Midwifery Scope of Practice by State: VBAC, Multiple Births, Breech Births in Non-Hospital Settings

State	VBAC Allowed?	Multiples Allowed?	Breech Allowed?
Alaska – Statutes: AS 01.65-010 through 01.65.190. Rules: AAC 14. Comprehensive document here.	No. AS 08.65.140(d)(15)	No. AS 08.65.140(d)(6)	No. AS 08.65.140(d)(9)
Arizona – Statutes: A.R.S. §§ 36-751 through 36-760. Rules: 9 A.A.C. 16, Article 1.	No. A.A.C. R9-16-108(A)(1)	No. A.A.C. R9-16-108(A)(14)	Yes, but after 36 weeks must obtain a medical consultation which may recommend treatment, referral, or transfer. A.A.C. R9-16-109(A)(18)
Arkansas – Rules: Ark. Admin. Code 07.13.4-400 *et seq*.	No. § 406.1	No. § 406.1	No. § 406.1
California – Requires supervision of a licensed physician, supervision does not require physical presence. Statutes: Business and Professions Code Business §§ 2505-2521 here Standards of Care here.	Yes. Code §2516(a)(3)(K)	Yes. Code §2516(a)(3)(K)	Yes. Code §2516(a)(3)(K)
Colorado – Statutes: C.R.S. §§ 12-37-101 through 12-37-110. Rules: 4 CCR 739-1. Midwifery statutes here Midwifery rules here	Yes, if consent, transfer, and documentation protocols followed, if no c-section within 18 months, for prior multiple c-sections a subsequent vaginal delivery has already occurred, and no prior classical or vertical incision. 4 CCR 739-1 Rule 4(A)(11) and Rule 12	No. 4 CCR 739-1 Rule (5)(F)	No. 4 CCR 739-1 Rule 4(B)(3) (May not perform versions); Rule 5(F)(requires referral if discovered)

Delaware – Collaborative agreement with licensed physician with obstetrical hospital privileges required, which may provide for any or all of the three instances. Statutes: 16 Delaware Code, Chapter 1, §§ 122(3)(h) here and 163 here Rules: 16 Delaware Administrative Code 4106.	By protocols in physician's agreement and contract with patient outlining scope of practice, potential risks/complications. 16 Delaware Administrative Code 4106, Regulations 4.3 and 4.4.	By protocols in physician's agreement and contract with patient outlining scope of practice, potential risks/complications. 16 Delaware Administrative Code 4106, Regulations 4.3 and 4.4.	By protocols in physician's agreement and contract with patient outlining scope of practice, potential risks/complications. 16 Delaware Administrative Code 4106, Regulations 4.3 and 4.4.
Florida – Based on risk factor scoring, midwife must consult with physician and if physician and midwife agree that client is expected to have normal pregnancy, labor, and delivery, may proceed. Florida Statutes: Title XXXII §§ 467.001 through 467.207 . Rules for risk protocols: F.A.C. 64B24-7.004, Risk Assessment here. (Click on View Rule.)	Yes, if risk factor protocol met. Prior c-section followed by previous vaginal delivery reduces risk factor below threshold for required consultation. F.A.C. 64B24-7.004.	Not addressed in risk factor criteria	Not addressed in risk factor criteria
Idaho – Statutes (licensing) here . Rules: I.A.C. 24.26.01.356 here. Scroll down to 356 Scope and Practice Standards.	Yes, if no more than one previous c-section, not within 18 months of current delivery, and not closed with classical or vertical incision. ID statute: 54-5505(e)(ii)(5) I.A.C. 24.26.01.356(02)(b)(i).	No. ID statute: 54-5505(e)(ii)(2) I.A.C. 24.26.01.356(02)(a)	No. ID statute: 54-5505(e)(ii)(3) I.A.C. 24.26.01.356(02)(a).

Louisiana – Statutes here . Limitations on "unapproved practice" appear in statute.	No, unless approved by Board on a case-by-case basis after physician agreement that no "untoward medical/obstetrical risk" is present. 53 Stat. C § 5361(B)(1).	53 Stat. C § 5361(B)(11).	53 Stat. C § 5361(B)(14).
Maine – State doesn't license but allows practice by lay midwives certified by NARM. State does not consider childbirth a medical condition. Guild guidance on practice in Maine.	Unregulated	Unregulated	Unregulated
Missouri – State allows practice by any licensed CNM, CM, or CPM, who must be certified by NARM or ACNM. Revised Statutes Missouri Section 376.1753 here Missouri Supreme Court dismissed challenge to statute here	Unregulated	Unregulated	Unregulated
Montana – "Direct Entry" midwives, licensed by Alternative Health Care Board, which also licenses naturopaths. Statutes: Montana Code Annotated Title 37, Chapter 27. Rules: 24.111.602 Administrative Rules of Montana 24.111.601 et seq. here	Yes – with protocols including offer of transfer, documentation, informed consent, consultation. R24.111.612. Rules also state that VBAC is only by a midwife skilled in VBAC support; and midwife must consult if history of previous cesarean birth R24.111.611(1)(a)(xxx)	No. MCA 37-27-104; R24.111.610(1)(b)(vi)	No. MCA 37-27-104; R24.111.610(1)(b)(v)

