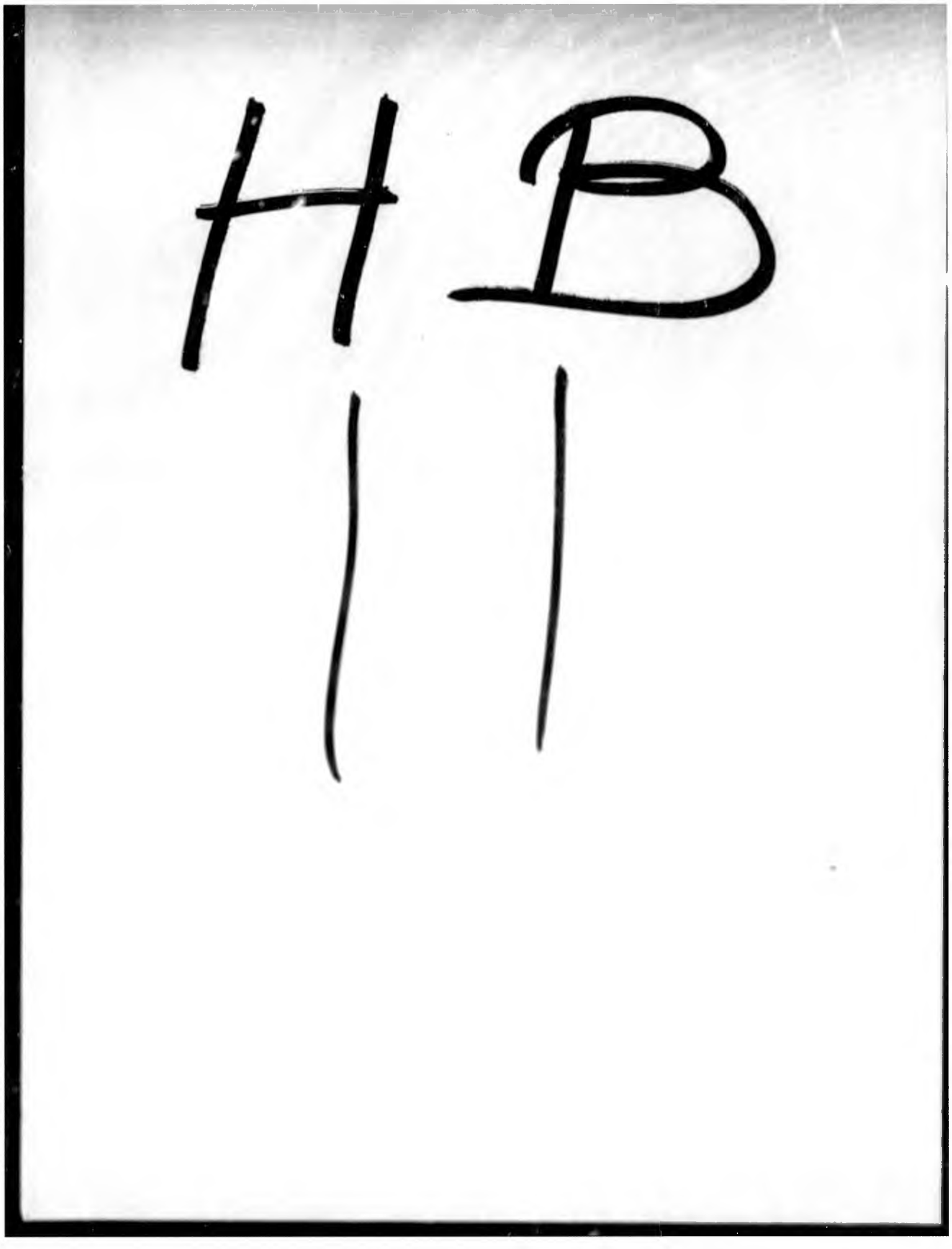
H B

COMMITTEE REPORT

HOUSE

(5) FURTHER: FINANCE

3/17/82

Date: _____

Mr. Speaker:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had 2d SSHB 11

"An Act relating to midwifery."

under consideration and ~~(a majority of the committee) (the committee)~~ reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for 2d SSHB 11 [X] same title [ ] new title

and recommends _____

[X] AND attaches a "Letter of Intent" [ ] New Fiscal Note (x) with Zero fiscal impact

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

Jerry Nutcher

MEMBERS HAVING
OTHER RECOMMENDATIONS:

_____
CHAIRMAN

H 60 (Rev. 12/78)

COMMITTEE REPORT

HOUSE

4/27/81

(5)

FURTHER:

Date: March 1981

Mr. Speaker:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had SSHB 11

"An Act relating to midwifery."

under consideration and reports it back as follows:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for [ ] same title [ ] new title

and recommends

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

CHAIRMAN

H 60 (Rev. 3/81)

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 1, 1982

The Hon. Joe Hayes, Speaker
House of Representatives

Dear Mr. Speaker:

It is the intent of this Committee that this bill, CS2dSS HB 11, establish a legislative basis for licensure of midwives in Alaska. This optional licensure is expected to result in an upgrading of the services provided by all midwives in the state.

The examination provided for in this legislation should be structured so as to uphold the standards of the occupation. Whenever possible, the examination should include oral, written and practical components. This Committee recognized that the unique features of Alaskan geography and culture demand flexibility in the implementation of this intent.

Sincerely,

Mike Beirne, Chairman
House H.E.S.S. Committee

Introduced: 4/27/81
Referred: Health,Education &
Social Services

IN THE HOUSE BY ROGERS AND VASKA

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 11

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to midwifery."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND INTENT. The legislature recognises the unique physical and emotional aspects of childbirth, and the need to protect and enhance the religious, cultural, and individual freedoms in the manner, setting, and cost of childbirth. The legislature finds that the traditional and cultural use of midwives continues and that the demand for midwifery service is increasing in Alaska without adequate regulation and licensure. Therefore, the legislature intends that midwifery be regulated in the public interest to assure that users of midwifery services are aware of the competency levels of their health care providers, and that licensing of midwives does not remove from the parents the responsibility for choosing where, when, how, and with whom to deliver their babies.

* Sec. 2. AS 08 is amended by adding a new chapter to read:

CHAPTER 69. MIDWIFERY.

Sec. 08.69.010. LICENSED MIDWIFE PRACTICE. A person who practices as a licensed midwife shall obtain a license granted by the Department of Commerce and Economic Development as provided in this chapter and shall practice midwifery in accordance with this chapter.

Sec. 08.69.020. UNLAWFUL REPRESENTATION. It is unlawful for a person to represent oneself as a licensed midwife unless the person is currently licensed under this chapter.

Sec. 08.69.030. DUTIES OF THE DEPARTMENT. The department shall

(1) license persons to practice midwifery;

(2) prepare and administer examinations which test competence in midwifery;

(3) prescribe a biennial license fee for licensed midwives not to exceed $25;

(4) develop, publish, and make available to interested parties at a reasonable cost, a bibliography and guide to the examination administered to applicants;

(5) require the compliance of licensed midwives with vital statistic recording requirements;

(6) require licensed midwives to maintain statistics relating to births they attend.

Insufficient requirements

Sec. 08.69.040. LICENSURE AS A MIDWIFE. A person is eligible for licensure as a midwife if that person

(1) is at least 18 years of age;

(2) furnishes proof of having received a high school degree or its equivalent;

National Midwifes Assoc. recommend 50 births

(3) furnishes proof of having attended at least 20 births as a midwife in the two-year period immediately preceding the date of application or has completed a midwife apprenticeship; proof is by affidavit of the applicant for births which occurred before January 1, 1987;

(4) passes an examination administered by the department meeting the requirements of AS 08.69.060;

(5) pays the license fee prescribed in this chapter.

Sec. 08.69.050. LICENSURE BY ENDORSEMENT. A person who is licensed as a midwife by another state may be licensed as a midwife if the requirements for that license are essentially the same as the requirements for licensure under AS 08.69.040.

Sec. 08.69.060. EXAMINATION OF APPLICANTS. (a) The examination

for licensure as a midwife shall be administered at times and locations selected by the department.

(b) The examination shall be in written form.

(c) Subjects examined by the examination shall include, and are limited to,

(1) anatomy of the pelvis and female genital organs;

(2) physiology of the female genital organs;

(3) recognition and management of pregnancy;

(4) understanding fetal presentations and positions;

(5) mechanisms and management of normal labor;

(6) management of puerperium;

(7) injuries to the genital organs following labor;

(8) sepsis and antisepsis in relation to labor;

(9) preparation and management of the delivery site and lying-in area;

(10) hygiene of mother and infant;

(11) asphyxiation, convulsions, malformation, and infectious diseases of the newborn;

(12) causes, effects, and prevention of opthalmia neonatorum;

(13) emergency occurrences requiring the attention of a physician;

(14) requirements of vital statistics law relating to reporting of births and infectious diseases of the newborn;

(15) the pharmacology of drugs used in emergency maternity care for both mother and infant following childbirth;

(16) nutrition as it relates to the prenatal, partal and postpartum period;

(17) management of breast feeding;

(18) knowledge of the bonding process and family interrela-

tionships;

(19) knowledge of conscious control techniques for labor management.

Sec. 08.69.070. RENEWAL OF LICENSES. (a) A midwife's license is renewable biennially on June 30.

(b) Notice of renewal will be mailed to every currently licensed midwife on or before May 1 of each even-numbered year.

(c) A license not renewed by June 30 will lapse on July 1 or be placed on the inactive list at the request of the licensee.

(d) A lapsed license will be reinstated within 90 days of lapse upon receipt of payment of the license renewal fee and satisfaction of other renewal requirements.

Dept's recommended continuing practice and continuing education for license renewal

(e) The department shall establish requirements which must be met before a license may be renewed, which must include a requirement that an applicant for renewal has attended 20 births in the previous two years or has completed 20 hours of continuing education. Continuing education may include childbirth-related postsecondary coursework, workshops, or practice in association with another midwife, or any combination of training and experience or a combination of experience and continuing education.

suggest deleting

Sec. 08.69.080. DISCIPLINE, DENIAL, SUSPENSION, OR REVOCATION OF A LICENSE. (a) The department may revoke or suspend the license of a midwife, or the licensee may be reprimanded, censured, or disciplined if the board finds after a hearing that

(1) the midwife has obtained or attempted to obtain a license under this chapter by fraud or deceit;

(2) the licensed midwife has wilfully violated a provision of this chapter; or

(3) the licensed midwife has engaged in unprofessional

(4) – Dept. recommends including section to cover: "intentional or negligent conduct that results in a significant risk to health or safety of a client or in injury to a client." (Similar to proposed statutes in SB 238 "An Act relating to the practice of nursing"

conduct.

(b) The department shall afford a midwife whose license has been denied or revoked the opportunity to have the license reinstated by demonstrating ability to resume the competent practice of midwifery with reasonable skill and safety.

Sec. 08.69.090. SCOPE OF PRACTICE. (a) A midwife licensed under this chapter may perform functions within the scope of practice. The scope of practice for licensed midwives includes

(1) recognition of pregnancy and management of prenatal care;

(2) preparation and management of the delivery site and lying-in area;

(3) management of the birth process and delivery of the infant;

(4) clamping and severing the umbilical cord;

(5) delivery of the placenta, with anti-hemorrhage techniques;

(6) recognition of an emergency labor or delivery situation involving the mother or infant;

(7) emergency procedures for asphyxiation, convulsions, malformation, and infectious diseases of the newborn;

(8) administration of preventive prophylaxis for ophthalmia neonatorum;

(9) postnatal care of mother and infant;

(10) suturing;

(11) routine laboratory investigation for normal prenatal care.

(b) In a medical emergency the scope of practice, to the extent needed for the emergency includes

(1) intramuscular injections for maternal hemorrhage;

(2) penetration of human tissue for emergency episiotomy, repair, and severing the umbilical cord;

(3) oxygen use.

(c) The department shall designate the medications, therapeutic agents, and techniques which a licensed midwife is authorized to administer and the circumstances under which those medications, therapeutic agents, and techniques may be administered.

Sec. 08.69.100. INFORMED CONSENT FORM. (a) The department shall develop an informed consent form which the licensed midwife shall provide for clients at their initial meeting. The form will describe the licensed midwife's

(1) philosophy of practice;

(2) education and training;

(3) experience;

(4) services and fees;

(5) procedures for meeting medical emergencies.

(b) The licensed midwife shall inform the client that the statistical information required by AS 08.69.110 is maintained by the licensed midwife and is available for inspection.

Sec. 08.69.110. STATISTICS. (a) The department shall determine the information concerning the practice of midwifery which must be collected and retained. This information is subject to audit by the department. The information is required to be retained in statistical form and shall include

(1) infections;

(2) hemorrhage;

(3) hospital transfers;

(4) malpresentations;

(5) normal deliveries;

(6) absence of physical examinations performed by a physician and the reason examinations were not performed.

(b) The statistical information required shall be filed with the department every six months on a form prescribed by the department.

Sec. 08.69.120. MEDICAL HISTORIES. (a) The department shall require licensed midwives to maintain a comprehensive medical and obstetrical history of each client. The history shall include

(1) the mother's name and address;

(2) the mother's date of birth;

(3) the mother's gravidity and parity;

(4) progress in pregnancy, including routine laboratory investigation;

(5) progress of mother and infant in labor and delivery;

(6) characteristics of placental delivery and cessation of bleeding of mother;

(7) APGAR administered to infant;

(8) immediate postpartum progress of mother and infant;

(9) general health of mother and infant at the time the midwife services terminate;

(10) other information required by the department.

Sec. 08.69.130. PRACTICE OF A LICENSED MIDWIFE. A person licensed as a midwife under this chapter must

(1) ensure that if reasonably possible before the onset of labor the mother has received a general physical examination by a physician— recommends adding "or a nurse midwife" (they are qualified - & it would allow more flexibility)

(2) recommend that the mother be transferred to the care of a physician if a medical emergency is indicated.

Sec. 08.69.140. POSSESSION OF DRUGS. A licensed midwife may

(2) that the section of regarding transferred to medical care be changed to:

"The mother will be transferred to the care of the physician if she develops any high risk conditions; and that the birthing attendant have available adequate resources during labor and delivery to transfer the mother to a hospital and/or physician if a medical emergency develops".

(3) that the following requirement be added:

"Birth attendants shall have an approved written collaborative relationship with a physician. This requirement would be similar to regulation of nurse-practitioner and physician assistant and is essential to assuring that the mid-level practitioner have sufficient medical back-up. The collaborating physician should be protected by statute from liability related to the care of a client not directly under his supervision".

possess and administer in accordance with a prescription from a consulting physician agents used to stop maternal hemorrhage, oxygen, and antibiotic eye drops.

Sec. 08.69.150. MIDWIFE APPRENTICESHIP. (a) A person may complete a midwifery apprenticeship by observing and assisting in the management and care of the mother and infant in at least 50 births. In the course of 25 of those births, the apprentice must assume primary responsibility, under the supervision and observation of the sponsor, for the prenatal, intrapartal, and postpartal management and care of the mother and child. A person undertaking a midwifery apprenticeship shall register with the department at the beginning of the apprenticeship.

(b) A midwife apprenticeship must be under the immediate supervision of a sponsor. A sponsor may not supervise more than three apprentice midwives simultaneously. The sponsor shall secure the compliance of the apprentice midwife with this chapter.

Sec. 08.69.160. DEFINITIONS. In this chapter

(1) "department" means the Department of Commerce and Economic Development;

(2) "medical emergency" means a situation of a serious nature which develops suddenly and unexpectedly and demands immediate action during pregnancy, labor or delivery;

(3) "normal childbirth" means a normal physiological state of health in which the expectant mother is in a stable condition without disease or complications;

(4) "sponsor" means a physician or a nurse midwife licensed to practice in this state; (rather than including lay midwives)

(5) "unprofessional conduct" includes the habitual overuse of alcoholic beverages or depressant, hallucinogenic or stimulant

drugs, as defined in AS 17.12.150(3), or addiction to the use of narcotic drugs as defined in AS 17.12.230(13).

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

MEMORANDUM May 21, 1980

TO: Representative Brian Rogers

FROM: Betty Barton, Issues Analyst

RE: The Effects of Regulation on Lay Midwifery
Research Request No. 120

This memorandum is in response to your request for information regarding the effects of State regulation on lay midwifery. At the time of your request, you asked that we research changes in the midwife population of various states, which may have occurred as a result of regulatory control. We have determined the existing data to be insufficient for responsible analysis of midwifery trends. Because there is no hard data available, we have compiled opinions concerning the effects of regulation through telephone interviews with staff from alternative birth associations, State public health programs, and conversations with lay and nurse-midwives in Alaska and other states. Our interview list is attached for your review. Alaskan lay midwives did not grant us permission to use their names and so, are identified in neither the text nor the attachments of this memorandum.

We have gathered what we consider to be a representative sampling of current attitudes and experiences regarding the effects of State regulatory control. However, our perspective in presenting this is that of the midwives. We have not attempted to draw any information from medical associations and obstetricians; and, consequently, should this memorandum reflect any biases, they should be construed solely as the opinions of the persons interviewed.

Proponents of lay midwifery are not necessarily proponents of one anothers politics and philosophies. Consequently, our findings regarding the current practice of lay midwifery are varied to some extent. Lay midwifery is a small, albeit developing, movement in the U.S. with much internal diffusion. Nonetheless, midwives appear united in an overriding belief that distinct advantages and disadvantages are to be realized from regulation. When regulations embody fairly derived standards and an adequate mechanism for attaining those standards, it is safe to say that most contemporary lay midwives view State regulation to be worthwhile.

However, most lay midwifery advocates feel that equitable standards have rarely been established at the state level and thus, exercise caution in recommending regulatory measures. Conditions vary from state to state; and whether the general findings reported in this memorandum might apply in Alaska could bear further investigation. Alaska has a very small lay midwife population as evidenced by the fact that there are only two known lay midwives practicing in Anchorage. Because of this, it might not be in the State's interest to pursue steps toward regulation at this time. The subject of regulation of these practitioners can evoke heated and emotional debate by lay midwives, medical professionals, and public health administrators. On occasion, it appears that more conflict has emerged from the process of legislative action than existed prior to the public's attention to the matter. Part of the problem is surely due to the new definitions that lay midwifery has assumed combined with a lack of model legislation at the State level. Consequently, it may be wise for Alaska to sit back and watch the effects of other states' regulatory provisions prior to adopting legislation of its own.

Background Information

The definition of midwifery has expanded since its inception in the U.S. but basically still refers to the management and attendance of childbirth. In today's society, there are three types of midwife: 1) the traditional midwife, known as the "granny," who has obtained her training in labor and delivery solely through apprenticeship and experience; 2) the nurse-midwife, who generally has obstetric nursing experience and graduate coursework in midwifery; and 3) the modern lay midwife, who generally has been trained through a combination of coursework and apprenticeship. There are more lay midwives, including both the "granny" and her contemporary counterpart, than practitioners of nurse-midwifery. There are about 1800 nurse-midwives in the U.S. In Texas alone a state which exemplifies the proclivity of lay midwifery in the South, there are an estimated 1500 lay midwives. The predominance of the lay midwifery population may be due to the rigorous training required for nurse-midwifery certification. Conversely, state laws that in the past have made it relatively easy to be certified as a lay midwife have been a factor in the maintenance of lay midwives populations.

Most laws governing the practice of lay midwifery were adopted by states in the first quarter of this century. These laws were aimed at the "granny" midwife and, for the most part, set very basic standards of control, generally only requiring a certificate of practice dispensed by the authorized licensing board or agency. As the availability of medicine

and professional health care expanded, the use of midwifery declined from about 50 per cent of all births in 1900 to only 12 per cent by 1935. But many states left their lay midwifery laws unaltered, presumably in deference to the few remaining "granny" midwives. The rate of decline continued until the 1960's when a resurgent interest in lay midwifery occurred. At this point, a number of states found themselves with laws considered by many medical associations and health departments to be outmoded by current health standards. As a result, movements were made in some states to amend existing legislation, thus marking the beginnings of a conflict between the medical and lay midwifery communities regarding a mutually satisfactory interpretation of their respective roles.

At basic issue is the question of home delivery versus hospital delivery. Births attended by lay midwives generally take place in the home or in some instances at special maternity centers. The American Medical Association contends that non-hospital based deliveries place undue risk upon the safety of the infant, presumably because of the mother's distance from emergency medical equipment and professional medical staff. Conversely, lay midwives argue that the nation's obstetricians have poorer maternal and child morbidity and mortality rates than do lay midwives who often are attending impoverished, high-risk patients. As an added point, lay midwife associations offer World Health Organization data that indicate better morbidity and mortality rates in developed countries, such as Sweden and Great Britain, where midwives are used more extensively than is the case in the United States.

Midwives maintain that as doctors of medicine, obstetricians have been taught to treat pregnancy from a pathological perspective rather than as a natural condition, and consequently have developed the same reliance upon anaesthetics and surgery as is prevalent in the medical diagnosis of morbidity. Lay midwives further contend that such procedures as episiotomy, a surgical incision of the perineal tissue to enlarge the vaginal opening, have become routine obstetrical practices because they shorten the delivery time rather than for any health function. The medical profession, in turn, regards lay midwifery and home-births as unnecessary regressions to a lost era, which ignore the capabilities of modern medicine.

In comparison to other developed nations, the U.S. utilizes midwives to a very limited degree. In Sweden, every pregnant woman, including those who are to deliver by Caesarean section, has a midwife. In the

Netherlands, midwives have responsibility for all normal births as is evidenced by the Dutch government's refusal to pay for a doctor's services. if a midwife is available. According to an article by Christopher Norwood in a May 1978 issue of Ms., approximately 80 per cent of the world's babies are delivered by midwives. In the U.S., according to the National Center for Health Statistics, only approximately 1.5 per cent of the nation's births occur out-of-hospitals. Of these, 92% are attended by lay midwives and others, e.g. relatives, taxi cab drivers.*

DDETERMINING THE ROLE OF REGULATION IN LAY MIDWIFERY

The need for regulation of health care personnel has long been regarded as essential by state governing entities. Occupational licensing, as with other professionals, is the basic component of the regulatory process. The fundamental purposes of licensure are to control entry into a profession and to establish and enforce minimum standards of practice. Persons found to be deficient in, or in violation of, these basic standards may be denied licensure; or, if already licensed, may have their licenses revoked or suspended. It is generally regarded that this process protects the public from the purchase of incompetent or unsafe health care services.

The degree to which regulatory controls should be employed proffers controversy. In this matter, development of regulatory provisions for midwifery can be especially complex because of the conflicting opinions regarding its function..The resultant effects of the regulatory process, according to lay midwifery advocates, have been varied.

Potential Benefits of Regulation

Most midwifery advocates interviewed concurred that licensure may be necessary to establish minimum standards of practice, an assurance that is apparently becoming more essential as the interest in home birth continues to grow. For example, Shari Daniels, President of the National Midwives Association and Director of the El Paso Birth Center, stated that under current Texas law, the only requirement to practice midwifery is registration at the local courthouse. Under this relatively loose Texas law, the resurging interest in home births has prompted a number

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* The percentage of hospital-based births attended by certified nurse-midwives is not available. However, as there are only about 1800 certified nurse-midwives in the United States, the percentage of births attended by these practitioners is projected to be equally low.

of untrained, unskilled people to register as midwives. The danger in this, of course, is the assumption by a consumer seeking midwifery services that she is obtaining the care of an adequately experienced individual. As a result, amendments to the Texas law are currently being proposed that will establish much stricter standards and guidelines for the practice of lay midwifery, e.g. the successful completion of State-approved training and a State-administered examination prior to licensure.

Arizona has pursued similar measures by strengthening a lenient law with precise regulations. In effect since 1957, Arizona's law on lay midwifery merely requires submittal of application to practice, establishes conditions under which a license is revoked or suspended, and authorizes its Department of Health Services to draft rules and regulations, which until several years ago, had few restrictions. The Department of Health Services now requires lay midwives to have completed an approved course of study and to pass a State-administered examination comprised of written, oral, and practical sections. The Department also requires every client of a lay midwife to retain a back-up support physician. Ruth Beeman, the State's administering officer for the lay midwifery program, considers these measures to have been worthwhile in providing better assurances for the health and protection of the public.

An anticipated secondary result of state regulation is improved quality of training in lay midwifery programs. Because a purpose of licensure is the establishment of quality standards, a certain degree of service deficiency in lay midwifery programs can exist in those states, such as Alaska, that do not legally address alternative childbirth practice.

Although not prohibited by law to practice, neither are midwives actually recognized by states such as ours. The result is legal ambiguity clouding the scope and, in turn, the quality of service provided by lay midwives. An example of paramount significance concerns the relationship between lay midwives and physicians. Because Alaskan law does not identify the function of lay midwifery, a number of physicians will not admit as a client any pregnant woman intending to have a lay midwife-attended birth. Consider Juneau: of three clinics available for prenatal care, one clinic refuses the admission of home-delivery patients; a second admits alternative-birth clients but charges them a $400 set fee rather than billing on a per visit basis (thereby automatically committing a client to $400 worth of visits); leaving the third, a public clinic operated through the State, as the only clinic admitting home-birth

clients without restriction. Lay midwives maintain that situations such as these would be alleviated to some extent by regulation.

One local lay midwife compares Alaska to Washington where lay midwifery is regulated. She maintains that regulation can assist to strengthen the relationship between lay midwives and physicians, noting that most lay midwives in Washington perform their deliveries with emergency transport vans and adequate back-up support of physicians. By contrast, in Juneau, she maintains, a number of women have been forced to misrepresent their intentions to their physicians in order to obtain prenatal examinations. She added that because there is no licensure she is denied the use of certain health care tools and equipment, contrasting the local situation with those of Washington and Colorado where she would be entitled to access to labs. Although not a proponent of licensure of lay midwifery in Alaska at this time, she feels that regulation should be considered for the state in the future.

Another Alaskan midwife, who asked that her identity not be disclosed, feels that practitioners would be better protected under licensing. Licensed to practice nursing, she feels she has had problems maintaining her license because of obstetrical opposition to her practice of lay midwifery. She feels her past problems could have been eased had Alaska promulgated clear regulations regarding the role of lay midwifery. Nonetheless, she views the degree of current bias by the medical community to be so strong that an objective consideration of regulation is not currently possible.

Potentially Negative Effects of Regulation

Lay midwifery advocates seem to agree that the primary disadvantage of regulatory control lies not in the concept of licensure but rather in the potential for abuse of its purpose. In other words, lay midwives believe that state regulatory laws can be merely a slimly disguised means for the elimination of midwifery practice. Upon examination of developments subsequent to licensure in states such as Alabama, it is difficult to allay lay midwives' fears. Alabama's law exempts lay midwives from the licensing requirements of nurse-midwifery, stating that these requirements shall not "prevent lay midwives holding valid health department permits from engaging in the practice of lay midwifery as heretofore provided until such time as said permit may be revoked by the county board of health." In 1979, the Alabama State Department of Health issued an order to suspend approval of any new licenses and suggested that old licenses be proscribed from renewal. Other states, through the process of regulation, have established standards so high that the purpose

of lay midwifery appears violated with only "professional" practitioners able to meet requirements. Arizona, with its oral, written, and practical exams has been criticized by the National Midwives Association for its overly competitive admissions criteria; the Association cites the state's total population of only 24 licensed midwives as evidence.

Along similar lines, lay midwives also express apprehension regarding the basis for the minimum standards of eligibility set by states. In this area, there appear to be two issues of concern: 1) should physicians have a role in developing standards for lay midwifery? and 2) can a consensus be reached concerning minimum standards? Regarding the former issue, the InterNational Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) assume unequivocally that medical doctors cannot give valid consideration to lay midwifery regulation because of their philosophical opposition to the practice. David Stewart, Executive Director of NAPSAC, views the Association's attitude to be justified because midwifery is a profession distinct from that of a physician. Juneau's lay midwife views NAPSAC's philosophy to be biased. She believes that physicians can serve a valuable function in lay midwifery, noting the support she received from medical doctors in Washington as an example. However, she, too, expressed concern that the objectivity of an occupational licensing board may be susceptible to biased philosophies of any physicians on the board.

Similar in nature to this issue, is the general area of concern regarding minimum standards for lay midwifery. Lay midwives differ from one another concerning what constitutes minimally acceptable experience. Unlike certified nurse-midwives, governed by uniform standards defined by the American College of Nurse Midwives, lay midwives operate from no agreed upon standards. For example, David Stewart feels it is important that lay midwifery remain distinct from nurse-midwifery. As spokesperson for NAPSAC, he asserts that lay midwives want concentrated training for all aspects of childbirth and care rather than courses of study required in nursing programs which may be largely irrelevant to childbirth.

Shari Daniels believes in stressing practical experience in training lay midwives, nurse-midwives, and family-practice physicians alike. In terms of lay midwifery, she maintains that lay practitioners must have intensive experience in all aspects of normal and abnormal childbirth in order "to expect the unexpected" in delivery conditions anticipated to be routine. Unlike most lay midwifery birth clinics, her El Paso Maternity Center handles twin and breech deliveries as well as other abnormal births. Five per cent of the Center's patients are classified as high-

risk, requiring emergency transport and hospitalization. According to Ms. Daniels, some states do not want to license lay midwives trained at her center because of the extent of their experience. Because most regulations limit lay midwives to the attendance of normal deliveries, there apparently is some apprehension that lay midwives experienced with abnormal births will not provide for emergency transport when there is cause.

Regulatory Control; Is it Necessary?

In analyzing the effects of regulation, some consideration should be given to the validity of licensure in general as it is currently conceived. At the national level, recent research has questioned the appropriateness and effectiveness of regulations. For example, there appears to be a growing thought that occupational licensing places unequitable and unnecessary restrictions on the mobility of licensed professionals that are no longer in accord with today's transient society. The effectiveness of licensure as a consumer protection tool has been examined in other research. Dr. Patrick O'Donoghue (a medical doctor), in a publication entitled Evidence About the Effects of Health Care Regulation, as prepared for the National Science Foundation, states the following:

> Licensure stops at least one step short of actually assuring on a continuing basis the quality of health care delivered by a paractitioner. In other words, the real concern of a governmental licensing agency should be the protection of the public over the professional lifetime of the practicing health care professional. Up to the present, however, measures of the quality of care have not permitted direct regulation of professional activity. Therefore, the states through their laws have attempted to assure the quality of health care by establishing and certifying the entering qualifications of professionals. They do go slightly beyond this initial assurance in that if a practitioner has been licensed as qualified and shows himself to be unqualified, the law puts the police power of the state into action in removing the dangerous practitioner from his profession. On the other hand, ... the grounds on which a practitioner may disqualify himself are relatively narrow.

Research performed under Dr. O'Donoghue's direction leads him to a tentative conclusion that licensure may not be valid unless it employs continuing education opportunities and routine reviews of a professional's practices

throughout the duration of his or her career. Dr. O'Donoghue notes that the rate of disciplinary actions by state medical licensure boards is quite low, averaging less than 200 actions per year nationally between 1963-1967.

Commensurate with these findings, lay midwifery proponents question apparent disparities between physicians and lay midwives in the matter of license revocation. As one lay midwife in Alaska articulated, "A single error in judgment by a licensed midwife in California can cause her to be unqualified for practice, while such is rarely the case with a physician." Advocates feel that should licensure be employed, it must be devoid of professional bias. Current practices weigh the responsibility for protection of the mother and infant over the individual rights of the mother to exercise her own decision concerning the type of care to be received. NAPSAC argues that this practice violates the freedom of choice and feels that current practice must be amended to embody this freedom in public health law. As the concept of health care expands from traditional interpretations to new philosophies as imbued in naturapathic medicine and alternative birth, NAPSAC maintains that a State's regulatory function also will require expansion and a more adaptable structure so that freedom of individual choice in the treatment of morbidity and health conditions may be respected.

NAPSAC recommends voluntary compliance with licensure standards combined with a strong consumer education program. Voluntary compliance permits the State to establish minimum standards of practice for licensure and to penalize practitioners who falsely represent themselves as having attained state licensure. However, voluntary compliance does not force practitioners to seek licensure if this means acceptance of standards that they regard as foreign to their philosophies of health care. With non-mandatory licensure, the health care consumer, it is argued, has greater freedom concerning the type of services to be purchased.

MODEL REGULATORY PROVISIONS REGARDING LAY MIDWIFERY

Although not requested by your office, in the course of our research, we became curious about the nature of regulatory legislation in certain states having recently addressed the lay midwifery issue. and felt this information might be useful for your purposes. We also became interested in learning what alternative birth associations view to be model legislation regarding lay midwifery. Only two states, Arizona and Florida, were commended to us. Arizona's legislation has met with mixed reaction, but

appears to be generally regarded by midwives as representing a positive approach to regulation. Copies of Arizona's rules and regulations have not as of yet been received by this office; we will transmit them to your office upon arrival.

In Florida, a comprehensive legislative proposal regarding lay midwifery was developed over the past few years. However, the bill, recently died in committee in a 9-affirmed, 10-opposed vote. It is attached for your review. Probably the bill's greatest significance is the standards for licensure eligibility it contains. The bill grants authority to the Department of Professional Regulation to promulgate standards for the development of a midwife apprentice program; proscribes apprentice lay midwives from the receipt of compensation for the provision of services except under the supervision of the sponsoring licensed midwife or physician; and requires the apprentice midwife to participate in a minimum of 50 births, 25 of which have included the "primary responsibility for the prenatal, intrapartal and postpartal management and care, under the observation and supervision of the sponsor."

Although successful completion of a state-administered examination is required, the standards permit the option for a lay midwife seeking a license to include as evidence of experience either a certificate from a midwifery school, a certificate of completion from a training program approved by the administering department, or "evidence of completion of a midwife apprenticeship program."

Training and experience appear to be regarded as essential components of regulatory legislation. This is of special significance in Alaska as no formal training programs are available in the state. Consideration should be extended to the minimum standards of eligibility, especially in light of the varying opinions on this matter. Shari Daniels of the National Midwives Association recommends a program of lay midwifery training that entails a minimum of 50 births with a practicing midwife. Although no states currently offer training for beginning lay midwifery, she regards the following to be a model training course:

3 months prenatal care in a hospital

3 months labor and delivery, "on-floor" in a hospital

3 months neo-natal intensive care and postpartal care

50 births minimum with practicing lay midwife

6 months in-class training with lay midwife, e.g., childcare education and postpartum education

3-12 months probationary status with normal deliveries (with lay midwife on call)

She added that lay midwifery training programs in Europe generally place far greater emphasis on "on-floor," practical training than do programs offered in the United States. Arizona's standards place more emphasis on the amount of theoretical or academic training received, requiring only an attendance at 15 births. Ms. Daniels regards their standards to be highly deficient.

