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# 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;244:2741-2746)

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 23/1,000 live births in 1940 to 12/1,000 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.

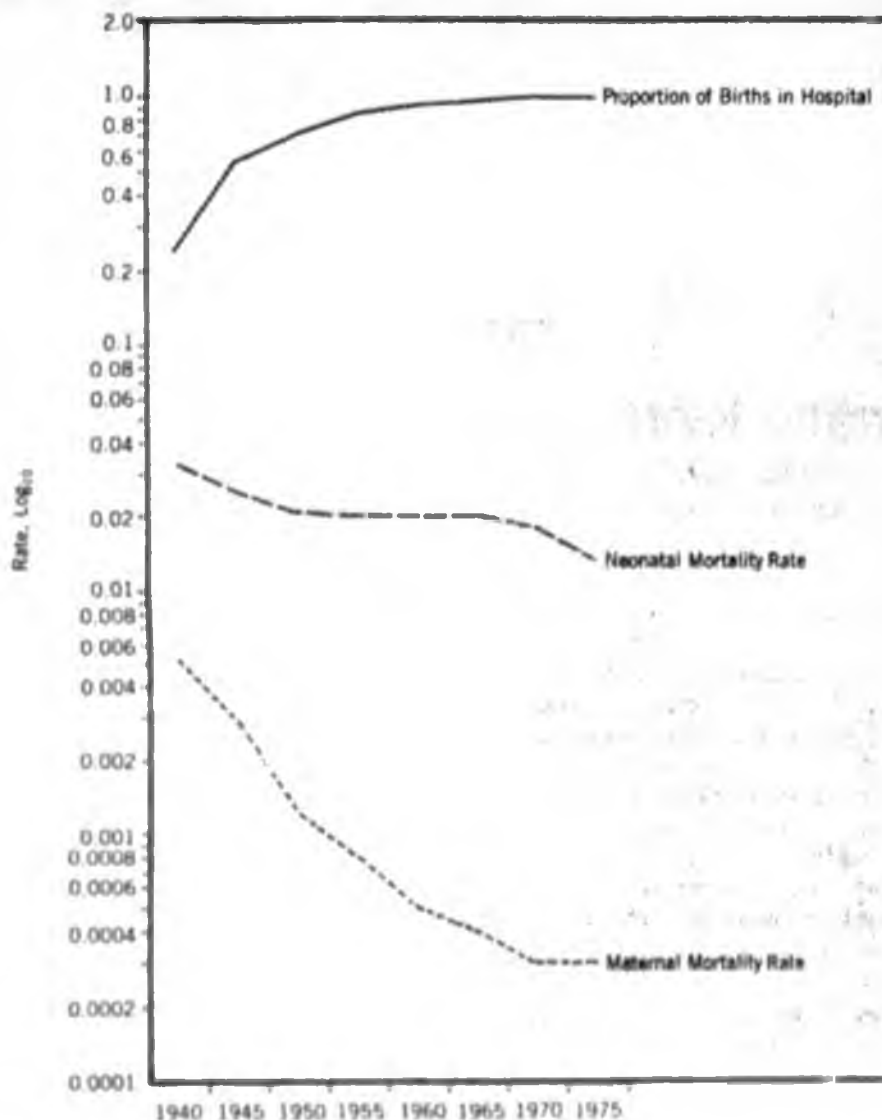
Lay-midwives legally attend home deliveries in some counties of North Carolina. The practice of these lay-midwives is regulated by county health departments. Prenatal care involving physician-supervised screening for risk factors must be provided by the health department for each patient, and every home 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 1978

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 1978 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. Microclassification of a small number of these deaths would have had a notable effect on reported neonatal mortality rates. Therefore, these deaths were indi-

vidually 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. There 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 1978. 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.

	No.	%
Planned	934	72
Lay midwife (assumed planned)	768	
Classified by questionnaire	186	
Unplanned	250	19
Birth weight $\leq 2,000$ 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

	Deaths, No (%)	Births	Rate†
Planned	6 (17)	934	6
Infant normal	3 (8)		
Congenital anomaly	3 (8)		
Unplanned	30 (83)	250	120
Precipitate	23 (84)		
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

	Deaths	Births	Rate†
Home—planned, attendant physician	0	55†	0
Home—planned, attendant lay-midwife	3	768	4
Hospital	2,805	242,245	12
Clinic or office	16	949	16
Home—planned, attendant not physician or lay-midwife	3	100‡	30
Enroute	12	177	68
Home—unplanned	30	250‡	120
Total	2,806	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

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

	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	16
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	6
Birth weight, g			
≤2,000	0	3	285
2,001-2,500	8	5	24
2,501-3,000	20	18	6
>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 prena-

tal 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<sup>1</sup> 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<sup>2</sup> and later Levy et al<sup>3</sup> 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<sup>4</sup> have reported that a maternal and infant care project, which provided prenatal care to girls who conceived when they were younger than 15 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, Kessler et al<sup>5</sup> in New York and Dott and Fort<sup>6</sup> 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.<sup>1</sup> 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.

#### References

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7. Rooks J. *Nurse-Midwifery in the United States 1976-1977*. Washington, DC, American College of Nurse-Midwives, 1978, pp 29, 40-41.

# DIRECTORY FOR PARENTS

## AMERICAN SOCIETY FOR PSYCHOPROPHYLAXIS IN OBSTETRICS (ASPO)

1411 K Street Northwest  
Washington, D.C. 20005

*This organization sponsors classes in the Lamaze psychoprophylaxis method of prepared childbirth for expectant parents.*

## INTERNATIONAL CHILDBIRTH EDUCATION ASSOCIATION (ICEA)

P.O. Box 20048  
Minneapolis, Minnesota 55420

*This organization is dedicated to family-centered maternity care. Membership of both parents and professionals works toward improving the outcome of maternity and infant care.*

## NATIONAL ASSOCIATION OF PARENTS AND PROFESSIONALS FOR SAFE ALTERNATIVES IN CHILDBIRTH (NAPSAC)

P.O. Box 267  
Marble Hill, Missouri 63764

*This organization is dedicated to assisting parents in finding alternatives in childbirth—both within and outside of the hospital. They have publications with information on childbirth alternatives and also a directory that can refer parents to appropriate alternative birth services.*

## MATERNITY CENTER ASSOCIATION

48 East 92nd Street  
New York, New York 10028

*Information on maternity care and prenatal classes are available at the Center. Total family centered maternity care for non-risk deliveries is offered by the Center's midwifery service. Deliveries are in a homelike atmosphere, and all members of the family may share in the experience.*

## NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF LEBOYER'S BIRTH WITHOUT VIOLENCE, INC.

P.O. Box 248455  
University of Miami Branch  
Coral Gables, Florida 33124

*For those parents interested in the Leboyer method of gentle birthing, write for more information.*

## ACTION FOR CHILD TRANSPORTATION SAFETY (ACTS)

Child Restraint Committee  
P.O. Box 266

Bothell, Washington 98011

*An organization devoted to educating parents about child automobile safety. Send a self-addressed, stamped legal-size envelope and money for the following: "Guide to Dynamically Tested Safety Devices, New and Used," 15¢. "This is the Way Baby Rides," a pamphlet telling what you should know before you buy an infant car seat and lists models found satisfactory in simulated crash tests; 25¢. "Don't Risk Your Child's Life," a pamphlet telling what you should know before you buy an auto restraint for any child weighing less than 40 lbs., plus satisfactory models; 35¢.*

## LA LECHE LEAGUE

9016 Minneapolis Avenue  
Franklin Park, Illinois 60131

*Everything you want to know about breast-feeding this organization will tell you. They offer encouragement to new breast-feeding mothers and a bi-monthly newsletter of shared experiences in child rearing.*

## NATIONAL SUDDEN INFANT DEATH SYNDROME FOUNDATION

310 S. Michigan Avenue  
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*Offers advice to parents and up-to-date information on this mysterious killer, sudden infant death syndrome.*

## AMERICAN NATIONAL RED CROSS

17th & D Streets  
Washington, D.C. 20006

*By addressing inquiries to the Nursing Department, parents can find out about the Red Cross baby care and parent classes in their locality.*

## CHILDBIRTH WITHOUT PAIN EDUCATION LEAGUE, INC.

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## NATIONAL ORGANIZATION OF MOTHERS OF TWINS CLUB

5402 Amberwood Lane  
Rockville, Maryland 20853

*Through this organization, you can learn of local chapters which will put you in touch with other mothers of twins, triplets, etc. with whom you can share problems and solutions.*

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243 North Lindbergh Blvd.  
St. Louis, Missouri 63141

*By sending a stamped, self-addressed envelope, this organization will send you information on children's vision care and the importance of eye examinations.*

## READ NATURAL CHILDBIRTH FOUNDATION, INC.

1300 H. Eliseo Drive, Suite 102  
Greenbrae, California 94904

*This group promotes the philosophies of Grantly Dick Read, M.D., through childbirth classes for expectant parents and offers assistance to anyone wanting to become familiar with the Read teachings.*

## U.S. CONSUMER PRODUCT SAFETY COMMISSION

Washington, D.C. 20207  
800-493-2937

*By calling the above toll-free number anytime, you can get information on safety standards for cribs, toys, and other accessories for children. Or contact the area office in your own major city.*

## PARENTS WITHOUT PARTNERS

7901 Woodmont Avenue  
Bethesda, Maryland 20814

*This organization describes itself as "directed toward raising children in a single parent home."*

## C/SEC, INC.

## CESAREAN/SUPPORT, EDUCATION AND CONCERN

66 Christopher Road  
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*This group offers emotional and physical support plus education to parents who have had Cesarean births, as well as addresses of Cesarean support groups in other states.*

# INTERNATIONAL CHILDBIRTH EDUCATION ASSOCIATION, INC.

## RESOURCE AND REFERENCE LIST

This list has been compiled for use of ICEA Province/State Coordinators. Inclusion on this list does not indicate ICEA endorsement of an organization, service or product.