New Hampshire – Statutes and rules both included here, Title XXX, Chapter 326-D Midwifery. Additional Organizational Rules, Chapter Mid-100, apply. (Scroll down to organizational rules.)	Yes, if only one previous c-section, low transverse incision, no other uterine surgeries, 18 months ago or more, ultrasound verifies placenta is not in a low-lying anterior position, birth site within 20 minutes of a hospital by road, and document protocols followed. Mid 503.02(a) thru (g).	No, and must transfer if discovered. Mid 502.10(a)(2) and 502.09(r)	No, and must transfer if discovered. Mid 502.10(a)(3).
New Jersey – Regulations contain risk factor protocol system that requires an "affiliated physician" to preapprove the midwife to continue with care when risk factors are present. Statutes here; rules here.	Yes, but risk protocol requires physician involvement and birth must occur in a hospital. Rules 13:35-2A.9(b)(2)(v) and 2A.11(a)(4).	Yes, but risk protocol requires physician involvement and birth must occur in a hospital. Rules 13:35-2A.9(b)(3)(iv) and 2A.11(a)(7).	Yes, but risk protocol requires physician involvement and birth must occur in a hospital. Rules 13:35-2A.11(a)(8).
New Mexico – Statutes (licensing) here; NMDH licensed midwifery rules here. Rules delegate practice particulars to New Mexico Midwives Association Standards of Core Competencies of Practice and Policies and Procedures.	Yes, with protocols including only one previous c-section, no prior c-section within 18 months, prior c-section must have transverse incision, ultrasound for placenta location, birth site within 30 minutes by road of a hospital. Practice Guidelines, pp93-97. (and pg 88 primary care must be by physician or nurse-midwife.)	Yes, but primary care must be managed by a physician or nurse-midwife and must transfer if variances occur. Practice Guidelines, pp 88 and 119.	Yes but primary care must be by physician or nurse-midwife until 36 weeks, then must transfer. Practice Guidelines, pp 88 and 120.
Oregon – "Non-absolute risk" protocol applies to each of these cases and a midwife must prepare for a possible transfer scenario and have a physician consulting. Practice standards.	Yes, if 2 or fewer previous ceasarians or 3 previous ceasarians followed by previous successful vaginal birth. R 332-025-0021 (2)(a)(Y), (BB), (CC); (5)(a)(P) and (Q)	Yes if, 2 or fewer gestations, twins are not monochorionic or monoamniotic, no twin-to-twin transfusion, and neither twin is presenting transverse. R 332-025-0021 (2)(a)(U), (V), (W); (5)(a)(M) and (N).	Yes, if "frank and complete breech presentation" and no other aspects of non-cephalic presentation. R 332-025-0021 (2)(a)(X), (AA).

South Carolina – Regulation # 61-24: Standards for Practicing Midwives. Also, letter from SC Health Dept prohibiting VBAC by midwives.	No. (Letter)	Yes, consultation and referral required. R# 61-24(L)(24), (N)(1)(e). Multiple births expressly declared life-threatening complications that require emergency measures by midwife "in absence of medical help."	Yes, consultation and referral required. R# 61-24(L)(25), (N)(1)(e).
Tennessee – Statutes: Title 63 Tenn. Code Ann. Chapter 29, Midwifery Practice Act; A certified profession midwife must have collaborative plan with a physician for all clients. T.C.A. 63-29-115(a) Rules of the Bd. of Osteopathic Examinations, Council of Certified Professional Midwifery, Division of Health Related Boards Chapter 1050-5: here. Rules delegate scope of practice to "Practice Guidelines" issued by Tennessee Midwives Association.	Yes, with consultation and referral and/or transfer required if previous c-section with classical incision, within one year of current EDD, or three or more previous c-sections. TMA Guidelines IX (A)(13) through (15).	Yes, with consultation and referral required. TMA Guidelines IX (B)(3).	Yes, but consultation and referral required and must transfer if the physician says so. TMA Guidelines IX (B)(2) and (C)(7). This subsection states that a transverse lie may require emergency interventions pending physician consultation.