Arizona is the only state, however, to offer a state-administered program in continuing education for lay midwives. Offering workshops in subject areas needing special concentration, such as treatment for excessive bleeding during intrapartal and postpartum stages, the program has been well received by NAPSAC. A strong program in continuing education could possibly counteract the deficiencies perceived by Dr. O'Donoghue in occupational licensure of health care professionals as a public protection mechanism.

We hope this memorandum has met your purposes. It is important to note that David Stewart, of NAPSAC, and Shari Daniels, of the National Midwives Association, were pleased to learn that we were conducting preliminary research regarding regulation of lay midwifery whether or not legislation is proposed based on our findings. In the event that legislation is drafted, Ms. Daniels has offered her assistance in reviewing any drafts.

BB/bf
Attachment

INTERVIEW LIST

Dr. David Stuart:

Executive Director
NAPSAC
Post Office Box 267
Marble Hill, Missouri 63764
Telephone: (314)238-2010

Ms. Shari Daniels:

Director
El Paso Maternity Center
1119 E. San Antonio
El Paso, Texas 79901
Telephone: (915)533-8142 (Maternity Center)
(915)565-9623 (Home number)*
*After 6:00 p.m. El Paso time

President
National Midwives Asso
P. O. Box 163
Princeton, N.J.

Ms. Ruth Freeman:
(Nurse-midwife)

Coordinator
Lay Midwifery Program
Department of Health Services
State of Arizona
Tucson, Arizona
Telephone: (602)255-1024

Ms. Margaret Crawford:
(nurse-midwife)

Greater Juneau Borough Health Clinic
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Ms. Peggy Newman:

Director
BABE
Prince of Peace Drive
Anchorage, Alaska
Telephone: 694-9050

Dr. Charles Muller:

Medical Director
Blue Cross of Washington & Alaska
P. O. Box 327
Seattle, Washington 98111
Telephone: (206)361-3417

Dr. Patrick O'Donoghue:*

President
Policy Center, Inc.
Denver, Colorado

*Although we did not interview Dr. O'Donoghue, we have included information provided by him as compiled in his book, Evidence About the Effects of Health Care Regulation.

372 Shaw Circle
Anchorage, Alaska 99504
333-1745

Representative Mike Bierne
House - HESS
Pouch V
Juneau, Alaska 99811

Dear Representative Bierne:

I am writing in response to House Bill No. 11. I am a practicing lay midwife in the Anchorage area, and would really like to be licensed by the State of Alaska. But I can support this bill only if the following changes are made.

Sec. 08.69.010 - I feel that it would only be fair to be governed by a board of peers. The board should be composed of a majority of lay midwives, one supportive consumer and one physician or C.N.M. I oppose regulation by a physician, nursing or C.N.M. board.

Sec. 08.69.040.(2). - I feel that a prerequisite of 15 births in two years is more reasonable than 30. If the amount of births is kept at 30, there is only one person that would be licensed in the state. In my opinion, this would not be beneficial to either the consumer or the midwife. It would definitely limit the consumer's right to choose whom they prefer as their birth attendant.

In another state, or bigger city, it would be easy to have the stated 30 births. In towns outside of Anchorage, there would not be enough births to meet the requirement. Hopefully, in the future, midwives in Anchorage will have more clients as a result of this type of legislation. But as it stands now, only a few here would be able to have the 30 births and that would greatly reduce the choice of birth attendant.

I also feel that the January 1, 1982 due date for the prerequisite births should be changed to June 30, 1982 (the date of license renewal).

Sec. 08.69.060. - I feel that the exam should be made up by the governing body, comprised of a majority of lay midwives, as I stated in the second paragraph of this letter. I fear the recurrence of what has happened in other states after passing legislation regulating midwifery, where they either give tests no one can pass, or choose to not give tests very often. I hope this bill will give the midwives a place in our state as health care providers that recognize the "wellness" of pregnancy and birth. And to give the consumer a freedom of choice of birth attendant other than a physician.

Sec. 08.69.070.(e). - The midwife should be required to attend 10 births in two years to renew her license. Actual "laying on of hands" is not required by other boards for license renewal, such as the nursing board. I feel that 20 hours of continuing education in two years is reasonable.

Sec. 08.69.150. - The midwife and apprentice should be able to count the same births toward licensing and renewal. The apprentice should be required to have primary responisibility of 15 births in a two year period.

Also, I feel that licensing should be voluntary and not mandatory. The consumer should still have a choice of having an unlicensed midwife attend their birth. Licensing does not guarantee the competency of the midwife. It provides the midwife with some protection, and just gives the consumer an idea of the midwife's qualifications.

I appreciate you taking the time to read my letter. I sincerely hope that you will consider the changes I have written of.

Sincerely,

Zelda Collett-Paule

Charlene "Zelda" Collett-Paule

January 30, 1982
P.O. Box 1327
Eagle River, Alaska
99577

Dear Representative,

This letter is in regard to House Bill 11. House Bill 11 should only be supported if the following changes are made:

Sec. 08. 69 010. Midwives should be governed by a board of peers, composed of the majority of lay midwives and one supportive consumer, and one physician or certified nurse midwife

Sec. 08. 69 040. Fifteen births attended in two years is more reasonable than thirty. As it stands only one person would qualify to be licensed in Alaska, which is beneficial neither to the consumer or to the midwife.

Sec. 08. 69 070 The midwife should be required to attend 10 births in three years to renew her license. Other licensing boards such as the Nursing Board do not require actual "hands on" experience for renewal. Twenty hours of continuing education in two years is reasonable.

Sec. 08 69 50 The midwife and apprentice should be able to count the same births toward licensing and renewal. The apprentice should be required to have primary responsibility of fifteen births in a two year period.

House Bill 11 should be voluntary licensing; and the exam should be made up by the governing board of lay midwives, and administered under their direction.

My experience as a childbirth educator with the Childbirth Education Association and Better Alaska Birth Experiences has shown that people benefit from having all alternatives in childbirth available.

Sincerely,

Jane Osgood

MSG 82-00011309 PRTY 1 03/02/82 18:44:02 ORIG: LA00 IN= 0026 OUT= 0
FROM: JEAN, ANCH INFO TO: POM, JUNEAU INFO
TARGET: L.H2 SUBJ: POM PAGE 0

TO: ALL SENATORS
REPRESENTATIVES BEIRNE,MARTIN, CATO, MALONE AND SMITH

FROM: AL RUSHING
1403 E 27TH
ANCHORAGE 99504 (H) 279-0181

SB 747

-I AM IN FAVOR OI SB 747 AND HOPE THAT YOU WILL SUPPORT ITS PASSAGE AS SOON AS POSSIBLE. IF I CAN BE OF ASSISTANCE IN PROVIDING INFORMATION REGARDING THIS BILL FOR MIDWIFERY PLEASE CONTACT ME. PLEASE SCHEDULE A TELECONFERENCE AS SOON AS POSSIBLE.

March 3, 1982

To: Representative Pat Carney, Chair
House Finance Subcommittee

From: Representatives Brian Rogers
and Tony Vaska

Prepared
By: Ginger Baim, Aide to
Senator Vic Fischer

Re: CS SS House Bill 11 and Senate Bill 747

During today's subcommittee work session on House Bill 11, the following issues should be considered:

1. Approximately 5% of all births in Alaska occur at home.

2. Most home-birth parents are covered by health care insurance but chose to pay a midwife "out-of-pocket" rather than use the services of a physician or a certified nurse midwife in a hospital setting covered by insurance.

3. Physicians and Certified Nurse Midwives (CNM) face suspension of licensure if they participate in a home-birth even though such practice is not in violation of the law in Alaska.

4. Most homebirth parents state they would chose an out-of-hospital birth with a midwife even if such a practice were in violation of the law.

5. The average cost of a "natural " and uncomplicated hospital birth attended by a physician or CNM, is $2,000 and up. This fee covers both birth attendents and facility charge.

6. Some Alaskan hospitals and physicians average 20% C-sections. Consumer cost for this surgery is nearly double the average for a "natural" birth.

7. The average cost of childbirth at Alaska's only birthing center is $1,500. Because the facility is not licensed, only the services of the CNM are covered by health care insurance, requiring out-of-pocket payment of nearly a $1,000.

8. Average costs for the services of a "lay" midwife for a homebirth is less than $500. This fee includes all pre and post natal care, laboratory costs, services of the midwife and, usually, an assistant or apprentice, during the acutal birth.

9. Statistically the incidence of complications, mortality, morbidity and risks to both infant and mother in a home birth attended by a midwife compare favorably with hospital births attended by a physician.

10. Current practice prevents licensed health care providers from attending home births and limits consumers in free choice of health care. Consumers currently have no mechanism for determining the competency

levels of midwives attending homebirths.

11. HB 11 and SB 747 provide a mechanism for voluntary licensing of midwives, regulation and supervision of the practice of midwifery through a self-regulating agency appointed by the Governor, a handle for consumers to determine the competency levels of their health care providers and a method of gathering information and statistics on the practice of midwifery and homebirths in Alaska.

12. According to a position paper from the Department of Health and Social Services on HB 11, prior to widespread availability of medical facilities, adequate transportation and professional providers, the Department promoted training for birth attendants in remote areas. Current revenue forecasts may require cuts in transportation, facilities and professional services by health care providers. This gives strong argument for reinstating licensing and training procedures for midwives to handle low-risk births in low-cost settings for consumers desiring these services.

13. The state has a legitimate interest in providing consumer protection and information. The state should not allow its laws to be used to promote a certain type of health care or to coerce or punish consumers exercising free choice in health care services.

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

TO: Representative Joe McKinnon January 14, 1980

FROM: Christine Johnson, Research Analyst CEJ
House Research Agency

THROUGH: Duncan L. Read, Director
House Research Agency

SUBJECT: Comparative Analysis of Midwife Statutes
Research Request No. 10

Enclosed please find statutes from twenty-one states pertaining to the licensing of midwives. We have included several pages of charts which indicate by state the types of midwives (ie., lay, professional or nurse-midwives) who are licensed to practice, the range of their responsibilities, and any special provisions the statutes contain. The chart can be used as an index reference for the statutes, all of which are attached in full.

If you need further information on this or any other matter, please do not hesitate to contact us.

CJ/bf
Encl.s

The following state statutes enable the licensing of midwives by an appropriate board or commission. In general, they do not address the types of midwives who will practice in the state or the kind of care they may provide, leaving these decisions to the licensing board. (Virginia is an exception to this. The practice of midwifery is limited to nurse-midwives, although other midwives who are presently practicing may continue to renew their permits.)

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		ALABAMA (Professions and Businesses 4.34-19-1-.34-19-10)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Licensed registered nurse; certificate from school for nurse-midwives.
	Limitations on Practice	Cases of normal childbirth; physician's supervision necessary.
	Special Statutory Provisions	All deliveries must be planned to take place in hospital.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	Lay midwives holding health department permits may continue to practice until permits are revoked by Board of Health.

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	Practice supervised by physician or surgeon (physician's presence not required); cases of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortions.
	Special Statutory Provisions	Requirements for censure are left up to appropriate boards and committees. In general, California's statutes establish the confines of the practice.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CONNECTICUT (377.20-35)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Graduate of school of midwifery.
	Limitations on Practice	Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drugs, instruments, nor perform version or attempt to remove adherent placenta. Shall not attend woman in labor until after seventh month of gestation.
	Special Statutory Provisions	Examination required for licensing.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		FLORIDA (30.485.011 - 30.485.091)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from school for midwives; sponsorship by two practicing physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	Cases of normal labor; shall not use drugs, instruments, nor assist labor in any artificial, forcible, or mechanical manner, nor attempt to remove adherent placenta. Shall not use poisonous drug or herb medicine, nor attempt treatment of disease when attendance of physician cannot be secured.
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional	Requirements	Attendance, under the supervision of a physician, at not less than fifteen cases of labor and the care of fifteen or more mothers and newborns for periods of at least ten days each; sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		INDIANA (25-22-1-5, 22-22-1-6; Admin. Rules (25-22.5-5-5)-1, (25-22.5-5-5)-2
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Diploma from school of midwifery which has proper equipment to teach anatomy, physiology, hygiene, anticepsis, neurology, toxicology, and the proper management of labor; high school education; ability to read and write the English language[A] [A]There are few schools in this country which train midwives who are not nurses. Since many professional midwives were educated at foreign institutions, some states feel is necessary to require proficiency in English.
	Limitations on Practice	
	Special Statutory Provisions	(Statutes pertaining to midwifery in Indiana date to the late 1800's. Midwifery in the state is presently controlled by administrative code. Both the statutes and codes have been included.) Examination required for licensing. Gratuitous services in an emergency not prohibited by act, nor does it restrict licensed physicians.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MARYLAND (Art.43.82-94)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certified by American College of Nurse-Midwives as a nurse-midwife.
	Limitations on Practice	Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion.
	Special Statutory Provisions	Person who isnot licensed midwife may practice under the personal and direct supervision of a physician. Subtitle does not restrict physician or person volunteering service in an emergency.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MINNESOTA (148.30 - 148.32)
NURSE-MIDWIFE Definition: Registered nurse who has expended his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from a school of midwifery.
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional	Requirements	Consent of seven members of the State Board of Medical Examiners given after examination of condidate.
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MONTANA (66-1246)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certificate in nurse-midwifery from the American College of Nurse-Midwives.
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		NEW JERSEY (45:10)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Certificate from school of midwifery, or maternity hospital granted after 1000 hours of instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician.
	Limitations on Practice	Shall not perform criminal abortion. Normal labor cases, only.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		OHIO (4731.30-4731.34)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Diploma from college for nurse-midwives
	Limitations on Practice	Practice under direction and supervision of physician. Shall not perform version, treat breech or face presentation, use instruments or treat abnormal condition, except in emergencies.
	Special Statutory Provisions	Examination may be required.
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		UTAH (58-44-1 - 58-44-11)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Completed approved certified nurse-midwifery education program.
	Limitations on Practice	Under this act, may also provide normal gynecological services.
	Special Statutory Provisions	Establishes committee to supervise practice or nurse-midwifery. Examination required Act does not affect rights of parents to deliver their baby, where, when, how and with who they choose regardless of certification.
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WASHINGTON (18.50.090 - 18.50.110)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Diploma from legally incorporated school on midwifery in good standing, granted after at least 2 courses of instruction of at least seven months each in different calendar years. Diploma from foreign institution on midwifery of equal requirements.
	Limitations on Practice	Shall not prescribe any drugs or medicine except some household remedy.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Gratuitous service not prohibited by chapter. Washington's midwifery laws similar to New Jersey's.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WEST VIRGINIA (30-15-1 -30-15-8)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Graduate of school of midwifery; certified by American College of Nurse-Midwives.
	Limitations on Practice	Practice under the supervision of or in association with physician engaged in family practice or specialized field of gynecology or obstetrics.
	Special Statutory Provisions	Persons holding licenses issued before current laws enacted may continue to practice until expiration of licenses without privilege of renewal.
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional	Requirements	
	Limitations on Practice	

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. ~~CSSSHB 11 (Finance) (DRAFT)~~ 2nd SS HB 11
Title An Act relating to midwifery.
Requested by House Finance Date 2-26-82

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, Or Subprogram(s) Affected Regulation & licensing of professions; admin boards, an investigati
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL		9.4	10.3	11.4	12.5	13.7
300 CONTRACTUAL		14.8	16.1	17.5	19.1	20.9
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.						
TOTAL		24.2	26.4	28.9	31.6	34.6

FUNDING (Thousands of Dollars)

GENERAL FUND		24.2	26.4	28.9	31.6	34.6
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

TRAVEL - 10% inflation factor projected.

Board of Midwifery; 5 members (anticipate 1-Anch, 1-Fbks, 1-Southeast, 1-Kenai area, and 1-Nome area); 3 meetings per year (1 ea. in Anch., Fbks, & S.E.), travel costs plus 3 days per diem @ $80/day $ 6,000.00

Department staff - 1 licensing examiner to attend meetings of the Board of Midwifery, travel costs plus per diem 1,200.00

1-Regulations Specialist to hold regulation hearings throughout the state, travel costs plus per diem 1,200.00

1-Investigator, additional travel costs to investigate complaints concerning lay midwives; average 1 trip every 4 months @$200/trip plus per diem @$80/day 1,000.00

$ 9,400.00

(continued. .

IV. DATE March 2, 1982 PREPARED BY Marjorie Odland
AGENCY Division of Occupational Licensing
PHONE 465-2535

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

CONTRACTUAL - 9% inflation factor projected.

Printing of new statute booklets, applications and licenses for midwives desiring to become licensed.	$ 2,000.00
Meeting notices, regulation publications, mailing costs of application packets and statute booklets	800.00
General operating costs including phones, computer time (pro-rated by board), and similar daily costs.	1,000.00
Development of examination, professional services contract basis, including updates, pool of questions for use by state board, storage in in-house computer system	5,000.00

Licensing/Disciplinary Hearings - Anticipate three hearings per year. In estimating one day hearings, the following costs are considered:

Average 6 hour days:	
Hearing Officer, @$75/hr	450.00
Court Reporter, @$25/hr	150.00
10 exhibits, $.45 ea.	4.50
3 witnesses, 1/2 day ea.@ $12.50	37.50
1 expert witness, 2 hrs. @ $150./hr.	300.00
Transcript, avg. 210 pages @ $4.50/page	945.00
	1,887.00
	X 3
	$ 5,661.00

Room Rental for examinations: 2 exams per year., 1 day each.	200.00
Proctors for examinations:	
Head Proctor - $50/day	100.00
Monitor - $35/day	70.00
TOTAL CONTRACTUAL -	$ 14,831.00

HB 11

Roger Board

Robeson - No.

Europe - diff. stds. - are Nurses.

Cert N. Midwife

Phy. Asst

collaborative relationship

Urgent. dia. test

1. PICU
2. Thyroid
3.

Treager - D.O. Lic.
fiscal note

Pat Dutton

STATE OF ARIZONA

DEPARTMENT OF HEALTH SERVICES

ARTICLE 2. LICENSING OF MIDWIFERY

R9-16-200. Reserved

R9-16-201. Minimum qualifications

An application for a license to practice midwifery shall submit:
1. An application on a form prescribed by the Department;
2. Evidence satisfactory to the Director of the Department of Health Services showing successful completion of a course of instruction meeting the requirements of R9-16-203;
3. The initial license fee prescribed by A.R.S. §36-754;
4. A request to undertake the next available qualifying examination to be administered by the Department.

Historical Note

Former Section R-9-16-201 repealed, new Section R9-16-201 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-202. Renewal application

An applicant for renewal of a license to practice midwifery shall submit a renewal application on a form prescribed by the Department.

Historical Note

Former Section R9-16-202 repealed, new Section R9-16-202 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-203. Course of instruction

A. Each applicant for an initial midwife license shall show evidence of having completed a course of instruction with a standard curriculum containing:

1. Information regarding the laws and Regulations concerning midwifery in Arizona;

2. Basic course in aseptic techniques, basic observational skills, recognition and management of emergency situations, and special requirements of home delivery;

3. Clinical courses covering the knowledge and skills necessary for:

a. Provision of care during the antepartum, intrapartum, postpartum and newborn periods, and

b. Management of birth and the immediate care of the mother and newborn infant;

4. Observation of a minimum of ten (10) births;

5. Delivery of a minimum of fifteen (15) women, under direct supervision by a licensed physician, licensed midwife or certified nurse-midwife, and verified by a written statement from the supervisor that competence has been demonstrated.

B. The program of study shall assure that course content includes the requisite knowledge and skills needed to recognize those conditions listed in R9-16-205.

Historical Note

Former Section R9-16-203 repealed, new Section R9-16-203 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-204. Qualifying examination

Prior to receiving a license to practice midwifery, each applicant shall pass a qualifying examination administered at least twice a year by the Department which will consist of three parts:

1. A written examination designed to test knowledge of the subjects required in the course of instruction;

2. An oral examination designed to test clinical judgment in midwifery case management;

3. A practical examination designed to demonstrate the mastery of skills necessary for practice in midwifery, meeting the requirements of R9-16-203.

Historical Note

Former Section R9-16-204 repealed, new Section R9-16-204 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-205. Responsibilities of the midwife

A. The midwife shall encourage all clients requesting her services to seek regular prenatal care, and shall require that they show evidence that they have been examined at least once during the last trimester of pregnancy by a licensed physician or other practitioner operating under the supervision of a licensed physician. Such examination shall include laboratory tests to determine the following:

1. Blood type, Rh group, and Rh titers if indicated;
2. Results of a serologic test for syphilis;
3. Hemoglobin or hematocrit level;
4. Results of a urinalysis for protein and sugar.

B. The midwife shall visit the prospective birth place at least once before the expected delivery date to make sure conditions are adequate for delivery and to prepare the family.

C. The midwife shall have formal arrangements prior to each delivery for backup medical care for the mother and infant. The midwife shall call a physician and/or transfer the mother and/or infant to a hospital whenever any of the conditions listed below are present:

1. Maternal conditions:

a. Abnormal vaginal bleeding before, during or after delivery;
b. Edema of the face and hands;
c. Excessive vomiting;
d. Persistent headache;
e. Visual disturbances such as blurring or dimness of vision;
f. Blood pressure elevated over 140 mm Hg systolic and/or 90 mm Hg diastolic, or an increase of 30 mm Hg systolic and/or 15 mm Hg diastolic during labor;
g. Blood pressure that falls below 90 mm Hg systolic and/or pulse rate that increases to 120 or above during or after labor;
h. A fetal heart rate that is below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular;
i. Meconium stained amniotic fluid;
j. Elevation in temperature over 100°F or 37.8°C, orally;
k. Unengaged head in primigravida or in multipara in labor;
l. Presenting part other than vertex;
m. Ruptured membranes of more than 24 hours;
n. Prolonged labor using established criteria;
o. Multiple gestation;
p. Retained placenta over 1 hour, earlier if bleeding occurs;
q. Retained placental fragments or membranes;
r. Persistent uterine atony;
s. Vaginal or perineal laceration;

R9-16-206. Reports

A. Each licensed midwife shall submit quarterly, to the Department of Health Services a summary report of each case on forms supplied by the Department. The report shall contain information concerning the pregnancy listed in "Responsibilities of the midwife" (R9-16-205).

B. Failure to submit quarterly reports on a timely basis shall constitute grounds to deny renewal of a license.

Historical Note

Former Section R9-16-206 repealed, new Section R9-16-206 adopted eff. Jan. 23, 1978 (Supp. 78-1).

R9-16-207. Prohibitions or limitations to the practice of midwifery

A. Prohibitions: The midwife shall not knowingly accept responsibility for births in which there are the following conditions:

1. History of third trimester bleeding.
2. Preaclampsia, eclampsia;
3. Persistent hemoglobin level below 10 g during the third trimester or at the time of delivery;
4. Multiple gestation;
5. Abnormal presentation or lie;
6. Client under 15 years of age;
7. Previous Cesarean section, or other known uterine surgery such as hysterotomy or myomectomy;
8. Rh negative with positive titers, or if titers are not available;
9. Syphilis or gonorrhea;
10. Active infectious diseases, i.e. tuberculosis, hepatitis, or genital herpes;
11. Severe psychiatric disorders;
12. Any systemic conditions which are generally recognized as having the potential for creating problems at delivery;
13. Suspected or diagnosed congenital anomaly that may require immediate medical intervention.
14. Contracted pelvis;
15. Current narcotic addiction;
16. Suspected prematurity, immaturity or postmaturity.

B. Limitations: The midwife shall not knowingly attend any childbirth where the following conditions exist except under the supervision of a licensed physician:

1. Women between 15 and 18 years of age, and over 35 years of age;
2. Parity greater than 4;
3. History of severe postpartum hemorrhage;
4. History of stillbirth or neonatal death;

t. Excessive pain or discomfort during or after labor;
u. Shortness of breath;
v. Seizures;
w. Wishes of the client.
2. Conditions of the infant:
a. Weight less than 2,500 g or 5½ pounds;
b. Congenital anomalies;
c. Apgar score less than 7 at 5 minutes;
d. Respiratory distress;
e. Irregular heartbeat;
f. Signs of immaturity, prematurity, or postmaturity on physical assessment;
g. Jaundice;
h. Abnormal cry;
i. Pale, cyanotic or gray color;
j. Excessive edema.
3. Any other abnormal condition not listed above that might endanger the woman or infant.

D. At the time of delivery the midwife shall:

1. Place two drops of 1 percent silver nitrate solution into each of the infant's eyes (or in lieu of silver nitrate, any other preparation specifically approved by the Director) in accordance with R9-6-115;
2. Inspect the umbilical cord for the appropriate number of vessels and record on the birth record;
3. Inspect the placenta and membranes to note their completeness;
4. Inspect the perineum for laceration.

E. The midwife shall observe both mother and infant for a minimum of two (2) hours following birth.

F. The midwife shall file a birth certificate with the local Registrar within ten (10) days after birth.

G. The midwife shall reevaluate the condition of the mother and infant between 36 and 72 hours of delivery to determine whether physician consultation is required.

H. All equipment used in the practice of midwifery shall be maintained in an aseptically-clean manner and in working order.

I. The midwife shall maintain records of each patient attended and make them available for audit and review as requested by the Director or his staff.

Historical Note

Former Section R9-16-205 repealed, new Section R9-16-205 adopted eff. Jan. 23, 1978 (Supp. 78-1).

5. History of birth injury to either mother or previous child;
6. History of difficult delivery and/or depressed baby at birth.

C. The midwife will not perform any operative procedures other than that of clamping and severing the umbilical cord.

D. The midwife will not use any artificial, forcible or mechanical means to assist birth, nor may the midwife attempt to correct fetal presentations by external or internal version.

E. Except as provided in R9-6-205.D.1. the midwife will not administer any drugs, medications or herbs.

Historical Note

Former Section R9-16-207 repealed, new Section R9-16-207 adopted eff. Jan. 23, 1978 (Supp. 78-1).

STATE OF NEW MEXICO
HEALTH AND ENVIRONMENT DEPARTMENT
POST OFFICE BOX 968
SANTA FE, NEW MEXICO 87503

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

FILE CATEGORY:
REGULATION NO.: HED-80-3A (HSD)
ORIGINATOR: Health Services Division

STATUTORY AUTHORITY: The statutory authority for these regulations is contained in Section 9-7-6 and Section 24-1-3(R) NMSA 1978 and Section 61-6-16(C) NMSA 1978. Enforcement is provided by Section 24-1-21 NMSA 1978.

REASONS FOR ADOPTION:

(1) These regulations are an amended version of the similarly-named Regulations numbered HED-80-3(HSD), filed with the State Records Center on February 5, 1980.

(2) The changes made in this amendment are non-substantive, and there is no public interest that would require a further hearing. Therefore, they are adopted without a public hearing.

GEORGE S. GOLDSTEIN, Ph.D., Secretary
Health and Environment Department
Post Office Box 968
Santa Fe, New Mexico 87503

Health and Environment Department
Health Services Division
725 Saint Michael's Drive
Post Office Box 968
Santa Fe, New Mexico 87503

HED-80-3A(HSD)

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

General Provisions

100. LEGAL BASIS: The regulations set forth herein are promulgated by the Secretary of Health and Environment by authority of 9-7-6(F) NMSA 1978 and 24-1-3(R) NMSA 1978. Administration and enforcement of these regulations is the responsibility of the Health Services Division of the Health and Environment Department. Enforcement is provided by 24-1-21 NMSA 1978.

101. PURPOSE: These regulations establish policies, standards and criteria relating to registration, practice and continuing education of persons who practice lay midwifery. These regulations do not apply to any licensed medical or osteopathic physician or certified nurse midwife.

102. GUIDELINES: In the absence of specific direction in these regulations as to standards of practice or ethics, the Standards of Care of the American College of Obstetricians and Gynecologists and procedures and policies of the Health and Environment Department and Health Services Division are established as guidelines.

103. OTHER LAW AND REGULATIONS: These regulations are subject to the provisions of the Health and Environment Department's Regulations Governing Promulgation of Regulations and Regulations Governing Public Access to Department Records. In addition, department regulations on related subjects include: registration of nurse midwives; prevention of infant blindness; newborn screening for phenylketonuria and other congenital malfunctions; registration of births, deaths and fetal deaths, and control of diseases and conditions of public health significance. Copies of regulations may be obtained by writing to the Health Services Division, Post Office Box 968, Santa Fe, New Mexico 87503. Appeal of an adverse decision of the Division shall be in accordance with the Uniform Licensing Act, 61-1-1 thru 61-1-28 NMSA 1978.

104. DEFINITIONS: As used in these regulations, the following terms shall have the meaning given to them, except where the context clearly requires otherwise:

104.0... "Apprentice permit" means a permit issued by the Division to authorize a person desiring to become a lay midwife and pursuing the required course of study to obtain clinical experience under supervision of a physician, certified nurse midwife or registered lay midwife.

104.02. "Certified nurse midwife" means a graduate nurse licensed to practice in this state who has been certified by the American College of Nurse-Midwives and registered with the Division pursuant to the provisions of the Department's Nurse-Midwife Regulations.

104.03. "Contact hour" means a unit of measurement to describe 50-60 minutes of an approved, organized learning experience or two hours of planned and supervised clinical practice which is designed to meet professional educational objectives.

104.04. "Continuing education" means participation in an organized learning experience under responsible sponsorship, capable direction and qualified instruction and approved by the Division for the purpose of meeting requirements for renewal of registration under these regulations.

104.05. "Division" means the Health Services Division of the Health and Environment Department.

104.06. "Lay Midwifery" means the provision of health care services in pregnancy and childbirth by a person not a licensed physician or a certified nurse-midwife.

104.07. "Physician" means a person licensed to practice medicine or osteopathy in this state.

104.08. "Registered lay midwife" means a person who is currently registered and in good standing on the registry of lay midwives maintained by the Division.

104.09. "Registration" means a document issued by the Division identifying a legal privilege and authorization to practice within the scope of these regulations. Registration under these regulations is not transferable.

104.10. "Registration year" means the period from December 31 of any year through December 30 of the following year; initial registration may be issued at any time but shall expire on the following December 30; apprentice permits may expire at any time but no later than the following December 30.

104.11. "Supervision" means the coordination, direction and continued evaluation at first hand of the person in training or engaged in obtaining clinical experience or engaged in direct delivery of lay midwifery services within the scope of these regulations.

APPLICABILITY

200. LIMITATION: Lay midwifery in New Mexico is limited in scope to practice as outlined in these regulations.

201. SCOPE: The lay midwife may provide care to low risk patients determined by physician evaluation and examination to be prospectively normal for pregnancy and childbirth. Such care includes:

referral by md

201.01. prenatal supervision and counseling;

201.02. preparation for childbirth;

201.03. supervision and care during labor and delivery and care of the mother and the newborn in the immediate postpartum period, so long as progress meets criteria generally accepted as normal.

202. REQUIREMENT OF REGISTRATION: From and after July 1, 1980 no person shall hold him/herself out as a lay midwife or offer, for compensation or otherwise, any services which constitute lay midwifery unless currently registered as a lay midwife under these regulations, or holding a provisional or apprentice permit issued by the Division. Violation of this provision is subject to prosecution or civil action as may be provided by law.

REGISTRATION OF LAY MIDWIVES

300. TYPES OF PERMITS AND FEES: Upon application, meeting requirements and payment of fees, a person subject to these regulations may be issued an apprentice permit, a provisional registration permit, or a regular registration permit, as applicable, in accordance with these regulations. Permits shall be issued without fee through December 31, 1980; thereafter fees, new or renewal, shall be submitted in accordance with the fee schedule prescribed in Section 400. hereof.

301. APPRENTICE PERMIT: An apprentice permit may be issued to any person for a period not to exceed one year and may be renewed once only for an additional one-year period. Education and clinical experience required for regular registration may be obtained during the apprentice period.

302. PROVISIONAL REGISTRATION PERMIT: Upon application a provisional registration permit may be issued to:

302.01. Any person who under former regulations of the Division is currently permitted to engage in lay midwife practice under the supervision of the District Health Officer, or,

302.02. Any person who presents satisfactory evidence of education, training and experience; such person shall submit:

302.02.01. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;

302.02.02. Evidence of satisfactory completion of required clinical experience cited in Section 600.

302.02.03. Evidence of satisfactory completion of a Health Services Division approved course in prenatal nutrition (may be completed during provisional registration period);

302.02.04. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting (may be completed during provisional registration period);

302.02.05. Current physician's statement certifying absence of communicable disease;

302.02.06. Satisfactory reference from a physician, certified nurse midwife or midwifery instructor;

302.02.07. Fee as prescribed by the Division.

302.03. A provisional permit may be issued for a period not to exceed one year and may be renewed once only for an additional one-year period.

302.04. The requirements of section 600 hereof may be met during the provisional registration period.

303. REGISTRATION UNDER REGULAR PERMIT: Upon meeting the requirements of Section 600, a person holding an apprentice or provisional permit may apply for regular registration as a lay midwife and shall submit:

303.01. An application to sit the next qualifying examination;

303.02. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;

303.03. Evidence of satisfactory completion of a course in theory of pregnancy and childbirth;

303.04. Evidence of satisfactory completion of required clinical experience;

303.05. Evidence of satisfactory completion of an HSD approved course in prenatal nutrition;

303.06. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting;

303.07. Evidence of satisfactory completion of a certified course in cardiopulmonary resuscitation of the adult and newborn;

303.08. Current physician's statement certifying absence of communicable disease;

303.09. Four recommendations (one each from a physician or certified nurse midwife, a midwifery instructor, a consumer and a member of the community); and

303.10. Fee as prescribed by the Division.

304. FOREIGN EXPERIENCE: Applicants for registration as a lay midwife who lack the required clinical experience in New Mexico, but who have equivalent experience from another jurisdiction, may apply to sit the qualifying examination after submitting evidence of experience and of all other requirements. Action of the Division on the request may be appealed under the provisions of the Uniform Licensing Act.

305. LIMITATION: Registration as a lay midwife in New Mexico is not to be construed as valid in any other jurisdiction.

306. EXAMINATION REQUIRED: Registration as a lay midwife in New Mexico is by examination only; there is no reciprocity with other jurisdictions.

307. RENEWAL OF REGISTRATION: Every lay midwife registration must be renewed annually. An applicant for renewal of registration shall submit to the Department:

307.01. A renewal application on the form prescribed by the Department;

307.02. Evidence of completion of eight contact hours of continuing education as required by Section 604; and

307.03. Renewal fee as prescribed by the Division.

308. GRACE PERIOD: Delinquency in renewal of registration of 6 months or greater shall result in termination of registration.