### Nearest ICEA Member/Member Group

Parents Centres Australia  
Andree Robertson  
148 Hereford Street  
Forest Lodge 2037, NSW, Australia

Naissance-Renaissance  
891 des Erables CP 2363  
St. Nicholas-Est, P.Q., Canada  
G0S 3L0

### ICEA Service/Committee

C.E.A. (Childbirth Education Association)  
Sydney  
84 Tambourine Bay Road  
Land Cove 2066

C.E.A. Melbourne  
Pam Farfor  
17 Albert Street  
Brighton 3186

### BIRTH CENTER AND HOME BIRTH ORGANIZATIONS

Australian Homebirth Association  
Ms. Libby Jenkins  
41 Cutlack Street  
Evatt, Act., Australia 2617

Home Oriented Maternity Experience  
(HOME)  
811 New York Avenue  
Takoma Park, Washington, D.C. 20012

### CHILDBIRTH PREPARATION-EDUCATION

International Childbirth Education  
Association, Inc. (ICEA)  
P.O. Box 20882  
Milwaukee, WI 53220

American Society for Psycholprophylaxis  
in Obstetrics (ASPO)  
1411 K Street NW Suite 200  
Washington, D.C. 20005

Childbirth Without Pain Parent Leagues  
(CWPPPL)  
P.O. Box 233  
Dana Point, CA 92629

American Academy of Husband Coached  
Childbirth (AAHCC)  
P.O. Box 6224  
Sherman Oaks, CA 91413

National Childbirth Trust  
9 Queensborough Terrace, Bayswater  
London, W2 3TB England

Mothercraft Society  
37 Heath Street West  
Toronto, Ontario Canada  
M4V 1T3

Cesareans/Support, Education and  
Concern (C/SEC)  
18 Maynard Road  
Dedham, MA 02026

National Association of Parents and  
Professionals for Safe Alternatives  
in Childbirth (NAPSAC)  
Rt. 1, Box 300  
Marble Hill, MD 63764

Maternity Center Association  
48 East 92nd Street  
New York, NY 10028

American College of Nurse Midwives  
1012 14th Street NW # 801  
Washington, D.C. 20005

Campaign Association for the Legalization  
of Midwifery  
c/o 2210 West 12th Avenue  
Vancouver, B.C. Canada  
V6K 2N6

Midwives Association  
Pam Hayes  
Crown St. Hospital  
Paddington Australia 2021

Association for Childbirth at Home, Inc.  
(ACHI)  
18706 Monte Cristo  
Cerritos, CA 90701

ACHI  
RR #2  
Calumet, P.O. Canada

Women & Children First  
(Interested in setting up a Birth Centre)  
Pam Ladden  
62 Hyde Road  
Hunters Hill, Australia 2110

American College of Home Obstetrics  
664 North Michigan Avenue, Suite 800  
Chicago, IL 60611

Birth at Home League  
4010 West 90th Street  
Prairie Village, KS 66207

Holistic Childbirth Institute  
1677 10th Avenue  
San Francisco, CA 94122

Toronto Home Birth Group  
Prunella Lane  
430 Heath Street East  
Toronto, Ontario Canada  
M4C 1B5

#### BREASTFEEDING

La Leche League International, Inc. (LLL)  
9616 Minneapolis Avenue  
Franklin Park, Illinois 60131

La Leche League Canada  
Box 11, Postal Station Z  
Toronto, Ontario Canada  
M5N 2Z3

Ligue La Leche du Canada  
C.P. 118, Succursale Laval Ouest  
Laval, P.Q. Canada  
H7R 5B7

Parents Centres Australia  
Shonagh Moore  
Box 234 Glebe Australia 2037

Nursing Mothers Australia  
99 Burwood Road  
Hawthorn, Australia 3122

#### NUTRITION

Montreal Diet Dispensary  
2182 Lincoln Avenue  
Montreal, Quebec Canada  
H3H 1J3

Society for the Protection of the  
Unborn through Nutrition (SPUN)  
17 North Walsh Avenue, Suite 603  
Chicago, IL 60607

Dr. John Quoyte (Paediatrician)  
Medical Director  
Tresillian Nursing Homes  
32 Grosvenor Street  
Sydney, Australia 2000

#### FERTILITY CONTROL

United Infertility  
P.O. Box 73  
Scarsdale, NY 10583

National Family Planning Federation  
of America  
Suite A  
1721 Massachusetts Ave. NW  
Washington D.C. 20005

Planned Parenthood - World Population  
(International Office)  
810 7th Avenue  
New York, NY 10019

Planned Parenthood (la federation pour la  
planning des naissances)  
1226 A rue Wellington Street  
Ottawa Ontario Canada  
K1Y 3A1

Family Planning Resource Center  
Family Planning Division,  
Health and Welfare Canada  
Suite 658  
Brooke Claxton Building  
Ottawa, Canada K1A 1B5

Ms. Colette Parr  
Family Planning Association of NSW  
161 Broadway  
Australia 2007

Serena  
55 Parkdale  
Ottawa, Ontario Canada

Couple to Couple League  
P.O. Box 11084  
Cincinnati, OH 45211

A Book, *Natural Family Planning*  
\$1.50 by Dr. John Billings from:  
The Liturgical Press  
Collegeville, MN 56321

Resolve  
P.O. Box 474  
Belmont, MA 02178  
(infertility problems)

#### PARENTING AND OTHER SERVICE ORGANIZATIONS

Canadian Association for Young  
Children (L'Association Canadienne pour les  
jeunes Enfants)  
Box 38, Station C  
Winnipeg, Manitoba Canada  
R3M 3S3

One Parent Family Association  
2279 Yonge Street, Suite 17  
Toronto, Ontario, Canada  
M4P 2C7

Parents without Partners,  
7910 Woodmont Avenue  
Suite 1000  
Washington, D.C. 20014

Canadian office  
706 Yonge Street, Suite 13  
Toronto, Ontario Canada  
M5B 1N7

Child Study Association of America  
853 Broadway  
New York, NY 10003

American Institute of Family Relations  
5287 Sunset Blvd.  
Los Angeles, CA 90027

Centre Rosalie Jette, au service  
de la Mere- celibataire  
8054 est rue Notre Dame  
Montreal, P.Q., Canada  
H1L 6J2

Canadian Young Family  
37 Hanna Avenue  
Box 8, Station C  
Toronto, Ontario, Canada  
M6J 3M8

Family Life Education in N.S.W.  
(A Committee of Voluntary &  
Statutory Agencies)  
Ms. V. Wishart  
121 Lucinda Avenue  
South Wahroona, Australia 2076

Parents Centres Australia (The Early Years)  
Box 234 Glebe, Australia 2037

Family Life Movement of Australia  
(Pre-marital Education and Marriage  
Counselling)  
41 The Boulevard  
Lewisham, Australia 2049

National Association for Loss & Grief  
N.A.L.A.G.  
Mr. Milton Coleman  
Chaplain-Gladesville Hospital  
Gladesville, Australia 2111

AMEND (self-help group for parents  
grieving over birth of imperfect or  
dead baby)  
Dianna Hoffman  
1548 Brenthaven  
Florissant, MO 63031

National Center for Prevention and  
Treatment of Child Abuse and Neglect  
University of Colorado Medical Center  
Denver, CO 80210

Parent's Anonymous  
2810 Arroyo Blvd, Suite F  
Huntington Beach, CA 90728

Parent's Anonymous  
Box 843  
Burlington, Ontario Canada

Canadian Foundation for the Study  
of Infant Deaths  
4 Lawton Blvd  
Toronto, Ontario Canada  
M4B 1Z4

**INTERNATIONAL CHILDBIRTH EDUCATION ASSOCIATION, INC.****RESOURCE & REFERENCE**

(Cot Death-Parent Support)  
Sudden Infant Death Association B.I.D.A.  
Box 172 St. Ives, Australia 2075

National Sudden Infant Death  
Syndrome Foundation  
310 South Michigan Avenue  
Suite 1904  
Chicago, IL 60604

Association for the Welfare of Children  
in Hospital (A.W.C.H.)  
Ms. Doris Hart  
79 Boundry Road  
Wahroonga, Australia 2078

Association for Care of Children in Hospital  
Southwestern Ontario Affiliate  
c/o Jeannette McFadden  
Recreation Department  
Hospital for Sick Children  
555 University Avenue  
Toronto, Ontario Canada  
M5G 1X8

Association for the Care of  
Children in Hospital  
Box H  
Union, WV 24983

Parents of Twins, Mrs. M. Moffat  
57 Wortham Drive  
Scarborough, Ontario, Canada  
11G 1W6

National Organization of Mothers of Twins Club  
5402 Amberwood Lane  
Rockville, MD 20853

Canadian Cerebral Palsy Association  
1 Yonge Street  
Suite 2110  
Toronto, Ontario M5E 1E8

Canadian Cleft Lip and Palate Family Association  
4961 Bathurst Street  
Apt. 215  
Willowdale, Ontario Canada  
M2H 1Y5

Canadian Dental Association  
1815 Alta Vista Drive  
Ottawa, Canada K1G 3Y8

Canadian Diabetic Association  
173 Eglarist Street  
Suite 601  
Toronto, Ont. Canada  
M5G 1E2

Parent Relief Services for Multihandicapped  
Children  
Children's Services Committee  
18 Kempland Blvd.  
Willowdale, Ontario Canada  
M2N 2R9

Canadian Hearing Society  
60 Bedford Road  
Toronto, Ontario Canada  
M5R 2K2

Provincial Ministries of Community and  
Social Services  
contact local office

Provincial Ministries of Health Publications  
contact local office

Service Social Ville-Marie  
874 Est rue Sherbrooke  
Montréal, Québec, Canada  
H2L 1L1

Provincial Medical Associations'  
Child Welfare Committees  
contact local office

Secus (Sex Information Education  
Council of the U.S.)  
137 N. Franklin Street  
Hempstead, NY 11550

SEIC - Dr. M. Barrett  
423 Castlefield Avenue  
Toronto, Ontario Canada  
M5N 1L4

American Cancer Society, Inc.  
777 3rd Avenue  
New York, NY 10017

Canadian Cancer Society  
77 Bloor Street W  
Toronto, Ontario Canada  
M5S 2V2

Societe Canadienne du Cancer  
1118 Rue St. Catherine Ouest  
Montreal, Quebec Canada  
H3B 1M5

Association for Children with  
Learning Disabilities, Inc.  
4158 Library Road  
Pittsburgh, PA 15236

Rehabilitation International USA  
(Information on all areas of  
rehabilitation)  
20 West 40th Street  
New York, NY 10018

