *supra* note 40, at 7.

timing of enactment. In 1930, the White House Conference on Child Health and Protection, a national response to the United States maternal and infant death statistics,⁵⁴ urged each state to study and implement the Conference findings.⁵⁵ In particular, the Conference's Subcommittee on Education of Midwives urged the improvement of the quality of midwife care.⁵⁶ Florida's governor, Doyle E. Carlton, in compliance with the White House Conference suggestions, approved a state counterpart of the national meeting, which met just a few weeks before enactment of the Midwifery Act.⁵⁷

A statewide movement to improve health care in Florida may also have encouraged the passage of the 1931 midwifery law.⁵⁸ This movement, which sponsored auto tags for 1931 reading "Florida for Health,"⁵⁹ probably stimulated many other refinements in state public health laws in addition to the legislative endorsement of regulation of lay midwives.

IV. THE FLORIDA MIDWIFERY ACT OF 1931

When Florida passed its first midwifery regulatory law a substantial number of midwives—over 1,400—were practicing.⁶⁰ Despite this significant number of midwives, the legislature failed to frame a law affording any professional status to these practitioners, a defect engendered most likely by the prevailing prejudices to-

54. See Letter from F. L. Adams to Governor Doyle E. Carlton (Dec. 1, 1930) (located in Gov. Doyle E. Carlton Records, Administrative Correspondence, 1929-1932, Public Health Conference File, Florida State Archives, Bureau of Archives and Records Management, Tallahassee, Florida); Letter from John Tigert, President of Florida Health Council, to "Friend" (Apr. 18, 1931) (located in Gov. Doyle E. Carlton Records, Administrative Correspondence 1929-1932, Public Health Conference File, Florida State Archives, Bureau of Archives and Records Management, Tallahassee, Florida).

55. See Letter from F. L. Adams to Governor and Letter from John Tigert to "Friend," *supra* note 54.

56. This subcommittee "reported that the ultimate solution for good obstetrics was not in the midwife but in developing a sufficient number of doctors . . ." Ely Address, *supra* note 40, at 5.

57. See Letter from F. L. Adams to Governor and Letter from John Tigert to "Friend," *supra* note 54.

58. See generally Gov. Doyle E. Carlton, Administrative Correspondence 1929-1932, Public Health Conference File, Florida State Archives, Tallahassee, Florida.

59. Letter from Tampa Motor Club to Governor Doyle E. Carlton (June 1, 1931). *Id.*

60. See Letter from Mrs. W.S. Jennings, President, Legislative Council of Florida Federation of Women's Clubs to State Board of Health Officials 1 (Dec. 17, 1929) (located in Gov. Doyle E. Carlton Records, Administrative Correspondence 1929-1939, Board of Health File, Florida State Archives, Tallahassee, Florida [hereinafter cited as Jennings Letter]; Ely Address, *supra* note 40, at 4. There were reportedly some 4,000 midwives when regulation first started around 1920. Jennings Letter, *supra*, at 1.

ward the profession. Unfortunately, the bare-bones terms of the statute exhibited an absence of legislative commitment to the kind of educational or supervisory programs that would have established a first-rate, expansive system of midwifery. The statute did not attempt to incorporate midwifery into the prevailing system of scientific medicine.⁶¹

Notwithstanding its deficiencies, the Act regulated Florida midwives for fifty years by empowering the Florida Board of Health (later changed to the Department of Health and Rehabilitative Services ["HRS"])⁶² to promulgate rules governing midwifery practices.⁶³ The authorization for the state health officer to "make such rules and regulations as it may deem necessary for regulating the practice of midwifery within the state"⁶⁴ was vague. The statute failed to define the terms "midwife" or "midwifery" and left unclear the exact activities subject to licensure. The Act limited the midwife's involvement to cases of "normal labor,"⁶⁵ yet omitted any guidelines as to what might be deemed "normal." And finally, it delegated broad authority to the state health officer to reject applicants deemed not "reasonably skilled and competent," once again failing to set forth any guidelines for acceptable levels of competence.⁶⁶

The state Board of Health and its successor, HRS, did fill some of the gaps in the 1931 Act by promulgating rules.⁶⁷ In some respects the rules sufficiently carried forth the clear intent of the statute: the rules defined the term "lay midwife,"⁶⁸ established an application procedure for licensing⁶⁹ and enumerated record-keeping requirements.⁷⁰

Unfortunately, the scope of the rules exceeded the delegated authority. Midwives trained under physicians in other states could

61. D. Wennlund, Nursing Program Director of HRS, reports that a centralized training program instituted in 1932 was unsuccessful. D. Wennlund, *The Issue: Midwives* (1981) (unpublished manuscript).

62. 1969 Fla. Laws ch. 69-106, §§ 19, 35.

63. FLA. STAT. § 485.051 (1981) (repealed by 1982 Fla. Laws ch. 82-99, § 2).

64. *Id.*

65. *Id.* § 485.081.

66. *Id.* § 485.031.

67. FLA. ADM. CODE Rule 10D-36 (1982).

68. *Id.* at 10D-36.21. The Rule defined a lay midwife as "a person not less than eighteen (18) years of age other than a licensed physician or certified nurse-midwife, who shall attend or agree to attend any woman at or during childbirth, outside of a hospital setting, and accept for such services rendered any compensation or remuneration." *Id.*

69. *Id.* at 10D-36.22.