309. INACTIVE LIST: Any person registered as a lay midwife in New Mexico who moves from the state may retain registration by fulfilling the requirements previously described. Absence from the State of New Mexico for longer than 10 years shall result in termination of registration.

310. RECERTIFICATION: Any person previously registered as a lay midwife in the State of New Mexico whose registration has been terminated may be recertified as a registered lay midwife by:

310.01. Submitting evidence of eight contact hours of continuing education annually;

310.02. Submitting evidence of being current in practice in another jurisdiction;

310.03. Applying for a lay midwife apprentice permit in order to obtain clinical experience to become current in practice as determined by the Department;

310.04. Sitting any or all portion(s) of the qualifying examination as required by the Department; and

310.05. Submitting renewal fee as prescribed by the Division.

400. FEES: From and after January 1, 1981, all applications for apprentice permit or provisional or regular registration must be accompanied by a money order payable to the Division in the amount of fifty dollars ($50.00). Such fee provides for initial registration for the registration year, or part thereof, remaining. If the application is deemed insufficient, the fee will be returned.

400.01. Fee for annual renewal of provisional and regular registration shall be $25.00 a year.

400.02. Examination fee shall be $25.00 and is not included in registration fee.

500. REVOCATION OF REGISTRATION: The Division may refuse to issue, suspend for a definite period, or revoke a registration for any of the following causes:

500.01. Dereliction of any duty imposed by law;

500.02. Incompetence;

500.03. Conviction of a felony;

500.04. Practicing while suffering from a contagious or infectious disease;

500.05. Practicing under a false name or alias;

500.06. Violation of any of the standards of practice set forth in Sections 800 and 905;

500.07. Obtaining any fee by fraud or misrepresentation;

500.08. Knowingly employing directly or indirectly any suspended unregistered person or persons not holding an apprentice permit to perform any work covered by these regulations;

500.09. Using or causing or promoting the use of any advertising matter, promotional literature, testimonial, or any other representation however disseminated or published, which is misleading or untruthful.

500.10. Representing that the service or advice of a person licensed to practice medicine will be used or made available when that is not true, or using the words "doctor," "clinic" or similar words, abbreviations or symbols so as to connote the medical profession when such is not the case;

500.11. Permitting another to use his registration;

500.12. Directly or indirectly giving or offer to give, or permitting, or causing to be given money or anything of value to any person who advises another in a professional capacity as an inducement to influence him or have him influence others to use the services of the registration or permit holder, or to influence persons to refrain from seeking services elsewhere; or

500.13. Violating any of the provisions of these regulations.

EDUCATION

600. COURSE OF STUDY: The Division shall, on the advice of the Lay Midwifery Advisory Board, periodically maintain and periodically revise a list of approved courses, texts, and trainers covering at least the following subject matters. The Division may use the list as a guideline in determining the acceptability of a non-listed educational source which an applicant submits as complying with any educational experience requirement. A course of study in theory of pregnancy and childbirth must include the following:

In each category applicant shall cite approved training source or indicate reasons why source should be approved.

		Provisional Requirements	Regular Requirements
600.01.	Basic aseptic techniques	Required by both the registration levels	
600.02.	Basic Observation skills	Required by both the registration levels	
600.03.	Basic prenatal nutrition	May be done during provisional registration period	Required at application
600.04.	Basic parent education for prepared childbirth	May be done during provisional registration period	Required at application
600.05.	Provision of care during the antepartum, intrapartum, postpartum and newborn periods	Required by both the registration levels	
600.06.	Management of birth and immediate care of the mother and the newborn Identify source of Education	Required by both the registration levels	
600.07.	Recognition of early signs of possible abnormalities Identify source of Education	Required by both the registration levels	
600.08.	Recognition and management of emergency situations	Required by both the registration levels	

		Provisional Requirements	Regular Requirements
600.09.	Special Requirements of home delivery	May be done during provisional regis-tration period	Required at application
600.10.	Information regarding the laws and regulations relating to the practice of midwifery in New Mexico	Required by both the registration levels	

601. LIMITATION: The course of study must not include the independent, medically unsupervised use of any drugs in the antepartum, intrapartum, postpartum or newborn periods except for prophylactic treatment of the eyes; and the course must not contain any training in any surgical procedures other than the procedure for repair of a first or second degree laceration.

602. CLINICAL EXPERIENCE: Clinical experience in lay midwifery may be obtained in any setting (i.e., office, clinic, hospital, maternity center, home). Clinical experience must include at least the following types and numbers of experiences:

		Provisional Requirements	Regular Requirements
602.01.	Prenatal visits at least 15 different women	60	100
602.02.	Labor observations (at least 10 must be before first delivery; all deliveries may be included in this number	20	40
602.03.	Delivery of newborn and placenta	10	20
602.04.	Newborn examinations	10	30

		Provisional Requirements	Regular Requirements
602.05.	Postpartum home visits (within 36 hours of delivery	10	30
602.06.	BCMC Department of Pediatrics NICU and Nursery (8 hours minimum). Other acceptable observations entities will be considered	May be done during registration period	Required at application
602.07.	BCMC Department of Obstetrics and Gynecology High Risk perinatal Unit observation entities will be considered	May be done during registration period	Required at application
602.08.	Observation of one complete series of prepared childbirth classes	May be done during registration period	1-6 hour class series preferred
602.09.	Observation of one complete La Leche League series	May be done during registration period	1 series of 4 meetings

602.10 Five experiences in each of categories 602.01, 02, 03 and 04 must be with an approved physician or certified midwife trainer. Required at application.

603. SUPERVISION OF CLINICAL EXPERIENCE: Clinical experience may be obtained under the supervision of a physician, certified nurse-midwife or registered lay midwife. This must be direct, present in the same room supervision. Those providing supervision must be approved by the Division for training and should have had previous experience with home birth. Postpartum home visit supervision may be provided by an HSD public health nurse.

604. CONTINUING EDUCATION: Continuing education is required for annual renewal of registration.

604.01. In each calendar year, eight contact hours of continuing education must be obtained. One hour each of management of antepartum, intrapartum, and newborn periods and one hour of recognition and management of emergency situations must be obtained: other hours may cover any topics applicable to midwifery practice.

604.02. Continuing education may be obtained through convention, conferences, area midwives meetings or other mechanism as approved by the Division.

604.03. In any calendar year the Department may require specific topics for continuing education based upon any problem areas indicated by registered lay midwives' semi-annual reports.

700. REQUIREMENTS OF EXAMINATION: Any person applying for regular registration, as a lay midwife must pass a qualifying examination administered under the auspices of the Department. The Department shall offer the examination at least twice a year.

701. FIELDS TESTED: The examination shall consist of three parts:

701.01. A written examination designed to test knowledge in theory regarding pregnancy and childbirth;

701.02. An oral examination designed to test clinical judgment in lay midwifery case management; and

701.03. A practical examination designed to demonstrate the mastery of skills necessary for the practice of lay midwifery.

702. SCOPE OF WRITTEN EXAMINATION: The written examination shall cover:

702.01. Theory regarding pregnancy and childbirth including but not limited to:

702.01.01. Anatomy and physiology of the female reproductive system, in both pregnant and non-pregnant states;

702.01.02. Normal growth and development of fetus and placenta;

702.01.03. Normal progress of pregnancy, labor and delivery;

702.01.04. Comfort measures in the antepartum, intrapartum and postpartum periods;

702.01.05. Significance of laboratory studies in pregnancy and the neonatal period; and

702.01.06. Prenatal nutrition.

702.02. Patient teaching;

702.03. Special requirements of home delivery;

702.04. Risk factors in pregnancy;

702.05. Terminology used in the practice of lay midwifery;

702.06. Normal newborn characteristics and possible problems including anomalies;

702.07. Care of the newborn; and

702.08. Pertinent legislation and regulations for lay midwifery in New Mexico.

703. SCOPE OF ORAL EXAMINATION: The oral examination shall cover:

703.01. Evaluation of judgment to cover areas of:

703.01.01. Early recognition of abnormalities in the antepartum, intrapartum, postpartum and neonatal periods: their significance and possible sequelae if untreated

703.01.02. Recognition and treatment of emergency situations

703.01.03. Course and management of normal labor and selected normal antepartum situations (nutritional counseling, patient teaching, dealing with normal discomforts).

704. SCOPE OF PRACTICAL EXAMINATION: The practical examination shall cover basic observational skills:

704.01. Temperature, pulse, and respiration

704.02. Blood pressure

704.03. Fetal heart tones

704.04. Abdominal palpation

704.05. Cervical dilatation

704.06. Fetal position

704.07. Measurement of fundal height

704.08. Exam for edema

DUTIES AND RESPONSIBILITIES

800. COVERAGE: The registered lay midwife must assure that all women she plans to deliver receive required tests.

801. MEDICAL EVALUATION: The lay midwife must require the patient to have a risk evaluation and physical examination by a physician before a registered lay midwife assumes her care.

802. REQUIRED TESTS: Initial physician examination shall include clinical pelvimetry and the following laboratory tests -- VDRL, GC screen, blood type and group, hematocrit and hemoglobin, rubella titer and urinalysis: Hematocrit must be rechecked at 28 and 36 weeks gestation.

803. PRENATAL VISITS: Prenatal vists should be every 4 weeks until 28 weeks gestation, every 2 weeks from 28 until 35 weeks gestation and weekly from 36 weeks until delivery.

804. PHYSICIAN VISITS: Each woman must also have one prenatal visit with a physician at 36 to 40 weeks.

805. RECORDS: The lay midwife shall maintain records of physician's visit with evidence of his/her exam for the Division.

806. ADVANCE PREPARATION FOR NEED: The registered lay midwife, prior to the onset of labor, must have:

806.01. Arrangements made for transport of mother and/or infant to a hospital; and

806.02. Agreement for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.

807. INFORMED CONSENT: The registered lay midwife must inform any woman seeking home birth of possible risks of home birth and must obtain informed consent of the woman for home birth prior to the onset of labor on a form provided by the Department.

808. COMMUNITY RESOURCES: The registered lay midwife must be familiar with community resources for pregnant women such as prenatal classes, WIC program, La Leche League and HSD clinics.

809. LATE PREGNANCY PERIOD: The registered lay midwife will make a home visit no more than 4 weeks prior to the EDC to assess the physical environment, to ascertain that the woman has all neces sary supplies to prepare the family for the birth and to instruct the family to correct problems or deficiencies.

810. NORMAL DELIVERY: The registered lay midwife must remain with the mother and infant for at least two hours postpartum, or until the mother's fundus is firm and lochia normal, the mother has voided and the infant has a normal temperature and is nursing well, whichever is longer.

811. HOSPITALIZATION: The registered lay midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and a verbal report to the physician assuming care. If possible, she should remain with the mother and/or infant to ascertain outcome.

812. PHYSICIAN EVALUATION OF NEWBORN: The registered lay midwife must recommend that any infant delivered at home be evaluated by a physician within 3 days of age, or sooner when it becomes apparent that the newborn needs medical attention.

813. POSTPARTUM VISITS: The registered lay midwife shall make post-partum home visits to evaluate the condition of mother and infant at least twice - once within 36 hours of birth and once on the fourth or fifth postpartum day. Additional visits shall be made as indicated.

814. RH BLOOD FACTOR: In the case of an unsensitized Rh negative mother, the registered lay midwife shall:

814.01. Obtain a sample of cord blood from the placenta and deliver it to a laboratory within 24 hours of the birth.

814.02. Be certain that the mother consults a physician within 24 hours.

815. PREVENTION OF INFANT BLINDNESS: Within one hour of birth, the registered lay midwife shall administer two drops of 1% solution of silver nitrate or other antiseptic of equal potency and harmlessness into the eyes of the infant in accordance with the Health and Environment Department's Regulations Governing the Prevention of Infant Blindness.

816. BIRTH REGISTRATION: The registered lay midwife must complete a birth certificate and file it with the local registrar within ten days of the birth.

817. SANITATION: The registered lay midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.

818. RECORDS: The registered lay midwife shall maintain records of each patient on forms approved by the Department. Inactive records shall be maintained no less than ten years.

819. ANTEPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the antepartum period:

819.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.

819.02. Develops edema of the face and hands.

819.03. Develops severe, persistent headaches, epigastric pain or visual disturbances.

819.04. Does not gain 14 pounds by 30 weeks gestation or at least 4 pounds a month in the last trimester or gains more than 6 pounds in two weeks in any trimester.

819.05. Develops glucosuria or proteinuria.

819.06. Has symptoms of vaginitis.

819.07. Has symptoms of urinary tract infection.

819.08. Has vaginal bleeding before onset of labor.

819.09. Has premature rupture of membranes.

819.10. Noted decrease in or cessation of fetal movement.

819.11. Has inappropriate gestational size.

819.12. Has demonstrated anemia by blood test (hematocrit less than 30%).

819.13. Has a fever of 100.4 degrees F. or 38 degrees C for 24 hours.

819.14. Has effacement and/or dilatation of the cervix prior to 36 weeks gestation.

819.15. Has polyhydramnios or oligohydramnios.

819.16. Has excessive vomiting or continued vomiting after 24 weeks gestation.

819.17. Is found to be Rh negative.

819.18. Has severe, protruding varicose veins of extremities or vulva.

819.19. Is 36 years of age or older.

820. INTRAPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the intrapartum period:

820.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.

820.02. Develops severe headache, epigastric pain or visual disturbance.

820.03. Develops proteinuria.

820.04. Develops a fever over 100.4 degrees F or 38 degrees C.

820.05. Develops respiratory distress.

§20.06. Has fetal heart tones below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular.

§20.07. Has ruptured membranes without onset of labor after 12 hours.

§20.08. Has bleeding prior to delivery.

§20.09. Has meconium stained amniotic fluid.

§20.10. Has a presenting part other than a vertex.

§20.11. Does not progress in effacement, dilatation or station after 2 hours in active labor (or 1 hour if distance to hospital is greater than 60 miles).

§20.12. Does not show continued progress to delivery after 2 hours of second stage labor (or 1 hour if distance to hospital is greater than 60 miles).

§20.13. Does not deliver the placenta within 2 hours if there is no bleeding and the fundus is firm (or 1 hour if distance to hospital is greater than 60 miles).

§20.14. Has a partially separated placenta with bleeding or has a blood pressure below 100 systolic or a pulse rate over 100 beats per minute or is weak or dizzy.

§20.15. Bleeds more than 500 cc (2 cups) with or after the delivery of the placenta.

§20.16. Has retained placental fragments or membranes.

§20.17. Desires medical consultation or transfer.

§21. POSTPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the postpartum period:

§21.01. Has a second, third or fourth degree laceration.

§21.02. Has uterine atony.

§21.03. Bleeds in an amount greater than normal lochial flow.

821.04. Does not void within 6 hours of birth.

821.05. Develops a fever greater than 100.4°F. 38°C on any 2 of the first 10 days postpartum excluding the first 24 hours.

821.06. Develops foul smelling lochia.

822. NEWBORN PROBLEMS: The registered lay midwife will refer for medical evaluation and/or care any infant who:

822.01. Has an Apgar score of 7 or less at 5 minutes.

822.02. Has any obvious anomaly.

822.03. Develops grunting respirations, retractions or cyanosis.

822.04. Has cardiac irregularities

822.05. Has a pale, cyanotic or grey color.

822.06. Has an abnormal cry.

822.07. Weighs less than 5 1/2 pounds or 2500 grams or weighs more than 9 pounds or 4100 grams.

822.08. Shows signs of prematurity, dysmaturity or postmaturity.

822.09. Has meconium staining.

822.10. Does not urinate or pass meconium in the first 12 hours after birth.

822.11. Is lethargic or does not nurse well.

822.12. Has edema.

822.13. Appears weak or flaccid, has abnormal frenum or appears not to be normal in any other respect.

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

900. UNAPPROVED PRACTICE: The registered lay midwife shall not knowingly accept responsibility for the prenatal or intrapartum care of a woman who:

900.01. Has had a previous Cesarean section or other known uterine surgery such as hysterotomy or myomectomy.

900.02. Has a history of difficult to control hemorrhage with previous deliveries.

900.03. Has a history of low birth weight infants (2500 grams or less), stillbirths or neonatal deaths.

900.04. Has a history of birth injury to mother or infant in any previous delivery.

900.05. Has a history of third trimester bleeding.

900.06. Has history of thrombophlebitis or pulmonary embolism.

900.07. Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, hepatitis, heart disease or kidney disease.

900.08. Has genital herpes simplex in the first trimester or in the last four weeks of pregnancy.

900.09. Has a contracted pelvis.

900.10. Has severe psychiatric illness or a history of psychiatric illness in the 6 month period prior to pregnancy.

900.11. Is addicted to narcotics or other drugs.

900.12. Ingests more than 2 ounces of alcohol or 2 beers a day on a regular basis or participates in binge drinking.

900.13. Has a multiple gestation.

900.14. Has a fetus of less than 37 weeks gestation at the onset of labor.

900.15. Has a gestation beyond 42 weeks by dates.

900.16. Has a fetus in any presentation other than vertex at the onset of labor.

900.17. Is a primigravida with an unengaged fetal head at the onset of labor, or any woman who has rupture of membranes with unengaged fetal head, with or without labor.

900.18. Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention.

900.19. Has pre-eclampsia.

900.20. Has a parity greater than 5.

900.21. Is 17 years of age or younger.

900.22. Smokes 20 cigarettes or more, per day, and is not likely to cease in pregnancy.

901. EXAMINATION IN LABOR: The registered lay midwife will not perform any vaginal examinations on a woman with ruptured membranes and no labor, other than an initial examination to be certain there is no prolapsed cord. Once active labor is assuredly in progress, exams may be made as necessary.

902. OPERATIVE PROCEDURES: The registered lay midwife will not perform any operative procedure other than: clamping and cutting the umbilical cord; repair of a first or second degree laceration.

903. MEDICATIONS: The registered lay midwife will not administer any drugs, medications or herbs except when specifically ordered to do so by a physician and when administering medication in accordance with Regulations Governing the Prevention of Infant Blindness.

904. ARTIFICIAL MEANS: The registered lay midwife will not use any artificial, forcible or mechanical means to assist the birth.

905. CORRECTION OF PRESENTATION: The registered lay midwife will not attempt to correct fetal presentations by external or internal version.

SUPERVISION BY DIVISION

1000. ADVISORY GROUP: The Division shall appoint a Lay Midwifery Advisory Group which will assist in the development, practice and problems of lay midwifery, assist Division staff in the development of examinations (written and oral). The Lay Midwifery Advisory Group will be composed of five (5) members:

1000.01. One physician who must be active in perinatal care;

1000.02. One certified nurse midwife;

1000.03. Two regularly registered lay midwives;

1000.04. One member at large.

The Lay Midwifery Advisory Group will meet at least biennially to evaluate practice of lay midwifery as reflected in the semi-annual reports during the time that the program is becoming established.

1001. QUARTERLY REPORTS: The registered lay midwife shall submit quarterly to the Health Services Division, Health and Environment Department, a summary report in a form prescribed by the Division. This report must be submitted within 30 days of the end of the quarterly period. Individually identifying information shall not be required.

1002. MORTALITY: IMMEDIATE REPORTING: The registered lay midwife must report within 48 hours to the Health Services Division any fetal, neonatal or maternal mortality in patients she has cared for or any major morbidity as outlined in the section Prohibitions and Limitations of Practice.

1003. FORMS SUPPLIED: The Department will send to each registered lay midwife an ample supply of quarterly reports one month prior to the beginning of each three month period. The Division will also furnish any other forms required.

1004. STATISTICS: The Department will compile annual lay midwifery statistics and make them available to registered lay midwives and other interested groups or persons.

1005. PREVENTION OF INFANT BLINDNESS: The Department will provide necessary supplies for prophylactic treatment of infant eyes as required by these regulations.

1006. These regulations supersede the Regulations Governing the Practice of Midwifery adopted by the State Board of Public Health, May 4, 1944, and the previous version of the same Regulations, No. MED-80-3 (HSD) filed on February 5, 1980.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SSHB 11
Title An Act relating to midwifery.
Requested by Rogers Date 4-27-81

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Regulation &licensing of professions; admn/investigati
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	-	0	0	0	0	0
200 TRAVEL	-	4.2	4.7	5.3	5.9	6.6
300 CONTRACTUAL	-	104.7	112.0	119.8	128.1	137.0
400 COMMODITIES	-	0	0	0	0	0
500 EQUIPMENT	-	0	0	0	0	0
600 LAND & STRUCTURES	-	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	-	0	0	0	0	0
	-					
TOTAL		108.9	116.7	125.1	134.0	143.6

FUNDING (Thousands of Dollars)

GENERAL FUND		108.9	116.7	125.1	134.0	143.6
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

TRAVEL - 12% inflation factor projected.

Dept. staff to administer examination, 2 times/yr.	$ 700.00
Dept. staff to attend regulation hrgs., Anch/Fbks/Jnu	1,600.00
Additional travel and field work by investigators, located in Anchorage & Juneau, to investigate midwife complaints:	
2 Investigators (1 day per diem/mo. @ $67 per day (1 trip every 4 mos. @ $160 per trip	1,900.00
	$ 4,200.00

CONTRACTUAL - 7% inflation factor projected.

Legal notices, publications, duplicating and printing costs of applications, consent forms etc.; printing/mailing/distribution costs of statute and regulation booklets; development of exam.	$ 3,000.00

(continued next page.

IV. DATE 5-1-81 PREPARED BY Marjorie Odland
AGENCY Division of Occupational Licensing
PHONE 465-2535

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Hearings - estimated 2 hearings concerning midwives per year. Costs estimated at $50,000 per hearing: hearing officer @ $55/hr, plus travel & expenses; court reporter @ $20/hr; judicial process approx. $1,000 per hearing.	100,000.00
Room Rental for examinations and hearings.	
2 exams per year, in Anch/Fbks/Jnu, 1 day ea.	900.00
2 regulatory hearings per year, 2 days ea.	600.00
Proctors for examinations.	200.00
$50 for head proctor	
$35 for monitors	
Total contractual	$104,700.00

*Administrative support functions could be absorbed by staff budgeted for in FY'82 budget.

STATE OF ALASKA

Holli

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

POUCH K – STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

May 5, 1981
465-3600 x 56

The Honorable Representative Donald E. Clocksin
House of Representatives
Chairman, Health, Education and Social
Services Committee
Pouch V
Juneau, AK 99811

Re: SSHB 11 -- Services of Nurse Midwives

Dear Representative Clocksin:

The Department of Law would like the opportunity to comment on the above bill, but has been unable to do so yet, due to the press of business. Since we handle enforcement for the Division of Occupational Licensing, we are quite interested in that aspect of the legislation. I would appreciate it if you could notify me prior to any further hearing or work session on the bill.

Also, did you know that the Code Revision Commission has done considerable work on developing uniformity throughout AS 08, in regard to licensing and disciplinary procedures, etc, and has a fairly sophisticated draft of a comprehensive bill it hopes to introduce next session? We would hope to have SSHB 11 coordinated with that legislation for uniformity, if possible.

Thank you for your help. I will hope to hear from you.

Sincerely,

WILSON L. CONDON
ATTORNEY GENERAL

By: Sarah T. Kavasharov
Sarah T. Kavasharov
Assistant Attorney General

STK/jb

5-1-81

Rogers

AB 11
SB 4

Mice Phillips of DHSS
U of W, U of O

Shirley Moxbeer -
mand. vs vol. lic.

Bert Walker, ANA
SB 4 - yes.
Adv. Nurse Pr. - always has coll. rel. c M.D.
Prof. Nurse (R.P. -

Dave ~~[illegible]~~ - DPA

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

BE IRWE
5-1-81

MEMORANDUM May 21, 1980

TO: Representative Brian Rogers

FROM: Betty Barton, Issues Analyst

RE: The Effects of Regulation on Lay Midwifery
Research Request No. 120

This memorandum is in response to your request for information regarding the effects of State regulation on lay midwifery. At the time of your request, you asked that we research changes in the midwife population of various states, which may have occurred as a result of regulatory control. We have determined the existing data to be insufficient for responsible analysis of midwifery trends. Because there is no hard data available, we have compiled opinions concerning the effects of regulation through telephone interviews with staff from alternative birth associations, State public health programs, and conversations with lay and nurse-midwives in Alaska and other states. Our interview list is attached for your review. Alaskan lay midwives did not grant us permission to use their names and so, are identified in neither the text nor the attachments of this memorandum.

We have gathered what we consider to be a representative sampling of current attitudes and experiences regarding the effects of State regulatory control. However, our perspective in presenting this is that of the midwives. We have not attempted to draw any information from medical associations and obstetricians; and, consequently, should this memorandum reflect any biases, they should be construed solely as the opinions of the persons interviewed.

Proponents of lay midwifery are not necessarily proponents of one another's politics and philosophies. Consequently, our findings regarding the current practice of lay midwifery are varied to some extent. Lay midwifery is a small, albeit developing, movement in the U.S. with much internal diffusion. Nonetheless, midwives appear united in an overriding belief that distinct advantages and disadvantages are to be realized from regulation. When regulations embody fairly derived standards and an adequate mechanism for attaining those standards, it is safe to say that most contemporary lay midwives view State regulation to be worthwhile.

However, most lay midwifery advocates feel that equitable standards have rarely been established at the state level and thus, exercise caution in recommending regulatory measures. Conditions vary from state to state; and whether the general findings reported in this memorandum might apply in Alaska could bear further investigation. Alaska has a very small lay midwife population as evidenced by the fact that there are only two known lay midwives practicing in Anchorage. Because of this, it might not be in the State's interest to pursue steps toward regulation at this time. The subject of regulation of these practitioners can evoke heated and emotional debate by lay midwives, medical professionals, and public health administrators. On occasion, it appears that more conflict has emerged from the process of legislative action than existed prior to the public's attention to the matter. Part of the problem is surely due to the new definitions that lay midwifery has assumed combined with a lack of model legislation at the State level. Consequently, it may be wise for Alaska to sit back and watch the effects of other states' regulatory provisions prior to adopting legislation of its own.

Background Information

The definition of midwifery has expanded since its inception in the U.S. but basically still refers to the management and attendance of childbirth. In today's society, there are three types of midwife: 1) the traditional midwife, known as the "granny," who has obtained her training in labor and delivery solely through apprenticeship and experience; 2) the nurse-midwife, who generally has obstetric nursing experience and graduate coursework in midwifery; and 3) the modern lay midwife, who generally has been trained through a combination of coursework and apprenticeship. There are more lay midwives, including both the "granny" and her contemporary counterpart, than practitioners of nurse-midwifery. There are about 1800 nurse-midwives in the U.S. In Texas alone a state which exemplifies the proclivity of lay midwifery in the South, there are an estimated 1500 lay midwives. The predominance of the lay midwifery population may be due to the rigorous training required for nurse-midwifery certification. Conversely, state laws that in the past have made it relatively easy to be certified as a lay midwife have been a factor in the maintenance of lay midwives populations.

Most laws governing the practice of lay midwifery were adopted by states in the first quarter of this century. These laws were aimed at the "granny" midwife and, for the most part, set very basic standards of control, generally only requiring a certificate of practice dispensed by the authorized licensing board or agency. As the availability of medicine

and professional health care expanded, the use of midwifery declined from about 50 per cent of all births in 1900 to only 12 per cent by 1935. But many states left their lay midwifery laws unaltered, presumably in deference to the few remaining "granny" midwives. The rate of decline continued until the 1960's when a resurgent interest in lay midwifery occurred. At this point, a number of states found themselves with laws considered by many medical associations and health departments to be outmoded by current health standards. As a result, movements were made in some states to amend existing legislation, thus marking the beginnings of a conflict between the medical and lay midwifery communities regarding a mutually satisfactory interpretation of their respective roles.

At basic issue is the question of home delivery versus hospital delivery. Births attended by lay midwives generally take place in the home or in some instances at special maternity centers. The American Medical Association contends that non-hospital based deliveries place undue risk upon the safety of the infant, presumably because of the mother's distance from emergency medical equipment and professional medical staff. Conversely, lay midwives argue that the nation's obstetricians have poorer maternal and child morbidity and mortality rates than do lay midwives who often are attending impoverished, high-risk patients. As an added point, lay midwife associations offer World Health Organization data that indicate better morbidity and mortality rates in developed countries, such as Sweden and Great Britain, where midwives are used more extensively than is the case in the United States.

Midwives maintain that as doctors of medicine, obstetricians have been taught to treat pregnancy from a pathological perspective rather than as a natural condition, and consequently have developed the same reliance upon anaesthetics and surgery as is prevalent in the medical diagnosis of morbidity. Lay midwives further contend that such procedures as episiotomy, a surgical incision of the perineal tissue to enlarge the vaginal opening, have become routine obstetrical practices because they shorten the delivery time rather than for any health function. The medical profession, in turn, regards lay midwifery and home-births as unnecessary regressions to a lost era, which ignore the capabilities of modern medicine.

In comparison to other developed nations, the U.S. utilizes midwives to a very limited degree. In Sweden, every pregnant woman, including those who are to deliver by Caesarean section, has a midwife. In the

Netherlands, midwives have responsibility for all normal births as is evidenced by the Dutch government's refusal to pay for a doctor's services if a midwife is available. According to an article by Christopher Norwood in a May 1978 issue of Ms., approximately 80 per cent of the world's babies are delivered by midwives. In the U.S., according to the National Center for Health Statistics, only approximately 1.5 per cent of the nation's births occur out-of-hospitals. Of these, 92% are attended by lay midwives and others, e.g. relatives, taxi cab drivers.*

DETERMINING THE ROLE OF REGULATION IN LAY MIDWIFERY

The need for regulation of health care personnel has long been regarded as essential by state governing entities. Occupational licensing, as with other professionals, is the basic component of the regulatory process. The fundamental purposes of licensure are to control entry into a profession and to establish and enforce minimum standards of practice. Persons found to be deficient in, or in violation of, these basic standards may be denied licensure; or, if already licensed, may have their licenses revoked or suspended. It is generally regarded that this process protects the public from the purchase of incompetent or unsafe health care services.

The degree to which regulatory controls should be employed proffers controversy. In this matter, development of regulatory provisions for midwifery can be especially complex because of the conflicting opinions regarding its function..The resultant effects of the regulatory process, according to lay midwifery advocates, have been varied.

Potential Benefits of Regulation

Most midwifery advocates interviewed concurred that licensure may be necessary to establish minimum standards of practice, an assurance that is apparently becoming more essential as the interest in home birth continues to grow. For example, Shara Daniels, President of the National Midwives Association and Director of the El Paso Birth Center, stated that under current Texas law, the only requirement to practice midwifery is registration at the local courthouse. Under this relatively loose Texas law, the resurging interest in home births has prompted a number

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* The percentage of hospital-based births attended by certified nurse-midwives is not available. However, as there are only about 1800 certified nurse-midwives in the United States, the percentage of births attended by these practitioners is projected to be equally low.

of untrained, unskilled people to register as midwives. The danger in this, of course, is the assumption by a consumer seeking midwifery services that she is obtaining the care of an adequately experienced individual. As a result, amendments to the Texas law are currently being proposed that will establish much stricter standards and guidelines for the practice of lay midwifery, e.g. the successful completion of State-approved training and a State-administered examination prior to licensure.

Arizona has pursued similar measures by strengthening a lenient law with precise regulations. In effect since 1957, Arizona's law on lay midwifery merely requires submittal of application to practice, establishes conditions under which a license is revoked or suspended, and authorizes its Department of Health Services to draft rules and regulations, which until several years ago, had few restrictions. The Department of Health Services now requires lay midwives to have completed an approved course of study and to pass a State-administered examination comprised of written, oral, and practical sections. The Department also requires every client of a lay midwife to retain a back-up support physician. Ruth Beeman, the State's administering officer for the lay midwifery program, considers these measures to have been worthwhile in providing better assurances for the health and protection of the public.

An anticipated secondary result of state regulation is improved quality of training in lay midwifery programs. Because a purpose of licensure is the establishment of quality standards, a certain degree of service deficiency in lay midwifery programs can exist in those states, such as Alaska, that do not legally address alternative childbirth practice.

Although not prohibited by law to practice, neither are midwives actually recognized by states such as ours. The result is legal ambiguity clouding the scope and, in turn, the quality of service provided by lay midwives. An example of paramount significance concerns the relationship between lay midwives and physicians. Because Alaskan law does not identify the function of lay midwifery, a number of physicians will not admit as a client any pregnant woman intending to have a lay midwife-attended birth. Consider Juneau: of three clinics available for prenatal care, one clinic refuses the admission of home-delivery patients; a second admits alternative-birth clients but charges them a $400 set fee rather than billing on a per visit basis (thereby automatically committing a client to $400 worth of visits); leaving the third, a public clinic operated through the State, as the only clinic admitting home-birth

clients without restriction. Lay midwives maintain that situations such as these would be alleviated to some extent by regulation.

One local lay midwife compares Alaska to Washington where lay midwifery is regulated. She maintains that regulation can assist to strengthen the relationship between lay midwives and physicians, noting that most lay midwives in Washington perform their deliveries with emergency transport vans and adequate back-up support of physicians. By contrast, in Juneau, she maintains, a number of women have been forced to misrepresent their intentions to their physicians in order to obtain prenatal examinations. She added that because there is no licensure she is denied the use of certain health care tools and equipment, contrasting the local situation with those of Washington and Colorado where she would be entitled to access to labs. Although not a proponent of licensure of lay midwifery in Alaska at this time, she feels that regulation should be considered for the state in the future.

Another Alaskan midwife, who asked that her identity not be disclosed, feels that practitioners would be better protected under licensing. Licensed to practice nursing, she feels she has had problems maintaining her license because of obstetrical opposition to her practice of lay midwifery. She feels her past problems could have been eased had Alaska promulgated clear regulations regarding the role of lay midwifery. Nonetheless, she views the degree of current bias by the medical community to be so strong that an objective consideration of regulation is not currently possible.

Potentially Negative Effects of Regulation

Lay midwifery advocates seem to agree that the primary disadvantage of regulatory control lies not in the concept of licensure but rather in the potential for abuse of its purpose. In other words, lay midwives believe that state regulatory laws can be merely a slimly disguised means for the elimination of midwifery practice. Upon examination of developments subsequent to licensure in states such as Alabama, it is difficult to allay lay midwives' fears. Alabama's law exempts lay midwives from the licensing requirements of nurse-midwifery, stating that these requirements shall not "prevent lay midwives holding valid health department permits from engaging in the practice of lay midwifery as heretofore provided until such time as said permit may be revoked by the county board of health." In 1979, the Alabama State Department of Health issued an order to suspend approval of any new licenses and suggested that old licenses be proscribed from renewal. Other states, through the process of regulation, have established standards so high that the purpose

of lay midwifery appears violated with only "professional" practitioners able to meet requirements. Arizona, with its oral, written, and practical exams has been criticized by the National Midwives Association for its overly competitive admissions criteria; the Association cites the state's total population of only 24 licensed midwives as evidence.