Texas – Referral, when required, gives patient the final say on whether to transfer to care of a licensed physician, and is documented. Statutes here do not cover scope of practice. Texas Midwifery Board Rules, Subchapter D covers scope of practice.	Yes, with referral required, except that transfer is mandatory for prior classical or vertical incision or prior uterine surgery with incision in uterine fundus. Rules Subch. D. § 831.60(b)(9) , (c)(8). Rules Subch. D. § 831.60(d) states that in lieu of referral or transfer, a midwife may manage the client in collaboration with an appropriate health care professional.	Yes, with referral required. Rules Subch. D § 831.60(b)(10).	No, transfer mandatory. Rules Subch. D § 831.65 (e)(12).
Utah – "Direct-Entry Midwife Act" Central landing page for all statutes and rules. DEMA § 58-77-601(2)(b) midwife must recommend and facilitate consultation, referral, transfer, or mandatory transfer to care of licensed health care professional in accordance with rules.	Yes, with conditions. Consultation optional if prior c-section. Transfer unless waived by patient with informed consent for prior c-section with unknown uterine incision type not discovered by "reasonable effort." Transfer is mandatory if more than two prior c-sections or any prior c-section meeting specified conditions. DEMA § 58-77-601(2)(a); DEMA Rule R156-77-601(1)(a)(xi), (5)(a)(v); (6)(a)(xi) through (xv); (6)(b)(x).	No, transfer is mandatory once multiple gestations confirmed. DEMA Rules state: R156-77-601(1)(a)(viii); consultation must be recommended if multiple gestation is suspected; R156-77-601(6)(a)(ix) transfer mandatory for confirmed multiple gestation; R156-77-601(6)((b)(viii) transfer mandatory intrapartum for undiagnosed multiple gestation unless delivery is imminent.	Yes, with consultation mandatory if "after 36.0 weeks gestation". DEMA § 58-77-601 (2)(a)(i)(D). DEMA Rules state: R156-77-601(2)(c) consultation mandatory after 36.0 weeks;R156-77-601(6)(b)(ii) and (iii) transfer mandatory intrapartum.

Vermont – Laws only address CPMs and not lay midwives. Lay midwives must meet the North Amer. Registry of Midwives (NARM) requirements for certified professional midwife (CPM) status as well as that Vermont licensing requirements. Administrative Rules for Midwives. Midwives Act, 26 V.S.A. §§ 4181-4191	Yes, with 10 protocols: (1) Consultation with a licensed physician verifying certain history; (2) 18 months from previous CS; (3) ultrasound locating placenta; (4) Informed consent; (5) Ausculation every 15 mins during labor; (6) Birth site within 30 minutes transport time to an ER; (7) Two licensed midwives must be there; (8) No labor induction or augmentation; (9) and (10) documentation required. ARM 3.14.2.1.	No. ARM 3.14.1 and 3.14.3.	Yes, if between 35 and 38 weeks gestation with mandatory consultation with a licensed M.D. or D.O. 3.14.2(19). No, if at or after 38 weeks. ARM 3.14.2(15).
Washington – Licensure required and consultation with physician required if there are any "significant deviations from normal" in the course of birth. Statutes: RCW 18.50. Rules: WAC 246-834. (Rules are licensure-oriented and do not address scope of practice.) See Midwives Assn of Washington State (MAWS) document on discussion, consultation, and transfer here. See MAWS transport guideline here	Yes. RCW 18.50.010; 18.50.108 (must annually submit written plan for consultation with health care providers, emergency transfer, and transport of woman and infant). Per the MAWS document at p.4, prior cesarean birth is an indication for consultation with a physician.	Yes. RCW 18.50.010; 18.50.108. Per the MAWS document at p. 5, multiple gestation is an indication for transfer of care to a physician or other hospital-based provider.	Yes. RCW 18.50.010; 18.50.108. Per the MAWS document at 5 and 6, transverse lie, oblique lie, or breech presentation are indications for transfer. Per the MAWS transport guideline at p. 6, malpresentation is an indication for intrapartum transfer.

Wisconsin – Must consult with a physician or CNM before proceeding with a non-hospital birth in these instances. Rules: WI Admin. Code Ch. RL 182, Standards of Practice. Unable to open message for this link. The licensed midwives rules were renumber to Chs. SPS 180, 181, 182, and 183. WI Laws Chapter 440, Subchapter 13, Licensed Midwives, 440.9805 to 440.988 here	Yes, if midwife has protocol to disclose risks associated with VBAC (SPS 182.02(1)(d)); and, in consultation with physician or CNM, if no previous c-section with vertical incision and no current low-lying placenta if there was any previous c-section (SPS 182.03(4)(b)(1)(r) and (t)	Yes, with consultation. SPS 182.03(4)(b)(1)(v).	Yes, with consultation. SPS 182.03(4)(b)(1)(i) and (u) and 182.03(4)(b)(2)(g) Physician notification and emergency transport to hospital is required intrapartum. SPS 1882.03((5)(a)(13)
Wyoming – Statute: W.S. 33-46-103 Board of Midwifery. Rules: Wyoming Regulations Chapter 7, Professional Responsibility.	Yes, unless more than 1 prior c-section and no prior vaginal delivery, or a prior c-section within 18 months, or a prior c-section closed with vertical incision. Also, before providing care, the licensed midwife must recommend patient be examined by physician. 33-46-103(j)(A)(V); 33-46-103(j)(C)(II); W.R. 7 §§ 2(b)(ii)(A) and 2(d)(ii).	No. 33-46-103(j)(A)(II); W.R. 7 § 2(b)(i)(B).	No, "unless birth is imminent". 33-46-103(j)(A)(III); W.R. 7 §§ 2(b)(i)(C) and 2(e)(iii).