Children's Book Center  
86 Bloor Street West, Suite 200  
Toronto, Ontario Canada  
M5S 1M5

Actv for Child Transportation Safety  
400 Central Park West, 15F  
New York, NY 10026

National Safety Council  
444 N. Michigan Avenue  
Chicago, IL 60611

National Alliance Concerned with  
School-Age Parents  
(NACSAP)  
7315 Wisconsin Avenue N.W.  
Suite 211-W  
Washington, D.C. 20014

National Association for Mental Health  
1800 N. Kent Street  
Roanoke, VA 22209

National Clearinghouse for  
Smoking and Health  
Rockville, MD 20852

National Council on Family Relations  
1219 University Avenue S.E.  
Minneapolis, MN 55414

National Easter Seal Society  
2023 W. Ogden Avenue  
Chicago, IL 60612

National Foundation-March of Dimes  
P.O. Box 1275  
White Plains, NY 10605

Canadian Lung Association  
78 Albert Street  
Suite 908  
Ottawa, Ontario Canada  
K1P 6E7

National Institutes of Health Information  
Officer, Division of Research Resources  
Bethesda, MD 20014

U.S. Consumer Product Safety Commission  
Washington, D.C. 20207

Consumer Association of Canada  
251 Laurier Avenue W  
Room 801  
Ottawa, Canada K1P 6Z7

Consumer and Corporate Affairs Canada  
Consumer Service Branch  
480 University Avenue  
9th Floor  
Toronto, Ontario Canada  
M5G 1V2

Family Leukemia Association  
72 Denison Avenue  
Toronto, Ontario Canada  
M4S 1E9

Health and Welfare Canada  
Suite 608  
Brake Claxton Building  
Ottawa, Canada K1A 1B5

U.S. Department of Health, Education  
and Welfare  
Children's Bureau  
Washington, D.C. 20201

U.S. Government Printing Office,  
Superintendent of Documents  
Washington, D.C. 20402

**COMMERCIAL ORGANIZATIONS**  
send for catalog/flyer of services offered

National Dairy Council  
6300 N. River Road  
Rosemont, IL 60018

American Baby Magazine  
575 Lexington Avenue  
New York, NY 10022

Baby Talk Magazine  
68 East 34th Street  
New York, NY 10016

Mead-Johnson  
Evansville, IN 47721

Gerber Products  
Fremont, MI 49412

Johnson and Johnson  
Director of Professional Services  
501 George Street  
New Brunswick, NJ 08903

Ortho Corporation  
Raritan, NJ 08869

Ross Laboratories  
825 Cleveland  
Columbus, OH 43215

Carnation  
Medical Marketing  
5045 Wilshire  
Los Angeles, CA 90036

Proctor and Gamble Company  
Professional Service Division  
Box 171  
Cincinnati, OH 45201

Proctor and Gamble of Canada, Ltd.  
Consumer Relations  
P.O. Box 355 Station A  
Toronto, Ontario Canada

U.S. Shoe Corp.  
1858 Herald Avenue  
Cincinnati, OH 45212

Wyeth Laboratories,  
Philadelphia, PA 19101

American Optometric Association  
7000 Chippewa Street  
St. Louis, MO 63119

Arner-Stone Laboratories  
Mount Prospect, IL 60056

Ayerst Laboratories  
685 3rd Avenue  
New York, NY 10017

Beech-Nut Baby Food  
Professional/Consumer Service  
Canajoharie, NY 13317

Best Foods  
Consumer Service Department  
Englewood Cliffs, NJ 07632

Blue Cross  
contact local office

Borden, Inc.  
277 Park Avenue  
New York, NY 10017

Campbell Soup, Co.  
Home Economics Department  
Camden, NJ 08101

Lederle Laboratories  
Pearl River, NY 10965

Mead Johnson  
Evansville, IN 47721

Mennen Co.  
Professional Service Dept.  
Morristown, NJ 07960

Metropolitan Life Insurance Co  
local office

Mutual Assurance Co. of Canada,  
Waterloo, Ontario N2J 4C5



International Childbirth Education Association

INFORMATION SERVICES OFFICE  
Rt. 5, Box 234  
Decatur, Alabama 35603

Contact: Fran Harrison

FOR IMMEDIATE RELEASE

The International Childbirth Education Association (ICEA) adopted the following resolution presented November, 1979.

The International Childbirth Education Association recognizes --

- That the majority of births are normal and without complications
- That the nurse-midwife is a qualified, licensed practitioner of midwifery who offers personalized, comprehensive maternity care to healthy childbearing women and their families
- That the nurse-midwife functions within, and is committed to, a team concept of care that provides for physician consultation and referral for obstetrical complications
- That nurse-midwifery programs have been demonstrated to provide safe, quality, cost-effective care that is desired by the public

Therefore, be it resolved that the International Childbirth Education Association--

- Supports the development of nurse-midwifery through the expansion of nurse-midwife education and service programs
- Supports funding for nurse-midwifery education
- Supports third-party payment for nurse-midwifery care and rejects current policy that requires the physical presence of the physician for medically uncomplicated maternity care as a prerequisite for reimbursement

## CHAPTER 485

## MIDWIFERY

- 485.011 Midwifery; who may practice.  
 485.021 Application to practice midwifery.  
 485.031 Qualifications of applicant to practice midwifery.  
 485.041 License good for 1 year.  
 485.051 Department to make rules regulating practice of midwifery.  
 485.061 Revocation of license.  
 485.071 Midwives to conform to rules and regulations.  
 485.081 Midwives to practice in normal cases only.  
 485.091 Penalty for violation of chapter.

**485.011 Midwifery; who may practice.**—No person other than a duly registered and licensed physician shall practice midwifery or use the name or title of "midwife" unless such person shall be duly registered as a midwife with the Department of Health and Rehabilitative Services.

History.—s. 1, ch. 14780, 1931, CGL 1936 Supp. 3403(1); s. 19, 26, ch. 69-106, s. 406, ch. 77-147.

Note.—Former s. 487.01.

**485.021 Application to practice midwifery.**—No license to practice midwifery shall be issued unless written application therefor sponsored by two registered practicing physicians has been made in the form prescribed by the Department of Health and Rehabilitative Services.

History.—s. 2, ch. 14780, 1931, CGL 1936 Supp. 3403(2); s. 19, 26, ch. 69-106, s. 406, ch. 77-147.

Note.—Former s. 487.02.

**485.031 Qualifications of applicant to practice midwifery.**—Every applicant for a license to practice midwifery must possess the following qualifications:

- (1) Be not less than 18 years of age.
- (2) Be able to read the manual for midwives intelligently and to fill out the birth certificates legibly; provided that in case of persons who have extended experience or in other exceptional circumstances, this requirement may be waived by the Department of Health and Rehabilitative Services.
- (3) Be clean and constantly show evidence in behavior and in home habits of cleanliness.
- (4)(a) Possess a diploma from a school for midwives recognized by the department; or
- (b) Have attended under the supervision of a duly licensed and registered physician not less than 15 cases of labor and have had the care of at least 15 mothers and newborn infants during lying-in period of at least 10 days each; and shall possess a written statement from said physician that she has attended such cases in said 15 cases, with the date engaged and address of each; and that she is reasonably skilled and competent and establish the fact that she is reasonably skilled and competent to the satisfaction of the department; or
- (c) Present other evidence satisfactory to the department showing her qualifications; and
- (5) Present evidence satisfactory to the depart-

ment of good moral character in such form as the department by rule and regulation may prescribe.

History.—s. 3, ch. 14780, 1931, CGL 1936 Supp. 3403(3); s. 19, 26, ch. 69-106, s. 406, ch. 77-147; s. 407, ch. 77-147.

Note.—Former s. 487.03.

cf.—s. 112.011 Felons, removal of disqualifications for employment, except time.

**485.041 License good for 1 year.**—Unless revoked every license to practice midwifery shall permit the holder thereof to practice only during the current calendar year, the term of said calendar year being from January 1.

History.—s. 4, ch. 14780, 1931, CGL 1936 Supp. 3403(4).

Note.—Former s. 487.04.

**485.051 Department to make rules regulating practice of midwifery.**—The Department of Health and Rehabilitative Services may make such rules and regulations as it may deem necessary for regulating the practice of midwifery within the state.

History.—s. 5, ch. 14780, 1931, CGL 1936 Supp. 3403(5); s. 19, 26, ch. 69-106, s. 406, ch. 77-147.

Note.—Former s. 487.05.

**485.061 Revocation of license.**—The Department of Health and Rehabilitative Services may revoke the license of such persons practicing midwifery pursuant to this chapter, provided it has cause.

History.—s. 6, ch. 14780, 1931, CGL 1936 Supp. 3403(6); s. 19, 26, ch. 69-106, s. 406, ch. 77-147, s. 19, ch. 78-99.

Note.—Former s. 487.06.

**485.071 Midwives to conform to rules and regulations.**—

(1) All midwives to whom licenses shall be issued pursuant to this chapter must conform to all rules and regulations of the Department of Health and Rehabilitative Services, the provisions of public health laws of the state, the rules and regulations of any local boards of health and all lawful orders and directions of the department or local boards of health or local health officers.

(2) Any violation on the part of any midwife of any of the rules and regulations of the department, the provisions of the public health laws or the rules and regulations of any local boards of health, or the disobedience of any lawful order of the department, or any local boards or health officers, shall be sufficient cause for the revocation of the license issued to the midwife, and shall also be sufficient cause for the withholding of license to practice midwifery from any midwife offending in any manner as aforesaid by the department.

History.—s. 7, ch. 14780, 1931, CGL 1936 Supp. 3403(7); s. 19, 26, ch. 69-106, s. 410, ch. 77-147.

Note.—Former s. 487.07.

**485.081 Midwives to practice in normal cases only.**—A duly licensed and registered midwife may practice midwifery in cases of normal labor and in no others. No midwife shall in any case use instruments of any kind, or assist labor by any artificial, forcible or mechanical manner or attempt to remove adherent placentae, or administer, prescribe, advise or employ any poisonous drug or herb or medicine or at-

tempt the treatment of disease except where the attendance of a physician cannot be speedily secured and in such cases, the midwife shall secure the attendance of the physician as soon as possible.