Along similar lines, lay midwives also express apprehension regarding the basis for the minimum standards of eligibility set by states. In this area, there appear to be two issues of concern: 1) should physicians have a role in developing standards for lay midwifery? and 2) can a consensus be reached concerning minimum standards? Regarding the former issue, the InterNational Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) assume unequivocally that medical doctors cannot give valid consideration to lay midwifery regulation because of their philosophical opposition to the practice. David Stewart, Executive Director of NAPSAC, views the Association's attitude to be justified because midwifery is a profession distinct from that of a physician. Juneau's lay midwife views NAPSAC's philosophy to be biased. She believes that physicians can serve a valuable function in lay midwifery, noting the support she received from medical doctors in Washington as an example. However, she, too, expressed concern that the objectivity of an occupational licensing board may be susceptible to biased philosophies of any physicians on the board.

Similar in nature to this issue, is the general area of concern regarding minimum standards for lay midwifery. Lay midwives differ from one another concerning what constitutes minimally acceptable experience. Unlike certified nurse-midwives, governed by uniform standards defined by the American College of Nurse Midwives, lay midwives operate from no agreed upon standards. For example, David Stewart feels it is important that lay midwifery remain distinct from nurse-midwifery. As spokesperson for NAPSAC, he asserts that lay midwives want concentrated training for all aspects of childbirth and care rather than courses of study required in nursing programs which may be largely irrelevant to childbirth.

Shari Daniels believes in stressing practical experience in training lay midwives, nurse-midwives, and family-practice physicians alike. In terms of lay midwifery, she maintains that lay practitioners must have intensive experience in all aspects of normal and abnormal childbirth in order "to expect the unexpected" in delivery conditions anticipated to be routine. Unlike most lay midwifery birth clinics, her El Paso Maternity Center handles twin and breech deliveries as well as other abnormal births. Five per cent of the Center's patients are classified as high-

risk, requiring emergency transport and hospitalization. According to Ms. Daniels, some states do not want to license lay midwives trained at her center because of the extent of their experience. Because most regulations limit lay midwives to the attendance of normal deliveries, there apparently is some apprehension that lay midwives experienced with abnormal births will not provide for emergency transport when there is cause.

Regulatory Control; Is it Necessary?

In analyzing the effects of regulation, some consideration should be given to the validity of licensure in general as it is currently conceived. At the national level, recent research has questioned the appropriateness and effectiveness of regulations. For example, there appears to be a growing thought that occupational licensing places unequitable and unnecessary restrictions on the mobility of licensed professionals that are no longer in accord with today's transient society. The effectiveness of licensure as a consumer protection tool has been examined in other research. Dr. Patrick O'Donoghue (a medical doctor), in a publication entitled Evidence About the Effects of Health Care Regulation, as prepared for the National Science Foundation, states the following:

> Licensure stops at least one step short of actually assuring on a continuing basis the quality of health care delivered by a paractitioner. In other words, the real concern of a governmental licensing agency should be the protection of the public over the professional lifetime of the practicing health care professional. Up to the present, however, measures of the quality of care have not permitted direct regulation of professional activity. Therefore, the states through their laws have attempted to assure the quality of health care by establishing and certifying the entering qualifications of professionals. They do go slightly beyond this initial assurance in that if a practitioner has been licensed as qualified and shows himself to be unqualified, the law puts the police power of the state into action in removing the dangerous practitioner from his profession. On the other hand, ... the grounds on which a practitioner may disqualify himself are relatively narrow.

Research performed under Dr. O'Donoghue's direction leads him to a tentative conclusion that licensure may not be valid unless it employs continuing education opportunities and routine reviews of a professional's practices

throughout the duration of his or her career. Dr. O'Donoghue notes that the rate of disciplinary actions by state medical licensure boards is quite low, averaging less than 200 actions per year nationally between 1963-1967.

Commensurate with these findings, lay midwifery proponents question apparent disparities between physicians and lay midwives in the matter of license revocation. As one lay midwife in Alaska articulated, "A single error in judgment by a licensed midwife in California can cause her to be unqualified for practice, while such is rarely the case with a physician." Advocates feel that should licensure be employed, it must be devoid of professional bias. Current practices weigh the responsibility for protection of the mother and infant over the individual rights of the mother to exercise her own decision concerning the type of care to be received. NAPSAC argues that this practice violates the freedom of choice and feels that current practice must be amended to embody this freedom in public health law. As the concept of health care expands from traditional interpretations to new philosophies as imbued in naturapathic medicine and alternative birth, NAPSAC maintains that a State's regulatory function also will require expansion and a more adaptable structure so that freedom of individual choice in the treatment of morbidity and health conditions may be respected.

NAPSAC recommends voluntary compliance with licensure standards combined with a strong consumer education program. Voluntary compliance permits the State to establish minimum standards of practice for licensure and to penalize practitioners who falsely represent themselves as having attained state licensure. However, voluntary compliance does not force practitioners to seek licensure if this means acceptance of standards that they regard as foreign to their philosophies of health care. With non-mandatory licensure, the health care consumer, it is argued, has greater freedom concerning the type of services to be purchased.

MODEL REGULATORY PROVISIONS REGARDING LAY MIDWIFERY

Although not requested by your office, in the course of our research, we became curious about the nature of regulatory legislation in certain states having recently addressed the lay midwifery issue, and felt this information might be useful for your purposes. We also became interested in learning what alternative birth associations view to be model legislation regarding lay midwifery. Only two states, Arizona and Florida, were commended to us. Arizona's legislation has met with mixed reaction, but

appears to be generally regarded by midwives as representing a positive approach to regulation. Copies of Arizona's rules and regulations have not as of yet been received by this office; we will transmit them to your office upon arrival.

In Florida, a comprehensive legislative proposal regarding lay midwifery was developed over the past few years. However, the bill, recently died in committee in a 9-affirmed, 10-opposed vote. It is attached for your review. Probably the bill's greatest significance is the standards for licensure eligibility it contains. The bill grants authority to the Department of Professional Regulation to promulgate standards for the development of a midwife apprentice program; proscribes apprentice lay midwives from the receipt of compensation for the provision of services except under the supervision of the sponsoring licensed midwife or physician; and requires the apprentice midwife to participate in a minimum of 50 births, 25 of which have included the "primary responsibility for the prenatal, intrapartal and postpartal management and care, under the observation and supervision of the sponsor."

Although successful completion of a state-administered examination is required, the standards permit the option for a lay midwife seeking a license to include as evidence of experience either a certificate from a midwifery school, a certificate of completion from a training program approved by the administering department, or "evidence of completion of a midwife apprenticeship program."

Training and experience appear to be regarded as essential components of regulatory legislation. This is of special significance in Alaska as no formal training programs are available in the state. Consideration should be extended to the minimum standards of eligibility, especially in light of the varying opinions on this matter. Shari Daniels of the National Midwives Association recommends a program of lay midwifery training that entails a minimum of 50 births with a practicing midwife. Although no states currently offer training for beginning lay midwifery, she regards the following to be a model training course:

3 months prenatal care in a hospital

3 months labor and delivery, "on-floor" in a hospital

3 months neo-natal intensive care and postpartal care

50 births minimum with practicing lay midwife

6 months in-class training with lay midwife, e.g., childcare education and postpartum education

3-12 months probationary status with normal deliveries (with lay midwife on call)

She added that lay midwifery training programs in Europe generally place far greater emphasis on "on-floor," practical training than do programs offered in the United States. Arizona's standards place more emphasis on the amount of theoretical or academic training received, requiring only an attendance at 15 births. Ms. Daniels regards their standards to be highly deficient.

Arizona is the only state, however, to offer a state-administered program in continuing education for lay midwives. Offering workshops in subject areas needing special concentration, such as treatment for excessive bleeding during intrapartal and postpartum stages, the program has been well received by NAPSAC. A strong program in continuing education could possibly counteract the deficiencies perceived by Dr. O'Donoghue in occupational licensure of health care professionals as a public protection mechanism.

We hope this memorandum has met your purposes. It is important to note that David Stewart, of NAPSAC, and Shari Daniels, of the National Midwives Association, were pleased to learn that we were conducting preliminary research regarding regulation of lay midwifery whether or not legislation is proposed based on our findings. In the event that legislation is drafted, Ms. Daniels has offered her assistance in reviewing any drafts.

BB/bf
Attachment

INTERVIEW LIST

David Stuart:	Executive Director NAPSAC Post Office Box 267 Marble Hill, Missouri 63764 Telephone: (314)238-2010
Ms. Shari Daniels:	Director El Paso Maternity Center 1119 E. San Antonio El Paso, Texas 79901 Telephone: (915)533-8142 (Maternity Center) (915)565-9623 (Home number)* *After 6:00 p.m. El Paso time President National Midwives Assoc. P. O. Box 163 Princeton, N.J.
Ms. Ruth Beeman: (Nurse-midwife)	Coordinator Lay Midwifery Program Department of Health Services State of Arizona Tucson, Arizona Telephone: (602)255-1024
Ms. Margaret Crawford: (nurse-midwife)	Greater Juneau Borough Health Clinic Juneau, Alaska Telephone: 586-3736
Ms. Peggy Newman:	Director BABE Prince of Peace Drive Anchorage, Alaska Telephone: 694-9050
Dr. Charles Muller:	Medical Director Blue Cross of Washington & Alaska P. O. Box 327 Seattle, Washington 98111 Telephone: (206)361-3417
Dr. Patrick O'Donoghue:*	President Policy Center, Inc. Denver, Colorado

*Although we did not interview Dr. O'Donoghue, we have included information provided by him as compiled in his book, Evidence About the Effects of Health Care Regulation.

HB11

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 27, 1981

MEMORANDUM

TO: Representative Tony Vaska

FROM: Leslie Longenbaugh LL
Research Staff

RE: Lay Midwifery in Oregon
Research Request Number 81-89

You have asked that we investigate the history and consequences of the Oregon Attorney General's opinion of June 17, 1977 regarding lay midwifery. Specifically, you asked about 1) the legal rationale used by the Attorney General in his opinion; 2) how the legislators who oppose lay midwifery happened to forego the opportunity to legislate against the practice; 3) whether Oregon has been held liable for health problems or deaths resulting from lay midwifery; and 4) whether Oregon keeps a register or other list of lay midwives.

Linda Vaska asked that we relay the information to your office in installments, if necessary. This memorandum presents the preliminary results of our research.

We spoke with Marianne Remy, of the Oregon Department of Health[1], who was able to answer your questions as follows.

1. What was the legal rationale used by the Attorney General's office in his opinion?

Oregon law apparently provides that only those medical procedures defined as involving a "disease state" require the presence of a physician or registered nurse. Childbirth is not defined by the Attorney General as a "disease state," or as an intrusive and surgical procedure, and therefore is not a precedure that requires the attendance of a licensed medical practitioner. The Attorney General's opinion prohibits lay midwives from administering medication and from performing episiotomies.[2] In the case of an emergency during a delivery, a lay midwife either calls

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[1]Marianne Remy, Oregon State Department of Health, Portland, Oregon; phone: (503) 229-5806.

[2]According to Ms. Remy, lay midwives rarely violate these prohibitions, in large part because of the "nonintrusive" philosophy that informs their work.

a local physician or transports the mother and child to the emergency room of a local hospital. The question of whether lay midwives may cut the cord of an infant has not been addressed, either in the opinion or in the enforcement of the opinion's prohibition against surgical procedures.

2. Why have Oregon legislators who oppose lay midwifery not attempted to pass legislation to restrict or limit the practice?

Ms. Remy reports that the members of the medical community and legislators who oppose lay midwifery and home childbirth were not aware of the extent of lay midwifery that was practiced in Oregon at the time of the Attorney General's opinion. Now that lay midwives have formed associations and have become quite visible in the state, such organizations as the Oregon Medical Association have begun to press for legislation to restrict attendance at a childbirth to licensed physicians and nurses. In fact, such a bill apparently has been introduced during the current session of the Oregon Legislature.

3. Has Oregon been held liable for illness or death attributable to the practice of lay midwifery?

Ms. Remy is not aware of any suits charging that the state is liable in cases of complications resulting from childbirth through lay midwifery. She indicated that this question could be better answered by the Attorney General's office.

4. Does Oregon keep a register of lay midwives?

There is no list of midwives compiled by the state.

The member of the Oregon Attorney General's staff who wrote the 1977 opinion will not be in the office until Monday, March 30; we will call him then, and send you additional information based on this conversation. Ms. Remy is sending us a copy of the Attorney General's opinion.

The Oregon Public Health Association has recently formed a resource committee to study the issue of alternative childbirth; Ms. Remy is a member of this new committee. The committee plans to study the outcomes of several types of childbirth, among them lay midwifery.

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[3]David Spence, Director, Family Health Section, Division of Public Health, Department of Health and Social Services; phone: 465-3100.

In Alaska, David Spence is the Director of the Family Health Section of the Division of Public Health in the Department of Health and Social Services.[3] He might be able to give more information on lay midwifery, not only in Alaska and Oregon but for other states as well.

If you would like us to analyse the opinion in light of Oregon and Alaska law, please call on us.

LL/dp

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 31, 1981

MEMORANDUM

TO: Representative Tony Vaska

× 3954 FROM: Leslie Longenbaugh
Research Staff

RE: Lay Midwifery in Oregon, Additional Information
Research Request Number 81-89

In our memorandum to you of March 27, we mentioned that we would be contacting the author of the Oregon Attorney General's opinion on lay midwifery. We spoke this morning with Arnie Silver[1] of the Oregon Attorney General's office, who offered a somewhat different perspective on lay midwifery in that state.

Mr. Silver described his legal approach in writing the opinion as one which employed not only the "disease state" criterion alluded to by Ms. Remy (see our March 27 memorandum), but also an old Oregon statute that allows a midwife to sign a birth certificate. He interpreted this law to mean that the Oregon Legislature had intended to allow lay midwives to deliver babies.[2]

Mr. Silver is of the opinion that strong opposition to lay midwifery does not exist in Oregon, except among members of the medical community. He feels that, owing to Oregon's strong "naturalistic" movement, many people support the notion of "natural" childbirth performed at home under the guidance of a lay midwife.

In answer to your question concerning the state's legal liability, Mr. Silver believes that his state has no legal responsibility whatsoever in the practices of lay midwives, as Oregon does not participate in any licensing or training.

The copy of the Oregon opinion sent to us by Ms. Remy has not yet arrived; as soon as it does, we will forward a copy to your office.

If we can be of further assistance, please call on us.

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[1]Arnie Silver, Assistant Attorney General, Portland Division; phone: (503) 229-5725.

[2]Mr. Silver mentioned that the opinion was requested by the Oregon Board of Nursing, which wanted to know whether lay midwives were practicing nursing, and therefore would come withing the purview of Oregon laws governing nursing.

#B11

TO: Tim

FROM: Ed

RE: SB 4 Insurance Coverage of Nurse-Midwife Services

This bill would extend health insurance coverage to maternity services provided by licensed nurse-midwives. It would allow nurse-midwives to bill insurance companies directly instead of billing through physicians. This would affect only policies issued or amended after January 1, 1982.

Nurse-midwives are a long established (50 years), highly trained group of professionals. They are recognized and licensed in 47 states, including Alaska. Nurse-midwives are all registered nurses (R.N.) who have completed a graduate course in the specialty of midwivery. Thus, most nurse-midwives have 6 years of professional education. They also must pass a national certification examination.

Nurse-midwives are employed by hospitals, public health agencies, private physicians, the military, prepaid health plans and birthing centers. Nurse-midwives are limited to handling the 90 per cent of mothers who have normal, low-risk pregnancies and deliveries. They are trained to recognize any abnormalities which might arise and to refer such problems to an obstetrician.

Nurse-midwives are required by Alaska law to be associated with and "collaborate" with a licensed physician (obstetrician). The nurse-midwife profession is regulated jointly by the State Medical Board and by the State Nursing Board.

Nurse-midwives are preferred over physicians for normal delivery and maternity care by a large and growing number of women and men nationally. Women say they prefer the nurse-midwives because they spend more time with them throughout the entire pregnancy and labor, as well as follow-up treatment; they answer questions more readily and thoroughly; and since most nurse-midwives are women, many of whom have had babies themselves, they are more empathetic with the expectant mothers.

There is also strong evidence that nurse-midwives have a positive effect in reducing the rate of infant mortality. As seen in the tables below, the United States is not among the top developed countries with low mortality rates. Several other countries consistently have lower mortality rates. Most of those countries, especially Netherlands, Sweden, Norway, Finland, Denmark, Australia and Japan, employ midwives extensively.

INFANT MORTALITY RATES FOR SELECTED COUNTRIES

Country	*Rate per 1,000* 1971	1972*
Sweden	11.1*	10.8
Netherlands	11.1	11.4
Finland	11.8*	11.3
Japan	12.4*	11.7
Norway	12.8*	11.3
Denmark	13.5*	
France	14.4*	13.3
Switzerland	14.4	13.0

Country	*Rate per 1,000* 1971	1972*
New Zealand	16.6	
Australia	17.3	16.7
Canada	17.6	17.1
United Kingdom	17.9*	
East Germany	18.0	17.7
Ireland	18.0	17.7
Hong-Kong	18.4	17.5
United States	19.2*	18.5

Information from the Statistical Office of the United Nations provided by Doris Haire.
*Provisional.

INFANT MORTALITY RATES FOR SELECTED COUNTRIES

(Rate per 1,000)

Country	1964	Country	1964
Sweden	14.2	England and Wales	19.9
Netherlands	14.8	Japan	20.4
Norway	16.4	Czechoslovakia (provisional)	21.2
Finland	17.0	Ukrainian SSR	22.0
Iceland	17.7	France	23.3
Denmark	18.7	China (Taiwan)	23.9
Switzerland	19.0	Scotland	24.0
New Zealand	19.1	Canada	24.7
Australia	19.1	United States of America	24.8

Information from the Statistical Office of the United Nations, provided by U.S. Public Health Service

CHAPTER ONE

The New Homebirth

THE HOMEBIRTH REVOLUTION

Despite the fact that almost all of the people now alive in the world were born at home,[1] the homebirth movement in the United States, which I call the new homebirth, is completely revolutionary, something which has never before happened in human history. We now find that women, together with their partners, are giving birth at home as safely and with fewer complications than in the average hospital birth,[2] and are finding it a joyous process, indeed a peak experience in their lives.

This joyful experience of birth is the keynote of the new homebirth. Indeed the current return to home deliveries is not a return at all, because it involves a new *consciousness* of birth. When your great-grandmother gave birth at home, she probably did so shouting, moaning and praying that it would soon be over. She believed that the pains of childbirth were women's lot and was embarrassed before her husband, who either paced nervously downstairs, or went out to get drunk. After participating in just such births in rural Mexico, I am strengthened in the conviction that there is no such thing as "natural childbirth"—a woman either follows her cultural conditioning or makes the leap to a new realization which, although still only recognized by a minority of women, is now available to us all.

The new homebirth is a completely new response to birth, a recognition that what we need to vitalize our lives, save our humanity, and renew our sensitivity, is to choose actively to *feel* and to know ourselves, our lives, our births, our deaths. Through this realization, women are not only actively giving birth with dignity and joy, but are also reclaiming their birthright—the right to be self-determined and recognized, especially in the uniquely feminine act of giving birth.

The second key to the new homebirth is women's desire to assume active responsibility for their bodies, their lives and their birth experiences. Instead of showing a blind dependency on experts, passively allowing doctors to impose their authority on them, couples are informing themselves as much as possible and selecting birth attendants who will help *them* in their actions—attendants who are not only medically skilled, but also sensitive and aware of the emotional and psychological qualities of birth. For people are coming to know in their hearts that the *way* in which something is done may be even more important than *what* is done, and they have found that the medical establishment has placed a very low priority on the emotional and spiritual experiences of the people it serves. This has forced couples to find new types of birth attendants, to learn for themselves what has formerly been the sacred domain of the experts, and to come to trust the knowledge of their own bodies, minds and intuitions.

The third key, then, in understanding the new homebirth is the recognition that birth is a spiritual process, one which has lasting psychological and physiological effects. Parents are demanding, from the moment of birth, the recognition that their child is a whole and sensitive person to be treated with care and respect. And although these realizations have so far been consciously formulated only by a minority of parents, the

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[1] Marion Sousa claims, "Fully 98 percent of the people now alive were born at home." *Childbirth at Home* (New York: Bantam, 1977), p. 15.

[2] See pp. 4-7 for documentation.

force of this realization has been so strong that it has already affected changes in many hospitals' procedures and will continue to transform the American way of birth.

Reclaiming Birth: Historical Roots of the Change

The reclaiming of the birth experience by women has been fueled by prepared childbirth classes and ignited by books such as Suzanne Arms' *Immaculate Deception.*[3] It has transformed hospitals, led to the establishment of birth centers, and been the driving force behind the new homebirth. The recognition is emerging everywhere: birth is a joyful and spiritual process with lasting impact on everyone involved. To see how radical this statement really is, we have only to glance at the history of birth in the West.

For centuries birth was not only a painful, but also a dangerous prospect. In the Middle Ages, it is estimated that 60 percent of babies and 35 percent of mothers died in childbirth. The invention of forceps in 1598 began the gradual shift towards safer births, but also resulted in births being turned over to specialists, men who guarded the secret of forceps not only from women but from discovery by other doctors.

Queen Victoria's radical choice of using chloroform at the birth of Prince Leopold in 1853 was the start of overcoming the conviction, here expressed by a minister in 1855, that

> Pain during childbirth is, in the majority of cases, even desirable! . . .Yet there are those bold enough to administer the vapor of ether, even at this critical juncture, forgetting it has been ordered that "in sorrow shall she bring forth."[4]

But the introduction of anesthetics didn't really change the conviction that birth was painful, and it left women even more passive and completely dependent on their obstetrician to deliver their baby.

The discovery by Semmelweis in the mid-nineteenth century that lack of antiseptic technique was responsible for the tremendous death rate in hospitals from "childbed fever" helped to make hospital births safer than they had been (although American hospitals were especially slow in adopting sterile methods, not using them for more than three decades after Semmelweis' discoveries).

By the 1930s, an increasing number of births were being done in hospitals and more and more drugs were being used. In 1935, 37 percent of U.S. births were in hospitals. By 1950 the percentage had risen to 88 percent, and by 1960 it had reached 96 percent.[5] Doctors discouraged homebirths because technicalization of birth and the shortage of civilian doctors during World War II required the equipment and centralization of the hospital environment. Birth had become a technological process, requiring experts to bring the baby out of a mother who was unconscious on the delivery table.

The counterswing to this trend has its roots in Grantly Dick-Read's *Childbirth Without Fear*, published in 1933 in England and in 1945 in America. But it was Marjorie Carmel's *Thank You, Dr. Lamaze* (1956) which first brought a large number of Americans the message that a woman could approach childbirth consciously and with dignity, without depending on drugs.

This was a remarkable shift, allowing women to make such statements as, "I gave birth to Thomas by the psychoprophylactic method called childbirth without pain. When friends say to me, 'Well, did you feel nothing?' I reply, 'Quite the opposite, I felt everything, and that is the wonderful part of it . . . the amazing experience in which each second has remained imprinted on my memory and in which pain has simply found no place.' "[6]

The next major step forward we owe to Dr. Robert Bradley, whose *Husband-Coached Childbirth* made the father an integral part of the birthing team and allowed him not only to be present but also to take an active role in the birth of his child.

But even though prepared childbirth leaves the woman awake and aware, it does so within a framework in which she is still a patient, under the authority of a doctor and subject to the schedules and indignities of hospital routine. The woman has not yet truly been recognized as the central, and hence responsible, person in the act of birth. Lamaze classes in this country, despite all the good they have done, have often become so watered down that neither obstetricians nor women feel that spinal anesthesia is incompatible with prepared childbirth. Although most Lamaze teachers will discuss how to ward off unwanted anesthesia, they ask for a permission slip from the woman's doctor to attend classes, then urge her not to be a martyr and to accept anesthesia if it hurts, rather than dealing squarely with the issues of feeling and experiencing her baby being born, and the effects of anesthesia on the baby.

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[3]For complete information on all books mentioned herein, see the bibliography at the end of the book.

[4]Quoted in Theodore Claufrani, *A Short History of Obstetrics and Gynecology* (Springfield, Ill: Charles Thomas, 1960), p. 293.

[5]Neal Devitt, "The Transition from Home to Hospital Birth in the United States, 1930-1960," *Birth and the Family Journal* 4 (Summer 1977): 47.

[6]Fernand Lamaze, *Painless Childbirth: The Lamaze Method* (New York: Pocket Books, 1972), p. 17.

This compromise with anesthetics (unless necessitated by a *medical* emergency) is a far cry from Dr. Lamaze's injunction:

> Those who still maintain that anesthesia should be used during delivery can never have seen the face of a woman who has herself brought her child into the world. No obstetrician or midwife can forget that face, radiant with joy and full of pride, as the mother sees her child being born.[7]

I will add, sees and feels her baby being born *by her own efforts*, not by forceps, which are usually necessary with regional anesthesia.

And while students of the Bradley Method on the other hand, do succeed in giving birth without drugs in over 90 percent of cases, Dr. Bradley still regards the "little woman" as a little girl who is "nuttier than a fruitcake" during pregnancy[8] and needs to follow her husband's and obstetrician's more rational leads in areas such as routine episiotomy, for example.

NATURE OF THE CHANGE

Thus we see that self-awareness is not yet intrinsically present in prepared childbirth classes in this country. The completely new realization is the recognition by the couple that they themselves are the pivot and focus, the responsible parties and the intentional agents, of the birth process. As such they are seeking help, both inside and outside the medical system, in trying to understand themselves and birth, and they deserve all the respect, knowledge and acknowledgment that can be given them by friends, childbirth educators and birth attendants.

Does this mean they have turned their backs on medicine, technology and medical expertise? No, not at all. Couples involved with homebirth today are seeking to be informed, to make responsible decisions, and to have a skilled birth attendant present who is willing to work with them. They are seeking and demanding quality prenatal care, and if doctors are refusing them because of their plans to have a home delivery, they are forming their own self-help prenatal clinics or starting birth centers. People are coming to trust their bodies and their own ability to learn and make informed decisions. They are coming to feel that medical technology should be reserved for those cases in which it is required (i.e., high-risk pregnancies, which can be detected through prenatal care, and unforeseen complications, which occur in five to ten percent of prepared homebirths).

However, as is the case with all revolutions in consciousness, the people are changing faster than the institutions, and there are more couples involved with the new homebirth than there are medical people prepared to help them. Couples are searching for skilled birth attendants who not only regard birth as a normal physiological process, but who also encourage couples to share in decision-making rather than being "patients." Since so few doctors are either trained in normal birth[9] or willing to enter into this new relationship with women, couples are turning to midwives as the "guardians of normal birth" and asking that doctors fulfill their role of medical experts by providing backup in the small percentage of births requiring medical intervention.

Although they are not turning their backs on technology, parents involved with the new homebirth have realized what doctors in Holland have always known: that birth is a natural human function, which in general works best if not meddled with (see Kloosterman's discussion, p. 5). Recently the evidence has been multiplying that the technological approach to birth not only robs a woman of a unique experience, but that it also has many health disadvantages. Just as people are coming to know that a blind devotion to industrial technology which does not recognize the integrity of the earth may become lethal, so we are coming to know that an overly medical approach to health has *iatrogenic*, or self-induced, counter-productive results.[10] The new homebirth is an ecology of the body and an expansion of the spirit.

In summary, the driving force behind the new homebirth is the realization that, in order to be fully alive, it is necessary for us to participate actively in what we do, to bring our consciousness, feelings, sense of responsibility and decision-making ability to bear as fully as possible in every action of our daily lives, and especially in an event as momentous as birth.

THE ADVANTAGES OF HOMEBIRTH

You don't have to have your baby at home to participate in this new consciousness. Some women or couples may choose to deliver in a birth center or hospital, either because of risk factors or because they feel more comfortable in an environment where many factors are predetermined and emergency equipment is close at

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[7] *Ibid.*, p. 173.

[8] Robert Bradley, *Husband-Coached Childbirth* (New York: Harper & Row, 1974), p. 117.

[9] Many doctors who have become involved with homebirth have attended homebirths with midwives and learned from them the confidence and techniques of normal birth, which are sadly lacking in the curricula of medical schools and missing from the wards of teaching hospitals.

[10] For a discussion of iatrogenesis, see Ivan Illich's *Medical Nemesis: The Expropriation of Health* (New York: Pantheon, 1976).

hand. Wherever you give birth, I urge you to explore what it means to take responsibility and to be an informed medical "consumer" (or, better yet, "determiner").

I certainly do not advocate homebirth for everyone. Rather, I recommend that you give birth in the place where you feel best. But to help balance the scales against the counter-arguments that are so common, I would like to enumerate some of the advantages of giving birth at home.

SELF-DETERMINISM

In the comfort of your own home, you are not reduced to the status of a patient. You are in charge. You can do what you want in the way you want. Everyone is present at your request, including birth attendants, who are more likely to view birth as a normal process and share knowledge and decision-making with you.

STRENGTHENING OF THE FAMILY

The father can take an active role in the birth, rather than being "allowed" to be present in the delivery room. You can share in the intimacy of labor and birth without being interrupted by changing shifts of nurses or interns coming in to do exams. Some midwives will even help the father catch the baby as the mother delivers her to the outside world. If you choose, your other children can share in the birth and immediately bond with the baby, and no one has to be separated after the birth. The birth is an integrated part of your lives.

NO UNNECESSARY MEDICAL INTERVENTION

You can avoid the dangers and discomfort of routine spinal anesthesia and accompanying forceps, routine electronic fetal monitoring, use of pitocin or relaxants, and routine episiotomy. You do not require a pubic shave, routine enema or IV drip. You don't need to interrupt your rhythms by going from home to hospital or from labor bed to delivery room. You and your labor are granted much more individuality at home. In short, your baby is born without medical procedures which can be valuable in high-risk cases but which, when used on the normal mother and baby, can actually jeopardize the health of both.

CHOICE OF POSITION FOR LABOR AND BIRTH

Delivering on a narrow table with your legs strapped into stirrups (in the hospital in Los Angeles where I taught Lamaze classes they still strapped your wrists down as well) is not only uncomfortable and degrading but is also the worst position for your perineal muscles and almost necessitates an episiotomy (cutting of the birth canal) to avoid tearing. Delivering in a more relaxed position at home with a skilled birth attendant, you almost never need an episiotomy (standard in 95 percent of hospital births) and you rarely tear. You can also be on your hands and knees or relax in the bathtub during labor if they help you feel comfortable, and squatting can often overcome lack of progress without the need for drugs or forceps.

ADVANTAGES FOR BABY

The baby is born without being drugged and dragged out by forceps. He or she is welcomed into a loving environment where the trauma of birth is eased by soft lights, gentle touch and reassurance. Immediately after the birth your baby can nurse and can bond with you both instead of being whisked off to be bathed, weighed, banded, footprinted, and so forth. Your baby is treated as an individual, and his or her uniqueness is clearly recognized and honored.

There is less chance of infection at home than in a hospital nursery, and your baby's every need is instantly satisfied when she or he is with you rather than being one of many under a nurse's care. Breastfeeding on demand helps your milk come in and prevents some common problems of nursing. It also results in a happier and more secure baby who doesn't experience separation, or having to wait for what must seem like eternity when she or he is hungry or in pain or lonely.

FOCUS ON QUALITY

You have the total attention of your birth attendant, rather than thirty minutes of your obstetrician's time and occasional help from nurses. Because your birth is the only thing happening in your home, the total focus of attention and energy of everyone present can be directed towards creating the emotional qualities you want. You are surrounded and assisted by people who love you, not by strangers. If you are more comfortable and more relaxed at home, your labor will go better.

The emotional, spiritual and transforming qualities are not something we have to add to birth—they are inherent in the nature and magnitude of this holy event. If we open to these qualities, we cannot help being transformed.

BUT IS HOMEBIRTH SAFE?

A common misconception, fostered by well-meaning medical professionals, is that homebirth poses grave risks and dangers, while hospitals, with their immense

arsenal of equipment and emergency procedures, provide the safest birth money can buy. So strongly do they feel this that several state medical associations have been contemplating revoking licenses of physicians who participate in out-of-hospital births, and some hospitals revoke hospital privileges to any on their staff who even offer assistance to homebirth couples.

However, as the homebirth movement matures and more studies are completed on maternal and infant outcome, the results demonstrate that prepared homebirths (with prenatal care and a skilled birth attendant) not only have a mortality rate as good as or better than hospital births, but have a much *better* record in terms of complications and damage to the baby.

How can this be true? How can it be that all the tools of modern medicine don't improve on the simplicity of a homebirth?

Every farmer and veterinarian knows that interfering with an animal in labor will cause problems in the birth, but our medical system does not apply the wisdom of this benign non-interference to humans. Rather, it is moving towards ever-greater use of dangerous medical and surgical procedures (which may be helpful in high-risk situations) on what should be normal mothers and babies.

For example, the cesarean rate in U.S. hospitals ranges from 10 percent to nearly 50 percent, while the rate at The Farm in Tennessee, where prenatal care and delivery are done at home by "empirical" midwives, is only 1.2 percent. And in considering other populations as a whole, we find the cesarean ratio to be between two and five percent in Holland and England. There is abundant evidence of the damage and dangers inherent in cesarean sections, including risks of anesthesia, higher risk of pelvic infection, and risk of complications for the baby.[11] But rather than working to reduce the cesarean rate, the medical profession is encouraging c-sections by adopting routine use of electronic fetal monitoring.

The electronic fetal monitor (EFM) is perhaps the outstanding current example of needless and harmful meddling in normal labor. It requires that the mother lie flat on her back and involves premature artificial rupture of the amniotic sac and insertion of an electrode puncturing the baby's scalp. Studies such as that of Haverkamp[12] have shown that the use of EFM triples the cesarean rate *while not providing a single area of improved outcome.*

The unfortunate dehumanization and mechanization of birth by American hospitals is thoroughly discussed by Doris Haire in *The Cultural Warping of Childbirth* and Suzanne Arms in *Immaculate Deception.* I will cite only one other example, the use of forceps in up to 65 percent of American hospital births. The incredibly high forceps rate in this country is necessitated by the lithotomy position for delivery, the use of regional anesthesia, and by the belief (not shared in other countries) that forceps have no deleterious effect on the baby.