70. *Id.* at 10D-36.29.

not qualify for a license in Florida.⁷¹ The Board of Health added a one-year limitation to the statutory requirement that an applicant attend fifteen cases of labor.⁷² And the rules created new requirements altogether. One rule required a written recommendation for licensure by the county medical director.⁷³ Another rule allowed a midwife to serve only patients certified by a physician as "expected to have a normal, uncomplicated labor and delivery . . .,"⁷⁴ a requirement not in the statute and one arguably infringing the patient's right to avoid physician care altogether.⁷⁵

These rules worked to inhibit the licensing of midwives. The provisions required the endorsement and cooperation of one or more physicians for a midwife to procure a license and proceed with her practice. Such endorsement was unlikely, especially in light of the "relatively uniform resistance of the medical community to provide supervision of the midwife trainee and medical care for the patient planning a home birth attended by a midwife."⁷⁶

Florida courts viewed the statute and the rules promulgated pursuant to it with disfavor.⁷⁷ The few cases involving challenges

71. *Id.* at 10D-36.21. HRS rules defined "physician" as one "who shall have been duly licensed in Florida to practice medicine or osteopathy." *Id.* According to Dolores Wennlund, Nursing Program Director, Florida Department of Health and Rehabilitative Services, only a Florida physician could be "registered" under laws applicable in 1931. The Midwifery Statute's requirement, therefore, that "two registered practicing physicians" supervise the midwife applicant during 15 cases of labor and sponsor the midwife applicant, FLA. STAT. § 485.021 (1981) (repealed by 1982 Fla. Laws ch. 82-99) impliedly limited sponsorship to Florida physicians. Telephone conversation with Dolores Wennlund, Nursing Program Director, Florida Department of Health and Rehabilitative Services, (Jan. 8, 1982).

72. FLA. ADM. CODE Rule 10D-36.22(1)(a) (1982).

73. *Id.* at 10D-36.22 (1982). Some county medical directors, opposed to the practice of midwifery, refused to make such recommendations. Interview with Terry De Meo, attorney representing various lay midwives (Oct. 13, 1981).

74. FLA. ADM. CODE Rule 10D-36.25(1)(a) (1982).

75. In the months preceding enactment of the Midwifery Practice Act, HRS had proposed substantial revisions in its Lay Midwife Program Manual. These revisions would have seriously curtailed the practice of lay midwifery by enlarging the discretion of the county medical director to reject applicants, severely restricting the patient population available to a midwife, and disallowing the practice of many techniques essential to traditional midwife-assisted delivery. Memorandum from Dolores Wennlund to state health officials, lay midwives and attorneys, Revision of the Lay Midwife Program (Sept. 1981).

76. D. Wennlund, Current Status of Midwifery 7 (1981) (unpublished paper) [hereinafter cited as Wennlund, Current Status]. Joyce Ely, State Supervisor of Midwives, described this problem as early as 1933 noting that it "seems to be a real hardship at the present time for the young midwives to get the experience under the licensed, registered physicians." Ely Address, *supra* note 40, at 4.

77. At the House Committee Hearings preceding enactment of the new law, Representative Elaine Gordon, sponsor of the House version of the bill, erroneously stated that the Florida Supreme Court had "struck down [the 1931 law] as being vague." Tapes of proceedings of House Committee on Tourism and Economic Development (Feb. 15, 1982) (available

to the rules had outcomes favorable to the midwife applicant. In *State v. McTigue*,⁷⁸ a New York-trained midwife challenged a denial of licensure. The First District Court of Appeal held that two rules constituted an invalid exercise of delegated authority—the rule requiring the furnishing of a written statement of endorsement from a Florida physician and the rule requiring a midwife to provide the names of patients she had attended.⁷⁹ The court noted that “[w]hile there is obviously room for some rule-making and regulation by the Department . . . , [it] is not authorized to add to or modify those provisions which spell out with particularity the criteria which must be met in order to be eligible for a license.”⁸⁰

Two circuit courts in unreported decisions found the 1931 statute unconstitutional. In *State v. Baya*,⁸¹ the court denied the State an injunction to prohibit the defendant’s practice of midwifery, holding that the statute “unlawfully delegate[d] to HRS legislative power . . . contrary to Article II, section 3, Florida Constitution.”⁸² It found that “[t]he Statute clearly fails to fix minimal standards and guidelines to be applied by HRS in determining who shall be licensed.”⁸³ And, in a private letter, a judge discussed his reasons for dismissing the state’s prosecution for the unlicensed practice of midwifery in *State v. Brown*,⁸⁴ emphasizing that “the Statute on its face does not in any way put the reader on notice as to what conduct is proscribed,” since “[n]owhere is midwife defined, and the prohibited activities . . . are nowhere to be found.”⁸⁵

The limitations imposed by HRS on midwifery practice and licensure coincided with a declining public interest in and demand for midwife care. Statistics from 1920 to 1970 reveal a significant increase in physician/hospital supervision of delivery, and a corresponding decrease in midwife care.⁸⁶ By 1972 the number of mid-

at UNIV. MIAMI L. REV. Office) [hereinafter cited as Committee Hearings].

78. 387 So. 2d 454 (Fla. 1st DCA 1980).

79. *Id.* at 456.

80. *Id.* at 457.

81. No. 79-313 CA (Fla. 7th Jud. Cir. Ct., Oct. 10, 1979).

82. *Id.* at 2.

83. *Id.* at 3.

84. No. 80-10136, Div. B (Fla. 13th Jud. Cir. Ct., July 24, 1981).

85. Letter from Judge Fred J. Woods, Jr. to Terry De Meo (Aug. 4, 1981) (explaining his disposition of the case, for which he wrote no opinion) [hereinafter cited as Woods Letter]. In this letter the judge, noting “that the legislature revisited the Statute in 1977 and failed to make any changes in it,” said that he “hope[d] that [his] ruling [would] spur the legislature to redraft and modernize the midwifery law.” *Id.* at 1-2.

86. Physician-attended births increased from 10% in 1920 to 94% in 1970 for non-

wives in Florida had dwindled to eighty-five, and public health officials were urging an end to lay midwifery practice.⁸⁷ A resurgence of interest in midwifery challenged this objective. Disillusioned with physician- and hospital-controlled birth experiences and unable or unwilling to afford the high costs, a significant number of parents and soon-to-be-parents began to demand again the option of midwife obstetrical care.