History.—s. 8, ch. 14780, 1931; CGL 1938 Supp. 2403(8)

Note.—Former s. 487.08

**485.091 Penalty for violation of chapter.—**

Any person who fails or neglects to register as required by the provisions of s. 485.011, or who shall violate the provisions of this chapter shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083.

History.—s. 7, ch. 12006, 1937; CGL 7703, s. 437, ch. 71-136

Note.—Former s. 487.09

# Virginia

§ 32.1-145

HEALTH

§ 32.1-149

## ARTICLE 4.

### *Midwives.*

§ 32.1-145. Who deemed midwife; compensation defined. — A. Any person who, for compensation, assists in delivery and postnatal care by affirmative act or conduct immediately prior and subsequent to the labor attendant to childbirth in conjunction with or in lieu of a member of the medical profession shall be deemed a midwife and to be practicing midwifery.

B. As used in this section, "compensation" means anything of value received before or after the labor attendant to childbirth, with or without an express agreement between the person so assisting and the patient or anyone in the patient's behalf. (Code 1950, §§ 32-167.1, 32-167.2; 1962, c. 198; 1979, c. 711.)

§ 32.1-146. Registration and permits. — No person shall practice midwifery unless such person is registered and possesses a permit to practice midwifery as provided for in this section. Any person who fulfills such requirements to practice midwifery as the Board may, by regulation, promulgate shall be eligible for a permit. Upon registration and qualification, the permit shall be issued without charge by an official of the Department designated by the Commissioner and countersigned by the director of the local health department. (Code 1950, § 32-167.3; 1962, c. 198; 1979, c. 711.)

§ 32.1-147. Application of article. — The provisions of this article shall apply only to midwives who are not registered nurses and who are registered and permitted to practice pursuant to this article prior to January one, nineteen hundred seventy-seven. All subsequent licensure for midwifery shall be limited to registered nurses who are trained as nurse midwives pursuant to regulations jointly promulgated by the State Board of Nursing and the State Board of Medicine under the authority of § 54-274. Subject to the regulations of the State Board of Health, the permits of midwives who are not registered nurses and who have been previously licensed under this article shall be renewed on a biennial basis. (Code 1950, § 32-167.7; 1976, c. 15; 1979, c. 711.)

## ARTICLE 5.

### *Emergency Medical Service Vehicles*

§ 32.1-148. Definitions. — As used in this article:

1. "Agency" means any person engaged in the business, service or regular activity, whether or not for profit, of transporting persons who are sick, injured, wounded or otherwise incapacitated or helpless or of rendering immediate medical care to such persons.

2. "Emergency medical service vehicle" means any privately or publicly owned vehicle, vessel or aircraft that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated to provide immediate medical care to or to transport persons who are sick, injured, wounded or otherwise incapacitated or helpless. (Code 1950, § 32-310.1; 1968, c. 430; 1979, c. 711.)

§ 32.1-149. Exemptions from operation of article. — The following are exempted from the provisions of this article:

1. Emergency medical service vehicles based outside this Commonwealth, except that any such vehicle receiving a person who is sick, injured, wounded, incapacitated or helpless within this Commonwealth for transportation to a

## NOTES OF DECISIONS

Under the statute as it stood in 1889, a physician who rendered services from a time commencing before his certificate was issued until a time after issuance was permitted to recover the value of his services from the time of issuance, though he did not register his certificate until a later date. *Gardner v. Tatum* (1889) 81 C 370, 22 P 880.

In an action for personal injuries, the plaintiff was

entitled to recover the reasonable value of services performed by an orthopedic surgeon, although the surgeon's certificate to practice medicine was not registered in the county clerk's office until about one year after the rendition of such services. *Gastine v. Ewing* (1944) 65 CA2d 131, 150 P2d 266.

## ARTICLE 12.5

## Midwifery

[Added by Stats 1974 ch 1044 § 18, effective September 23, 1974.]

- § 2350. Authority conferred by midwifery certificate
- § 2351. Use of improper antiseptic procedures
- § 2352. Violation of health ordinances
- § 2353. Illicit treatment of complicated vertex presentations
- § 2354. Failure to make referral of complicated cases
- § 2355. Failure to summon physician
- § 2356. Failure to make referral of complicated pregnancies
- § 2357. Failure to refer sickly child
- § 2358. Hand-removal of placenta
- § 2359. Lacking proper equipment

## Cross References:

- Revocation of midwifery certificate upon third conviction under chapter pertaining to reporting conditions of ophthalmia neonatorum: § 557.
- Unlawful sale of midwifery certificates: § 580.
- Construction against section, pertaining to issuance of license on failure to renew original license within five years after expiration, as authorizing issuance of midwifery certificates: § 2451.1.
- Effect of possession of receipt for payment of fees on possibility of revocation of certificate: § 2453.
- Renewal of midwife's certificate: § 2746.3.
- Practice of midwifery by midwife's certificate: § 2746.4.
- Duty of registering birth occurring outside hospital: H & S C § 10102.

## § 2350. Authority conferred by midwifery certificate

The certificate to practice midwifery authorizes the holder to attend cases of normal childbirth.

As used in this chapter, the practice of midwifery constitutes the furthering or undertaking by any person to assist a woman in normal childbirth. But it does not include the use of any instrument at any childbirth, except such instrument as is necessary in severing the umbilical cord, nor does it include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version, nor the removal of adherent placenta, nor the administering,

prescribing, advising, or employing, either before or after any child-birth, of any drug, other than a disinfectant or cathartic.

A midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2140, as added by stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 8 4th subd p 725, as amended by Stats 1915 ch 105 § 5 p 187, Stats 1917 ch 81 § 2 p 96, Stats 1921 ch 587 § 1 p 995, Stats 1933 ch 499 § 1 p 1275.

(c) Stats 1907 ch 212 § 6 p 253, as amended by Stats 1911 ch 740 § 1 p 1437.

**Cross References:**

Illicit practice of medicine and surgery: § 2141.

Authority conferred by nurse-midwifery certificate: § 2746.5.

**Collateral References:**

**Law Review Articles:**

California's new therapeutic abortion act: an analysis and guide to medical and legal procedure. 15 UCLA LR 1.

**Attorney General's Opinions:**

55 Ops Atty Gen 353 (prohibited issuance of certificates to practice midwifery or authorization to practice midwifery in experimental program; propriety of certificates for and establishment of areas of specialty of "physician's assistant," relating to midwifery).

§ 2351. Use of improper antiseptic procedures

*see last page*

The certificate to practice midwifery may be revoked if it appears to the satisfaction of the board that due caution and circumspection were not used or that proper aseptic and antiseptic precautions were not taken in any case that the holder of this form of certificate may have treated.

*Division of Allied Health Professions*

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2400, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 13th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 99 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References:**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

§ 2352. Violation of health ordinances

The certificate to practice midwifery may be revoked upon conviction for the violation of any health statute, order or ordinance, or for the

neglect or refusal to comply with the health rules and regulations of any state, county, city or township.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2401, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 14th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

**§ 2353. Illicit treatment of complicated vertex presentations**

The certificate to practice midwifery may be revoked for the treatment of a complicated vertex presentation by the holder of this form of certificate in any case of labor in which this condition occurs without calling or attempting to call a person authorized to practice a system, including the practice of obstetrics, under this chapter or any preceding medical practice act.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2402, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 15th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

**§ 2354. Failure to make referral of complicated cases**

The certificate to practice midwifery may be revoked for failure to refer to a person authorized under this chapter or any preceding medical practice act to practice a system including obstetrics, a case which has or develops any of the following conditions during pregnancy.

(a) Contracted pelvis or other deformity that will interfere with labor.

(b) Bleeding from the uterus.

(c) Swelling of the face and hands.

(d) Excessive vomiting.

(e) Persistent headache.

(f) Dimness of vision.

**(g) Convulsions.**

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2403, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 16th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

**§ 2355. Failure to summon physician**

The certificate to practice midwifery may be revoked for failure to call or summon a physician if any of the following conditions exist or develop at the beginning of or during labor:

(a) Complicated presentation of vertex (head).

(b) Convulsions.

(c) Excessive bleeding.

(d) Protrusion of the cord.

(e) A swelling or tumor that obstructs the birth of the child.

(f) Signs of exhaustion or of collapse.

(g) Unduly prolonged labor.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2404, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 16th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

**§ 2356. Failure to make referral of complicated pregnancies**

The certificate to practice midwifery may be revoked for failure to refer to a person authorized under this chapter or any preceding medical practice act to practice a system including obstetrics, a case which develops any of the following conditions during the lying-in period:

(a) Convulsions.

(b) Excessive bleeding.

(c) Foul smelling discharge (lochia).

- (d) Persistent rise of temperature to 101 degrees Fahrenheit for 24 hours.
- (e) Swelling and redness of the breasts.
- (f) Severe chill (rigor) with rise of temperature.
- (g) Inability to nurse the child.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

- (a) Former § 2405, as added by Stats 1937 ch 414 p 1377.
- (b) Stats 1913 ch 354 § 14 subd 16th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.
- (c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

**§ 2357. Failure to refer sickly child**

The certificate to practice midwifery may be revoked for failure to refer to a person authorized under this chapter or any preceding medical practice act to practice a system including obstetrics, a case where the child has or develops any of the following conditions:

- (a) Deformities or malformations or injuries.
- (b) Inability to suckle or nurse.
- (c) Inflammation around or discharge from the navel.
- (d) Swelling and redness of the eyelids with a discharge of pus from the eyes (ophthalmia neonatorum).
- (e) Bleeding from the mouth, navel or bowels.
- (f) Inability to urinate.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

- (a) Former § 2406, as added by Stats 1937 ch 414 p 1377.
- (b) Stats 1913 ch 354 § 14 subd 16th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.
- (c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

**§ 2358. Hand-removal of placenta**

The certificate to practice midwifery may be revoked for the treatment by the holder of this form of certificate that is known as the

§ 2358

MEDICINE

introduction of the hand into the vagina or uterus to remove placenta or membranes.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2407, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 17th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

§ 2359. Lacking proper equipment

The certificate to practice midwifery may be revoked for the failure to have the following equipment in each case:

Nail brush; wooden or bone nail cleaner; jar of green or soft castile soap; rubber gloves; tube of sterile vaseline; clinical thermometer; agate or glass douche reservoir; two rounded vaginal douche nozzles; two rectal nozzles, large and small; one soft rubber catheter; blunt scissors for cutting cord; either lysol, carbolic acid or bichloride of mercury tablets; boric acid powder; 1-percent solution of nitrate of silver; medicine dropper; narrow tape or soft twine for tying cord; and absorbent cotton (preferably in one-quarter-pound packages). No other instruments are to be used by a holder of this form of certificate.