The application of forceps and other procedures is being done with such vigor in an effort to improve maternal and infant outcome, and yet that doesn't happen—as evidenced by the fact that there are fifteen countries which have better infant mortality rates than the United States.

In The Netherlands, which has the third lowest rate in infant mortality,[13] about two-thirds of all babies are born at home with trained midwives usually doing the deliveries. Transfers to the hospital occur at a rate of less than 2 percent for multiparas and about 8 percent for primaparas (mothers with first babies). Holland's cesarean rate is only 2.3 percent, and forceps are used only in about 3 percent of the births.[14]

OBSTETRICS IN HOLLAND

Dr. G. J. Kloosterman, chief of obstetrics and gynecology at Amsterdam University, describes the philosophy upon which Dutch obstetrics is so successfully based:

> (1) Childbirth in itself, even in human beings, is a natural phenomenon that in the large majority of all cases needs no interference whatsoever, only close observation, moral support and protection against human meddlesomeness.
>
> (2) A healthy woman who delivers spontaneously performs in the large majority of all cases a job that cannot be improved.
>
> (3) This job can be done in the best way if the woman is self-confident and stays in a surrounding where she is the real center (as for example, in her own home).

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[11] A recent study by two Brown University researchers in Rhode Island has shown that the risk of maternal death is twenty-six times greater with a cesarean birth than it is for women who deliver vaginally. This was found in an eleven-year study of maternal death in cesarean sections by Dr. John R. Evrard and Dr. Edwin M. Gold and reported in the journal of *Obstetrics and Gynecology.* The percentage of cesarean births doubled in Rhode Island between 1965 and 1975, which is similar to the pattern nationally. Reported in *NAPSAC News*, Vol. 3, No. 3, Summer 1978, p. 19.

[12] Haverkamp's study and other data on EFM from Dr. Frederic Ettner, "Hospital Obstetrics: Do the Benefits Outweigh the Risks?" in *21st Century Obstetrics Now!* (Chapel Hill, N.C., NAPSAC, 1977), pp. 147-62. His list of complications induced by EFM includes scalp abscesses and cellulitis, infection, fear and pain in the mother, and fetal distress.

[13] Infant mortality figures for 1972 from the United Nations Office of Statistics.

[14] "Obstetrics in the Netherlands: A Survival or a Challenge?" address by G. J. Kloosterman, M.D., before the Mens Tunbridge Wells Meeting, 1975.

(4) It is possible during pregnancy, by thorough prenatal care, to divide the expectant mothers into two groups: a large one that shows no recognizable symptoms of pathology (the so-called low-risk group) and a much smaller one in which there are signs of slight or gross abnormalities.

(5) Only this last group, the group at risk, belongs in a highly qualified hospital under the care of specialists.[15]

The country with the lowest infant mortality rate, Sweden, has almost all births occurring in the hospital, so it obviously not the location *per se* that is at issue. Rather, it is the attitudes, procedures and approach toward birth that determine outcome and cause problems and dissatisfaction with hospital birth. (It must be noted that in Sweden, all normal births use the Lamaze techniques with no anesthesia and are attended by midwives in the hospital).

Until the training and orientation of American doctors undergoes a profound shift in these areas, any attempt to humanize the hospitals by adding flowered wallpaper and an easy chair, while still welcome, will remain only superficial and fail to address the real issues. Hospital procedures can be life-saving when needed, but their routine application to low-risk births can be detrimental to the health of both mother and baby, as well as being emotionally unsatisfying for the mother and other members of the family.

Homebirth Safety in the United States

As already mentioned, the percentage of U.S. births taking place in hospitals rose from 37 percent to 96 percent between 1935 and 1960. Since outcomes improved considerably during this period as well, doctors often point to this as an indication of the effectiveness of their approach. In fact, however, homebirths were becoming safer during this period as well. A recent analysis of the studies done between 1930 and 1960 shows that even then the incidence of birth injuries and obstetric mortality was greater in hospitals than in homebirths—despite the poverty, ill health and frequent high-risk conditions of the women who delivered at home.[16]

For example, the Chicago Maternity Center delivered more than 12,000 babies at home without a single maternal death (despite the fact that fully 60 percent or more of home deliveries in poverty areas are high-risk births); at the same time the maternal death rate in hospitals was 2 per 1,000.

Despite all the brouhaha raised by the medical profession over techniques of labor and delivery, by far the most important factors in determining birth outcome are nutrition, prenatal care and preparation (like prepared childbirth classes). In fact, 66 percent of our perinatal mortality is due to low birth weight, and although medical science has improved in keeping premature and low birth weight babies alive, Devitt states that 75 percent of the recent reduction in neonatal mortality is due to the reduction in the rate of low birth weight, *not to changes in obstetrical care*.[17]

HOMEBIRTH VS. HOSPITAL BIRTH: THE MEHL STUDY

The largest scientific study comparing outcomes of homebirth with hospital birth is Dr. Lewis Mehl and associates' "Home Birth Versus Hospital Birth: Comparisons of Outcomes of Matched Populations."[18] In the study, 1046 homebirths were compared with 1046 hospital births of equivalent populations in the U.S. For each home-delivered patient, a hospital-delivered patient was matched for age, length of gestation, parity, risk factor score, education and socio-economic status, race, presentation of the baby and individual major risk factors. The homebirth population had trained attendants and prenatal care.

Their study shows a three times greater likelihood of cesarean operation if couples gave birth in a hospital instead of at home with the hospital standing by. The data from their hospital population revealed twenty times more forceps, twice as much use of oxytocin to accelerate or induce labor, greater use of analgesia and anesthesia, and nine times greater incidence of episiotomy (while at the same time having more severe tears in need of major repair). The hospital sample showed six times more infant distress in labor, five times more cases of maternal high blood pressure, and three times greater incidence of postpartum hemorrhage. There was four times more infection among the newborn; three times more babies needed help to begin breathing. While the hospital sample had thirty cases of birth injuries, including skull fractures, facial nerve palsies, brachial nerve injuries and severe cephalohematomas, there were no such injuries at home.

The infant death rate of their study was low in both cases and essentially the same. There were no maternal deaths for either home or hospital. The main differences were in the significant improvement of the mother's and baby's health if the couple planned a homebirth, and this was true despite the fact that the homebirth statis-

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[15] Ibid.

[16] Neal Devitt, op. cit., pp. 47-58.

[17] Neal Devitt, op. cit., p. 51.

[18] Presented on October 20, 1976 before the 104th annual meeting of the American Public Health Association. For further information, contact the Institute for Childbirth and Family Research, 2522 Dana St., Suite 201, Berkeley, CA 94704.

tics of their study included those couples who began labor at home but ultimately needed to be transferred to the hospital.

STATISTICS FROM THE FARM, SUMMERTOWN, TENNESSEE

Perhaps the best example of a self-contained system of prepared homebirth within the United States is provided by The Farm, an intentional spiritual community founded and led by Stephen Gaskin. Beginning with his wife, Ina May Gaskin, The Farm gradually evolved a group of self-trained or "empirical" midwives. They have recently published their statistics for the 722 births managed by The Farm midwives between October 1970 and August 1977. These statistics include twenty-eight deliveries the midwives considered high-risk and which delivered at a nearby hospital.

Of the 722 births, 44 percent were babies of first-time mothers (primipara). Of all the births, 94 percent were delivered at home by the midwives; there were only nine cesarean sections (1.2 percent) and two forceps births (0.3 percent). The largest baby they delivered weighed 11 lbs. 4 oz., and the smallest living baby, 2 lbs. 10½ oz. They have never had a mother die, and their total number of perinatal deaths (babies dying between 28 weeks gestation through 28 days after birth) was fifteen, a rate of 20.8/1000, which compares favorably to hospitals.

Of their nineteen breech births (buttocks first), eleven were first-time mothers and none required a cesarean. The most recent nine were all done at home or in The Farm Maternity Center. All of the breeches (except one of the first ones) were done without anesthesia, and thirteen of the nineteen were done with no episiotomy. This is in dramatic contrast to hospital practice, which in most hospitals results in a nearly-automatic c-section for breech births, with anesthesia and forceps for those who do delivery vaginally.

The Farm attributes some of their outstanding statistics to their vegetarian diet and healthy lifestyle. In birth they focus on the psychological and spiritual aspects and on having strong husband-wife and mother-midwife relationships.[10]

YOUR OWN BIRTH DECISION

We have just discussed birth statistics at some length. But when you have your baby, you are not a statistic. No one can say with absolute certainty that because most cases like yours have gone well, yours will; or, conversely, that just because your case is "high-risk" it will have problems. Since there are no guarantees in birth, your individual situation will be governed by your actions and decisions during pregnancy and at the time of birth and by forces coming together in that particular moment, not by national averages.

It is never possible to eliminate all risk from giving birth or from being alive. But it is up to you, the pregnant woman, to inform yourself, weigh the risks, and make a responsible decision based on minimizing risk and maximizing satisfaction for you and your family. This book is intended to help you to focus your ideas and come to a decision that best expresses your real feelings and attitudes.

Whatever your choice, studying the process of birth will be invaluable for you. Even if you prefer a homebirth but end up with a hospital delivery, your having informed yourself will ensure a hospital experience quite different from that of someone who has abnegated responsibility for the birth process.

This book is designed as a practical guide for pregnancy and homebirth. At the end of most chapters is a list of other books which explore in detail the issues involved in making the homebirth decision, give personal accounts of home deliveries, and so forth. Read! Confidence based on knowledge and certainty is one of the keys to a satisfying homebirth experience.

Talk with other couples. If there are homebirth classes in your area, be sure to attend them; no book can replace the first-hand information and emotional support they provide. Chapter 4 lists the national organizations providing such classes. If there are no classes specifically geared for homebirth couples in your area, start a homebirth study group. You'll be amazed at the number of interested people you will find. Informed Homebirth offers posters and suggestions for forming such a group based on its homebirth course, which is available on cassette tapes.

Above all, communicate with each other as a couple. If your partner is apprehensive about homebirth, really listening to his fears, discussing birth, reading and talking with other people will often help him to see things differently. After all, men in our culture are given very little support for being in touch with their bodies, and practically no information or feeling for their relationship to the normal birth process.

If, on the other hand, it is the man who is pushing for a home delivery, he should recognize that the ultimate decision needs to be his wife's. My experience has been that if a woman wants to give birth in a hospital, she will probably end up there one way or another. It is important for a homebirth that the couple be in agreement about what they are doing and have a high level of intention and responsibility.

[10] For more information see Ina May Gaskin, *Spiritual Midwifery* (Summertown, TN: The Book Publishing Company, 1978), pp. 474-5.

Once you have made your decision to have a homebirth, there is still a great deal to do. Later chapters in this book discuss the issues of finding prenatal care, finding a midwife and preparing an emergency backup plan. The sooner these activities get underway, the better, especially if you live in an area without much support for homebirth.

Because we have all been culturally conditioned with so many irrational attitudes about birth, you may well encounter opposition to your plans at some point, whether from friends, family, doctors, or other members of the medical community whom you approach for health care. It is best not to argue with people if it fosters upset. Instead, focus your attention on building a community of support to help your intention strengthen and grow; you are not alone in your knowledge and convictions. If you encounter people who are worried but truly open-minded, recommend that they read some of the books on the subject.

We are living in a time of rapid change in our culture's attitudes about birth. You are part of that change. Our right to give birth as we choose is a right well worth reclaiming.

FOR FURTHER READING

Childbirth at Home by Marion Sousa. Provides a detailed discussion of the American way of birth and the advantages of homebirth. Afterword by Dr. Lewis Mehl on the management of complications in Santa Cruz home deliveries. Excellent for people considering the idea of homebirth.

Commonsense Childbirth by Lester Hazell. Presents birth as a natural, dignified, creative experience in which the mother has many choices; includes sections on homebirth and unexpected outcome.

The Cultural Warping of Childbirth by Doris Haire. A booklet detailing how American hospital practices have distorted the process of giving birth, with recommendations for change.

The Home Birth Book by Charlotte and Fred Ward. Essays by various contributors on the advantages of homebirth and why people from all lifestyles are choosing it. Beautiful photographic work. Excellent to give to relatives and friends.

Immaculate Deception by Suzanne Arms. An in-depth presentation of the way in which American hospital practices are robbing women of their birth experience; contrasts with birth in European countries.

Living-In: A History of Childbirth in America by Richard and Dorothy Wertz. A fascinating study of childbirth practices from colonial times to the present.

Safe Alternatives in Childbirth, David and Lee Stewart, eds. Proceedings from the first annual conference of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC).

Spiritual Midwifery by Ina May Gaskin. One of my favorite books, describing births as managed by midwives on The Farm in Tennessee ("Amazing Birth Tales," advice to parents, section for midwives). Although the active role of their midwives works well within a community of agreement and everyone gets high, if a male doctor came into one's home and did some of the same things, it would feel like gross interference and lack of respect. My own preference is for some of the insights of The Farm combined with the parents' maintaining an active role (see "The Birth of Phoebe Rose" after Chapter 8).

21st Century Obstetrics Now! David and Lee Stewart, eds. Proceedings from the 1977 NAPSAC conference; 2 volumes.

Table One
Infant Mortality Rates*

Country	1977	1978
1. Sweden	8.0†	7.7†
2. Japan	8.9	
3. Denmark	8.9†	8.9†
4. Finland	9.1	
5. Norway	9.2	
6. Netherlands	9.5	9.5†
7. Switzerland	9.8	
8. France	11.4	10.6†
9. Belgium	11.9†	11.7†
10. Singapore	12.4	12.6
11. Canada	12.4	
12. Australia	12.5	
13. German Democratic Republic	13.1†	13.2†
14. Hong Kong	13.5	11.6†
15. England and Wales	13.7†	13.1†
16. United States	14.1	13.6†
17. New Zealand	14.2	
18. German Federal Republic	15.5	14.7†
19. Spain	15.6	15.1†
20. Ireland	15.7†	
21. Austria	16.9†	14.9†
22. Italy	17.6†	16.0†
23. Israel	17.8	15.1†
24. Czechoslovakia	19.6†	18.7†
25. Greece	20.3†	18.8†

* Lowest 25 countries with population of 2,000,000 or more. Rates per 1,000 live births. United Nations data. Reprinted from Wegman, M.E., *Annual Summary of Vital Statistics*, J.Pediat., 64:6, Dec. 1979.
† Provisional; 1978 figure from France excludes live-born infants dying before registration of birth.
‡ For a discussion of the definitions and ambiguities of statistics such as those given above, see Appendix C of this book.

the United States. [4,5,88] The characteristic features of American maternity care since 1940 have been doctors and hospitals. The characteristic features of Dutch maternity care have been midwives and home birth.

American physicians point out, in defense of their hospitals, that throughout this century birth related mortalities have fallen dramatically around the world with the increased hospitalization of birth. They conclude that there

is a causal relationship between th
ments and hospital care. They ignor
factors, independent of hospitals,
provements much more satisfacto
statistical study has confirmed the
should be credited with the perinat
century. Kloosterman and Gasthui
Holland, commented that if one w
during the past decades the impr
outcomes are due to increased hosp
two seem to parallel, one could just
improvements to global inflation
inflation rates also seem to parallel
ment in perinatal outcome.[164]

If the better outcomes of the wo
due to higher rates of hospitalizati
with the most hospitals should be
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at the top. Sweden used to have a
birth system based upon midwifery.
midwives, but since the middle 19
nearly 100% hospital births. At th
worst countries in Table One also hav
births. Furthermore, Holland, which
sixth place had 42% home births in
(1977). Hence, the practice of total
birth does not statistically correlate w
outcomes. There is simply no such co
data. It should be noted here, in con
countries such as the U.S. (with a
Holland (with what has traditionally
while both countries have enjoyed
pregnancy outcome over the past seve
of improvement have been much great

By comparing regions within the sa
period of transition from home to ho
further insight into the relative safet
the home. If high rates of hospitaliza

HB11

March 18, 1981

Senator Charles Parr, Chairman
Senate Health, Education and Social Services Committee
Pouch V
Juneau, Alaska 99801

Dear Senator Parr:

I have just, tonight, learned of Alaska Senate Bill 237, submitted to the Senate Health, Education and Social Services Committee on March 4. Tomorrow I will contact Wally Richardson of our Legislative Affairs Office and request a copy of the bill in its entirety. I am requesting, in this letter, that a local teleconference be held on this bill that I might testify rather than a public hearing in Juneau which would be impossible for me to attend. I will follow-up on this request by contacting Wally Richardson and ask that I be notified well in advance of the teleconference date. If there is something further I can do to stress my position, I ask you to advise me. I realize an individual has little hope of an effective stand when the opposition is the powerful Alaska State Medical Association, but I am hoping that members of the Senate Health, Education and Social Services Committee will not make a decision without accurate statistics and information, nationally and internationally, on the many safe alternatives in childbirth and that each of you is fully acquainted with the many controversies in modern obstetrics. I hope the committee will not simply bow to the authority of the Alaska State Medical Association without considering that it is a union as much as a professional organization and financial gain is as much a factor in their position on this bill as the interest of maternal and child health.

I am opposed to SB237. I understand this bill will allow the State Medical Board to authorize who shall assist at childbirths. I would not be averse to this if the State Medical Board were moving in the direction of expanding safe alternatives in childbirth through the certification of lay midwives, with criterion to be met determined by skilled midwives rather than obstetrical surgeons, but I have no doubt the intent of this bill is to restrict rather than expand safe birthing options for the people of Alaska.

I am 32 years old, an education administrator and the mother of an eleven-month-old daughter. My master's degree is in education of the severely and profoundly retarded, with particular interest in the multiply handicapped. I am quite familiar with the many events which may occur during pregnancy, childbirth and the neonatal period which can damage the body and mind of an infant.

I approached pregnancy as I would any new experience in my life, by educating myself as completely as possible to be sure I made the best decision for my baby, my husband and myself. In the three years prior to my pregnancy and the subsequent nine months, I read countless texts and articles on pregnancy and childbirth. I talked with several doctors, nurses, midwives and parents and went through the standard hospital prepared childbirth course. I feel I am as competent as anyone on your committee to know what constitutes a safe alternative in childbirth.

I spent the first several months of my pregnancy trying to find a doctor who was not patronizing, but truly believed a normal, healthy birth is the rule and not the exception; one who believed it the woman's responsibility to prepare her body and

mind for the experience and believed in her ability to do so; one whose ego would allow him or her to "attend" a birth, yet maintain control over the desire to medicate, monitor and otherwise intervene unless it was medically necessary. I know such physicians exist, but I did not find one. In the seventh month of my pregnancy, following-up on a number of names I had encountered, I found a lay midwife with whom, after one afternoon's meeting, I knew I had found the person to attend the birth of my child.

After thoroughly educating myself, working hard to maintain a healthy, complication-free pregnancy, selecting a skilled birth attendant and preparing for emergency back-up, I chose a homebirth with a lay midwife. I do not, in any way, feel my choice was irresponsible; on the contrary, I did more research and gave more thought to this decision than most women give to a hospital birth. From all I have learned, I also believe my healthy and normal delivery would have been at greater risk had I subjected myself and my child to a "normal hospital birth". Most medical personnel would say my choice was foolish. One doctor told me it was "stupid to even consider a homebirth", yet statistics prove the opposite: a well-planned, well-screened homebirth, attended by a skilled midwife with arrangements for good emergency back-up is as safe as any hospital birth with the added benefits to homebirth of shorter labor, less complications and the opportunity for immediate family bonding with its long-term psychological advantages. From a very personal standpoint, it provides a feeling of such great joy and accomplishment, I cannot possibly describe it well enough and can only feel terrible sadness and a sense of loss for those who recall only an unpleasant birth experience.

What SB237 is really about is not safer births because statistics do not support physician-supervised births as being necessarily safer; rather, this bill is really about money.

The birth of my daughter cost $350. Had I elected a routine hospital birth in Anchorage, the bill would have been $2,000 to $3,000 and would likely have included IV's, amniotomy, fetal monitors, episiotomy, labor room charges, delivery room charges, newborn nursery charges, an unnecessarily long hospital stay and perhaps, if I really went first class, a C-section -- they seem to be excessively popular these days. It is certainly to the doctor's economic benefit to have all births required, by law, to fall under his or her supervision. This is, I believe, the basis of the Alaska State Medical Association's request to the State Medical Board and to the Governor for the passing of SB237, and does, by virtue of the obvious financial gain to be had, present a question regarding the objectivity and sincerity of the request. I, on the other hand, experienced no financial gain through my deliberate and well-planned choice of a lay midwife, and my desire to see safe alternatives expand is based entirely on what I have learned about current obstetrical trends and what I believe to be good physiological and psychological health care and basic common sense. Had I delivered under a physician's supervision, regardless of the cost, my insurance company would have covered the birth. Because I elected an alternative other than the AMA approved method of giving birth, the insurance company denied my claim stating it did not coincide with their list of "reasonable, necessary and customary" maternity services. I am well aware of how the medical community manipulates private medical coverage -- will it now manipulate and dictate to the State of Alaska how and under what circumstances a woman may give birth?

The intent of my letter is not to encourage homebirth, lay midwifery, or any particular birthing alternative. I refer to these approaches because it was what I chose, as it was my right to choose, and that, Senator Parr, is the point of this correspondence, to stress the right of the individual to choose from a wide spectrum of safe

alternatives. Highly sophisticated modern obstetrical care must continue to be available for it sometimes becomes very necessary, but necessary, too, is the availability of the family doctor, the certified nurse midwife and the certified lay midwife, for somewhere in this range is the skill and philosophy which meets the needs of each family.

I am enclosing several recent, brief and informally written articles from a variety of sources which support points on which I have generalized. I would also like to recommend the following books as essential. They provide an in-depth statistical look at childbirth in this country and how we compare with other countries, as well as a good review of obstetrical history in the United States and a discussion on current controversies. Perhaps the committee is already familiar with this literature. If not, and if these titles are unavailable to you, I will send my own copies of those I presently have at hand, if you request.

Benefits and Hazards of the New Obstetrics, Tim Chard and Martin Richards

Lying-In: A History of Childbirth in America, Richard and Dorothy Wertz

The Cultural Warping of Childbirth, Doris B. Haire

Immaculate Deception: A New Look at Women and Childbirth in America, Suzanne Arms

To attend a birth is a privilege, not a right to be determined by Alaska State Law; rather, an honor which should only be granted by the birthing parents, the ones who, let us not forget, must also pay for the service. Please acknowledge the individual intelligence and right of Alaskan families to plan their own birth experience; defeat Senate Bill 237. Help us expand safe alternatives in childbirth, not restrict them.

This has been a lengthy letter. Thank you for your time and patience. I can provide much more information if you feel it would be useful. You need only ask.

Sincerely,

Julie Gorham
Box 1037
Bethel, Alaska 99559

Enclosures: Five articles

cc: Representative Tony Vaska
Senator George Hohman

HB11

MSG 81-00009590 PRTY 1 03/24/81 16:57:14 ORIG: LA00 IN= 0016 OUT= 0068
FROM LOU TO: JNU INFO
TARGET: LJH2 SUBJ: POM PAGE 0003

SB237

TO: ALL LEGISLATORS

FROM: JANET BALICE, 2156 ALDER STREET, ANC.99504 279-5803

I'M OPPOSED TO SB-327 BECAUSE IT RESTRICTS A WOMAN FROM GIVING BIRTH WITH ANY QUALIFIED BIRTH ATTENDENT OF HER CHOICE. I FEEL LICENSING OF BIRTH ATTENDENTS WHO ARE NOT PHYSICIANS, SUCH AS MIDWIFES IS NEEDED. BUT THIS BILL WOULD ONLY OUTLAW THEM AND RESTRICT HUMAN RIGHTS.

HB11
NA

PUBLIC OPINION MESSAGE

To: All legislators

From: The Alaska Women's Resource Center
204 E. 5th suite 224
Anchorage, Alaska 99501

Concerning S.B. 237 (The Medical Practice Act)

*** *** *** *** *** *** ***

The Alaska Women's Resource Center is against the revision that would limit to physicians only the right to attend or assist at childbirth. We believe it is the parents right to choose who assists at the birth of their children. This provision is unrealistic and impractical in rural Alaska.

Please send immediately.

Thank you,
Eileen Smith Levinson
AWRC Education Specialist

Legislative Affairs Office
1024 W. 6th Ave.
Anchorage, Ak. 99501

Attn: Public Opinion Message

International
Association of
Parents & Professionals for
Safe
Alternatives in
Childbirth

NAPSAC

Post Office Box 267, Marble Hill, MO 63764
Telephone: (314) 238-2010

April 12, 1981

Representative Brian Rogers
Pouch V
Juneau, Alaska 99811

Dear Representative Rogers:

Thank you for your letter and check for $24 for two copies of the book, THE FIVE STANDARDS FOR SAFE CHILDBEARING. When I had last talked with your secretary, whose name I believe is "Ginger," she had said to send up one copy right away and a check for $12 would be sent at the same time. Hence, one copy of the book has already been sent. Enclosed is your second copy.

As for licensing in general, NAPSAC's idea on this is contained in the book, COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH, Chapter 34, pp. 399-450, entitled, "Midwifery Licensing: Problems, Pitfalls, and Alternatives to Licensing," by Allen Solares. Instead of mandatory licensing for all health professionals in order for them to practice, freedom to practice is given to everyone--but what is mandatory is disclosure to the public of one's education, experience, practice policies, and results. Hence, a doctor or midwife can practice with or without certification, but must, by law, reveal their status to all. Every doctor or midwife must compile and make available to everyone--clients and the public alike, their results--perinatal mortalities, fetal deaths, cesarean rates, hemorrhage rates, etc. If parents have knowledge of a practitioners education, extent of experience, practice policies and statistical outcomes--then, and only then, do they have a rational basis for choice. To choose on the basis of whether or not a practitioner has a mandatory state administered liscense is not very useful information. Most of the most dangerous birth attendants in practice today are liscensed medical doctors and many of the safest birth attendants are unlicensed lay midwives functioning outside the law. You and your aides should read this chapter.

As for my availability to testify, I would be pleased to do so and have some experience in more than several states in this regard. My expenses must be fully provided and although I charge no consultant's fee, as such, since I receive a salary from NAPSAC, I do ask for $100 per day to be made payable to NAPSAC. This would be for total days absent from headquarters here--including travel time. This helps compensate NAPSAC for my absence and also helps maintain NAPSAC in its continued efforts to provide resources in this field for everyone, such as your office, to use.

Please let me know how things come out with your efforts. It was a pleasure talking with you via the phone and I was impressed with your understanding of the issues at stake.

Sincerely, David Stewart, PhD, Executive Director David Stewart

over

Women and Children's Health Associates

Box 2101 Palmer, Alaska 99645

Wasilla Phone: (907) 376-3237 Palmer Phone: (907) 745-4711

OBSTETRICS / GYNECOLOGY PEDIATRICS PREVENTIVE MEDICINE

March 19, 1981

Representative Brian Rogers
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Rogers:

Thank you for your letter of February 4, 1981; I was out of town and have only recently returned to read through it.

I have reviewed your letter carefully and have once again gone over Senate Bill #4. I do appreciate that the purpose of the Bill was to make a little more liberal the insurance problems related to delivery in this State. This I can accept. However, there are still certain points within the proposed Bill which I think need extremely careful evaluation:

1. I do believe most firmly that advanced nurse practitioners certified to practice as nurse midwives must do so under the supervision of a licensed medical doctor in this State. No doubt you are aware of the problems which the State of California has had in home deliveries of babies by midwives. I believe a proposed Bill in California which would have allowed home delivery of babies by midwives was killed. I certainly think that untrained persons should not be given legal sanction to provide this type of health care and I do not see this in the proposed Bill as stated.

2. Why was the definition "provider" placed instead of physician? If medical care is to remain reasonably scientific, I believe it must remain within the hands of licensed medical doctors. I certainly see no reason to substitute the word "providers" for physicians in Senate Bill 4. I believe this does nothing but to water down the Bill and make possible interpretations of provision of medical care by other than licensed medical doctors.

3. An even greater serious problem is indicated in the definition of "provider" which I read on Page 5 of the Bill as meaning a "physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner". If I read the Bill correctly, this would mean that a certified nurse midwife (who might otherwise be very qualified and trained) could and would work under the direct supervision of an optometrist or a

chiropractor in provision of deliveries. If we are to continue to provide any modicum of quality in health care, I certainly do not believe that a chiropractor or an optometrist can take on a certified nurse midwife and allow that person to provide deliveries.

In my own practice, I have cared for a number of women who were planning to have a home delivery by an alleged midwife. These women came to a "real doctor" just for a final check-up prior to their home delivery. In evaluating these women, it became obvious that a number of them have extremely high risk problems, such as pre-eclampsia, severe anemia, gross obesity, prenatal history which is not conducive to a normal delivery, and estimated due dates which were not consistent with either physical exam or menstrual dates. Certainly to sanction the home delivery of these women is, in my judgement, a genuine step back in obstetric care in this State. Most of these women had no real idea about the competence or training of their "midwife".

I believe that until a person can substantiate that he is qualified to do deliveries inside or outside the hospital, that person should not do deliveries. I can assure you that we have problems enough within the hospital for those last-minute disasters which are completely unknown until the point of delivery.

My own feelings about the present surge of home births is that we ought to be making every available accessability and convenience for parents to have their deliveries within hospitals. If I thought a home delivery could be carried out with safety, I would be doing them. I believe that most of the people doing home deliveries are doing them very uninformed. It has also been my experience in my office practice that when I discuss with a woman who plans a home delivery, she will elect a hospital delivery when she understands her risks.

No woman would deliberately choose to have an unsafe delivery. Those who choose a home birth, in my experience, are not sufficiently informed to make that kind of a decision. Those who do when they have been fully informed of all the risks and benefits and hazards often do so for religious or financial reasons.

To your question of what I think we can do to encourage patients to voluntarily choose the best health care for the birthing process, I would simply state that the medical profession must be in a position to provide more information to parents. We must liberalize our birthing policies within hospitals and we must develop better family oriented birthing centers. Most of this can be done within the constraints of already existing hospital environments as we have done at Valley Hospital.

I can only say to you that the statistics I understand indicate that 90% of the time a baby could be born almost anywhere and do all right.

For that 10% of the time in which there will be a real problem or a near-disaster, the problem will not be known until just prior to delivery. For this to happen in an unsafe environment without available emergency care and life-supporting systems for both the mother and the child, to me is unconscionable. For that baby and that mother the 10% becomes a possible 100%.

I would like to at least strongly suggest that the definition of a "provider" be limited to a licensed medical doctor in this State. If we do not do this, I believe we are opening ourselves to increased quackery in this State.

Please let me know where I can be of further help.

Sincerely,

Carolyn Brown

Carolyn V. Brown, M.D.

cVB/dd

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Rep. Don Clocksin, Chairman
465-3797

Pouch V
State Capitol
Juneau, Alaska 99811

May 1, '981

TO: HESS Committee Members

FROM: Holli Ploog, Staff Counsel

RE: SSHB 11 Highlights

1. Department of Commerce - Occupational Licensing Division - regulates and licenses midwives. Does not create new board.

2. Licensing is voluntary - bill is a consumer protection measure and sets out to the consumer all pertinent information regarding midwifery: education and training; services and fees; procedures for meeting medical emergencies; history of client infections; hemorrhage; hospital transfers; malpresentations and normal deliveries.

3. No third party insurance coverage

CSSB 4am allows 3rd party coverage to nurse midwives -
SSHB 11 deals with lay midwives

4. Licensure requires:

a - 18 years old
b - high school degree or equivalent
c - attend at least 20 births as mid-wife over 2 year period prior to date of application or completion of mid-wife apprenticeship. Proof is by affidavit if before 1/1/92.
d - pass exam administered by Department (written)

5. Renewal:

a - attend 20 births in previous 2 years or completed 20 hours of continuing education

6. Medications determined by Department - prescriptions from a consulting physician.

7. Apprenticeship - 50 births assist, 25 births primary responsibility under supervision of sponser.

HP:sp

BACKUP MATERIAL AND GENERAL INFORMATION

REGARDING THE SS FOR HOUSE BILL 11

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Licensing: The Myth of Government Protection

In most communities, if you want to cut hair, sell a candy bar, embalm a body—or argue a case in court, you need a license

Permits and licenses are ubiquitous features of modern American society. Activities as diverse as driving, building, barbering, lawyering, vending, nursing, embalming, selling liquor and polluting the environment all require some form of official governmental imprimatur.

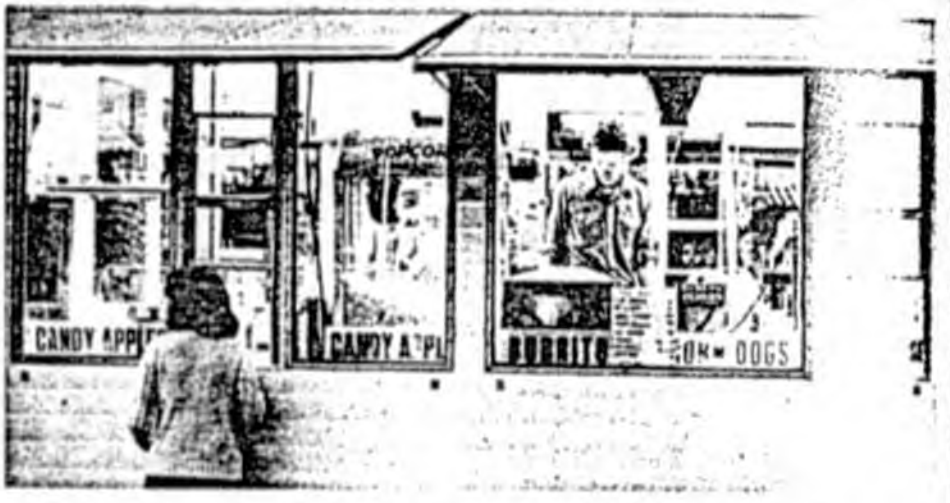
In the occupational areas alone, states now license nearly 500 professions, amounting to 25 percent of the labor force in some parts of the country. During one recent year, New York City had over 70,000 licenses and permits outstanding for businesses ranging from garages, parking lots and junk shops, to theaters, cabarets and coffee houses. California's Department of Consumer Affairs licenses and regulates over 850,000 people in more than 100 occupations.