V. CULTURAL CHANGES IN EXPECTATIONS CONCERNING CHILDBIRTH

In the decade before the modern natural childbirth movement, giving birth was often a frightening ordeal. The expectant mother experienced dehumanizing and often unnecessary manipulations; she was shut off from the support and comfort of family members.⁸⁸ The physician controlled the process of delivery, and he frequently withheld information relevant to that process.⁸⁹ Thus, a delivering woman could make little contribution to decisions about the course of her labor.

Unpleasant practices and unnecessary procedures accompanied the ritual of hospital labor and delivery. Upon admission, a woman in labor received an enema and a shave of the birth area.⁹⁰ After confining her to bed, the hospital staff administered medication for pain⁹¹ or medicine containing agents to speed a slow labor

white births, and from 77% to 99.5% for white births. The percentage of hospital births, which was close to 50% in 1920, reached 98% by 1970. D. Wennlund, *The Issue: Midwives*, *supra* note 61, at 3.

87. *Id.* at 7. Mrs. Wennlund reported that by 1972, the "Public Health Nursing Advisory Committee and County Nursing Directors with the endorsement of the Florida Association of County Health officers and approval of the director of the Division of Health called for the elimination of the lay midwifery program." *Id.*

88. Haire, *The Cultural Warping of Childbirth*, in *THE CULTURAL CRISIS OF MODERN MEDICINE* 185, 189 (J. Ehrenreich ed. 1978); S. KITZINGER, *THE EXPERIENCE OF CHILDBIRTH* 17 (1978); BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *OUR BODIES, OURSELVES* 249 (1976) [hereinafter cited as *OUR BODIES*].

89. Haire, *supra* note 88, at 188. The discussion accompanying notes 89-98 is also treated in Note, *Natural Childbirth: Rights and Liabilities of the Parties*, 17 J. FAM. L. 309, 318-19 (1978-79); *OUR BODIES*, *supra* note 88, at 249.

90. Haire, *supra* note 88, at 190. Both of these practices are now widely believed unnecessary. Their impact is in fact probably negative since they tend to aggravate apprehension in the laboring woman, "undermin[ing] her feeling of strength and capability." T. HOTCHNER, *PREGNANCY AND CHILDBIRTH* 312 (1979). Further, studies have shown that shaving the genital area causes a higher risk of postpartum infection. Haire, *supra* note 88, at 190; T. HOTCHNER, *supra* note 90, at 315. See also Graves, *supra* note 7, at 5.

91. Haire, *supra* note 88, at 190-91. Some authorities feel that drugs used to assuage the fears and discomfort of the expectant mother could be substituted with a little knowledge of the birth process and emotional support provided by the father, other family members, and a sympathetic, experienced midwife attendant. *Id.*

by increasing the frequency and violence of contractions.⁹² The delivery itself was awkward and uncomfortable; the lithotomy position required the strapping down of the mother's arms and legs.⁹³ And administration of general anesthesia was routine, as was the use of forceps and an incision (episiotomy) to hasten delivery.⁹⁴

After the birth, the indignities continued. Because she was unconscious, the newly delivered mother could not breastfeed her child for several hours—a contact now considered important for both physiological and emotional reasons.⁹⁵ The baby was in a separate, centralized nursery room, and was restricted to a four-hour feeding schedule.⁹⁶ And the hospital usually limited or disallowed early father-child contact, mother-child contact between feedings, and sibling visitation.⁹⁷ Not until release from the hospital, some three to five days after delivery, could a family assume control over their new relationships.⁹⁸

In contrast, the recent natural childbirth movement emphasizes “an orientation to birth which locates the prime focus on the mother-to-be, not the physician, and which concentrates attention on the care given in the course of a normal labor and delivery rather than on a cure for an abnormal one.”⁹⁹ Women in favor of natural childbirth now want to give birth in an environment affording them dignity, allowing them a large measure of control over the birth process, and emphasizing the normalcy and joy of the experience. They want to be awake and aware throughout, to have their families present, and to be free to hold and enjoy the

92. *Id.* at 191. “Some hospitals had regulations limiting the amount of time a woman was allowed to be in the delivery room.” R. WERTZ and D. WERTZ, *supra* note 3, at 165.

93. Haire, *supra*, note 88, at 192. The disadvantages of this position, one adopted for the convenience of the delivering attendant, are now widely accepted. The position alters the normal fetal environment, creating distress to the child, decreases the intensity of contractions, and obstructs the normal process of childbearing. *Id.* The position's initial use was for “the removal of bladder stone (hence lithus (stone) and temnein (cut)).” R. WERTZ and D. WERTZ, *supra* note 3, at 165. See also OUR BODIES, *supra* note 88, at 361; T. HOTCHNER, *supra* note 90, at 394-95.

94. Haire, *supra* note 88, at 193; T. HOTCHNER, *supra* note 90, at 405-06, 497.

95. Haire, *supra* note 88, at 195; T. HOTCHNER, *supra* note 90, at 419.

96. Haire, *supra* note 88, at 195-96; T. HOTCHNER, *supra* note 90, at 299-330; OUR BODIES, *supra* note 88, at 360-61. Breastfed newborn babies typically eat every 2½ to 3 hours. Even formula-fed babies, as newborns, will eat every 3 to 3½ hours if a demand schedule is followed. T. HOTCHNER, *supra* note 90, at 539. Some feel that centralized nurseries pose a greater risk of staphylococcus infections than systems that allow each mother to care for her own baby. OUR BODIES, *supra* note 88, at 361.

97. Haire, *supra* note 88, at 196-97; Note, *supra* note 89, at 318.

98. Haire, *supra* note 88, at 196-97.

99. Bogdan, *supra* note 23, at 98.

new child from the moment of birth.¹⁰⁰

As the natural childbirth movement gained momentum in the late 1960's, parents began to put pressure on doctors and hospitals to change their restrictive policies. But change was slow, and even today some or all of the undesirable practices still occur in many hospitals.