Added Stats 1974 ch 1044 § 18, effective September 23, 1974.

**Prior Law:**

(a) Former § 2408, as added by Stats 1937 ch 414 p 1377.

(b) Stats 1913 ch 354 § 14 subd 18th p 732, as amended by Stats 1915 ch 105 § 12 p 196, Stats 1917 ch 81 § 9 p 109, Stats 1921 ch 598 § 4 p 1012, Stats 1925 ch 130 § 1 p 282, Stats 1927 ch 59 § 1 p 100, Stats 1929 ch 311 § 1 p 626.

(c) Stats 1907 ch 212 § 11 p 255.

**Collateral References**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 62.

ARTICLE 13

Denial, Suspension and Revocation

§ 2360. Grounds for denial: Conduct of proceedings

§ 2361. Grounds for action against certificate-holders

§ 2361.5. Excessive prescribing of drugs, etc.

§ 2361.8. Willful failure to comply with sterilization regulations

§ 2362. Grounds for action against reciprocity certificates

ate, whose application is based on a  
r more years prior to the date his  
Licensing, shall comply with all the  
visions of Sections 2315 and 2320.

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f the division upon a recommenda-  
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of treating the sick and afflicted  
he shall be entitled to receive a

" for "board" before ", or, in the case of a  
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munity in which he has previously practiced

this chapter, the Division of  
of the division its authority to  
mination required by this article,  
nder this article, and to issue  
who have qualified for such  
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for "board" before "may delegate"; and (2)

ertificate

(1 Bus & Prof Code)

The midwifery practices authorized by former Bus. & Prof. Code, § 2140 (now § 2350), expressly relate only to normal childbirth, and cannot be deemed treatment of "the sick or afflicted" within the meaning of Bus. & Prof. Code, § 2141, under which one who, without a license, undertakes to practice, or practices, methods of treatment of the sick or afflicted, is guilty of a misdemeanor. Thus, a criminal allegation, to the extent that it charged unlicensed midwives with a violation of Bus. & Prof. Code, § 2141, based on treatment of the "sick and afflicted," failed to state a cause of action. The charge, however, was relieved from such due process deficiency, and stated a cause of action, by being qualified by a further reference to defendants unlawfully engaging in such practices as "undertaking to assist and treat a woman in childbirth as authorized in Bus. & Prof. Code,

§ 2137," which refers generally to surgery and other modes of medical treatment, thus embracing "sicknesses" or "afflictions" related to complications of pregnancy as distinguished from normal childbirth. *Bowland v Municipal Court* (1976) 18 C3d 479, 134 Cal Rptr 630, 556 P2d 1081.

The prohibition, in Bus. & Prof. Code, § 2141, against unlicensed persons treating a "physical condition" encompasses the unlicensed practice of midwifery. Thus, a cause of action was stated against unlicensed midwives, where, in the criminal charge, it was alleged that they had treated a woman for a "physical condition" by such practices as are authorized in the midwifery statute (former Bus. & Prof. Code, § 2140, now § 2350). *Bowland v Municipal Court* (1976) 18 C3d 479, 134 Cal Rptr 630, 556 P2d 1081.

### § 2350.5. Reference to Board of Medical Examiners as reference to Division of Allied Health Professions

All references in this article to the board, Board of Medical Examiners, or the division shall mean the Division of Allied Health Professions.

Added Stats 1976 ch 1185 § 45; Amended Stats 1978 ch 1161 § 122.

Amendments:  
1978 Amendment: Substituted "Board of Medical Examiners, or the division" for "or Board of Medical Examiners,".

### § 2351. Use of Improper antiseptic procedures

The certificate to practice midwifery may be revoked if it appears to the satisfaction of the Division of Allied Health Professions that due caution and circumspection were not used or that proper aseptic and antiseptic precautions were not taken in any case that the holder of this form of certificate may have treated.

Amended Stats 1978 ch 1161 § 123.

Amendments:  
1978 Amendment: Substituted "Division of Allied Health Professions" for "board".

## ARTICLE 13

### Denial, Suspension and Revocation

Enforcement of this article by Board of Osteopathic Examiners, Osteopathic Act, Appendix 11 § 2

### § 2360. Grounds for denial: Conduct of proceedings

Every certificate issued may be suspended or revoked. The Division of Licensing shall refuse a certificate to any applicant guilty of unprofessional conduct. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the Division of Licensing and the Division of Medical Quality shall have all the powers granted therein.

Amended Stats 1976 ch 1185 § 46.

(1 Bus & Prof Code)

Washington

## CHAPTER 18.50 MIDWIFERY

### Sections

- 18.50.010 Definitions—Gratuitous services—Duty to call physician.
- 18.50.020 License required.
- 18.50.030 Exemptions.
- 18.50.040 Application—Eligibility requirements.
- 18.50.050 Application—Examination fee.
- 18.50.060 Examination.
- 18.50.070 Recording license—Penalty for failure.
- 18.50.080 Recording—County clerk's duties.
- 18.50.100 Refusal and revocation of license—Grounds—Hearing
- 18.50.120 Unlawful practice—Penalties.
- 18.50.130 "Certificate" and "license" synonymous.
- 18.50.900 Repeal and saving.

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

#### Sections

- 18.50.090 Must call physician—When. [1917 c 160 § 8, part; RRS § 10181, part.] Now codified in RCW 18.50.010.
- 18.50.110 Revocation of license—Notice—Hearing. [1917 c 160 § 7, part; RRS § 10180, part.] Now codified in RCW 18.50.100.

### REVISER'S NOTE

"Director" and "director of licenses" have been substituted for "board", "board of medical examiners" and "secretary of the board" throughout this chapter, since the state board of medical examiners was abolished by 1921 c 7 § 135 and its powers and duties were transferred to the director of licenses by 1921 c 7 § 96 (RCW 43.24.020), which powers and duties subsequently devolved to the business and professional administration within the department of motor vehicles. See note following Title 18 RCW digest.

Department of motor vehicles redesignated department of licensing by 1977 1st exa c 334. See RCW 46.01.020.

### CROSS REFERENCES

Abortion: RCWA Chapter 9.02.

Adoption of children through hospitals, doctors, midwives, etc.: RCWA 26.36.040

Crimes relating to pregnancy and childbirth: RCWA 9A.32.060.

Filing certificate of birth: RCWA 70.58.080.

Record as to patients or inmates for purposes of vital statistics: RCWA 70.58.270.

## COLLATERAL REFERENCES

## Annotations:

30 ALR2d 1006 (right of person wrongfully refused license upon proper application therefor to do act for which license is required).

65 ALR2d 12, 60 (right to attack validity of statute, ordinance, or regulation relating to occupational or professional license as affected by applying for or securing license).

93 ALR2d 90 (single or isolated transactions as falling within provisions of commercial or occupational licensing requirements).

**18.50.010 Definitions—Gratuitous services—Duty to call physician.** Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid to a woman in childbirth for a fee or compensation 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 immediate services of a legally qualified physician whenever any abnormal signs or symptoms appear either in the mother or the infant.

## LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 8 p 721.

See RRS § 1081 and former RCW 18.50.010, 18.50.030, 18.50.090.

## COLLATERAL REFERENCES

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 82, 83, § 68.  
CJS Physicians and Surgeons § 3 et seq.

## Attorney General's Opinions:

Ops Atty Gen 1917-1918, p 27. (acts within exemptions not requiring license to practice midwifery).

## Annotations:

30 ALR2d 1006 (right of person wrongfully refused license upon proper application therefor to do act for which license is required).

65 ALR2d 660 (right to attack validity of statute, ordinance, or regulation relating to occupational or professional license as affected by applying for, or securing, license).

93 ALR2d 90 (single or isolated transactions as falling within provisions of commercial or occupational licensing requirements).

## Key Number Digests:

Physicians and Surgeons § 1.

## 18.50.010 BUSINESSES AND PROFESSIONS

### NOTES OF DECISIONS

The practice of obstetrics was outside the scope of practice given to drugless healers, and therefore a drugless healer who practiced obstetrics violated statute making it a misdemeanor for anyone to practice medicine or "surgery" without a valid certificate. *State v Houck* (1949) 32 Wn 2d 681, 203 P2d 693.

**18.50.020** License required. Any person who shall practice midwifery in this state after July 1, 1917, shall first obtain from the director of licenses of the state of Washington a license so to do, and the said director is authorized to grant such license after examination of the applicant as hereinafter provided.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 1 p 717.  
See RRS § 10174.

### CROSS REFERENCES

Application for license: RCWA 18.50.040, 18.50.050.  
Department of licensing: RCWA Chapter 46.01.  
Examination: RCWA 18.50.060.  
Exemptions: RCWA 18.50.030.  
Penalty for violation: RCWA 18.50.120.

### COLLATERAL REFERENCES

Am Jur 2d Occupations, Trades, and Professions § 17-21, Physicians, Surgeons, and Other Healers § 29, 82, 83.  
CJS Physicians and Surgeons § 6 et seq.

#### Forms:

16 Am Jur Pl & Pr Forms (Rev ed), Licenses and Permits Forms 21, 23-26.

#### Attorney General's Opinions:

Ops Atty Gen 1917-1918, p 271 (midwifery practitioners to be licensed).

#### Annotations:

30 ALR2d 1006 (right of person wrongfully refused license upon proper application to do act for which license is required).

65 ALR2d 660 (right to attack validity of statute, ordinance, or regulation relating to occupational or professional license as affected by applying for, or securing, license).

93 ALR2d 90 (single or isolated transactions as falling within provisions of commercial or occupational licensing requirements).

#### Key Number Digests:

Physicians and Surgeons C-5(1).

## NOTES OF DECISIONS

In enacting laws to govern treating sick and afflicted, it was intention of legislature to prohibit holders of restricted licenses from practicing branches of art of healing not embraced within subjects on which licensee had been examined, and which by his certificate he was authorized to practice. *State v Houck* (1949) 32 Wn 2d 681, 203 P2d 693.