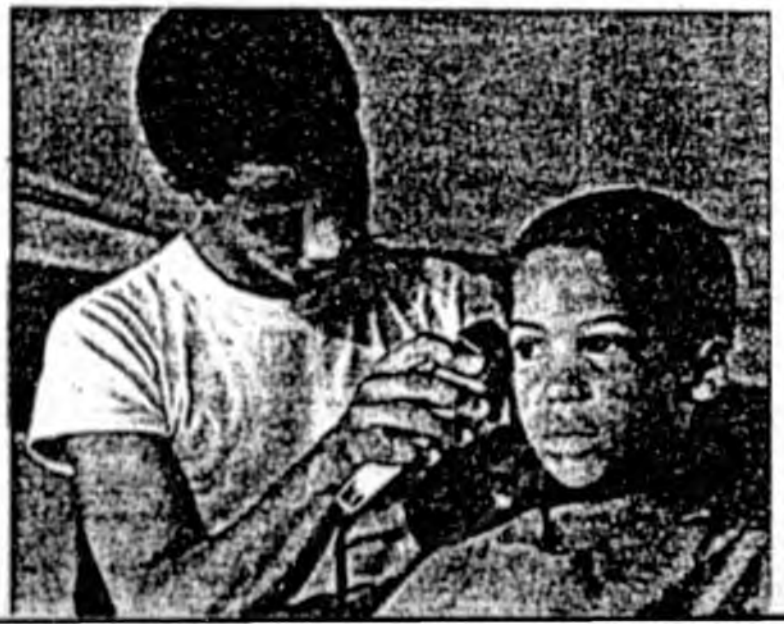
The popularity of the permit as a regulatory tool derives primarily from its apparent simplicity. Under the typical scheme, no one may engage in the regulated activity without a "permit" or "license" (as a practical matter the terms are interchangeable).

The government will not grant a permit unless the applicant meets minimum entry standards (e.g., education and experience), and will presumably suspend or revoke the permit if he fails

by David S. Baron

Assistant Attorney General, State of Arizona.





to comply with performance standards (e.g., competence, fair dealing). Enforcement against violators of the permit requirement is supposedly easy because the only issue is whether they are properly licensed. In theory, then, the permit system identifies those who meet government standards and weeds out those who do not.

Unfortunately, the realities of permit regulation are far different from the theory. In many instances, permits are issued almost automatically upon filing an application, with little review of the applicant's qualifications. Where eligibility standards are employed, they frequently bear no relationship to legitimate governmental interests and are applied restrictively merely to limit competition. Administrative agencies devote so much time and attention to issuance and renewal of permits that they often have few resources to devote to monitoring and enforcement. Permits are almost never revoked, and violators of permit conditions and performance standards are rarely punished.

Consider the example of New York City. According to a 1968 research study, only six of the 70,688 licenses and permits outstanding in 1964 were revoked, and only 19 were suspended, despite the filing of over 4,300 complaints against licensees with the city that year. At the same time, the city's Department of Licensing had far more employees working on administration and license issuance than on enforcement. License issuance and renewal were almost automatic unless applicants had criminal records. In only one instance did the department require an examination to establish occupational skills—an applicant for a sightseeing guide license had to take a written test on points of interest in New York City.

THE CASE OF THE MORAL MANICURIST

Unreasonable entry restrictions are most common in the area of occupational licensing. The state of Ohio, for example, requires pawnbrokers, barbers, sanitarians and manicurists to be of "good moral character" in order to ply their trades. Funeral directors are deemed unqualified if they are not U.S. citizens. Landscape architects must graduate from an accredited four-year school of landscape architecture or have at least seven years of practical training. Barbers are required to graduate with at least 1,800 hours from an approved school of barbering and complete an 18-month apprenticeship. At the same time, however, lawyers need no practical experience to be licensed and can handle serious criminal trials without ever before having set foot in a courtroom.

Licensing exams are particularly suspect. In a 1977 study, University of Tennessee economists Sidney Carroll and Robert Gaston found a direct correlation between pass rates and excess demand for professional services, concluding that occupational licensing boards often use exams to manipulate the supply of practitioners so as to maintain income levels for those already licensed.

Exams frequently test matters wholly unrelated to job capabilities, barring entry to the less formally trained and minorities. In some states, barber applicants must show generalized knowledge of anatomy, physiology and biology, and prospective architects must know about the history of architecture. Georgia requires auctioneers to be versed in the principles of land economics.

In the midst of this maze of entry restrictions and examination requirements, the monitoring and enforcement functions of permitting agencies are often forgotten. In the medical profession, for example, an estimated 16,000 incompetent or unfit physicians are in practice, according to a 1976 *New York Times* report. Despite this, an average of only 72 per year lost their licenses between 1971 and 1974. Although the number of revocations has since increased to over 400 annually, it still constitutes less than three percent of the total. A major part of the problem stems from lack of enforcement resources. As of 1976, New York state had only 7 investigators to monitor 55,000 physicians.

Recent statistics from Arizona provide further examples. There, the State Board of Technical Registration, which licenses professionals such as architects, engineers and geologists, did not revoke a single license between 1964 and 1978; the Board had over 6,500 licensees during the latter half of this period. The Arizona State Optometry Board revoked no licenses for violation of practice standards between 1975 and 1978, and issued only five suspensions, each for less than three days.

In Florida, most licensing agencies investigate fewer than one percent of their licensees annually, according to data in a 1974 legislative study. The state barber board, with a budget of over $140,000, conducted only 4 investigations in 1972, when 4,216 barber shop licenses were outstanding.

These examples are not mere aberrations. Government officials from all parts of the country have expressed concern about inadequate monitoring and enforcement by licensing agencies. Of course, unfairness and ineffective administration are not unique to permit systems; other forms of regulation can be abused as well. Licensing does have several basic flaws, however, that inevitably undermine its effectiveness.

WHEAT TO THE LEFT CHAFF TO THE RIGHT

The most significant weakness is the inherent deceptiveness of the permit. A license or permit confers a veneer of legitimacy on the activity of the holder. The logical assumption is that a licensed person knows what he is doing and is acting in accordance with government standards. Indeed, a major function of permit systems is to assist everybody in separating legitimate practitioners, operators and businesses from the incompetents, frauds and criminals.

In reality, however, a permit does not guarantee that the holder is acting properly or that he is even minimally qualified. Rather, it merely indicates that—at one time—the holder met minimum requirements for entry into a business for the exercise of a privilege. Even the best of regulatory agencies cannot continuously monitor to ensure that licenses are immediately suspended or revoked when practitioners break the law, lose their skill or abuse their positions. Yet between regulatory reviews, the permit remains on the wall, creating the impression that all is well regardless of any impropriety that may in fact exist.

This sort of deception can affect even the regulators themselves. With limited resources, it is tempting for officials to presume that licensees are acting properly and to focus enforcement efforts on unlicensed activity. This is particularly true where the licensing and enforcement functions are performed within the same agency.

Officials who have certified a particular person as "competent" may well be reluctant to call into question the

same person's ability at a later date. Such officials may also see their primary function as controlling entry into a profession or activity, with careful screening acting as the principal tool for ensuring compliance with standards. Unfortunately, no screening system, however thoughtfully devised, can predict with certainty how people will behave after being licensed; there will always be those who violate standards.

A second basic defect in permit regulation is the inadequacy of the revocation or suspension threat as an enforcement device. For regulatory violations of minor or moderate severity, revocation is neither a realistic nor credible deterrent. Under contemporary notions of justice and fair play, a total bar on future activity by the licensee is simply too harsh a penalty for a noncriminal transgression. Even where significant deficiencies are involved, revocation may be inappropriate if the violations stem from isolated imprudent acts rather than chronic noncompliance. A single violation does not necessarily show that the licensee is unfit to engage in the regulated activity. As both a punitive measure and a control device, permit revocation is too severe a sanction to be useful in most cases.

A third flaw of permit systems is their inefficiency in applying regulatory resources. Under the typical scheme, every person who wants to engage in the regulated activity must get a permit. This is necessary to effectuate the identification and exclusion functions of permits cited earlier. As a practical matter, however, many permittees will require no regulatory attention. Those who are truly competent, conscientious, law-abiding and diligent will comply with state standards whether or not there is a permit system. Inevitably then, permitting agencies will waste time and effort in licensing and supervising persons who already meet standards and who will continue to do so.

POLLUTION PERMITS PRESENT PROBLEMS

Permits also present special problems for the efficient administration of environmental laws. Pollution permits typically define specific control measures and compliance schedules for each polluter. The permit terms translate general statutory and regulatory mandates into particular requirements for each factory or plant. Invariably, the process of negotiating (and sometimes litigating) permit terms is time-consuming and costly. During this period the applicant may well be in gross violation of standards, causing severe environmental degradation.

Even after the permit is issued, there is no guarantee that the permittee will comply with its terms. Thus, a second level of administrative action or litigation is often required to enforce the permit standards. The whole process can drag on for many years, during which time regulatory objectives are thwarted. The flexibility of case-by-case standard-setting may be desirable from a policy standpoint, but lengthy delays in attainment of substantive goals are inevitable in such a system.

Beyond inherent flaws, permit systems are particularly susceptible to manipulation by regulated groups for anti-competitive purposes. In the occupational licensing area, most state agencies are run by members of the regulated profession, either directly or through their professional associations. Legislatures mandate such self-regulation on the often mistaken belief that only practitioners possess the required expertise to properly regulate other practitioners. The entry control mechanism provides these board members with a powerful tool for limiting the supply of professional services and maintaining high incomes for themselves.

Regulations restricting practice location, solicitation and advertising are also used to stifle free competition. The result, according to economists Carroll and Gaston, is that licensing tends to raise costs for consumers while actually lowering service quality.

PLUSES OF AN ENFORCEMENT SYSTEM

The inefficiency of permit regulation suggests governmental goals might be better served by a more direct approach, such as the enforcement system. Under such a system, all standards for conduct of the regulated activity are set out in statutes and regulations. If anyone violates those standards, the state seeks appropriate sanctions against the wrongdoer. For minor or isolated violations, a fine will ordinarily be appropriate. For serious or chronic violations an order or injunction restricting or prohibiting future activity may be justified. A combination of sanctions can also be used depending on the circumstances.

In the enforcement scheme, government agencies focus the bulk of their resources on monitoring the activities of regulated parties and on swift prosecution of violators. Although officials might not investigate everyone in a given year, the threat of enforcement action has a substantial deterrent effect throughout the regulated community. There are no permits to mislead people into believing that anyone is presumptively qualified or acting properly at any specific time.

The enforcement system accomplishes most of the goals of a permit system, with few of the disadvantages. Heavy reliance on entry control to ensure quality is eliminated and replaced by a more vigorous monitoring program to ensure that standards are in fact being met. The hollow threat of permit revocation or suspension is replaced by a very real threat of punishment that can be tailored to fit the violation. Government officials can focus their efforts on suspected wrongdoers, without wasting time on those in compliance. Hopefully, too, the influence of

regulated groups on administration of the laws is greatly weakened in a system requiring no licensing boards, and relying primarily on impartial enforcement officials for compliance review.

Of course, an enforcement system cannot totally replace the informational function performed by many permit systems. The entry screening process, although not always a fair or accurate method of ensuring quality, does assist in informing third parties of whether a person has met certain minimum standards. To a large degree, however, this informational function can be performed simply by requiring regulated parties to publicly disclose their backgrounds and qualifications. Validation by professional societies can also meet this need. Private validation standards would probably track existing licensing requirements, which are usually imposed by the professional societies or practitioners anyway through their control of licensing boards.

The notion that governmental validation is somehow more objective is belied by the substantial influence of regulated parties over regulatory agencies. At most, the government's role should be limited to voluntary certification of practitioners, leaving the consumer free to choose between the "certified" and "noncertified." This approach, advocated by economist Milton Friedman, minimizes the anticompetitive effects of licensing and avoids many of its costs.

An enforcement system also cannot totally replace the notification function of a permit system. The permitting process routinely identifies most parties engaged in a regulated activity. This greatly aids monitoring and enforcement efforts since officials need not spend time and money locating the people they are supposed to be regulating. An enforcement-only system does not identify all regulated parties; it works primarily on the basis of tips, complaints and spot checks.

In cases where identification of all regulated parties may be useful in an enforcement program, a simple registration system can serve the purpose. Under registration, anyone who enters the regulated field must notify (or register with) the government. There are no prerequisites to entry other than notification, although registrants ordinarily must inform the regulatory agencies of address changes. An enforcement system with registration allows for identification of all regulated parties without the burdens and disadvantages of entry controls and licenses.

WRIST-SLAPPING INEFFECTIVE

As for the supposed ease of enforcement provided by permit systems, the advantage is largely illusory. Because of the high stakes involved, a proceeding to halt an unlicensed practice or revoke an existing permit is often more complicated than a simple penalty action. Administrative officials and judges will invariably demand evidence of actual incompetence or wrongdoing before completely depriving a person of his livelihood. Unless serious transgressions are shown, the remedy will likely be limited to a temporary suspension or imposition of a compliance schedule. As a practical matter, mere proof of a technical violation of the permit requirement is rarely adequate for meaningful enforcement under a licensing scheme.

Likewise, a permit system does not really provide a greater degree of administrative flexibility or control than an enforcement system. It is true that permits can be used to apply general regulatory requirements to specific cases, as in the environmental area. But enforcement actions do essentially the same thing with greater speed and finality. By seeking a judicial determination of a regulated party's responsibilities in the first instance, an agency avoids the double layer of adjudication often required for permits: one to decide on whether the permit terms are reasonable, and another to enforce them. Moreover, the compromising of competing interests and tailoring of regulatory standards to specific cases—ostensible advantages of permit regulation—are routinely and more conclusively accomplished through litigation.

The failure of licensing is largely attributable to its use in fields where it is simply not needed. The primary distinguishing feature of permit systems—the control of entry through examination or setting of minimum qualifications—seems appropriate only where it is objectively possible to distinguish the competent from the incompetent, where conduct of the regulated activity by an "unqualified" party can cause serious harm. Unless these criteria are met, permit regulation produces no benefit over other forms of regulation. It makes no sense to license barbers, pawnbrokers, funeral directors and cabaret operators, when the "qualifications" for these jobs are nebulous, the potential harm from malpractice is limited, and the capacity of consumers to choose the competent is high.

Even where a permit system might otherwise be justified, it will be of questionable value unless the intent is to closely monitor the activities of every permittee. As already noted, a permit creates the impression that the permittee is currently in compliance with standards. Where 50,000 licensees are monitored by only 7 inspectors, it is pure deception to employ a regulatory scheme that pretends to allow license retention only so long as the holder is qualified and acts properly. Under such circumstances, the permit is no better than a certification, with the revocation sanction a meaningless threat that acts as a drain on other more effective enforcement tools.

The only areas in which permit regulation really makes sense are those that meet all of the criteria outlined above and that require fairly intense, constant governmental scrutiny. Nuclear power plants, for example, must be designed and operated by highly skilled scientists and engineers, and must be constantly monitored for safety and environmental hazards. The potential harm from incompetence or violation of standards is enormous, and citizens cannot realistically protect themselves from that harm.

Because there are very few nuclear power plants, the government can realistically and effectively regulate all of them by permit. Other ultrahazardous activities, such as disposal of toxic materials, may be in a similar category. Aside from activities creating major environmental risks, however, there are few areas in which permits appear either necessary or desirable for protection of the public or for regulatory efficiency.

Permits are supposed to ensure that an activity is closely regulated. But the permit itself accomplishes nothing in the way of guaranteeing quality or inducing compliance with standards. In most cases, it merely creates an illusion of regulation. Statutes and regulations will have little meaningful impact in advancing the public interest unless government officials forget their obsession with permits, and seek instead to vigorously enforce the law. ■

Regarding physicians refusing prenatal care to women contemplating home delivery vs. complications with malpractice insurance.

She previously contacted several lawyers regarding this allegation. She was informed that a physician could not be held liable for such care etc. If the physician did not wish to participate in a home birth per se - this could be stated and the physician would be entering into a contract then only for providing prenatal care (and perhaps the labor and birth - if it occurred in a hospital - and only then!). It has been assumed that by clearly stating that the physician would not participate in a home birth he/she would be clear of any liability, etc regarding the birth. This logically would be the case.

Previously I had been informed that a number of the health care and liability/malpractice insurance companies are controlled by physicians. If this is in fact the case it would appear that any question of malpractice insurance "complications" would be a rather moot rationale for refusing care.

The allegation of danger to mother and infant doesn't hold water as would be evident in studying the report written on Infant Mortality in North Carolina Home births. I believe I included a copy of it to you - if not I would be glad to send one.

Some physician defend themselves by stating this is not due to economic considerations or influences either.

This might also be questioned seriously. We estimate that well over 200 home births occur in the Anchorage Borough each year. If I recall correctly this is more than the total number of births in a number of other Boroughs including I believe Mat-Su. (≈300) I would point that some of the midwives probably attend more births than physicians in many areas of the State! I can see where this would threaten a number of physicians regardless of what is said.

Tallying up information of the economic aspects only here in Anchorage (conservatively):

$3,000 = approx cost of "normal" labor & delivery in area hospital including physician fees.

200 = approx # of home births.

$600,000 income not accrued by area hospitals & physicians assuming no C-section etc. [$600,000]

600,000
.70
$520,000

The C-section rate here is close to 30% if this is used the potential income increases drastically to [$ 820,000]

5,000
60
300,000
+ 520,000
$820,000

To me this works out to what I would consider a fair amount of money (even for Anchorage). I addressed only Anchorage and used rather conservative figures.

I believe it safe to assume that almost any group would work to perpetuate a virtual monopoly, especially when it is so lucrative.

SB 237 last session would have made it illegal and extremely difficult for homebirth couples to obtain the assistance of experienced help for their birth. There was language in it making the attendance of childbirth the practice of medicine. I had been informed that an area Obstetrician had requested those parts of the original bill.

I honestly can not believe that such legislation is for the benefit of the consumer, nor are the battles against HB 327/SB 274. Economically there is no doubt that some competition would be beneficial to the consumer. I am also aware of any progressive legislation proposed, in Alaska a supported ~~in support~~ or elsewhere by physicians, that is consumer oriented.

I believe that the above legislation and legislation similar to HB 11 are beneficial to the consumer in a variety of ways. One of the most obvious is the fact that people would not seek out these services if they their needs were being met by the established medical/surgical care system. They should have the right to obtain the services they choose, whether this be a naturopath or a midwife. I hope this will right will be insured and protected.

Sorry for the long letter - have a lot of thoughts to convey! Thank you very much for your time and assistance.

Sincerely,

Ann Gaskins
1403 E. 27
Anchorage, Ak 99504

1-9-82

Rep Mike Beirne, Chairman
House - Health & Soc. Services
Pouch V
Juneau, Alaska 99811

Dear Rep. Beirne,

I have a personal interest in the perinatal field, especially "homebirths", here in Alaska. Several of my sources have informed me that the Anchorage Municipality as well as the State of Alaska are concerned with the increased homebirths rate. I've been unable to obtain objective data that would demonstrate the need for this concern and some of the processes that are apparently being put in motion. From what I have been able to determine there have been no objective in depth studies completed in Alaska - of "planned and attended homebirths". Regardless of this fact of an alarming reference made of the growing homebirth "problem". Homebirths are apparently increasing - to the rate of approximately +/- 5% in Anchorage presently.

I sincerely believe that any "concern" by Anchorage or Alaska should be to insure people the choice of birth attendant and birth setting, and insure people of access to good perinatal care regardless of their choice of attendant or setting. Presently if a couple is planning or considering a homebirth in Anchorage they are almost invariably refused prenatal monitoring by local physicians

These same people are often intimidated and harassed should they seek care at any time through the private sector. Expectant women have also been refused lab work through local public clinics when it is known they are planning a homebirth. I do not believe this prejudiced treatment is in the best interest of the State, Municipality, the couple or the infant.

Physicians claiming their concern only for the health and welfare of mother and infant – while denying care – might well have their motives and perhaps ethics questioned. We are told by medical research that the majority of all perinatal complications are detected through good perinatal monitoring.

I have attempted to trade information with Mrs Carolyn Noyama – (Dept HSS – D.I.C – IPC) but have been seriously disappointed with her endeavor. At last her commitment that she would provide information I was pushing and myself obtained this last year to the Perinatal Advisory Committee. She was to make a report regarding homebirths in Alaska, last October. Enclosed you will find a copy of the letter I recently wrote to Mrs Noyama. I would be glad to answer any questions.

I would be grateful for any assistance you may be able to render on these matters. Thank you

Sincerely,
Al Pusling

Childbirth experiment goes well

by Peter Elsner
Associated Press

Fortaleza, Brazil — A pilot project that teaches basic health care to women in Brazil's poorest region may provide a Third World cure for the disease and death that threaten childbirth among the world's impoverished millions.

"The only pediatrician a new baby usually needs is its own mother," says Dr. Galba Araujo.

The Brazilian obstetrician has organized a network of traditional rural midwives who are taught methods that blend with traditional health care. They also learn to recognize warning signals in the few births which require a doctor's attendance.

"We've never had a woman die in childbirth," Araujo said in an interview. "The statistics show that 94 percent of the births were without complications."

With more than 8,000 births in five years, the project, supported by U.S. private money and Brazilian government funding, has also slashed the rate of infant death in one of the world's highest population growth areas.

"Underdeveloped countries have been imitating the developed countries in providing health care," Araujo said in an interview. "They have been adopting technology at high cost. But nobody can afford to pay."

The pilot project here stresses inexpensive methods which require minimal training, and also provides local training in family planning and birth control — a sensitive subject in this predominantly Roman Catholic country.

U.S. population specialists, based in Brazil, praise Araujo's work. With two-third of the world's people living without adequate medical care, these specialists say, the project may have major implications in the coming decades.

Araujo cited U.N. statistics which show that, if present trends continue, there will be three billion births worldwide between now and the year 2000. The statistics also indicate that one billion of those infants will die, an additional 200 million will not reach a year of age and 100 million women will die in the birth cycle.

Araujo, medical director of the Maternity Hospital in Fortaleza — an Atlantic coast city of 1.3 million 1,000 miles north of Rio de Janeiro — says the data he is gathering show at least 15 percent of pregnant women [illegible]

gary than a physiological act," said Araujo, who has sponsored international forums on health care and has lectured in the United States and elsewhere.

Araujo's project, which receives grant money from the Ceara State government, federal health officials and the Kellog Foundation of the United States, has established a series of regional and local health clinics. He and other physicians enlist the help of traditional midwives and offer them group training.

The project advocates the use of "birthing stools," either at home or in a clinic, instead of giving birth lying down. The birthing stools — which can be a simple as a wooden chair with part of the seat removed — place the mother in a squatting position so that gravity aids the birth process.

Three hundred midwives have been trained in Ceara state, learning about problems of infection and about modern preventive care. They also are taught warning signals of birth problems and can refer mothers to local "satellite clinics" for better care. The satellite clinics, in turn, can refer patients to "base hospitals" for more sophisticated help.

There are now eight satellite centers and three base hospitals. Araujo says he and the state health department plan to double the number by 1983, with eventual plans to cover the entire state.

Ceara, with a population of more than five million, is in Brazil's drought-stricken northeast poverty belt. The birth rate here is higher than the national rate of 35 per 1,000 and the infant mortality rate higher than the national rate of 109 per 1,000.

The statistics at the satellite center at Aquiras, 25 miles from Fortaleza, are markedly better. Since the clinic opened on May 1, 1977, there have been 2,039 admissions and 1,008 births. An additional 229 cases were referred to the Fortaleza center and other women received pre-and post-natal care. There were 25 infant deaths among the 1,008 births, a death rate of 12 per 1,000 — one-eighth of the national average and lower than the U.S. infant mortality rate of 15 per 1,000. The overall statistics in the Ceara project are similar, Araujo said.

The coordinator of the Aquiras Center, Dona Terezinha Pereira Lins, herself a traditional midwife, said the clinic has been able to convince reluctant local residents that the free health service works.

"I began learning (to be a midwife) from my grandmother when I was 21," she said. "When I got here, everything was different. But now, everyone is used to it and we deliver 50 to 60 babies a month."

Araujo said the northeastern project has important lessons for more developed areas of Brazil, as well as for countries like the United States.

HOME BIRTH—HOW SAFE IS IT?

by Robert E. Brooks, PhD., former professor of Quantative Analysis, University of Southern California.

One of the most common assumptions which doctors make when criticizing home birth is that they are much more dangerous than births in the hospital. Note that we say "assumptions" because, in fact, there is no proof at all to support such assertions.

According to Wegman (1975) the United States ranked 15th in infant mortality rates for 1973. (See Table 1)

The differences between the top six countries and the U.S. is quite substantial: the U.S. infant mortality rate is more than 50% higher than the sixth placed country, Norway. Yet this can hardly be blamed on home birth since only about 3% of births in the U.S. occur at home.

In fact in nearly all of the top twenty countries most births take place in some type of hospital or maternity home. The one exception to this fact is Holland where fully 53% of births took place at home. Huygen (1976) in his classic paper on home deliveries in Holland cited statistics showing the perinatal mortality rate for home births in 1973 to be only 6.9 per 1000 live births compared to 33.8 per 1000 for hospital deliveries. Since high-risk mothers are usually referred to hospitals for their births in Holland, one cannot conclude from these statistics that home birth is five times safer than hospital birth. On the other hand one can certainly conclude that it is possible to have a system wherein a low risk mother can have her baby at home with an extremely high chance for a safe birth.

In addition Huygen states that he has "serious doubts about the desirability and safety of hospital for normal deliveries. Home births offer important advantages from an emotional and psychological point of view. Research has made it clear that many women prefer to have their babies at home." And regarding the technology available in the hospital, "I feel that these advantages in technology at the same time carry with them the risk of unnecessary intervention."

Even though the percentage of home births in the U.S. has been small, it has experienced a rapid growth in the past few years. Statistics on the entire population of home births are not available. Some studies have been done, however, which can be used to indicate what kind of safety one can expect from home births.

Dr. Lewis Mehl's analysis of 1147 elective home births in northern California revealed the following outcomes (see Table 2).

In this study the incidence of infant mortality is less than half as much for home birth as it is for all births in California in 1973. While the total number of home births represented in this study is not large enough to statistically conclude that home birth is twice as safe as hospital birth, it is certainly indicative that the physicians' assumption that home birth is much more dangerous must be seriously questioned.

TABLE 1 - INFANT MORTALITY RATES (1973)

Country	Deaths per 1000 Live Births	% Hospital	Attendee
Sweden	9.6	100	Midwife
Finland	10.0	99.9	Doctor or Midwife
Japan	11.3	89.9	Doctor
Netherlands	11.5	47	Doctor or Midwife
Denmark	11.5	85	Midwife & Doctor
Norway	11.8*	99.4	Midwife
Switzerland	13.2*	99	Midwife
France	15.5*	97	Doctor
Canada	15.6	97	Doctor
German Democratic Repub	16.0	98	Doctor
New Zealand	16.2*	100	Doctor
Australia	16.5*	most	Doctor
Hong Kong	16.8*	76	Midwife
England & Wales	16.9	96	Midwife
Belgium	17.0	98	Midwife & Doctor
United States	17.7	97	Doctor
Ireland	18.0	85	Midwife
Czechoslovakia	21.2	99	Nurse-midwife
German federal Repub	22.7	97	Midwife
Israel	22.8	100	Midwife

Sources: Wegman, M. "Annual Survey of Vital Statistics-1974 Pediatrics 56: 960-966, December 1975
IFGO and JCM. Maternity Care in the World. 2nd Edition. 1976

TABLE 2

	Number	Rate	All California Birth rate-1973
Total Births	1152		
Live Births	1147		
Fetal Death	5	4.3	10.2
Neonatal Deaths	6	5.2	10.3
Total Perinatal Deaths	11	9.5	20.3
Low Birth Weight (2501g)	15	1.3%	6.4%

Source: L. Mehl. "Outcome of Elective Home Birth: A Series of 1147 Cases", Infant Health Unit, California State Department of Health, Berkeley, CA.
Birth Notes, Vol. 3, No. 2, page 6

*ACMI 1978

Home Delivery and Neonatal Mortality in North Carolina

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• **Neonatal mortality is examined by place and circumstances of delivery in North Carolina during 1974 through 1976 with attention given to home delivery. Planned home deliveries by lay-midwives resulted in three neonatal deaths per 1,000 live births; planned home deliveries without a lay-midwife, 30 neonatal deaths per 1,000 live births; and unplanned home deliveries, 120 neonatal deaths per 1,000 live births. The women whose babies were delivered by lay-midwives were screened in county health departments and found to be medically at low risk of complication, despite having demographic characteristics associated with high-risk of neonatal mortality. Conversely, the women delivered at home without known prenatal screening or a trained attendant had low-risk demographic characteristics but experienced a high rate of neonatal mortality. Planning, prenatal screening, and attendant-training were important in differentiating the risk of neonatal mortality in this uncontrolled, observational study.**

(*JAMA* 1980;244:2741-2745)

SUMMARY reports of state vital statistics have traditionally classified births as occurring in-hospital and out-of-hospital. Fetal and infant mortality has also been reported using this differentiation. Being the best that is generally available, such information has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery. However, with increasing interest in home delivery, the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them. This article provides an analysis of neonatal mortality in North Carolina during 1974 through 1976, with attention given to the places and circumstances that characterized out-of-hospital deliveries.

In North Carolina, the proportion of infants born at home has declined from 76% in 1940, to less than 1% in 1975 (Figure). With this shift to hospital delivery, maternal mortality fell from 50/10,000 live births in 1940 to 3/10,000 live births in 1975, a decline of 94%. Neonatal mortality also declined 61%, from 33/1,000 live births in 1940 to 13/1,000 live births in 1975. Neonatal mortality remained more than 40 times that of maternal mortality in 1975, despite nearly universal hospitalization for childbirth.

Most of the medical profession advocates hospital delivery and views home delivery as a regressive step that would reverse the historical improvement in the safety of childbirth. Most women choose to deliver in a hospital where physicians are able to intervene effectively in emergencies, many of which cannot be anticipated with even the best prenatal care. However, an increasing number of women prefer delivery at home in order to be among familiar people and surroundings, to avoid the perceived risks of highly technical medical care, and to reduce cost.

Lay-midwives legally attend home deliveries in some counties of North Carolina. The practice of these lay-midwives is regulated by county health departments. Prenatal care involving physician-supervised screening for risk factors must be provided by the health department for each patient, and every home delivery by a lay-midwife must be approved in advance as low risk. Since 1964, no lay-midwife has been initially certified to practice in any North Carolina county. Those lay-midwives still practicing are gradually being phased out; 25 were issued a required yearly permit in 1974, eighteen in 1975, and fifteen in 1976.

MATERIALS AND METHODS

This study used neonatal death rates as a measure of the risk associated with the place and circumstances of birth. Vital records of live births and neonatal deaths registered in North Carolina for 1974 through 1976 constituted the initial source

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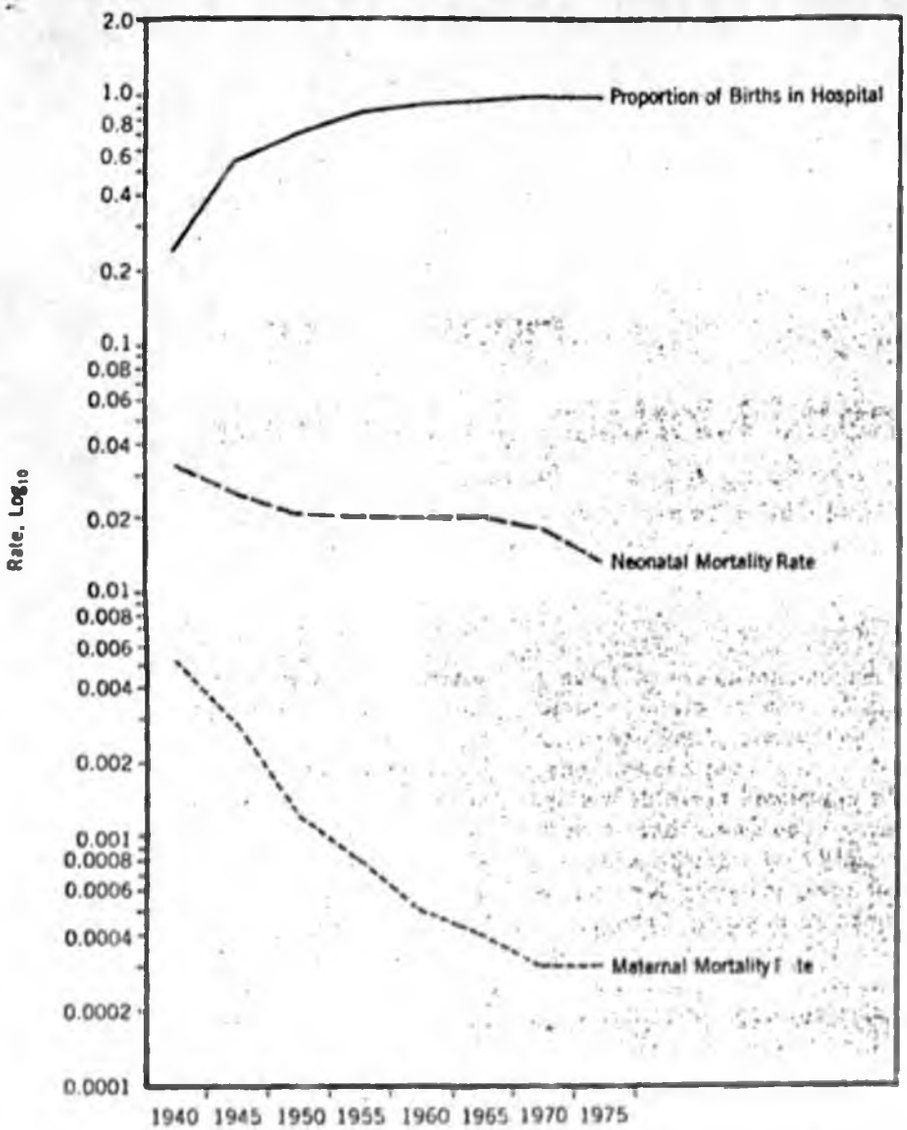

Proportion of births in hospital, neonatal mortality rate, and maternal mortality rate, North Carolina, 1940 to 1975.

of information. Birth records were coded as occurring in a hospital, in a clinic or office, enroute to a hospital, or at home. Infant death records are routinely linked with their corresponding birth records in North Carolina, making it possible to determine mortality by birth characteristics.

To estimate the risk of neonatal mortality associated with the circumstances of home delivery, the 1,296 home deliveries occurring in North Carolina during 1974 through 1976 were classified by both their planning status and the attendant present. If a home delivery was chosen and a healthy infant anticipated, it was classified as planned.