Courts have also been reluctant to interfere with traditional hospital policies and practices in the delivery room. The concept of absolute hospital and physician control during childbirth received judicial approval as late as 1975. In *Fitzgerald v. Porter Memorial Hospital*,¹⁰¹ the United States Court of Appeals for the Seventh Circuit denied relief to several parents trained in the LaMaze method of childbirth who had challenged the constitutionality of a public hospital's policy forbidding husbands' presence during childbirth.¹⁰² The court said:

The birth of a child is an event of unequaled importance in the lives of most married couples. But deciding the question whether the child shall be born is of a different magnitude from deciding where, by whom and by what method he or she shall be delivered. In its medical aspects, the obstetrical procedure is comparable to other serious hospital procedures. We are not persuaded that the married partners' special interest in their child gives them any greater right to determine the procedure to be followed at birth than that possessed by other individuals in need of extraordinary medical assistance.¹⁰³

The parents in *Fitzgerald* had asserted a constitutional right of privacy, based on *Griswold v. Connecticut*¹⁰⁴ and its progeny.¹⁰⁵ The *Fitzgerald* court rejected that assertion, refusing to let the alleged privacy right override a hospital policy adopted "for medical reasons."¹⁰⁶ Another court considering the procreative privacy right concluded that "the right of privacy has never been interpreted so broadly as to protect a woman's choice of the manner and circumstances in which her baby is born."¹⁰⁷ Confronted with resistance from doctors and hospitals and finding no solace in the

100. See S. KITZINGER, *supra* note 88, at 17-31.

101. 523 F.2d 716 (7th Cir. 1975), *cert. denied*, 425 U.S. 916 (1976).

102. *Id.* at 717 & n.2.

103. *Id.* at 721.

104. 381 U.S. 479 (1965).

105. See 523 F.2d at 720-21.

106. *Id.* at 721.

107. *Bowland v. Municipal Ct.*, 18 Cal. 3d 479, 495, 556 P.2d 1081, 1089, 134 Cal. Rptr. 630, 638 (1976) (midwives prosecuted for the unlicensed practice of the healing arts).

courts,¹⁰⁸ proponents of natural childbirth began to look for alternatives to hospital- and physician-controlled childbirth. The homebirth movement is, therefore, a direct result of the frustration many individuals felt at their inability to control the circumstances of their children's births.¹⁰⁹

The prohibitive costs of hospital delivery have also contributed to the increased interest in homebirth. In South Florida, the cost of physician obstetrical care, including prenatal check-ups, delivery, and postpartal care relating to the birth, was approximately \$900.00 in 1981.¹¹⁰ Hospital costs for mother and child ranged from \$800.00 to \$1,000.00.¹¹¹ In contrast, a lay midwife today typically charges only \$500.00.¹¹² And, of course, there is no cost comparable to hospital fees for a midwife-attended homebirth.¹¹³

Safety is also of significant concern to homebirth enthusiasts. One contemporary author notes that "many people who give birth in a hospital go on the misguided *assumption* that the medical setting assures them absolute safety, which does not exist."¹¹⁴ Yet, one recent study in California indicates that homebirth, for properly screened individuals, is safer than hospital birth.¹¹⁵ But the overriding justification for the homebirth philosophy is the view of homebirth advocates that "[b]irth is a personal and interpersonal experience—one of life's greatest events—and it belongs at home"¹¹⁶

Because lay midwives "are the birth attendants most willing

108. Since constitutional interests will only be protected against state action, lawsuits to force changes in physician or hospital policy were of limited value.

109. T. HOTCHNER, *supra* note 90, at 334.

110. P. Demick, M.D. & J. Wargo, M.D., Estimated Obstetrical Costs (1981) (unpublished information sheet distributed by doctors to pregnant patients).

111. *Id.*

112. D. Wennlund, The Issue: Midwives, *supra* note 61, at D-1 app.

113. The debates of the Florida House Committee on Tourism and Economic Development, which considered the House version of the bill creating the new midwifery law, focused mainly on the cost factor as a justification for continuation of a lay midwife program. Committee Hearings, *supra* note 77.

114. T. HOTCHNER, *supra* note 90, at 336.

115. *Id.* at 336-37. This result is confirmed by the fact that the United States, which ranked fifteenth among developed nations in the number of infant deaths per live births in 1978, relies less on midwife care than the nations having lower mortality rates in that year. Haire, *supra* note 88, at 185. Denmark and Holland, countries where midwife-attended births are the norm, possess the lowest infant mortality rate. E. DAVIS, A GUIDE TO MIDWIFERY 1 (1981); see also G. COREA, THE HIDDEN MALPRACTICE—HOW AMERICAN MEDICINE TREATS WOMEN AS PATIENTS AND PROFESSIONALS 187 (1977) (Midwives handle 85% of all deliveries in Denmark, which has one of the lowest infant mortality rates).

116. T. HOTCHNER, *supra* note 90, at 336.

and available" in this setting,¹¹⁷ homebirth is often equated with midwife-assisted delivery. Therefore, as interest in homebirth in the United States has increased in recent years, so has interest in the tradition and practice of midwifery.¹¹⁸ Florida has followed this trend.

Between 1973 and 1980 the percentage of reported midwife-assisted births in Florida increased from 1% to 2.6%.¹¹⁹ The number of inquiries about lay midwife licensing also increased as a result of public demand for homebirth. The HRS Nursing Program office received only six inquiries for licenses between 1972 and 1976; in contrast, the office received over seventy inquiries during an eighteen-month period from 1977 to mid-1979.¹²⁰ The 1931 Midwifery Act, established to provide only stop-gap supervision until midwives ceased to be part of the health care system, was an inadequate vehicle for establishment of the "new" midwifery envisioned by natural childbirth advocates.¹²¹

VI. THE 1982 MIDWIFERY PRACTICE ACT

The necessity of replacing the 1931 law was obvious. The 1931 Act was deficient in two ways—legally, because of its unconstitutionality, at least according to the state courts that had considered it;¹²² and socially, because of its focus on eliminating the midwife "problem." The 1931 Act was inadequate for dealing with contemporary problems and the new perception of midwives.