**18.50.030 Exemptions.** This chapter shall not be construed to interfere in any way with the practice of religion, nor be held to apply to or regulate any kind of treatment by prayer.

## LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 12 p 721.  
See RRS § 10185.

## CROSS REFERENCES

Gratuitous services exempted: RCWA 18.50.010.

## COLLATERAL REFERENCES

51 Am Jur 2d Physicians, Surgeons, and Other Healers, §§ 28, 29, 82, 83

CJS Physicians and Surgeons § 6 et seq.

## Attorney General's Opinions:

Ops Atty Gen 1917-1918, p 271 (acts within exemption not requiring a license to practice midwifery).

## Key Number Digests:

Physicians and Surgeons §5(1).

**18.50.040 Application—Eligibility requirements.** Any person seeking to be examined shall present to the said director, at least ten 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, nativity, residence, moral character and time spent in obtaining a common school education or its equivalent; 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 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 ap-

## 18.50.040 BUSINESSES AND PROFESSIONS

plicant was graduated. Foreign applicants 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.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 2 p 717.  
See RRS § 10175.

### CROSS REFERENCES

Examination fee: RCWA 18.50.050.

### COLLATERAL REFERENCES

Am Jur 2d Occupations, Trades, and Professions §§ 17-21, Physicians, Surgeons, and Other Healers §§ 29, 82, 83.  
CJS Physicians and Surgeons § 12.

### Annotations:

65 ALR2d 660 (right to attack validity of statute, ordinance, or regulation relating to occupational or professional license as affected by applying for, or securing, license).

### Key Number Digests:

Physicians and Surgeons 4.

**18.50.050 Application—Examination fee.** If the application is approved and the candidate shall have deposited an examination fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended with the director, the candidate shall be admitted to the examination, and in case of failure to pass the examination, may be reexamined at any regular examination within one year without the payment of an additional fee, said fee to be retained by the director after failure to pass the second examination.

### LEGISLATIVE HISTORY

1. Enacted Laws 1917 ch 160 § 3 p 718.
2. Amended by Laws 1st Ex Sess 1975 ch 30 § 51, (1) omitting "the sum of fifteen dollars as" after "deposited"; and (2) adding "determined by the director as provided in RCW 43.24.085 as now or hereafter amended".

See RRS § 10176.

18.46.010 BUSINESS AND PROFESSIONS

CHAPTER 18.46—MATERNITY HOMES

18.46.010 Definitions

(1) "Maternity home" means any home, place, hospital or institution in which facilities are maintained for the care of four or more women, not related by blood or marriage to the operator, during pregnancy or during or within ten days after delivery: Provided, however, That this chapter shall not apply to any hospital approved by the American College of Surgeons, American Osteopathic Association or its successor.

(2) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(3) "Department" means the state department of social and health services.

(4) "Board" means the state board of health.

[Amended by Laws 1979 ch 141 § 32, effective March 27, 1979.]

CHAPTER 18.50—MIDWIFERY

Reviser's note: "Director" and "director of licensing" have been substituted for "board", "board of medical examiners" and "secretary of the board" throughout this chapter, since the state board of medical examiners was abolished by 1921 c 7 § 135 and its powers and duties were transferred to the director of licenses by 1921 c 7 § 96, which powers and duties subsequently devolved to the business and professions administration within the department of licensing. See chapter 43.34 RCWA.

18.50.060 Examination

The director of licensing is hereby authorized and empowered to execute the provisions of this chapter and shall hold examinations in midwifery on the first Monday in January and July, at such 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 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 of the director at least ten days before examination. The cost of said 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) Septic and antiseptic in relation to labor.
- (9) Special care of the bed and lying in room.
- (10) Hygiene of mother and infant.
- (11) Asphyxiation, convulsions, malformation and infectious diseases of the new-born.
- (12) Causes and effects of ophthalmia neonatorum.
- (13) Abnormal conditions requiring attention of a physician.

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CHAPTER 18.46—MATERNITY HOMES

...ions  
...me" means any home, place, hospital or institution in  
...maintained for the care of four or more women, not related  
...to the operator, during pregnancy or during or within  
...ry: *Provided, however,* That this chapter shall not apply  
...ved by the American College of Surgeons, American Osteo-  
...its successor.  
...any individual, firm, partnership, corporation, company,  
...stock association, and the legal successor thereof.  
...means the state department of social and health services.  
...the state board of health.  
...1979 ch 141 § 22, effective March 27, 1979.]

CHAPTER 18.50—MIDWIFERY

...Director" and "director of licensing" have been substituted  
...of medical examiners" and "secretary of the board" through-  
...the state board of medical examiners was abolished by  
...its powers and duties were transferred to the director of li-  
...96, which powers and duties subsequently devolved to the  
...ions administration within the department of licensing. See

...ation  
...ensing is hereby authorized and empowered to execute the  
...chapter and shall hold examinations in midwifery on the  
...uary and July, at such places as the director may select,  
...m. to five o'clock p. m., and at such other times as the  
...deem expedient. The examinations may be oral, written, or  
...in the English language; if desired in any other language,  
...be provided by said director upon notification of the  
...n days before examination. The cost of said interpreter  
...the applicant for the license.  
...ll be held on the following subjects:  
...lvis and female genital organs.  
...menstruation.  
...management of pregnancy.  
...foetal presentation and position.  
...management of normal labor.  
...of puerperium.  
...genital organs following labor.  
...disorders in relation to labor.  
...of the bed and lying in room.  
...mother and infant.  
...n, convulsions, malformation and infectious diseases of the  
...effects of ophthalmia neonatorum  
...ditions requiring attention of a physician.

(14) Requirements of the vital statistics laws pertaining to the reporting of births and the rules of the state board of health relative to ophthalmia neonatorum or other infectious diseases of the newborn.

Said 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.

If said examination is satisfactory, said director shall issue to such candidate a license entitling the candidate to practice midwifery in the state of Washington: *Provided,* That said license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant.

[Amended by Laws 1979 ch 158 § 43, effective March 30, 1979.]

18.50.120 Unlawful practice—Penalties

Practice of assisting pregnant women to give birth to their children through "natural childbirth" constitutes the practice of obstetrics which drugless healers are prohibited from performing. *Griffith v Department of Motor Vehicles, State of Wash. (1979) 23 Wn App 722, 598 P2d 187.*

CHAPTER 18.51—NURSING HOMES

Resident care, operating standards: RCWA Chapter 76.42.

18.51.005 Purpose

Department of social and health services is required to enforce federal regulations relating to Medicaid, but the procedure for decertification is left to

the states. *Valley View Convalescent Home v Department of Social & Health Services (1979) 24 Wn App 192, 599 P2d 1812.*

18.51.007 Legislative intent—1975 Int ex.s.c. 99

Department of social and health services. In revoking appellant's nursing home license and Medicaid certification, failed to follow proper statutory procedure, where the notices of revocation and decertification accompanied the department's statements of deficiencies, and both notices imposed revocation with no time period for correction. *Valley View Convalescent Home v De-*

partment of Social & Health Services (1979) 24 Wn App 192, 599 P2d 1812.

Department of social and health services may not revoke a nursing home's license or its Medicaid certification without giving the home the opportunity to correct deficiencies or to show compliance. *Valley View Convalescent Home v Department of Social & Health Services (1979) 24 Wn App 192, 599 P2d 1812.*

18.51.060 Denial, suspension, revocation of license or provisional license—Penalty

The department is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars per violation in any case in which it finds that the applicant, or licensee, or any partner, officer, director, owner of five percent or more of the assets of the nursing home, or managing employee:

(1) Failed or refused to comply with the requirements of this chapter or the standards, rules and regulations established hereunder; or

(2) Was the holder of a license issued pursuant to this chapter, which was revoked for cause and never reissued by the department, or which license

## COLLATERAL REFERENCES

51 Am Jur 2d Physicians, Surgeons, and Other Healers ¶ 29, 82, 83.  
CJS Physicians and Surgeons ¶ 12.

## Key Number Digests:

Physicians and Surgeons 64

**18.50.060 Examination.** The director of licenses is hereby authorized and empowered to execute the provisions of this chapter and shall hold examinations in midwifery on the first Monday in January and July, at such 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 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 of the director at least ten days before examination. The cost of said 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 bed and lying-in room.
- (10) Hygiene of mother and infant.
- (11) Asphyxiation, convulsions, malformation and infectious diseases of the newborn.
- (12) Causes and effects of ophthalmia neonatorum.
- (13) Abnormal conditions requiring attention of a physician.
- (14) Requirements of the vital statistics laws pertaining to the reporting of births and the rules of the state board of health relative to ophthalmia neonatorum or other infectious diseases of the newborn.

Said examination shall be sufficient to test the scientific and practical fitness of candidates to practice midwifery and the

## 18.50.060 BUSINESSES AND PROFESSIONS

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.

If said examination is satisfactory, said director shall issue to such candidate a license entitling the candidate to practice midwifery in the state of Washington: *Provided*, That said license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 4 p 718.  
See RRS § 10177.

### REVISER'S NOTE

The last paragraph of 1917 c 160 § 4 reads: "If said examination is satisfactory, said board shall issue to such candidate a license with the certified copy signed by its president and secretary, and attested by its seal, entitling the candidate to practice midwifery in the state of Washington: *Provided*, That said license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant." This paragraph has been changed to refer to the "director of licenses" as the board of medical examiners was abolished and its powers and duties transferred to the director of licenses, which powers and duties subsequently devolved to the business and professional administration within the department of motor vehicles. See note following Title 18 RCW digest.

Department of motor vehicles redesignated department of licensing by 1977 1st ex.s. c 334. See RCW 46.01.020.

### COLLATERAL REFERENCES

51 Am Jur 2d Physicians, Surgeons, and Other Healers § 29, 32, 33  
CJS Physicians and Surgeons § 12

Key Number Digests:

Physicians and Surgeons C-4.

**18.50.070 Recording license—Penalty for failure.** Every person holding a license authorized in this chapter must have the same recorded in the office of the county clerk in the county in which the holder is practicing her profession, and the fact of such recording shall be endorsed on the certificate by the county clerk recording the same. Every such person, on a change of her residence, must have the license recorded in the county to which she shall have removed. The absence of such record shall be prima facie evidence of the want of possession of such certificate; and any person practicing midwifery in this state without

## MIDWIFERY

18.50.100

first having filed her certificate with the county clerk as herein provided, shall be deemed guilty of a misdemeanor.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 5 p 719.