Emphasis was placed on determining the planning status of those home deliveries that resulted in neonatal death. Misclassification of a small number of these deaths would have had a notable effect on reported neonatal mortality rates. Therefore, these deaths were individually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery.

Two simplifying assumptions were made in classifying all home deliveries by planning status. We assumed that all home deliveries attended by a lay-midwife were planned. This assumption was justified for two reasons. First, for a lay-midwife to receive a permit to attend a home delivery, a pregnant woman had to be approved by a health department as being at low risk of complications. This was considered evidence of careful planning. Second, a lay-midwife would probably not attend an unplanned home delivery and report it on the birth certificate because of the risk of permit revocation.

Our second assumption was that home deliveries of infants weighing 2,000 g or less at birth and not attended by a lay-midwife were precipitate and unplanned. There were 51 such deliveries. These may have been planned but were classified as unplanned. However, no such assumption was made in the classification of the neonatal deaths that followed home delivery. Therefore, any classification error introduced by the second assumption would have increased the apparent neonatal mortality rate of home deliveries classified as planned and not attended by a lay-midwife, and decreased the apparent neonatal mortality rate of home deliveries classified as unplanned.

In June 1978, birth certificate copies of the remaining unclassified home deliveries were sent to the health department of the county of residence of the mother. A brief questionnaire accompanied each certificate requesting that health department staff determine the reason for home delivery and identify the attendant present. Four reasons for home delivery were provided: precipitate, intended, failure to plan for health care, and unknown. Field work by county health department staff was necessary when no detailed record described the circumstances of the birth.

RESULTS

Births Associated With Home Delivery.—Table 1 shows a classification of all 1,296 home deliveries for 1974 through 1976. Seventy-two percent of home deliveries were classified as planned. Of these, 768 were attended by lay-midwives and were assumed to be planned; 166 were classified by questionnaire as "intended" and were therefore considered planned. Of the 166 home deliveries classified as "intended," 57% occurred by preference, 26% were for economic reasons, 8% were for religious reasons, and 9% were for other or unknown reasons.

Nineteen percent of home deliveries were classified as unplanned. The 51 infants born at home, attended by other than a lay-midwife, and weighing 2,000 g or less were assumed to be precipitate, unplanned home deliveries. An additional 199 were classified by questionnaire as either "precipitate" or "failure to plan for health care" and were also considered unplanned.

Neonatal Deaths Associated With Home Delivery.—The planning status of the home deliveries that resulted in neonatal death is shown in Table 2. Of the 36 neonatal deaths associated with home delivery during the three years, six (17%) followed planned home delivery, and 30 (83%) followed unplanned home delivery.

Table 1.—Planning Status of All Home Deliveries*

	No.	%
Planned	934	72
Lay-midwife (assumed planned)	768	
Classified by questionnaire	166	
Unplanned	250	19
Birth weight ≤2,000 g (assumed unplanned)	51	
Classified by questionnaire	199	
Unknown	112	9
Total	1,296	100

*North Carolina, 1974 through 1976

Six neonatal deaths occurred following planned home delivery. In three instances, a trained attendant was not present; in three others, delivered by lay-midwives, death was attributed to congenital anomalies.

Two of the 30 unplanned home deliveries resulting in death were classified as "unplanned—no alternative." Allegedly, one mother, who delivered a 2,800-g infant at eight months, went to a hospital but was turned away for lack of funds. The other, who delivered a 1,400-g infant at seven months, reportedly had been told not to go to the hospital without payment in hand. We concluded that these home deliveries were not intended.

Five of the 30 unplanned home deliveries resulting in death were classified as "unplanned—suspected homicide or neglect." Three involved unwed teenaged mothers charged with homicide. Of the two remaining deaths, one infant was found drowned in a canal and the other was grossly neglected. These home deliveries were judged to be either precipitate or intended without preparation for a healthy infant.

Neonatal Mortality Rates Associated With Home Delivery.—Home deliveries, without regard to their planning status, were associated with a neonatal mortality rate of 30 per 1,000 live births. However, when subdivided by their planning status (Table 2), a different picture emerged. The neonatal mortality of planned home deliveries was 6/1,000, while that of unplanned home deliveries was 120/1,000. The relative risk of unplanned home deliveries was 20 times that of planned home deliveries.

The planning status of 112 home deliveries remained unknown following the questionnaire survey. If these had been planned, the neonatal mortality rate of planned home deliveries would still have been 6/1,000. If all of these home deliveries had been unplanned, the neonatal mortality rate of unplanned home deliveries would have been 83 rather than 120 per 1,000.

The effect of possible classification error introduced by the assumption that the home deliveries of 51 infants weighing 2,000 g or less and not attended by a lay-midwife were precipitate and unplanned can be similarly examined. If all 51 home deliveries had been planned, the neonatal mortality rate of planned home deliveries would still have been 6/1,000; the neonatal mortality rate of unplanned home deliveries would have been 151/1,000.

Table 3 shows all neonatal deaths for the three-year period by place and circumstances of delivery, in rank order from the lowest to the highest neonatal mortality rate. The 112 home deliveries with unknown planning status and 11 planned home deliveries with an unknown attendant are not included in the births column or in the denominators of the neonatal mortality rates. The rates ranged from zero neonatal deaths for planned home deliveries attended by a physician, to 120 neonatal deaths per 1,000 unplanned home deliveries. Planned home deliveries, prenatally screened as low risk and attended by lay-midwives, were associated with a neonatal mortality rate of 4/1,000 live births. However, all three deaths following delivery by lay-midwives were associated with congenital anomalies and may not have been preventable.

Hospital deliveries, including high-risk pregnancies and low-birth-weight infants, were associated with a neonatal mortality rate of 12/1,000 live births. After excluding infants weighing 2,000 g or less at birth, the neonatal mortality rate for hospital deliveries was 7/1,000, while that for lay-midwife home deliveries remained 4/1,000. This difference was not statistically significant.

Three groups of home deliveries can be distinguished from Table 3: (1) unplanned; (2) planned without known medical screening and without a trained attendant; and (3) planned, selected based on medical screening, and with at least a minimally experienced attendant (grouping home deliveries by physicians and lay-midwives together). Group 1 had 4 times (95% confidence limits 1.4 to 11.4) the

Table 2.—Neonatal Mortality by Planning Status of Home Deliveries*

	Deaths, No. (%)	Births	Rate†
Planned	6 (17)	934	6
Infant normal	3 (8)		
Congenital anomaly	3 (8)		
Unplanned	30 (83)	250	120
Precipitate	23 (64)		
No alternative	2 (6)		
Suspected homicide or neglect	5 (14)		
Total	36 (100)	1,184	30

*North Carolina, 1974 through 1976
†Neonatal deaths per 1,000 live births

Table 3.—Neonatal Mortality by Place and Circumstances of Delivery*

	Deaths	Births	Rate†
Home—planned, attendant physician	0	851	0
Home—planned, attendant lay-midwife	3	768	4
Hospital	2,805	242,246	12
Clinic or office	15	949	16
Home—planned, attendant not physician or lay-midwife	3	100‡	30
Enroute	12	177	68
Home—unplanned	30	250‡	120
Total	2,868	244,544	12

*North Carolina, 1974 through 1976
†Neonatal deaths per 1,000 live births
‡Excludes 112 home deliveries with unknown planning status and 11 planned home deliveries with unknown attendant

Table 4.—Percent Distribution of Births by Selected Maternal Characteristics*

	Home Lay-Midwife, %	All Deliveries, %	Neonatal Mortality Rate† All Deliveries
Age, yr			
<20	40	24	14
20-24	34	35	11
25+	26	41	10
Race			
White	4	69	10
Nonwhite	96	31	15
Marital status			
Married	56	84	10
Unmarried	44	16	18
Education, yr			
<12	69	36	14
12	29	42	10
>12	2	22	9
Prenatal visits			
0-2	5	3	65
3-7	68	19	28
8+	27	78	5
Birth weight, g			
≤2,000	0	3	288
2,001-2,500	8	5	24
2,501-3,000	20	18	5
>3,000	74	74	2
N	467	159,333	...

*Home deliveries by lay-midwives vs all deliveries, and neonatal mortality rate for all deliveries North Carolina, 1975 through 1976.

†Neonatal deaths per 1,000 live births.

neonatal mortality rate of group 2. Group 2 had 8 times (95% confidence limits, 2.2 to 31.3) the neonatal mortality rate of group 3.

Lay-Midwife Deliveries.—Table 4 compares the maternal characteristics of the 467 women delivered by lay-midwives with all 159,333 deliveries occurring in North Carolina during 1975 and 1976. The table also shows the neonatal mortality rate for all deliveries relative to maternal characteristics. The distributions for the demographic variables of age, race, marital status, and education reveal a preponderance of mothers in high-risk categories among lay-midwife home deliveries compared with all deliveries. The women attended by lay-midwives were more likely to be young, black, unmarried, and less educated than the average woman who delivered in the state. Despite their high-risk demographic profile, these women had a relatively low-risk medical profile. None of their infants weighed 2,000 g or less, and their neonatal mortality rate was one third that for all deliveries.

Planned Home Deliveries Without a Trained Attendant.—Contrasted with women delivered by lay-midwives, women who delivered without a trained attendant had a low-risk demographic profile: 5% were younger than 20 years, 78% were white, 90% were married, and 48% were educated beyond high school. While they were at high risk with respect to prenatal care (38% with two or less prenatal visits), their deliveries were at low risk with respect to infant birth weight (only 2% of the infants weighing 2,000 g or less). Even with these favorable characteristics, their neonatal mortality rate was eight times that of lay-midwife home deliveries.

COMMENT

This study showed that the outcome of delivery varied importantly by both the place and circumstances of delivery. In-hospital vs out-of-hospital classification does not adequately group births by risk of neonatal mortality. Even more specific designation of the place of birth does not suffice to describe risk. Deliveries occurring at home ranged from lowest to highest risk of neonatal mortality depending on planning and the attendant present.

Medically selected women delivered at home by lay-midwives were at high demographic but low medical risk. The screening process carried out through physician-supervised prenatal care at local health departments was apparently effective.

In contrast, planned home deliveries without known medical screening and without a trained attendant resulted in high neonatal mortality despite their low-risk demographic profile. Having less prenatal care and not having a trained attendant at delivery appears to have lessened the demographic advantage for this group and predisposed their infants to higher mortality.

Unplanned home deliveries were associated with neonatal mortality even higher than deliveries en route to the hospital, although the difference was not statistically significant. After analyzing 100 consecutive cases of unattended home deliveries in England, Fraser[7] concluded that "while precipitate labour is an important factor, inadequate preparation and instruction of the patient are the commonest causes" of unattended home delivery.

Adequate prenatal care and provision of care appropriate to medical risk has been repeatedly associated with lower neonatal mortality. Montgomery[3] and later Levy et al[4] showed that a nurse-midwife program, which emphasized prenatal care for a medically underserved population, was associated with a notable decline in neonatal mortality followed by a sharp rise after discontinuation of the program. Zackler et al[5] have reported that a maternal and infant care project, which provided prenatal care to girls who conceived when they were younger than 18 years, was associated with lower neonatal mortality compared with a population that did not receive project services. In large-scale studies of vital statistics data, Kessner et al[1] in New York and Dott and Fort[2] in Louisiana found that adequate prenatal care was associated with less risk of low birth weight and neonatal mortality.

Several limitations of this study suggest cautious interpretation of its findings. Inferences regarding the safety of home births should await prospective controlled studies. Potential deficiencies of this study include the following: home delivery practices in North Carolina were not necessarily representative of practices in other states; there was a small number of neonatal deaths in the study; there

were possible errors in classifying the true place and circumstances of birth; underreporting of home births and neonatal deaths may have occurred.

Two factors restricted the scope of this study. First, home deliveries and hospital deliveries attended by nurse-midwives were not represented, but are an increasing proportion of deliveries in other states.[1] Second, lay-midwives practicing in North Carolina during the study were initially certified in 1964 or before and had at least ten years' experience with home deliveries.

Despite including all births in a three-year period, the number of home deliveries in this study remained small. There were so few neonatal deaths that the neonatal mortality rates of subgroups of home deliveries could be substantially altered by the addition or reclassification of several neonatal deaths. The findings need testing where home delivery is more common.

Retrospective classification of birth regarding intent to deliver in the place and circumstances in which delivery actually occurred is difficult at best. Intended home deliveries followed by neonatal death may have been misclassified as precipitate and unplanned. Women who chose home delivery but developed a problem during labor may have gone to the hospital to deliver. Hospitals are appropriately the intended place for most high-risk deliveries. This fact confounds comparison of the neonatal mortality of hospital and home deliveries.

Some home births may not have been reported to state registrars, especially if the infant died. Possibly such underreporting was more frequent in planned home deliveries when a preventable death caused guilt feelings. However, because lay-midwives need a permit for each home delivery and have a reputation to maintain, such underreporting is probably less likely than for home deliveries that did not come to the attention of the health department before delivery.

In conclusion, there has been a dramatic shift from home to hospital delivery in the last 40 years in North Carolina. The potential risk of delivery at home may be unacceptable to most women. However, some women still prefer or economically need an alternative to a high cost physician-hospital delivery. Indeed, cost and preference accounted for more than three fourths of the reasons for the dangerous planned home deliveries not attended by a physician or lay-midwife.

Poor women in some rural areas are still experiencing high levels of preventable neonatal mortality because of lack of medical attention. To extend adequate prenatal and delivery services to these women, economically realistic alternatives should be developed before existing traditional services are phased out. For prenatally screened low-risk women, delivery by a trained nurse-midwife under physician supervision, perhaps in a birthing center with hospital backup, may have a cost advantage over physician-hospital delivery without unacceptable risk of maternal or neonatal mortality. Whatever program a community develops, monitoring the quality of prenatal care, adequately identifying high-risk pregnancies, and training competent birth attendants all require the knowledge, expertise, and support of the medical community.

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Table
Neonatal and Infant Deaths of
Anchorage Residents, 1970-1979

	Neonatal Deaths/Rate		Infant Deaths/Rate		Number Live Res. Births
1970	55	17.2	74	22.5	3285
1971	36	11.6	52	16.3	3192
1972	36	11.6	51	16.4	3119
1973	39	13.5	51	17.5	2917
1974	36	11.6	46	14.8	3132
1975	13	4.0	36	11.3	3260
1976	25	6.4	47	12.0	3968*
1977	22	5.9	43	11.6	3720
1978	39	10.3	58	15.3	3825
1979	39	10.3	56	14.7	3823

* estimated

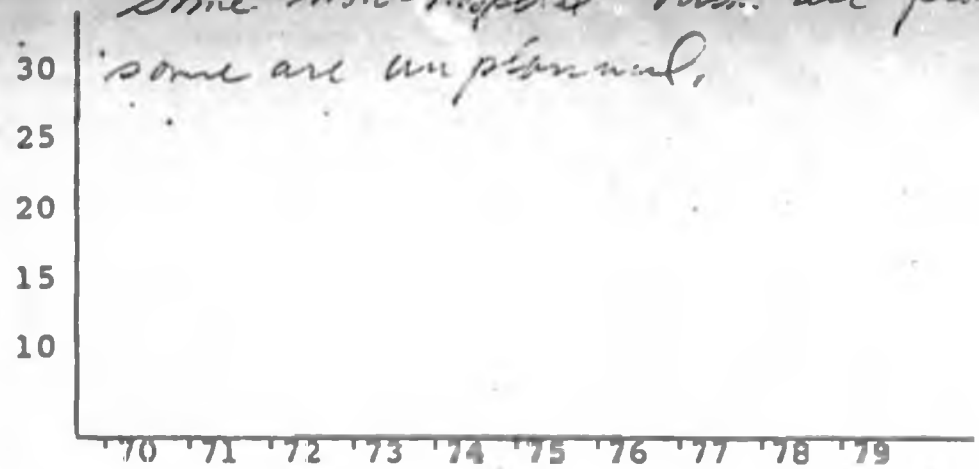
Resident neonatal and infant death rates dropped dramatically from 1970 to 1975, but have started climbing slowly gain. Because numbers are small the effect of each change may be misleading. Until 1978 local rates were below those of the nation. Since 1979 local rates (14.7) have exceeded national rates (13.6). The State Health Systems Plan recommends maintaining a neonatal mortality rate of no more than 9.0 per 1,000 live births, and an infant rate of no more than 15.0 per 1,000 live births. Further and careful review of Anchorage rates is necessary.

Table
Neonatal and Infant Mortality for Anchorage, Southcentral and Alaska, 1970-1979

	Infant Mortality Rates			Neonatal Mortality Rates		
Year	Anchorage	Southcentral	Alaska	Anchorage	Southcentral	Alaska
1970	22.5	17.2	23.4	17.2		
1971	16.3	20.3	18.3	11.6		12.6
1972	16.4	16.7	17.0	11.6		11.1
1973	17.5	21.8	19.9	13.5		13.0
1974	14.8	19.2	18.8	11.6		12.6
1975	11.3	13.7	14.3	4.0		9.4
1976	12.6 *	15.3	16.1	6.4		9.2
1977	11.6	13.9	14.8	5.9		8.2
1978	15.3		14.6	10.3		9.6
1979	14.7		147 6.1	10.3		9.1

*estimated

some "non-hospital" births are planned
some are unplanned.



* Anchorage
\- Southcentral
-- Alaska

Home Births and Perinatal Mortality. Growing numbers of Alaskan women are choosing to have their babies at home or at least outside of an acute setting. Table _ shows the number of Alaskan and Anchorage births which occured in a setting "other" than a hospital or clinic.

Table _ __

Number and Percent of Births Occuring Outside a Medical Facility
Anchorage and Alaska 19__ - 1979

	1976		1977		1978		1979	
	#	%	#	%	#	%	#	%
Anchorage	N/A		N/A		32	1.2	75	1.8
Alaska							302	3.3

It is not clear at this time exactly how many women who intended a home birth, developed complications and actually delivered in a hospital. Indicators of the incidences of problem deliveries are minimal. However, Annual Surveys of Anchorage hospitals indicate that from 15 to 30 percent of all hospital deliveries are classified (ICD-9-CM) as "Complications of Pregnancy, Childbirth and Puerperium." While that classification code may include relatively minor complications, it does indicate need for medical attention beyond that which occurs during a normal delivery. In addition, some physicians estimate that about one of every four women identified as low risk throughout pregnancy, experience (maternal or fetal) complications during delivery. The inference from these data is that there is sufficient risk to mother and infant during the perinatal period to question the adviseability of home births. Features such as alternative birthing rooms and centers,

WHAT DATA ?

liberal policies regarding attendance during birth and post-partum care, 24 hour rooming-in, and shorter lengths-of-stay are now available. Such services are offered to create a more personal, family-centered experiance for all involved, while assuring sound medical monitoring and treatment when needed.

Estimates of Service Requirement and Needs

Assumptions and Methodologies. Estimates are based upon the bed need projection formula as described below. Estimates assume that the use rate is appropriate for this service and that population estimates are valid. Anchorage NSCN units serve native and non-Natives, from Anchorage, Southcentral and the rest of Alaska. Better patient origin data is needed to more realistically determine future bed needs. For now the formula used will be:

$$\text{NSCN Use Rate (1979)} = \frac{\text{NSCN Pat. Days, 1979}}{\text{Health Service Area Births (State)}}$$

$$\frac{\text{Use Rate} \times \text{No. State Births in 198x (1000)}}{365 \text{ days}} = \text{Projected Average Daily Census}$$

$$\frac{\text{ADC}}{50\% \text{ occupancy}} = \text{Future NSCN Bed Need}$$

Estimates of Service Needs. Calculation of projected need for NSCN beds required estimating future numbers of live births in the State. Table __ shows projected state births and beds needed applying a 1979-base use rate of 283 Since 1973 there has been an average annual increase of 3.7 percent in the number of Alaskan births. That same growth has been applied to projections from 1981 to 1990, although future developments in the state may render these projections conservative.

Table
Projected Alaskan Births and Need for
NSCN Beds 1981 - 1990

	Alaska Births	NSCN Beds Needed	Current NSCN Beds Available
1981	10,198	16	20
1983	11,393	18	
1985	12,728	20	
1990	16,790	26	

Current total supply of NSCN beds would appear to meet demands generated by the service area. However, closer look at utilization of the two existing units shows that the 14

bed Providence unit is operating close to the 50 percent minimum occupancy standard recommended; whereas the 6 bed Alaska Hospital unit is operating below 20 percent occupancy. National guidelines recommend that for maximum efficiency and effectiveness minimum size for an NSCN unit is 15 beds. Recommendations regarding the appropriate distribution and supply of NSCN beds, as well as other Level I, II and III resources, are due by fall 1981 from the Perinatal Services Technical Advisory Group. Those recommendations will be proposed for public review, followed by amendment to this HSP.

Goals

Goal 1.0: Implement a regionalized system for perinatal care.

Objective 1.1: By 1983, establish a regional system for perinatal services with appropriate linkages at each level (I, II and III), that are responsive to consumer needs and meet the following criteria:

- Average annual occupancy of at least 75% in Level II/III units;
- at least 1500 annual live births in each Level II/III unit;
- no more than 4 intensive and intermediate care beds per 1000 live births in the service area;
- no fewer than 15 beds per unit;
- ongoing outreach and continuing education for providers in the service are aregarding appropriate referral procedures.

Goal 2.0: Improve prognosis and survival rates for high risk mothers and babies.

Objective 2.1: By 1983, increase by 10% the number of in-utero transports to Anchorage Level II/III Perinatal Center.

Objective 2.2: By 1983, reduce the number of home births to less than 1% of the total Anchorage occuring births.

Objective 2.3: By 1982, to improve personnel skills with and effective use of electronic fetal monitoring in all labor and delivery settings.

No data to correlate connection between Goal 2.0 and Objective 2.2 available. [illegible]

VAR20 RATE HOSP BIRTH

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
POOR	1.	18	18.2	32.7	32.7
UNSATISFACTORY	2.	18	18.2	32.7	65.5
UNDECIDED	3.	1	1.0	1.8	67.3
SATISFACTORY	4.	16	16.2	29.1	96.4
GREAT	5.	2	2.0	[illegible]	100.0
NOT APPLICABLE	8.	44	44.4	MISSING	100.0
	TOTAL	99	100.0	100.0	

MEAN	2.382	STD ERR	0.177	MEDIAN	2.028
MODE	1.000	STD DEV	1.312	VARIANCE	1.722
KURTOSIS	-1.291	SKEWNESS	0.471	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES 55 MISSING CASES 44

less than 1/3 satisfied!

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR24 RATE HOME BIRTH

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SATISFACTORY	4.	8	8.1	8.1	8.1
GREAT	5.	91	91.9	[illegible]	100.0
	TOTAL	99	100.0	100.0	

MEAN	4.919	STD ERR	0.028	MEDIAN	4.956
MODE	5.000	STD DEV	0.274	VARIANCE	0.075
KURTOSIS	7.917	SKEWNESS	-3.124	RANGE	1.000
MINIMUM	4.000	MAXIMUM	5.000		

VALID CASES 99 MISSING CASES 0

all satisfied!

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR25 WHO CAUGHT BABY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
MATORO DR	2.	32	32.3	32.3	32.3
FATHER	3.	19	19.2	[illegible]	51.5
LAY MIDWIFE	4.	42	42.4	42.4	93.9
FRIEND	5.	2	2.0	2.0	96.0
SELF	6.	3	3.0	3.0	99.0
	9.	1	1.0	1.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	3.293	STD ERR	0.119	MEDIAN	3.421
MODE	4.000	STD DEV	1.180	VARIANCE	1.393
KURTOSIS	4.393	SKEWNESS	1.271	RANGE	7.000
MINIMUM	2.000	MAXIMUM	9.000		

VALID CASES 99 MISSING CASES 0

VAR29 MEDICAL INSURANCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	47	47.5	[redacted]	47.5
NO	2.	52	52.5	52.5	100.0
	TOTAL	99	100.0	100.0	

MEAN	1.525	STD ERR	0.050	MEDIAN	1.548
MODE	2.000	STD DEV	0.502	VARIANCE	0.252
KURTOSIS	-2.031	SKEWNESS	-0.103	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	99	MISSING CASES	0		

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR30 MEDICAID INSURANCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	13	13.1	[redacted]	13.8
NO	2.	81	81.8	86.2	100.0
MISSING	9.	5	5.1	MISSING	100.0
	TOTAL	99	100.0	100.0	

MEAN	1.862	STD ERR	0.036	MEDIAN	1.920
MODE	2.000	STD DEV	0.347	VARIANCE	0.120
KURTOSIS	2.590	SKEWNESS	-2.130	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	94	MISSING CASES	5		

HOMEBIRTH
FILE BABE (CREATION DATE = 08-13-81)

VAR31 INCOME AFFECTS HB

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	1	1.0	1.0	1.0
NO	2.	98	99.0	[redacted]	100.0
	TOTAL	99	100.0	100.0	

MEAN	1.990	STD ERR	0.010	MEDIAN	1.995
MODE	2.000	STD DEV	0.101	VARIANCE	0.010
KURTOSIS	99.000	SKEWNESS	-9.950	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	99	MISSING CASES	0		

61.3% had medical coverage which would have covered the expenses for a hospital birth — but insisted they chose to pay out of pocket for a home birth. Most insurance plans will not cover births attended by midwives, some will cover any home birth.

VAR26 INCOME 1980

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
LESS THAN 10,000	1.	14	14.1	14.1	14.1
10,000 TO 20,000	2.	19	19.2	19.2	33.3
20,000 TO 30,000	3.	27	27.3	27.3	60.6
30,000 TO 40,000	4.	17	17.2	17.2	77.8
40,000 TO 50,000	5.	16	16.2	16.2	93.9
GREATER THAN 50,000	6.	2	2.0	2.0	96.0
	8.	2	2.0	2.0	98.0
	9.	2	2.0	2.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	3.303	STD ERR	0.172	MEDIAN	3.111
MODE	3.000	STD DEV	1.711	VARIANCE	2.928
KURTOSIS	1.679	SKEWNESS	1.011	RANGE	8.000
MINIMUM	1.000	MAXIMUM	9.000		
VALID CASES	99	MISSING CASES	0		

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR27 COUPLE OR SINGLE INCOME

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SINGLE INCOME	1.	5	5.1	5.1	5.1
COUPLE INCOME	2.	92	92.9	92.9	98.0
	9.	2	2.0	2.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	2.091	STD ERR	0.103	MEDIAN	1.934
MODE	2.000	STD DEV	1.021	VARIANCE	1.043
KURTOSIS	42.453	SKEWNESS	6.388	RANGE	8.000
MINIMUM	1.000	MAXIMUM	9.000		
VALID CASES	99	MISSING CASES	0		

IN THE LEGISLATURE
of the
STATE OF WASHINGTON

CERTIFICATION OF ENROLLED ENACTMENT

SUBSTITUTE HOUSE BILL NO. 716

CHAPTER NO. 23

Laws of 1981
47th Legislature

Effective Date:
Except Sections 1, 2, 3, 4, 8, 9, 10,
11, and 13 through 17, which take effect
January 15, 1982

Passed the House March 30, 1981

Yeas 71 Nays 22

Passed the Senate April 14, 1981

Yeas 47 Nays 5

CERTIFICATION

I, Vee T. Chesla, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is engrossed Substitute House Bill No. 716 as passed by the House of Representatives and the Senate on the dates hereon set forth.

Vee T. Chesla — Chief Clerk

SUBSTITUTE HOUSE BILL NO. 316

State of Washington
47th Legislature
1981 Regular Session

by Committee on Human Services (originally sponsored by Committee on Human Services and Representatives Teutsch and Wang)

Read first time March 6, 1981, and passed to Rules for second reading.

AN ACT Relating to midwifery; amending section 7, chapter 96, Laws of 1979 ex. sess. and RCW 7.70.020; amending section 8, chapter 160, Laws of 1917 and RCW 18.50.010; amending section 3, chapter 160, Laws of 1917 and RCW 18.50.040; amending section 4, chapter 160, Laws of 1917 as amended by section 43, chapter 154, Laws of 1979 and RCW 18.50.060; amending section 7, chapter 160, Laws of 1917 and RCW 18.50.100; amending section 21, chapter 266, Laws of 1971 ex. sess. as last amended by section 100, chapter 158, Laws of 19 and RCW 43.24.085; adding two sections to chapter 18.50 RCW; repealing section 5, chapter 160, Laws of 1917 and RCW 18.50.070; re-calling section 6, chapter 160, Laws of 1917 and RCW 18.50.080; providing an effective date; and making an appropriation.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Section 1. Section 7, chapter 96, Laws of 1979 ex. sess. and RCW 7.70.020 are each amended to read as follows:

As used in this chapter "health care provider" means either:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractic , physical therapist, psychologist, pharmacist, optician, physician's assistant, physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in part

-1-

Sub 316

(1) above, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in part (1) above, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including in the event such officer, director, employee, or agent is deceased, his estate or personal representative.

NEW SECTION. Sec. 2. There is added to chapter 18.50 RCW a new section to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter:

(1) "Department" means the department of licensing.

(2) "Director" means the director of licensing.

(3) "Midwife" means a midwife licensed under this chapter.

NEW SECTION. Sec. 3. There is added to chapter 18.50 RCW a new section to read as follows:

The midwifery advisory committee is created.

The committee shall be composed of one licensed physician to ~~[illegible]~~ a practicing obstetrician, one practicing licensed physician, one certified nurse midwife licensed under chapter 18.88 RCW, three midwives licensed under this chapter, and three public members who shall have no financial interest in the rendering of health services. The committee may seek other consultants as appropriate, including persons trained in childbirth education and perinatology or neonatology.

The members are appointed by the director and serve at the pleasure of the director but may not serve more than three consecutive years or more than five years in total. The terms of office shall be staggered. Members of the committee shall be reimbursed for travel expenses as provided in RCW 43.03.050 and

43.03.060 as now or hereafter amended.

NEW SECTION. Sec. 4. There is added to chapter 18.50 RCW a new section to read as follows:

The midwifery advisory committee shall advise and make recommendations to the director on issues including, but not limited to, continuing education, mandatory reexamination, and peer review. The director shall transmit the recommendations to the social and health services committee of the senate and the human services committee of the house of representatives on an annual basis.

Sec. 5. Section 8, chapter 160, Laws of 1917 and RCW 18.50.010 are each amended to read as follows:

Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman ((in-anticipation-for-a-fee-or-compensation)) during prenatal, intrapartum, and postpartum stages or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to ((always-secure-the-services-of-a)) consult with a legally qualified physician whenever ((any-abnormal-stages-or-symptoms-appear-either-in)) there are significant deviations from normal in either the mother or the infant.

Sec. 6. Section 3, chapter 160, Laws of 1917 and RCW 18.50.040 are each amended to read as follows:

((1)) Any person seeking to be examined shall present to the ((said)) director, at least ((ten)) forty-five days before the commencement of the ((said)) examination, a written application on a form or forms provided by the ((said)) director setting forth under affidavit ((the-name,-age,-residence,-and-time-and-place-of-obtaining-a-common-school-education)) such information as the director may require and proof ((as-to-the-graduation-of-the-applicant-from-the-high-school-course-or-its-equivalent)) that the applicant is not less than [illegible]

evidence that the candidate has received a certificate or diploma from a ((legally incorporated school on midwifery in good standing, granted after at least two courses of instruction of at least seven months each in different calendar years)) midwifery program accredited by the director and registered under chapter 28B.05 RCW, when applicable, or a certificate or diploma in a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued. The diploma must bear the seal of the institution from which the applicant was graduated. Foreign ((applicants)) candidates must present with the application a translation of the foreign certificate or diploma made by and under the seal of the consulate of the country in which the ((said)) certificate or diploma was issued. ((The application must be endorsed by a duly registered reputable physician of the state of Washington.))

(2) The candidate shall meet the following conditions:

(a) Obtaining a minimum period of midwifery training for at least three years including the study of the basic nursing skills that the department shall prescribe by rule. However, if the applicant is a registered nurse under chapter 18.88 RCW, a licensed practical nurse under chapter 18.78 RCW, or has had previous nursing education or practical midwifery experience, the required period of training may be reduced depending upon the extent of the candidate's qualifications as determined under rules adopted by the department. In no case shall the training be reduced to a period of less than two years.

(b) Meeting minimum educational requirements which shall include studying obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breast feeding; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization,

and aseptic technique; and such other requirements prescribed by rule.

(c) For a student midwife during training, undertaking the care of not less than fifty women in each of the prenatal, intrapartum, and early postpartum periods, but the same women need not be seen through all three periods. A student midwife may be issued a permit upon the satisfactory completion of the requirements in (a), (b), and (c) of this subsection and the satisfactory completion of the licensure examination required by RCW 18.50.040. The permit permits the student midwife to practice under the supervision of a midwife licensed under this chapter, a physician licensed under chapter 18.57 or 18.71 RCW, or a certified nurse-midwife licensed under the authority of chapter 18.79 RCW. The permit shall expire within one year of issuance and may be extended as provided by rule.

(d) Observing an additional fifty women in the intrapartum period before the candidate qualifies for a license.

The training required under this section shall include training in either hospitals or alternative birth settings or both with particular emphasis on learning the ability to differentiate between low-risk and high-risk pregnancies.

NEW SECTION. Sec. 7. There is added to chapter 18.50 RCW a new section to read as follows:

The director shall promulgate standards by rule under chapter 34.04 RCW for accrediting midwifery educational programs. The standards shall cover the provision of adequate clinical and didactic instruction in all subjects and noncurriculum matters under this section including, but not limited to, staffing and teacher qualifications. In developing the standards, the director shall be advised by and receive the recommendations of the midwifery advisory committee.

Sec. 8. Section 4, chapter 160, Laws of 1917 as amended by section 43, chapter 158, Laws of 1979 and RCW 18.50.040 are each amended to read as follows:

(1) The director of licensing is hereby authorized and

empowered to execute the provisions of this chapter and shall ((hold)) offer examinations in midwifery ((on the first Monday in January and July)) at least twice a year at such times and places as the director may select((, from ten o'clock a.m. to five o'clock p.m., and at such other times as the said director may deem expedient)). The examinations ((may)) shall be ((oral,)) written((, or both,)) and shall be in the English language((, if desired in any other language an interpreter may be provided by said director upon notification [illegible] interpreter shall be defrayed by the applicant for the license.