The questionable validity of the 1931 law¹²³ created essentially unlimited freedom to practice midwifery in Florida. Because HRS did not appeal its court losses to the Florida Supreme Court for a final resolution of the statute's constitutionality, the statute remained on the books, although apparently unenforceable.¹²⁴ This problem prompted HRS to endorse a revision of the law,¹²⁵ and,

117. *Id.* at 357.

118. See Sallomi, Pallow & McMahon, *Midwifery and the Law*, 1981 *MOTHERING* 63 (1981) (a state-by-state survey of the current legal status of the practice of lay midwifery).

119. D. Wennlund, *The Issue: Midwives*, *supra* note 61, at 7.

120. *Id.* at 7, 10.

121. See *supra* text accompanying notes 60-76.

122. See *supra* text accompanying notes 77-85.

123. *Id.*

124. At Hearings of the House Committee on Tourism and Economic Development, which considered the House version of the bill, Tim Monnihan of HRS explained that the Department had virtually given up enforcement under the 1931 statute, as HRS was "thrown out of court" each time it tried to enforce the statute. Committee Hearings, *supra* note 77.

125. *Id.*

upon the urging of courts,¹²⁶ health department officials¹²⁷ and advocates of lay midwives,¹²⁸ the Florida Legislature acted to improve the lay midwife regulatory statute. This common goal also promoted a spirit of cooperation between former opponents—public health officials and lay midwives.

Representative Elaine Gordon sponsored the House version of the bill,¹²⁹ which was drafted primarily by an attorney representing the Florida Association of Lay Midwives¹³⁰ and was modeled after the Washington State lay midwife regulatory law.¹³¹ Debate at the Hearings of the House Committee of Tourism and Economic Development, responsible for preliminary consideration of the bill, focused on three key issues: first, the need for a lay midwife licensing law; second, the standard of education that should be required; and finally, whether supervisory authority should rest with the Department of Professional Regulation, as originally proposed, or with HRS.¹³²

Advocates of the bill stressed its necessity in light of the growing demand for low-cost and more personalized obstetrical care. They argued that because the 1931 law was ineffective and allowed unsupervised midwives to practice, the increased demand for midwives would pose a great public danger.¹³³ Opponents of the bill, skeptical that the interpersonal benefits of lay midwifery overshadowed traditional obstetrical care, argued that licensure might augment the danger to the public by giving a "badge of authority" to midwives not competent to meet emergency situations.¹³⁴ As an alternative to defeating the bill, these opponents proposed certain amendments to stiffen educational requirements. In particular, they sought addition of a requirement that lay midwives acquire a baccalaureate degree.¹³⁵ These educational requirements amend-

126. See Woods Letter, *supra* note 85, at 1-2.

127. See D. Wennlund, Current Status, *supra* note 76, at 9-10.

128. Terry De Meo, the attorney representing the Florida Association of Lay Midwives and various individual midwives, assisted substantially in drafting the new law.

129. FLA. H.B. 887, 1982 Reg. Sess.

130. The attorney was Terry De Meo, referred to *supra* note 128.

131. WASH. REV. CODE §§ 18.50.005-52.015 (Supp. 1982).

132. Committee Hearings, *supra* note 77.

133. Statements by Representative Elaine Gordon. *Id.*

134. Statements by Representative John A. Grant, Jr. *Id.*

135. One of these amendments, proposed by Representative John A. Grant, Jr., would have required that a midwife applicant be a registered nurse and have acquired a bachelor's degree. The debate did not reveal the name of the sponsor of the other educational requirements amendment, which would have required either registered nurse status or a bachelor's degree "in midwifery." *Id.*

ments did not survive in the House Committee.

Officials representing HRS proposed the substitution of HRS as the supervisory agency.¹³⁶ Their argument was a technical one: since a Board of Midwifery under the Department of Professional Regulation would by law have to be supported by licensing and examination fees, creating an expensive licensing procedure in view of the small numbers of practicing lay midwives who would bear these costs, HRS, the supervisory agency under the 1931 law, would be a more suitable entity. Representative Gordon said she opposed this change in the bill because HRS lacked the investigatory capability to properly supervise midwife activity and had no system providing for hearings in the event a disciplinary action was necessary.¹³⁷

The HRS amendment failed initially, but later it passed as part of a compromise concession by Representative Gordon that became the basis for final committee approval of the bill. The Senate version of the bill¹³⁸ was substantially identical to this amended House version; and the House eventually passed the Senate version of the bill.¹³⁹

A. *Legislative Intent*

The new law's statement of legislative intent begins by recognizing "the need for parents' freedom of choice in the manner of, cost of, and setting for their children's births."¹⁴⁰ The statute has a twofold purpose: to protect the health and welfare of mothers and infants, and to make midwifery safe and available to women expecting normal deliveries.¹⁴¹ These statements reflect the legislature's acknowledgment of the critical issue of the modern midwife debate: choice.

The most positive aspect and the primary achievement of the new Act is its support for a positive and expansive view of the practice of midwifery—a view exhibited in most of the regulations. And should controversies arise, the courts will construe the statute in light of this legislative goal. Unlike the 1931 Act, with its lack of commitment to midwifery, its gaps and broad delegation of power

136. Proposal presented by Mr. Tim Monnihan, Department of Health and Rehabilitative Services. *Id.*

137. Committee Hearings, *supra* note 76.

138. FLA. C.S./S.B. 630, 1982 Reg. Sess.

139. *Id.*

140. FLA. STAT. § 467.002 (Supp. 1982).

141. *Id.*

to HRS, the new Act is comprehensive and detailed. By its careful attention to key definitions, the role of HRS, training of midwives, and creation of a multi-disciplinary Advisory Committee, the statute establishes a new state purpose—the integration of lay midwifery into the dominant health care delivery system.