See RRS § 10178.

### CROSS REFERENCES

Failure to record license as ground for revocation: RCWA 18.50.100.

Records of county clerk: RCWA 18.50.080.

### COLLATERAL REFERENCES

51 Am Jur 2d Physicians, Surgeons, and Other Healers ¶ 29, 82, 83.  
CJS Physicians and Surgeons ¶ 6 et seq.

#### Key Number Digests:

Physicians and Surgeons C-5(1).

**18.50.080** Recording.—County clerk's duties. The county clerk shall keep in a book provided for the purpose, a complete list of the certificates recorded by him, with the date of the record, and such book shall be open to public inspection during his office hours.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 6 p 721

See RRS § 10179.

### COLLATERAL REFERENCES

51 Am Jur 2d Physicians, Surgeons, and Other Healer ¶ 29, 82, 83.  
CJS Physicians and Surgeons ¶ 15, 23

#### Key Number Digests:

Physicians and Surgeons C-5(4).

**18.50.100** Refusal and revocation of license—Grounds—Hearing. Said director may refuse to grant or may revoke any license herein provided for, for any of the following reasons: Persistent inebriety; the practice of criminal abortion; the commission of any crime involving moral turpitude; presentation of a certificate or diploma for registration or license illegally obtained; application for examination under fraudulent misrepresentation; neglect or refusal to make proper returns to the health officer or health department 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

## 18.50.100 BUSINESSES AND PROFESSIONS

In which the licentiate resides or practices; failure to secure the attendance of a reputable physician in a case of miscarriage, hemorrhage, abnormal presentation or position, retained placenta, convulsions, prolapse of the cord, fever during parturient stage, inflammation or discharge from the eyes of a new-born infant, or whenever there are any abnormal or unhealthy symptoms in either the mother or the infant during labor or the puerperium.

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 said director in person or by attorney. 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 hereinafter prescribed.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 160 § 7 p 720  
See RRS § 10180 and former RCW 18.50.100, 18.50.110.

### CROSS REFERENCES

Abortion: RCWA Chapter 902  
Administrative procedure: RCWA Title 34  
Fraud: RCWA 9A.80.010 to 9A.80.150

### COLLATERAL REFERENCES

Ar. Jur 2d Administrative Law ¶ 37.426, Constitutional Law ¶ 294, Health ¶ 51, Physicians, Surgeons, and Other Healers ¶ 29, 44 et seq, CJS Physicians and Surgeons ¶ 16.

#### Forms:

16 Am Jur 11 & Pr Forms (Rev ed), Licenses and Permits, Forms 21, 23-26.

#### Annotations:

109 ALR 1450 (what offenses involve moral turpitude within statute providing grounds for revoking license).

113 ALR 1179 (what amounts to a conviction or satisfies requirement as to showing of conviction within statute making conviction a ground for refusing to grant or for canceling a license).

115 ALR 2, 12, 139 ALR 627, 632 (prohibition as means of controlling administrative or executive boards or officers in granting or revoking licenses).

165 ALR 1139 (license as revocable for fraud or other misconduct before, or at the time of, its issuance).

166 ALR 575 (stay pending review, of judgment or order revoking or suspending a professional, trade or occupational license).

## MIDWIFERY

18.50.120

3 ALR2d 107 (validity of statute or rule which makes specified conduct a ground for cancellation or suspension of license irrespective of licensee's personal fault).

18 ALR2d 553 (administrative decision or finding based on evidence secured outside of hearing, and without presence of interested party or counsel).

18 ALR2d 606 (administrative decision by officer not present when evidence was taken).

73 ALR2d 939 (power of administrative agency to reopen and reconsider final decision as affected by lack of specific statutory authority).

97 ALR2d 1210 (disqualification, for bias or interest, of member of occupation or profession sitting in license revocation proceeding).

36 ALR3d 12 (comment note on hearsay evidence in proceedings before state administrative agencies).

56 ALR3d 1191 (pardon as restoring public office or license or eligibility therefor).

### Key Number Digest:

Physicians and Surgeons 6-11 et seq.

**18.50.120 Unlawful practice—Penalties.** Any person hereafter practicing midwifery in this state without first complying with the provisions of this chapter, shall be guilty of a misdemeanor and shall be punished by fine of not less than fifty dollars nor more than two hundred fifty dollars, or by imprisonment in the county jail for not less than ten days nor more than six months, or both, at the discretion of the court.

### LEGISLATIVE HISTORY

Enacted Laws 1917 ch 100 § 9 p 720

See RLS § 101K.

### COLLATERAL REFERENCES

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 75-84

CJS Physicians and Surgeons § 20

### Annotations:

13 ALR2d 157 (failure to obtain occupational or business license or permit as defense to tort action).

20 ALR2d 1233 (recovery back of money voluntarily paid to unlicensed person required by law to have occupational or business license or permit to make contract).

90 ALR2d 7 (right to enjoin business competitor from unlicensed or otherwise illegal acts or practices).

90 ALR2d 654 (punishing medicine, surgery, dentistry, optometry, podiatry, or other healing arts without license as a separate or continuing offense).

### Key Number Digest:

Physicians and Surgeons 6-6(17)

**18.50.130**    **BUSINESSES AND PROFESSIONS**

**18.50.130**    "Certificate" and "license" synonymous. The words "certificate" and "license" shall be known as interchangeable terms in this chapter.

**LEGISLATIVE HISTORY**

Enacted Laws 1917 ch 160 § 11 p 721.  
See RRS § 10184.

**COLLATERAL REFERENCES**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 9 et seq.  
CJS Physicians and Surgeons § 15, 23.

**Key Number Digests:**

Physicians and Surgeons C-514 .

**18.50.900**    **Repeal and saving.** All acts or parts of acts inconsistent with the provisions of this chapter may be and the same are hereby repealed: *Provided*, This chapter shall not repeal the provisions of the vital statistics laws of the state, but shall be deemed as additional and cumulative provisions.

**LEGISLATIVE HISTORY**

Enacted Laws 1917 ch 160 § 10 p 721.

**COLLATERAL REFERENCES**

61 Am Jur 2d Physicians, Surgeons, and Other Healers § 17.  
CJS Physicians and Surgeons § 3 et seq.

**Key Number Digests:**

Physicians and Surgeons C-2.

March 23, 1981

Mr. Charles Parr  
Dept. of Health and Social Services  
Juneau, Alaska 99811

Dear Mr. Parr,

I am writing as one of the many who will be directly affected by senate bill #237.

I understand that this bill will effectively eliminate trained and qualified lay people from helping in any way in natural childbirth in the home.

Alaska in particular has a heritage resting on childbirth at home, and of lay midwives assisting at this time.

Is it true that the medical association now feels it has the authority to legislate where a child will be born, as though the hospital with it's pool of dangerous pathogens is the only safe place to give birth to a child? This belief was exposed as erroneous by the National Center for Disease Control at Denver. That study also pointed out that the well screened woman and her child did better giving birth at home because of having built up immunity to those germs in her own environment.

Is it necessarily true that a doctor who often arrives on the scene at the moment of birth is giving better care than a lay midwife, there thru all the labor and delivery, coaching the mother so that she can give birth to her child without drugs?

This bill won't stop couples from having their child at home, it will only serve to increase the risk of home birth by preventing qualified lay midwives from assisting them.

I have found from experience that couples prepare for home birth almost from the moment of conception. These mothers are in training for the upcoming birth; nutritionally, physically and emotionally. They enroll in childbirth classes, they read everything they can get their hands on, and they bond as a family unit. Wouldn't it be better to applaud these couples, not censure them by passing a restrictive bill?

I appreciate the time you have taken in reading this, and I hope this matter can receive your thoughtful consideration.

Sincerely,

Charlotte M. Davis

*Charlotte M. Davis*

*Bill 237 SA  
March 27, 1981  
575-1298*

(303)  
837-4741

the center for disease says  
they didn't do a study - they  
transferred me to

Dr. Nora

(303) 837-4664

837-4664?

who will call back tomorrow  
(Friday)

Dr. Don McNeill's  
Ob. consultant D.C.  
443-3163  
Rockville, Maryland

not good data - no required recording  
will send some info.

Valid question re: alternatives  
to hospital births —

1) who does prenatal?

V.D. tests

nutrition (sufficient Fe)  
protein  
calcium

2) what about PKU tests?

3) any requirements to register home births?

4) AgNi? ~~test~~ in baby's eyes  
AgN . Silver Nitrate

# Home birth

By Jessica J. Hollowell

At the beginning of this century, home birth, with a doctor or mid-wife in attendance, was the single choice for most women. Giving birth in a hospital was an alternative only for well-to-do urban dwellers, usually those with a private physician on the payroll.

The trend has changed over the past 80 years. Scientific advances in medicine and improvements in hospital care have all but eliminated childbirth-related deaths for both mother and child. Group insurance programs have made it economically feasible for average Americans to receive hospital care.

During the 1940's more and more women began checking into hospitals to have their babies. Women now expect to give birth in this setting. In fact, only a handful of births occur, by choice, out of the well-advertised safety of hospital delivery rooms.

## Home sweet home

Hospital birthing, while admittedly safe and convenient in most cases, is not the only alternative for prospective parents in the 80's. While the pendulum has not swung all the way back, many couples now look at home birthing as an inexpensive, relatively safe and emotionally fulfilling experience.

Recently, a Valley woman chose home birth for both her fourth and fifth child. "It was great. With my husband up on the slope, I would have had a hard time arranging for a babysitter at midnight. As it happened, the kids were all asleep and I just had the baby on the couch."

Home birth may sound like a lonely process, but in fact it involves many people. Most important in most home birthing situations is the immediate family. Husbands and siblings prepare, along with the mother, for the momentous event. They become familiar with the birth process and learn breathing and relaxation techniques.

Mothers normally visit a physician, in the months prior to delivery, who may also serve as medical back-up in home birth cases. A birth attendant or a mid-wife usually helps with the delivery itself.

## Contra-indications

Not all women are suitable home birth candidates, according to Valley resident Yvonne Watkins, author of *Better Home Birth*. High risk factors often eliminate home delivery as a viable choice. For instance, anyone over 40 or under 16 years of age should not try home birth. A mother with heart or kidney disease is precluded from home birth. Likewise, anyone experiencing heavy bleeding before birth or who has exhibited an abnormal presentation should enter the hospital for delivery.