Examinations shall be held on the following subjects:

(1) Anatomy of pelvis and female genital organs;

(2) Physiology of menstruation;

(3) Diagnosis and management of pregnancy;

(4) Diagnosis of foetal presentation and position;

(5) Mechanism and management of normal labor;

(6) Management of puerperium;

(7) Injuries to the genital organs following labor;

(8) Sepsis and antisepsis in relation to labor;

(9) Special care of the new born;

(10) Hygiene of mother and infant;

(11) [illegible] infectious diseases of the new born;

(12) Causes and effects of [illegible];

(13) Abnormal conditions requiring attention of a physician;

(14) [illegible])).

((Each)) (2) The director, with the assistance of the midwifery advisory committee, shall develop or approve a licensure examination in the subjects that the director determines are within the scope of and commensurate with the work performed by a licensed midwife. The examination shall be

sufficient to test the scientific and practical fitness of candidates to practice midwifery ((~~and the director may require examination on other subjects relating to midwifery from time to time~~)). All application papers shall be deposited with the director and there retained for at least one year, when they may be destroyed.

(3) If ((~~said~~)) the examination is ((~~satisfactory~~)) satisfactorily completed, ((~~said~~)) the director shall issue to such candidate a license entitling the candidate to practice midwifery in the state of Washington((~~: PROVIDED, That such license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant~~)).

(4) A midwife licensed under this chapter may obtain and administer prophylactic ophthalmic medication, postpartum [illegible] and may administer such other drugs or medications as prescribed by a licensed physician. A pharmacist who dispenses such drugs to a licensed midwife shall not be liable for any adverse reactions caused by any method of utilization by the midwife.

Sec. 9. Section 7, chapter 160, Laws of 1917 and RCW 18.50.100 are each amended to read as follows:

((~~Said~~)) The director may refuse to grant or may suspend or revoke any license ((~~herein granted for~~)), may reprimand or censure a license holder, or may place on probation subject to reasonable remedial conditions a license holder for any of the following reasons: Persistent inebriety; the practice of criminal abortion; the commission of any crime involving moral turpitude relevant to the practice of midwifery; presentation of a certificate or diploma for registration or license illegally obtained; application for examination under fraudulent misrepresentation; mishandling drugs authorized by this chapter; neglect or refusal to make proper returns to the ((~~health officers or boards~~)) department of social and health services of births or of puerperal contagion or infectious diseases within

the required limit of time; ((failure to record her license with the clerk of the county in which the midwife resides or practices)) failure to ((secure the attendance of a reputable)) consult with a physician in a case of ((hemorrhage, hemorrhage, abnormal presentation or position, retained placenta, convulsions, prolapse of the cord, fever during puerperium, fetal, inflammation or discharge from the eyes of the new born infant, or whenever there are any abnormal or unhealthy symptoms)) significant deviations from normal in either the mother or the infant ((during labor or the puerperium period)).

In complaints of violations of the provisions of this section, the accused shall be furnished with a copy of the complaint and be given a hearing before ((such director or person or by attorney)) a hearing examiner, with right of appeal to the director. Any midwife refused admittance to the examination or whose license has been revoked who shall attempt or continue the practice of midwifery((,)) shall be subject to the penalties ((hereinbefore)) prescribed under this chapter.

NEW SECTION. Sec. 10. There is added to chapter 18.50 RCW a new section to read as follows:

Registered nurses and nurse midwives certified by the board of nursing under chapter 18.[illegible] RCW shall be exempt from the requirements and provisions of this chapter.

NEW SECTION. Sec. 11. There is added to chapter 18.50 RCW a new section to read as follows:

Nothing in this chapter shall be construed to apply to or interfere in any way with the practice of midwifery by a person who is enrolled in a program of midwifery approved and accredited by the director: PROVIDED, That the performance of such services is only pursuant to a regular course of instruction or assignment from the student's instructor, and that such services are performed only under the supervision and control of a person licensed in the state of Washington to perform services encompassed under this chapter.

NEW SECTION. Sec. 12. There is added to chapter 18.50 RCW a new section to read as follows:

The director, with the advice of the midwifery advisory committee, shall develop a form to be used by a midwife to inform the patient of the qualifications of a licensed midwife.

NEW SECTION. Sec. 13. There is added to chapter 18.50 RCW a new section to read as follows:

Every person licensed to practice midwifery shall register with the director of licensing annually and pay an annual renewal registration fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended on or before the licensee's birth anniversary date. The license of the person shall be renewed for a period of one year. Any failure to register and pay the annual renewal registration fee shall render the license invalid. The license shall be reinstated upon written application to the director, payment to the state of a penalty fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended, and payment to the state of all delinquent annual license renewal fees. Any person who fails to renew his or her license for a period of three years shall not be entitled to renew such license under this section. Such person, in order to obtain a license to practice midwifery in this state, shall file a new application under this chapter, along with the required fee. The director, in the director's discretion, may permit the applicant to be licensed without examination if satisfied that the applicant meets all the requirements for licensure in this state and is competent to engage in the practice of midwifery.

NEW SECTION. Sec. 14. There is added to chapter 18.50 RCW a new section to read as follows:

Every licensed midwife shall develop an [illegible] consultation with other health care providers, emergency [illegible] appropriate obstetrical department or patient care area. The

written plan shall be submitted annually together with the
(license renewal fee in the appropriate

NEW SECTION. Sec. 15. There is added to chapter 18.30
RCW a new section to read as follows:
The director shall promulgate rules under chapter 34.04
RCW as are necessary to carry out the purposes of this chapter,

Sec. 16. Section 21, chapter 266, Laws of 1971 ex. sess.,
as last amended by section 100, chapter 158, Laws of 1979 and
RCW 43.24.086 are each amended to read as follows:
It shall be the policy of the state of Washington that
the director of licensing shall from time to time establish the
amount of all application fees, license fees, registration fees,
examination fees, permit fees, renewal fees, and any other fee
associated with licensing or registration of professions
or businesses, administered by the business and
professions administration in the department of licensing. In
fixing said fees the director shall, insofar as is practicable,
fix such fees relating to each profession, occupation, or
business in such a manner that the income from each will match
the estimated expenses to be incurred in the administration of
the laws relating to each such profession, occupation, or
business. All such fees shall be fixed by rule and regulation
adopted by the director in accordance with the provisions of the
administrative procedure act, chapter 34.04 RCW: PROVIDED, That
In no event shall the license or registration
renewal fee in the following cases be fixed at an amount less
than five dollars or in excess of fifteen dollars:
Barber
Barber
Cosmetologist (manager-operator)
Cosmetologist (operator)
Cosmetologist (instructor-operator)
Apprentice cosmetologist
Manicurist/pedicurist
Apprentice (general) manicurist

Registered nurse

Licensed practical nurse

Charitable organization

Professional solicitor.

(2) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than ten dollars or in excess of twenty dollars:

Dental hygienist

Barber instructor

Barber manager instructor

Psychologist

Embalmer

Funeral director

Sanitarian

Veterinarian

Cosmetology shop

Barber shop

Proprietary school agent

Specialized and advanced registered nurse

Physician's assistant

Osteopathic physician's assistant

(3) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than fifteen dollars or in excess of thirty-five dollars:

Architect

Dentist

Engineer

Land Surveyor

Midwife

Podiatrist

Chiropractor

Drugless therapeutic

Osteopathic physician

Osteopathic physician and surgeon

Physical therapist

Physician and surgeon

Optometrist

Dispensing optician

Landscape architect

Nursing home administrator

Hearing aid fitter;

(4) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than fifty dollars or in excess of two hundred dollars:

Engineer corporation

Engineer partnership

Cosmetology school

Barber school

Debt adjuster agency

Debt adjuster branch office

Debt adjuster

Proprietary school

Employment agency

Employment agency branch office

Collection agency

Collection agency branch office

Professional fund raiser.

NEW SECTION. Sec. 17. There is appropriated to the department of licensing from the state general fund for the biennium ending June 30, 1983, the sum of thirty thousand six hundred sixty-three dollars or so much as may be necessary to carry out the purposes of this act.

NEW SECTION. Sec. 18. The following acts or parts of acts are each hereby repealed:

(1) Section 5, chapter 160, Laws of 1937 and RCW 18.50.070; and

(2) Section 6, chapter 160, Laws of 1937 and RCW 18.50.080.

NEW SECTION. Sec. 19. Sections 1, 3, 5, 6, 8, 9, 11, 12, and 13 through 17 of this act shall take effect January 15,

Sec. 19

1 1981.

Passed the House March 31, 1981.

Speaker of the House.

Passed the Senate April 14, 1981.

President of the Senate.

Approved April 21, 1981

Governor of the State of Washington.

RECEIVED
APR 23 1981
STATE OF WASH

Senate Law Committee
Office of the Code Reviser
Legislative Building
Olympia, Washington
98504

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE - AMENDED

I. REQUEST
Bill/Resolution No. 2d SSHB 11
Title An Act relating to midwifery.
Requested by Rogers Date 2-11-82

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, Or Subprogram(s) Affected Regulation & licensing of professions.
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		27.9	27.9	27.9	27.9	27.9
200 TRAVEL		9.4	10.3	11.4	12.5	13.7
300 CONTRACTUAL		16.0	17.4	18.9	20.6	22.4
400 COMMODITIES		.5	.5	.5	.5	.5
500 EQUIPMENT		2.8				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		56.6	56.1	58.7	61.5	64.5

FUNDING (Thousands of Dollars)

GENERAL FUND		56.6	56.1	58.7	61.5	64.5
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

PERSONAL SERVICES - FY'82 salary schedule and benefits.
1 Licensing Examiner I, range 12, gen.govt., 12 mos. 27.9

TRAVEL - 10% inflation factor projected.
Board of Midwifery, 5 members(anticipate 1-Anch, 1-Fbks, 1-Southeast,1-Kenai area, and 1-Nome area); 3 meetings per year (1 ea. in Anch, Fbks, & S.E), travel costs plus 3 days per diem @$80/day $6,000.00

Department staff: 1-licensing examiner to attend meetings of the Board of Midwifery, travel costs plus per diem 1,200.00
1-regulations specialist to hold hearings and assist board in promulgation of regulations, travel and per diem 1,200.00
1-investigator, travel and per diem costs to investigate complaints concerning lay midwifery; average 1 trip every 4 months @$200/trip plus per diem @ $80/day 1,000.00

IV. DATE March 25, 1982 PREPARED BY Marjorie Odland
AGENCY Division of Occupational Licensing
PHONE 465-2535

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

13-001 (Rev. 12/81)

CONTRACTUAL - 9% inflation factor projected.

Printing of new statute booklets, applications and licenses for midwives desiring to become licensed.	$ 2,000.00
Meeting notices, regulation publications, mailing costs of application packets and statute booklets	800.00
General operating costs including phones, computer time (pro-rated by board), and similar daily costs.	1,000.00
Development of examination, professional services contract basis, including updates, pool of questions for use by state board, storage in in-house computer system	5,000.00

Licensing/Disciplinary Hearings - Anticipate three hearings per year. In estimating one day hearings, the following costs are considered:

Average 6 hour days:	
Hearing Officer, @$75/hr	450.00
Court Reporter, @$25/hr	150.00
10 exhibits, $.45 ea.	4.50
3 witnesses, 1/2 day ea.@ $12.50	37.50
1 expert witness, 2 hrs. @ $150./hr.	300.00
Transcript, avg. 210 pages @ $4.50/page	945.00
	1,887.00
	X 3
	$ 5,661.00

Room Rental for examinations: 2 exams per year., 1 day each.	200.00
Proctors for examinations: .	
Head Proctor - $50/day	100.00
Monitor - $35/day	70.00

Rental Space - 1 licensing examiner position: 60 sq.ft X $1.70 X 12 mos.= 1.2

COMMODITIES

General supplies needed by licensing examiner such as tapes for meetings, file folders, paper etc.	.5

EQUIPMENT - one time cost in FY'83.

1 desk,double pedestal 60" x 30"	426.92
1 chair, posture without arms (contour)	170.57
1 typewriter, correcting selectric, dual pitch	1,028.81
1 typewriter table	101.92
1 credenza, 90" x 62"	470.90
1 side chair	95.15
2 file cabinets, 4 drawer legal	505.20
	$2,799.48

Fairbanks
MEDICAL ASSOCIATION
P.O. BOX 1330
FAIRBANKS, ALASKA 99701

February 17, 1982

Barbara Wilkins, Assistant
House Committee on HESS
c/o Representative Mike Beirne
Pouch V
Juneau, AK 99108

Dear Ms. Wilkins:

I have received your letter of 1-23-82 to the Alaska Medical Association. This letter was presented at the Fairbanks Medical Society Meeting of 2-11-82. At that time, the members of our medical community who deliver babies were polled, and we were unable to document any cases of expectant mothers being denied prenatal care because they contemplated home delivery. This has not been a problem in the Fairbanks area that we know of.

If you have any evidence to the contrary, please bring it to my attention.

Sincerely,

RGP

Richard G. Parry, M.D., F.A.C.S.
President

RGP/co

SECTIONAL ANALYSIS FOR CS 2d SS HB 11

Purpose: The purpose of this legislation is to establish a Board of Midwifery, license and regulate lay midwives. There has been controversy over the scope of the statutorily mandated practice, over the means of regulation and examination, over the informed consent form, the extent of educational background, and formation of a collaborative relationship with physicians, and voluntary versus mandatory nature of licensure.

Changes:

Page 2, line 8: Changes the two elective members to one physician and one elective member appointed by the Governor.

Page 3, line 12: Adds the requirement of two years of nursing school or its equivalent to educational requirements.

Page 6, line 14: Adds the following sentence: "The form shall contain notice that injuries sustained during a home birth may not be covered by malpractice insurance even if a midwife or physician is in attendance." This section is purely experimental. It has been objected to in light of the 1978 SLA repeal of sections of law which mandated malpractice insurance for medical doctors. The collaborative nature of physician/midwife practice will eventually concern liability and may be one area of concern between the professions.

Page 8, line 10: Adds a section to the obligation of a midwife in that the midwife is responsible to establish and maintain a collaborative relationship with a physician. The scope is generally on referral, advice, and rarely in emergencies. However, the language would seem inadequate to reflect an ongoing professional relationship.

Page 9, line 8: Enlarges the definition of sponsor to add, "and authorized to act as a sponsor by the board." This was to ensure a responsible supervisor who must be board endorsed.

4-1-81

SB 717
Health Educ.

HB 11

Larry Kroeger - O.L.
/8 Cert Nurse midwives in State

6000 RN & LPN lic.!

Div of O.L. wants Bd to Lobby.

Don Koch - Div of Ins.:

[illegible] - no expense,

SB 276 - [illegible] Bd lic.

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

A G E N D A for April 1, 1982

House Bill 412, Relating to Preventive Dental Program

Representative Buchholdt

House Bill 111, Relating to Optometry

Senate Bill 650, Relating to Licensing of Facilities

John Pugh, Director, Family and Youth Services

House Bill 11, Relating to Midwifery

House Bill 327, Relating to Naturopathy

POSITION PAPER/Department of Health & Social Services

3/24/82

REVISED POSITION PAPER
2d Sponsor Substitute for House Bill No. 11

"An Act relating to midwifery."

WHAT THE BILL DOES

This bill creates an examining and licensing Board of Midwifery and establishes criteria to be used in issuing such licenses. However, since a license would not be required to practice midwifery, it would create three levels of midwifery care: (a) certified nurse (under 12 AAC 44.400), (b) licensed midwife, and (c) unlicensed midwife.

DISCUSSION

Historical Background - Alaska, like many states, had existing policies and procedures concerning lay-midwifery practice in the early part of this century. Before widespread availability of medical facilities, adequate transportation and professional providers, this Department promoted training for birth attendants in remote village areas through maternal and child health nurse consultants. In 1968, specific training was discontinued because of the establishment of the Community Health Aide training program by the Alaska Native Health Service. This program emphasizes the Community Health Aide's collaborative relationship with the Alaska Native Health physicians, which has resulted in moving the vast majority of village home births to the protected environment of hospitals.

Current Situation - While it is difficult to summarize the states' laws in this area, it can be stated that 13 states have licensure statutes for lay midwives. Some of these, while remaining on the books, are not operational in terms of issuance of new licenses. Of the remaining 37 states, approximately 8 have statutes which prohibit practice of lay midwifery. This information is summarized from a survey of states' laws printed in Mothering, Fall 1981, p. 63. There are three states (Washington, South Carolina, and New Hampshire) that have passed legislation within the last year dealing with this issue. These states have established midwifery regulatory boards which have the authority to establish licensure criteria and procedures. Typically, these boards include physician(s), certified nurse midwives and consumers in addition to lay midwives.

Problem areas of this bill - Assisting with childbirth is both an art and a science. In most instances the process proceeds to a normal outcome with nothing more than artful support and non-intervention. In some instances, however, the process requires utmost scientific knowledge and skill. Since it is not possible to know in advance which cases will require this higher level of care, it is in the best interest of Alaska's citizens to require quality care in as many births as possible. The licensure criteria in this bill are simply not adequate to assure that the licensee would have the judgment needed to recognize and refer the problem cases.

These deficiencies are in both formal education and in practical supervised training and experience. A required period of 9 months of formal training and participation in at least 50 births have been suggested by the National Midwives Association. The Washington law calls for 3 years of training and 100 births.

POSITION PAPER/Department of Health & Social Services

This Department has recently been appraised of the problem that lay midwives are having in getting prenatal blood tests performed. AS 18.15.150 currently addresses the legal issues in this matter. This bill (p. 5, line 28) will solve this problem only for the licensed midwife. This illustrates a much larger problem - that of the collaborative relationship between a lay midwife and a physician to whom any problems would be referred. This relationship is required for physician's assistants and for certified nurse midwives. Once a woman in labor develops a problem requiring referral there is not sufficient time to start searching for a physician with whom to consult. One of the basic tenents of midwifery practice is to handle only normal or low risk clients. This risk assessment can best be approached through a collaborative relationship with a physician. The collaborating physician should be protected by statute from liability related to the care of a client not directly under his supervision.

POSITION

This Department is opposed to passage of this bill as written. Inclusion of requirements for formal as well as practical training and a requirement for a collaborative relationship with a licensed physician are essential features. In addition to the Board members stated in Sec. 08.69.030(a), there should be a licensed physician who is a practicing obstetrician and a certified nurse midwife. Any contemplated legislation should include requirements for these practitioners to comply with AS 18.15.150 and AS 18.15.200 regarding prenatal blood work and newborn metabolic testing respectively.

"attempt to est. a collab. rel.

Recommended by: E. S. Rabeau

E. S. Rabeau, M.D., Director
Division of Public Health

Date: March 24, 1982

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health and
Social Services

Date: 3-24-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. 2d Sponsor Substitute for House Bill No. 11
Title "An Act relating to midwifery."
Requested by Commissioner's Office Date 3/17/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Public Health
BRU, Program, Or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

IV. DATE 3/19/82 PREPARED BY David Spence, M.D.
AGENCY Health and Social Services
PHONE 465-3100

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/8.)

POSITION PAPER/Department of Health & Social Services

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 11

An Act Entitled "An Act relating to midwifery".....

DISCUSSION

Before widespread availability of medical facilities, adequate transportation and professional providers, the Department promoted training for birth attendants in remote village areas through maternal and child health nurse consultants. In 1968, specific training was discontinued because of the establishment of the Community Health Aide training program by the Alaska Native Health Service. This program emphasizes the Community Health Aide's collaborative relationship with the Alaska Native Health physicians, which has resulted in moving the vast majority of village home births to the protected environment of hospitals.

Since that time there has been increasing demand for alternative birthing situations, including increased use of nurse midwives and birth attendants. This growing phenomenon is happening primarily in urban Alaska and is due to both economic reasons and to the desires for a family oriented birthing experience. Analysis of birth statistics (with an approximation for the number of unreported home births) in 1979 indicates that 200-300 out of 9,000 births probably occurred at home. These home births occurred primarily in Anchorage, Fairbanks, Homer and Juneau. The few home births that occurred in remote areas were primarily due to medical emergencies and hazardous travel conditions.

Alaska is attempting to address the needs of these individuals by:

1. expanding Medicaid coverage for maternity care;

2. extending general relief medical assistance for those not eligible for Medicaid;

3. providing support for family centered birthing attitudes and procedures in hospitals;

4. providing medical care assistance through Improved Pregnancy Outcome and high risk pregnancy projects; and

5. supporting the practice of nurse-midwives.

Alaska recognized the advanced nurse practitioner role by adopting regulation 12 AAC.44.400 which addresses the scope of practice and certification requirements. These increased training and educational requirements for nurse midwives have evolved to assure competent, quality, alternative health care for pregnant women.

RECOMMENDATIONS

Section 06.69.010 provides that a person who practices as a licensed midwife shall obtain a license. Since there is neither specific language requiring birth attendants to be licensed nor disciplinary action for practicing without a license, as presently worded only birth attendants who want to represent themselves as licensed midwives need to obtain a license. We question if this is the intent of licensing this field, when non-licensees are not prohibited from practicing.

Section 08.69.040 establishes requirements for licensure which include a minimum of 20 births or a completion of an apprenticeship and passing an examination administered by the Department of Commerce. Since the specific purpose of regulation of a profession is to limit entry to those persons qualified to administer the services and to protect the consumers (in this instance mothers and children), these proposed statutes may be insufficient to assure that birth attendants will have the minimum base skill level necessary to practice safely. The National Midwives Association regards training and experience as essential components to any regulation, and they recommend a minimum of 50 births with a practicing midwife for licensure. Arizona, which has birth attendant licensure, requires attendance at 15 births. These statutes are seen to be highly deficient by the National Midwives Association. The Department recommends that an apprenticeship be required for all persons who have not completed a course of study that includes a period of apprenticeship.

Section 08.69.070 provides for the renewal of birth attendants licenses. The proposed statutes require an applicant to have attended 20 births in the previous two years or to have completed 20 hours of continuing education. Since the practice of birth attendants is based both in knowledge and skills, the Department recommends that both continuing practice and continuing education be required for license renewal. It is recommended that continuing education requirements be in childbirth related courses only, and that practice with a midwife be deleted as a substitute for continuing education.

Section 08.69.08 outlines the conditions under which a license may be revoked or suspended, or the licensee may be reprimanded, censured, or disciplined. The Department recommends that a section be included that covers intentional or negligent conduct that results in a significant risk to the health or safety of a client or in injury to a client. This would be similar to the proposed statutes in Senate Bill No. 238 "An Act relating to the practice of nursing".

Section 08.69.130 outlines the conditions under which the birth attendant may practice. It provides that the client of a birth attendant must have a general physical examination by a physician, and that the mother be transferred to the care of a physician if a medical emergency is indicated. The Department recommends that:

(1) a required general physical examination of client be done by a physician or a nurse midwife. This will allow more flexibility, and the nurse midwife is qualified to perform a general physical exam.

POSITION PAPER/Department of Health & Social Services

(2) that th. section of regarding transferred to medical care be changed to:

"The mother will be transferred to the care of the physician if she develops any high risk conditions; and that the birthing attendant have available adequate resources during labor and delivery to transfer the mother to a hospital and/or physician if a medical emergency develops".

(3) that the following requirement be added:

"Birth attendants shall have an approved written collaborative relationship with a physician. This requirement would be similar to regulation of nurse-practitioner and physician assistant and is essential to assuring that the mid-level practitioner have sufficient medical back-up. The collaborating physician should be protected by statute from liability related to the care of a client not directly under his supervision".

Section 08.69.160 provides for definitions. The Department recommends that Section 08.69.160(4) be revised to read "sponsor" means a physician or a nurse midwife licensed to practice in this State. As presently written, a birth attendant (lay midwife) could serve as a sponsor to another birth attendant; this may become problematic in terms of assuring that the apprentice is trained by a practitioner with sufficient knowledge and skills to be a trainer. The Department believes the minimum skill level necessary to serve as sponsor are those possessed by nurse midwives or a physician.

DEPARTMENT POSITION

In order to assure clients a safe, alternative to physician services, nurse midwives have to meet specific educational, apprenticeship, and collaborating physician requirements. The Department fully supports the mode of nurse midwife practice and recommends that birth attendants (lay midwives) should have similar requirements in order to assure clients of an optimal outcome.

Recommended by: _____
David Bruce, Deputy Director
Division of Public Health

Date: 7/30/81

Approved by: _____
Helen O. Beirne, Commissioner
Dept. of Health & Social Services

Date: 7/30/81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 11
Title "An Act Relating to Midwifery"...
Requested by HOUSE HESS Date 4/28/81

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected Family Health
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0					
200 TRAVEL	0					
300 CONTRACTUAL	0					
400 COMMODITIES	0					
500 EQUIPMENT	0					
600 LAND & STRUCTURES	0					
700 GRANTS, CLAIMS, ETC.	0					
TOTAL	0					

FUNDING (Thousands of Dollars)

GENERAL FUND	0					
FEDERAL FUNDS	0					
OTHER (Specify Fund Source)	0					
	0					

POSITIONS

FULL TIME	0					
PART TIME	0					
TEMPORARY	0					

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE 4/30/81 PREPARED BY Vernellia Randall-Phillips
AGENCY Division of Public Health
PHONE 465-3100

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) M&B Approval [signature] Date 4/30/81

33-001 (Rev. 12/80

TO: CHARLIE PARR & ALL OTHER LEGISLATORS

DEAR SIR,

I am an R.N. lisensed in Alaska who has had the opportunity to attend many births in several different settings. I have worked in hospital labor & delivery, been a labor coach & observer in alternative birthing centers staffed by Nurse-Midwives & have attended many homebirths with certified nurse-midwives as well as empirical midwives. All of these places have distinct advantages & disadvantages of which I am sure you are well aware. It is my opinion that informed parents should have a choice of where they would like to safely have the birth of their child. The licensing of midwives would serve to ensure that safe birthing alternatives would be available to Alaskan parents. Therefore, I strongly support SB 747 and urge you to vote for its passage!

I had my first baby in Anchorage at home with midwives and ~~would~~ intend to do so with my second — safely & legal!

THANK YOU

(MARY CLAIRE) PEACE, R.N.
MARY-CLAIRE PEACE

GENERAL DELIVERY
SITKA, AK 99835

To Charlie Parr and all other legislators,

As a parent of a child born at home I am in favor of Senate Bill 747. I feel parents who fit the requirements & have been properly educated should have an alternative from hospital deliveries.

Midwifes who have been licensed or certified serve a viable means of serving our communities in a way that doctors cannot. The converse is true. The both in conjunction would be of obvious benefit to the well-being of home & should the case be, of hospital births too.

I urge your support of this bill.

Theodore T. Palmer
General Delivery
Sitka AK 99835

MSG 82-00011309 TY 1 03/02/82 18:44:02 ORIG: LA00 IN= 0026 OUT=
FROM: JEAN, ANC FO TO: POM, JUNEAU INFO
TARGET: LJH2 S POM PAGE

TO: ALL SENATORS
REPRESENTATIVES BEIRNE,MARTIN, CATO, MALONE AND SMITH

FROM: AL RUSHING
1403 E 27TH
ANCHORAGE 99504 (H) 279-0181

SB 747

I AM IN FAVOR OF SB 747 AND HOPE THAT YOU WILL SUPPORT ITS PASSAGE AS SOON AS POSSIBLE. IF I CAN BE OF ASSISTANCE IN PROVIDING INFORMATION REGARDING THIS BILL FOR MIDWIFERY PLEASE CONTACT ME. PLEASE SCHEDULE A TELECONFERENCE AS SOON AS POSSIBLE.

March 3, 1982

To: Representative Pat Carney, Chair
House Finance Subcommittee

From: Representatives Brian Rogers
and Tony Vaska

Prepared
By: Ginger Baim, Aide to
Senator Vic Fischer

Re: CS SS House Bill 11 and Senate Bill 747

During today's subcommittee work session on House Bill 11, the following issues should be considered:

1. Approximately 5% of all births in Alaska occur at home.

2. Most home-birth parents are covered by health care insurance but chose to pay a midwife "out-of-pocket" rather than use the services of a physician or a certified nurse midwife in a hospital setting covered by insurance.

3. Physicians and Certified Nurse Midwives (CNM) face suspension of licensure if they participate in a home-birth even though such practice is not in violation of the law in Alaska.

4. Most homebirth parents state they would chose an out-of-hospital birth with a midwife even if such a practice were in violation of the law.

5. The average cost of a "natural " and uncomplicated hospital birth attended by a physician or CNM, is $2 000 and up. This fee covers both birth attendents and facility charge.

6. Some Alaskan hospitals and physicians average 20% C-sections. Consumer cost for this surgery is nearly double the average for a "natural" birth.

7. The average cost of childbirth at Alaska's only birthing center is $1,500. Because the facility is not licensed, only the services of the CNM are covered by health care insurance, requiring out-of-pocket payment of nearly a $1,000.

8. Average costs for the services of a "lay" midwife for a homebirth is less than $500. This fee includes all pre and post natal care, laboratory costs, services of t' ''wife and, usually, an assistant or apprentice, during the actual birth.

9. Statistically the incidence of complications, mortality, morbidity and risks to both infant and mother in a home birth attended by a midwife compare favorably with hospital births attended by a physician.

10. Current practice prevents licensed health care providers from attending home births and limits consumers in free choice of health care. Consumers currently have no mechanism for determining the competency

levels of midwives attending homebirths.

11. HB 11 and SB 747 provide a mechanism for voluntary licensing of midwives, regulation and supervision of the practice of midwifery through a self-regulating agency appointed by the Governor, a handle for consumers to determine the competency levels of their health care providers and a method of gathering information and statistics on the practice of midwifery and homebirths in Alaska.

12. According to a position paper from the Department of Health and Social Services on HB 11, prior to widespread availability of medical facilities, adequate transportation and professional providers, the Department promoted training for birth attendants in remote areas. Current revenue forecasts may require cuts in transportation, facilities and professional services by health care providers. This gives strong argument for reinstating licensing and training procedures for midwives to handle low-risk births in low-cost settings for consumers desiring these services.

13. The state has a legitimate interest in providing consumer protection and information. The state should not allow its laws to be used to promote a certain type of health care or to coerce or punish consumers exercising free choice in health care services.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. ~~CSSSHB 11 (Finance)~~ 2nd SS HB 11 (DCRPT)
Title An Act relating to midwifery.
Requested by House Finance Date 2-26-82

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, Or Subprogram(s) Affected Regulation & licensing of professions; admi
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.) boards, a investigati

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL		9.4	10.3	11.4	12.5	13.7
300 CONTRACTUAL		14.8	16.1	17.5	19.1	20.9
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		24.2	26.4	28.9	31.6	34.6

FUNDING (Thousands of Dollars)

GENERAL FUND		24.2	26.4	28.9	31.6	34.6
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

TRAVEL - 10% inflation factor projected.

Board of Midwifery; 5 members (anticipate 1-Anch, 1-Fbks, 1-Southeast, 1-Kenai area, and 1-Nome area); 3 meetings per year (1 ea. in Anch., Fbks, & S.E.), travel costs plus 3 days per diem @ $80/day $ 6,000.00

Department staff - 1 licensing examiner to attend meetings of the Board of Midwifery, travel costs plus per diem 1,200.00
1-Regulations Specialist to hold regulation hearings throughout the state, travel costs plus per diem 1,200.00
1-Investigator, additional travel costs to investigate complaints concerning lay midwives; average 1 trip every 4 months @$200/trip plus per diem @$80/day 1,000.00
$ 9,400.00

(continued.

IV. DATE March 2, 1982 PREPARED BY Marjorie Odland
AGENCY Division of Occupational Licensing
PHONE 465-2535

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

CONTRACTUAL - 9% inflation factor projected.

Printing of new statute booklets, applications and licenses for midwives desiring to become licensed.	$ 2,000.00
Meeting notices, regulation publications, mailing costs of application packets and statute booklets	800.00
General operating costs including phones, computer time (pro-rated by board), and similar daily costs.	1,000.00
Development of examination, professional services contract basis, including updates, pool of questions for use by state board, storage in in-house computer system	5,000.00

Licensing/Disciplinary Hearings - Anticipate three hearings per year. In estimating one day hearings, the following costs are considered:

Average 6 hour days:

Hearing Officer, @$75/hr	450.00
Court Reporter, @$25/hr	150.00
10 exhibits, $.45 ea.	4.50
3 witnesses, 1/2 day ea.@ $12.50	37.50
1 expert witness, 2 hrs. @ $150./hr.	300.00
Transcript, avg. 210 pages @ $4.50/page	945.00
	1,887.00
	X 3
	$ 5,661.00

Room Rental for examinations: 2 exams per year., 1 day each.	200.00
Proctors for examinations:	
Head Proctor - $50/day	100.00
Monitor - $35/day	70.00
TOTAL CONTRACTUAL -	$ 14,831.00

SECTIONAL ANALYSIS FOR CS 2d SS HB 11

Purpose: The purpose of this legislation is to establish a Board of Midwifery, license and regulate lay midwives. There has been controversy over the scope of the statutorily mandated practice, over the means of regulation and examination, over the informed consent form, the extent of educational background, and formation of a collaborative relationship with physicians, and voluntary versus mandatory nature of licensure.

Changes:

Page 2, line 8: Changes the two elective members to one physician and one elective member appointed by the Governor.

Page 3, line 12: Adds the requirement of two years of nursing school or its equivalent to educational requirements.

Page 6, line 14: Adds the following sentence: "The form shall contain notice that injuries sustained during a home birth may not be covered by malpractice insurance even if a midwife or physician is in attendance." This section is purely experimental. It has been objected to in light of the 1978 SLA repeal of sections of law which mandated malpractice insurance for medical doctors. The collaborative nature of physician/midwife practice will eventually concern liability and may be one area of concern between the professions.

Page 8, line 10: Adds a section to the obligation of a midwife in that the midwife is responsible to establish and maintain a collaborative relationship with a physician. The scope is generally on referral, advice, and rarely in emergencies. However, the language would seem inadequate to reflect an ongoing professional relationship.

Page 9, line 8: Enlarges the definition of sponsor to add, "and authorized to act as a sponsor by the board." This was to ensure a responsible supervisor who must be board endorsed.

P.O. BOX 1330
FAIRBANKS, ALASKA 99701

February 17, 1982

Barbara Wilkins, Assistant
House Committee on HESS
c/o Representative Mike Beirne
Pouch V
Juneau, AK 99108

Dear Ms. Wilkins:

I have received your letter of 1-23-82 to the Alaska Medical Association. This letter was presented at the Fairbanks Medical Society Meeting of 2-11-82. At that time, the members of our medical community who deliver babies were polled, and we were unable to document any cases of expectant mothers being denied prenatal care because they contemplated home delivery. This has not been a problem in the Fairbanks area that we know of.

If you have any evidence to the contrary, please bring it to my attention.

Sincerely,

RGP

Richard G. Parry, M.D., F.A.C.S.
President

RGP/co