B. Definitions

The Midwifery Practice Act defines terms left undefined under the 1931 Act. "Midwifery" is defined as "the practice of supervising the conduct of a normal labor and childbirth, with the informed consent of the parent; the practice of advising the parents as to the progress of the childbirth; and the practice of rendering prenatal and postpartal care."¹⁴² This definition makes clear the precise activities that are subject to licensure and will expose the unlicensed practitioner to potential criminal liability.¹⁴³ The Act also defines "normal labor and childbirth," to which midwife assistance is limited, as "the physiological process of a healthy woman giving birth to a healthy infant and expelling an intact placenta, without injury, complications, or undue strain to the mother."¹⁴⁴ The 1931 Act, which also limited midwifery practice to "normal labor," had omitted any definition of this term.¹⁴⁵ HRS, responsible for filling critical gaps in the statutory scheme, had required physicians to certify expectant women as suitable for lay midwife delivery—presumably after applying a "normalcy" standard.¹⁴⁶ This certification requirement, by mandating the participation of physicians in the process, vested unlimited discretion in physicians to refuse certification. The new Act, by defining what is "normal," significantly limits such discretion, although it fails to eliminate HRS's requirement of physician participation.¹⁴⁷

HRS, under its rulemaking authority, has responded to the 1982 Act by setting up a risk-assessment calculus with specific criteria and a corresponding point system.¹⁴⁸ The point system, based

142. FLA. STAT. § 467.003(8) (Supp. 1982).

143. The failure to define adequately the proscribed conduct was the basis for a finding of unconstitutionality in *State v. Brown*, No. 80-10136, Div. B. (Fla. 13th Jud. Cir. Ct., July 27, 1981). See the explanation by the deciding judge, Woods Letter, *supra* note 85.

144. FLA. STAT. § 467.003(9) (Supp. 1982).

145. See *supra* note 65 and accompanying text.

146. See *supra* note 74 and accompanying text.

147. The new rules promulgated by HRS continue to require physician participation in evaluating patient potential for midwife attendance. See *infra* note 148 and accompanying text.

148. Midwifery Rules 10D-36.41-.42, Fla. Admin. Weekly, Jan. 21, 1983, at 89 (amended

on prior maternal problems, chronic health conditions, and the age and location of the mother, clearly indicates which patients are inappropriate for midwife delivery.¹⁴⁹

C. *Creation of Advisory Committee*

A third important aspect of the 1982 law is its creation of the Advisory Committee of Lay Midwifery within the Department of Health and Rehabilitative Services.¹⁵⁰ This five-member body consists of one nurse midwife, one physician practicing obstetrics, two licensed lay midwives, and one other disinterested citizen.¹⁵¹ Although the statute fails to specify the duties of this Committee, it presumably will function as its name implies; to advise HRS on the problems and needs of current midwifery practice.¹⁵² Depending on the scope of function eventually allowed this Committee, it may serve as a vital limiting force on HRS, an organization traditionally opposed to lay midwifery practice.

D. *HRS Rulemaking Authority*

The 1982 Act slightly revises the statement of HRS rulemaking authority.¹⁵³ The 1931 Act authorized HRS to "make such rules and regulations as it may deem necessary"¹⁵⁴ The 1982 revision allows the Department to promulgate "such rules . . . as may be necessary to carry out the duties and authority conferred . . . by this chapter and as may be necessary to protect the health, safety, and welfare of the public."¹⁵⁵ Although this revision adds some specificity, the change is not a dramatic one. Yet, the new

by Rule 10D-36.42, Fla. Admin. Weekly, Apr. 15, 1983, at 1029). The regulations require that "the initial examination to determine risk status be performed by a physician." Rule 10D-36.42(1), Fla. Admin. Weekly, Apr. 15, 1983, at 1029.

149. *Id.* at 10D-36.42(2) (Amended by rule 10D-26.4, Fla. Admin. Weekly, Apr. 15, 1983, at 1029). The rule lists many factors that carry a two point score, indicating that the patient is not suitable for midwife care: mental health problems, two or more previous abortions, heart disease, asthma, or chronic high blood pressure. *Id.*

150. FLA. STAT. § 467.004 (Supp. 1982).

151. *Id.*

152. According to a drafter of the new legislation, the Advisory Committee played a key role in the drafting of the HRS rules, Midwifery Rules, 10D-36.35-36.60, Fla. Admin. Weekly, Jan. 21, 1983, 88-93 (amended by Rules 10D-36.35-.60, Fla. Admin. Weekly, Apr. 15, 1983, at 1028-31). Interview with Terry De Meo, attorney representing various midwives (Sept. 1, 1982).

153. FLA. STAT. § 467.005 (Supp. 1982).

154. FLA. STAT. § 485.051 (1981) (repealed by 1982 Fla. Laws, ch. 82-99, § 2).

155. FLA. STAT. § 467.005 (Supp. 1982).

Act, by defining "midwifery,"¹⁵⁶ designating in detail the eligibility for licensure,¹⁵⁷ and specifying the grounds for disciplinary action,¹⁵⁸ has curtailed the overly broad authority possessed by HRS under the 1931 Act.

One area of controversy regarding HRS rulemaking authority is the regulation of the midwife's use of certain procedures and medications. Although midwives traditionally refuse to perform episiotomies for delivery, the practice is occasionally necessary in an emergency context.¹⁵⁹ The new Act does not directly address this possibility, but rather delegates authority to HRS to define the "allowable scope of midwifery practice regarding use of equipment, procedures, and medication."¹⁶⁰ HRS exercised this authority by promulgating a rule allowing the midwife, in an emergency situation, to perform an episiotomy "when there is fetal distress" and only if she "is trained . . . by a certified nurse midwife or physician."¹⁶¹ This rule reversed HRS's prior rules prohibiting episiotomies by lay midwives in any circumstances.¹⁶² Thus, HRS permits the midwife to handle emergencies competently and professionally, reinforcing her desirability as a birth attendant.

Unfortunately, HRS initially impaired the midwife's function in another procedure—the application of silver nitrate drops to the newborn's eyes to prevent blindness. The application of some prophylactic is mandated by section 383.04 of the Florida Statutes.¹⁶³ Silver nitrate, which irritates the eye and temporarily impairs the infant's vision, a factor relevant to immediate infant-mother bonding,¹⁶⁴ was one of several medications approved by HRS for administration to newborns pursuant to section 383.04.¹⁶⁵ The Midwifery

156. FLA. STAT. § 467.003(8) (Supp. 1982).

157. FLA. STAT. §§ 467.007-.008 (Supp. 1982).

158. 1982 Fla. Laws ch. 82-99, §§ 485.017-.019 (codified at FLA. STAT. § 467.201, .203 (Supp. 1982)).

159. If there is sudden fetal distress, for instance, it becomes necessary to deliver the baby as quickly as possible rather than wait for the gradual stretching and gentle pushing accompanying a normal birth. An episiotomy in such a case will hurry the delivery.

160. See *supra* note 153. FLA. STAT. § 467.005 (Supp. 1982).

161. Midwifery Rule 10D-36.46(9), Fla. Admin. Weekly, Jan. 21, 1983, at 92 (amended by Rule 10D-36.46, Fla. Admin. Weekly, Apr. 15, 1983, at 1029). In the event a midwife does perform an episiotomy she must file a special report with the Department within ten days, "describing in detail the emergency situation, the measures taken, and the outcome." *Id.*

162. HRS Proposed Emergency Rule 82-33(3) (1982).

163. FLA. STAT. § 383.04 (1981) requires the use of silver nitrate solution "or some equally effective prophylactic approved by the Department of Health and Rehabilitative Services"

164. See T. HOTCHNER, *supra* note 90, at 411.

165. The rules allowed the use of four alternatives to silver nitrate solution, but such

Practice Act requires midwives to comply with section 383.04.¹⁶⁶ HRS, which promulgated a rule allowing physicians the use of four alternative medications to comply with section 383.04, allowed the midwife to use only silver nitrate prior to July 31, 1983.¹⁶⁷ The authority for the original limitation presumably arose from HRS's power to regulate the scope of midwifery practice regarding the use of equipment, procedures and medication.¹⁶⁸

E. *Licensure under the 1982 Act*

Under the prior law a midwife applicant had to be "not less than 18 years of age,"¹⁶⁹ "able to read . . . and to fill out the birth certificates . . .,"¹⁷⁰ "clean . . .,"¹⁷¹ and "of good moral character."¹⁷² In addition, the applicant had to meet one of three other requirements: she had to possess a diploma from an HRS-recognized midwifery school;¹⁷³ or, she had to have attended, under the supervision of a physician, fifteen cases of labor and delivery;¹⁷⁴ or, she had to "present other evidence satisfactory to the department showing her qualifications."¹⁷⁵ Under the old law, HRS possessed broad discretion to deny licensure.

The new law establishes two broad bases for licensure: licensure by examination¹⁷⁶ for individuals who have completed training at an "approved program for the preparation of midwives,"¹⁷⁷ and licensure by endorsement,¹⁷⁸ for individuals already licensed by another country¹⁷⁹ or state.¹⁸⁰ HRS must issue a license to any appli-

use was "restricted in use only by [sic] physicians and shall not be used by any other person in attendance at the birth of a child." FLA. ADM. CODE Rule 10D-35.14 (1982).

166. FLA. STAT. § 467.015(4)(b) (Supp. 1982).

167. Health and Rehabilitative Services Rule 10D-35.14, Fla. Admin. Weekly, Mar. 25, 1983, at 643 (amended, Fla. Admin. Weekly, June 17, 1983, at 1576).

168. FLA. STAT. § 467.005 (Supp. 1982).

169. FLA. STAT. § 485.031(1) (repealed by 1982 Fla. Laws ch. 82-99, § 2 (1982)).

170. *Id.* § 485.031(2).

171. *Id.* § 485.031(3).

172. *Id.* § 485.031(5).

173. *Id.* § 485.031(4)(a). There is no evidence that HRS ever recognized any such schools.

174. *Id.* § 485.031(4)(b).

175. *Id.* § 485.031(4)(c).

176. *Id.* § 467.007.

177. *Id.* § 467.007(1)(b) (Supp. 1982).

178. *Id.* § 467.008.

179. *Id.* § 467.008(1). This section provides for licensure of an applicant from a foreign country who:

 Holds a valid certificate or diploma from a foreign institution of midwifery, bearing the seal of the institution or otherwise authenticated, which renders the

cant who meets the statutory requirements. The new statute thus curtails the discretion of HRS to deny licensure. The new law also contains a saving clause granting automatic licensure and renewal of licensure to any midwife holding a valid Florida license as of the day before the effective date of the new law—July 1, 1982.¹⁸¹

This provision, however, poses a problem for experienced and active Florida midwives who did not hold valid licenses on June 30, 1982. Because one district court and two circuit courts had declared the 1931 Act invalid,¹⁸² midwives in many areas of the state practiced without licenses since there was, in effect, no valid law requiring licensure. These midwives now can obtain Florida licenses only under section 467.007 of the new law, allowing licensure by examination. This section requires, among other things, three years of study and clinical training.¹⁸³ The application of these provisions imposes an unfair hardship on midwives who, because of the uncertain status of the prior statute, did not hold valid licenses on the appropriate date.

F. Training Program

Perhaps the most significant new feature of the 1982 Act is the requirement of a program of training for midwives not yet licensed under any law.¹⁸⁴ The new law mandates a three-year course of classroom study and clinical training,¹⁸⁵ participation in twenty-five cases of prenatal, intrapartal and postpartal care,¹⁸⁶ and observation of an additional twenty-five deliveries.¹⁸⁷ The program must

individual eligible to practice midwifery in the country in which it was issued, provided the requirements therefor are deemed by the department to be substantially equivalent to those established under this chapter and rules adopted hereunder, and submits . . . a translation of the foreign certificate or diploma made under the seal of the consulate of the country in which the certificate or diploma was issued.

Id.

180. *Id.* § 467.008(2).

181. *Id.* § 467.209(2).

182. See *supra* notes 77-85 and accompanying text.

183. FLA. STAT. §§ 467.007(1)(b), .009(2) (Supp. 1982). The three years can be reduced to two for experienced applicants. *Id.*

184. *Id.* § 467.009.

185. *Id.* § 467.009(2). Section 467.009(1) states that the standards for midwifery training programs "shall encompass clinical and classroom instruction in all aspects of prenatal, intrapartal, and postpartal care"

186. *Id.* § 467.009(3). This section states that a student midwife "under the supervision of a preceptor" shall care for women "in each of the prenatal, intrapartal, and postpartal periods, but the same women need not be seen through all three periods." *Id.*

187. *Id.* § 467.009(4).

also include training with a "particular emphasis on learning the ability to differentiate between low-risk pregnancies and high-risk pregnancies."¹⁸⁸ These stringent requirements reflect an intent to upgrade and professionalize the practice of midwifery.

G. *Informed Consent Requirement*

Section 467.016 of the Midwifery Practice Act mandates that midwives procure client signatures on "a uniform client informed-consent form," which states "the qualifications of a licensed midwife and the nature and risk of the procedures to be used"¹⁸⁹ This requirement may reflect the legislature's concern that licensure puts a "badge of authority on people"¹⁹⁰ and causes clients not to inquire into the midwife's actual qualifications. Nevertheless, the mandatory use of such consent forms¹⁹¹ is a requirement not imposed on physicians or nurses, and it arguably creates an unfair competitive disadvantage for the lay midwife.

H. *Integration with Dominant Health Care System*

The spirit of the new Act requires cooperation among midwives, physicians and hospitals. For example, each midwife must develop a written plan for emergency care, which includes "[c]onsultation with other health care providers," "[e]mergency transfer" and "access to neonatal intensive care units and obstetrical units or other patient care areas."¹⁹² In addition, midwife training must be under the supervision of a "preceptor," who may be "a physician, a licensed midwife, or a certified nurse midwife."¹⁹³ These requirements stimulate communication and joint effort between the various types of obstetrical caregivers, and they may in

188. *Id.* § 467.009(5).

189. *Id.* § 467.016. The informed consent form begins with the acknowledgment by the patient that she has been informed that, "in the course of childbearing, which is a normal human function, medical problems may unpredictably and suddenly arise which may present a hazard . . ." to the patient and her unborn child. HRS-H Form 3095 (available from Health Program Office, Dept. of Health and Rehabilitative Services, Tallahassee, Fla.). The form enumerates many risks of delivery outside of a hospital: fetal distress, excessive blood loss, infection, allergies, brain damage, uterine rupture, cardiac arrest and amniotic fluid embolism. *Id.*

190. Statement of Representative John A. Grant, Jr., Committee Hearings, *supra* note 77.

191. FLA. STAT. § 467.015(1)(a) (Supp. 1982).

192. *Id.* § 467.017 (Supp. 1982).

193. The "preceptor" . . . directs, teaches, supervises, and evaluates the learning experiences of the student midwife." *Id.* § 467.003(12).

the long term help to lessen ignorance of the midwife's functioning.

I. *Disciplinary Actions*

A weakness in the new law lies in its failure to provide due process safeguards to a midwife believed to have committed one of the acts that will evoke disciplinary action under section 467.203(1).¹⁹⁴ The statute states that "[w]hen the department finds any person guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more . . . penalties."¹⁹⁵ Subsection four requires HRS to "by rule establish guidelines for disposition of disciplinary cases"¹⁹⁶ HRS rules require the investigation of complaints "including but not limited to midwife law and rules, incompetence, malpractice, conviction of felony or any crime involving intoxication with alcohol or drugs, moral turpitude or fraud by the lay midwife."¹⁹⁷ HRS, subsequent to its investigation, may then take disciplinary action "as set forth" in the statute.¹⁹⁸ Neither the statute nor the rules provides for notice and an opportunity to be heard.

J. *Confidentiality*

Another serious shortcoming of the statute is its failure to provide midwife-client confidentiality.¹⁹⁹ The denial of the confidentiality privilege undermines the midwife's professional status and, like the requirement of client consent forms, may give a competitive edge to other practitioners, for whom confidentiality is a legally protected privilege.

VII. CONCLUSION

The Midwifery Practice Act is not without flaws; nevertheless, it represents the attempt by the Florida Legislature to strike a

194. Such grounds include fraudulent procurement of a license, revocation of a license issued by another jurisdiction, conviction of a crime that bears on midwifery practice, unprofessional conduct, and incompetence. *Id.* § 467.203(1)(a)-203(1)(i). The disciplinary action may range from revocation of license to issuance of a reprimand. *Id.* § 467.203(2).

195. *Id.* § 467.203(2).

196. *Id.* § 467.203(4).

197. Midwifery Rule 10D-36.54, Fla. Admin. Weekly, Jan. 21, 1983, at 93.

198. *Id.*

199. This issue has already arisen in connection with an application for licensure pursuant to the prior statute. Some former patients of a midwife, supervised by a physician, sued to prevent *The Miami News* from gaining access to their names. *Alice P. v. The Miami News, Inc.*, No. 82-1475 (Fla. 3d DCA) (oral argument held Nov. 15, 1982).

healthy balance between the interests of a historically persecuted profession and the needs and demands of the public. The statute endorses midwifery as a profession by providing detailed and necessary regulation. This regulation not only validates midwifery in a new way but also affords the public necessary protection against untrained childbirth assistance by encouraging the proper training and preparation for future midwife practitioners. Most importantly, the new law endorses parents' right to choice in the childbirth experience.