A mother who has undergone pre-natal examination and been pronounced fit for home delivery still needs to prepare to go to the hospital, in case of emergency. Watkins, who attended more than 400 home births before moving to Alaska, listed several preparations for a possible hospital visit in her book:

- ✓ Make arrangements for using the same room for labor, birth and recovery, if possible.
- ✓ Try to arrange to keep the baby for an hour or so directly after birth, to get acquainted, before the baby is subjected to hospital routine. Father and children should be present at that time, as well.
- ✓ Have the husband and/or coach there at all times.
- ✓ Choose a hospital with immediate rooming-in, if possible.
- ✓ Hold the baby close and cuddle immediately after birth. Nurse the baby as soon as possible after delivery.

## *...some dads deliver their own babies...*

### **Getting into the act**

The attitude toward involving family members, especially the proud papa, in the special moment of childbirth has changed drastically over the past 40 years. Many hospitals offer child-birth classes for expectant couples. They often include "natural" child-birth instruction to prepare couples for teamwork in the delivery room.

For the first time, perhaps in history, men have moved into the delivery room, whether at home or in the hospital, as an integral part of the childbirth process. In the Valley Hospital, said Carolyn Brown, obstetrician, "We let the dad become as involved as he wants. Most cut the cord and some actually deliver their own babies."

### **Back to nature**

Brown encourages natural procedures, she said. She uses no drugs, unless previously discussed with the patient. Most low-risk mothers are encouraged to labor and deliver in the same room, thereby saving about \$150. No standard preps are used and most women do not undergo episiotomy, the cutting and subsequent stitching of the perineum to enlarge the vaginal area.

"We like the mothers to stabilize at least six hours following birth. Any problems are likely to occur within that time," she said. If everything checks out favorably, the dad can cut the cord and deliver the baby.

# ing -times have changed



## Gambling on home delivery

Brown does not attend or back up home births, although some Anchorage area doctors will do so. "I try to discourage women from home deliveries, but I do not deny pre-natal care to anyone." She points out the potential difficulties, as she sees them. However, about 20 percent of the women she sees opt for home birth, she said.

Brown's major complaint against home delivery is the five percent of birth difficulties likely to present themselves only at the last moment. If the expectant mother is ready to give birth in her Talkeetna home when a problem arises, it may be too late to get her to the hospital, she said.

## ...husbands and kids share in the joy...

Brown is also concerned with the credentials of so-called birth attendants or mid-wives in Alaska. "There are no certified mid-wives doing home deliveries in Alaska." Those who are certified, by a national mid-wifery organization, deliver babies in hospitals here.

Governor Jay Hammond recently introduced a bill into the Senate to provide for the licensing of midwives in Alaska.

Eventually Brown hopes to have a birth attendant, sometimes called physician assistant, working in her practice. An assistant could take care of normal deliveries, histories and physical exams of patients. "I would not have a male assistant," she said, "because I believe women have a better feeling toward the childbirth process."

## At home in the hospital

Brown tries to give women a home birth atmosphere within the confines of a hospital setting, she said. If she wants to deliver on a bed, and there are no contraindications, it is arranged. Some women deliver on their sides, others squatting. One woman, gave birth on a bean bag chair.

Two family members or friends are permitted in the delivery room with the mother. "One mother had her 16-year-old daughter deliver the baby. We eventually we hope to have young children in on the birth too."

At the Valley Hospital, Carolyn Brown strives for safe babies and safe mothers in a family atmosphere.

## Legislation enters picture

Governor Jay Hammond recently introduced a bill into the Alaska State Senate to provide for regulation of midwives, or the delivery of children by persons other than doctors.

The intent of the bill is protection of the public when unforeseen medical emergencies arise. Many midwives in the state are fearful of seeking medical assistance when complications develop during delivery. The legislation would clear up legal uncertainties, said an administration news release.

"We don't want them to be afraid to turn to physicians or hospitals when it is necessary," the governor said.

The bill requires any unlicensed person who assists at child delivery for compensation to be authorized to do so by the State Medical Board or the Board of Nursing. It further requires the setting up of regulations to carry out that process.

## BRUISERS

Healthy home born babies, (shown above, left) seven-month old Paul and three-year-old Sean Sundvik smile brightly for the camera. Both weighed over 10 lbs. at birth. (Photo by Jessica J. Hollowell)

Table 21  
 Infant Mortality Rate<sup>1</sup>  
 Northern Alaska, Alaska, United States  
 1970-1978

	Year	Northern Alaska	Alaska <sup>4</sup>	United States <sup>5</sup>
Infant Mortality <sup>2</sup>	1970	24.9	23.4	20.0
	1971	18.6	18.3	19.1
	1972	15.3	17.0	18.5
	1973	18.7	19.9	17.7
	1974	19.1	18.8	16.7
	1975	13.9	14.3	16.1
	1976	17.9	16.1	15.2
	1977	16.6	14.8	14.1
	1978 <sup>6</sup>	13.5	13.9	13.6
	Neonatal <sup>3</sup>	1970	12.4	15.3
1971		13.4	12.6	14.2
1972		10.9	11.1	13.6
1973		14.0	13.3	13.0
1974		13.9	12.4	12.3
1975		10.9	9.4	11.6
1976		9.0	9.2	10.9
1977		10.9	8.2	19.9
1978		6.7	8.6	9.4

<sup>1</sup> Per 1,000 Births

<sup>2</sup> <1 Year (includes neonatal)

<sup>3</sup> <28 Days

<sup>4</sup> State Health Plan for Alaska, Volume II, Data Appendix, Statewide Health Coordinating Council, April, 1979.

<sup>5</sup> Monthly Vital Statistics Report, Provisional Statistics, Annual Summary for the United States, 1978. U.S. Department of Health, Education, and Welfare. National Center for Health Statistics, Vol. 27, No. 13. Hyattsville, August 13, 1979.

<sup>6</sup> 1978 Vital Statistics: Births and Deaths. Draft. Office of State Health Planning and Development, October 1979.

# Childbirth bill draws criticism

by Dave Carpenter  
Times Writer

Juneau — Health groups and home childbirth advocates around the state are up in arms over legislation they claim would virtually outlaw home births in Alaska.

The bill would prohibit anyone without a license to practice medicine from assisting in childbirth unless authorized to do so by the state Medical Board.

Its effect, according to adamant opponents, would be to all but require women to bear their children in a hospital — a charge physicians insist is unjustified.

The legislation, introduced in the Senate this month at the board's request, has refueled an emotional dispute between home birth advocates and the medical profession.

"If this bill were to pass, it would be horrible," Susan Faulk, president of a non-profit organization called

BABE — Better Alaskans' Birth Experiences — said Friday from Anchorage.

"Home birth is really a beautiful thing. It's (the legislation) against our basic human rights," she added.

Dr. Patton Pettijohn, an Anchorage physician who practices naturopathy — a system of health care stressing nutrition and physical therapy and rejecting the use of drugs — heartily agrees.

"I don't think the government has the right to dictate whether parents have the right to have a baby at home or not," said Pettijohn. "I think this is the intent of the bill."

The two Anchorage residents are among what Faulk says is a substantial number of Alaskans who have begun lobbying against the legislation.

The bill, SB237, makes some changes in the definitions and regulation of medical licensing. It comes

at a time when the number of homebirths nationally are on the increase and when several states are loosening making it easier for women to give births in their homes.

The measure is expected to be addressed in early April at hearings of the Senate Health, Education and Social Services Committee, chaired by Fairbanks Democrat Charlie Parr. Gov. Jay Hammond had it introduced on behalf of the Medical Board.

Physicians, saying they're leery of taking on the opponents on what is literally a motherhood issue, appear reluctant to discuss the bill publicly. But the chairman of the state Medical Board said Friday that it's "not the primary intent" of the legislation to do away with homebirths.

"We're trying to come up with a more comprehensive definition of the practice of medicine," board chairman Dr. Jeffrey Partnow said

from his Fairbanks office.

"It would allow us to do our job of licensing and investigations, should they become necessary . . . I don't think it's the intention of the medical board to put anybody out of business."

One physician, commenting only after being assured anonymity, said the issue has become so heated it pits two "armed camps" against each other.

The doctor said the medical community and state board, if facing loud and numerous objections to the bill, probably would allow the disputed portions to be removed or amended to ensure childbirth assistance rights for midwives and others.

The physician said backers of the bill are interested in consumer protection — not doctor protection, as home birth defenders claim.

"With the current atmosphere of (See BIRTHS, page A-3)

(Continued from page A-1)

the two sides glaring at each other over a pregnant belly, if there ends up being a problem (at birth), the appropriate medical care sometimes ends up being put off indefinitely or perhaps never rendered," the physician said.

"We just want to ensure that if the child gets sick or the mother hemorrhages, there's some way we can ensure that medical help would be possible."

The bill states that no unlicensed person may assist at childbirth for compensation unless "authorized under regulation of the board or if licensed or subject to regulations adopted" under Alaska statutes.

Faulk and Pettijohn said there is only one physician in Alaska — Dr. Peter Rossi of Sitka — who delivers babies at homes. Rossi was indicted

in 1979 but acquitted a year later in connection with an infant death that occurred 21 hours after a home birth.

"If medical doctors would deliver at home, there wouldn't be so much objection," said Pettijohn, who calls home birth safer and more comfortable for mothers than giving birth in a hospital.

Faulk also pointed out that the average home birth costs \$300, compared with \$2,000 for the average hospital costs for bearing a child.

"You can understand why the doctors are concerned — every time a person has a child at home means 2,000 bucks they don't get," she said.

Hammond, however, in a letter sent to the Senate explaining the bill, said the intent is to protect the public by better regulating the care of pregnant women.

SB 237

Anch Times 3/21/81

Family-Centered Birth, Inc.  
of Juneau, Alaska

Board of Directors:

Ms. Becky Bear  
Ms. Melinda Lee  
Ms. Mary Alice McKeen  
Mr. David Ottoson  
~~Ms. Lyn Rice~~

Advisors:

Ms. Margaret Crawford  
Ms. Pam Findley  
Ms. Bonnie Lang  
Mr. Richard Lee  
Dr. Will McCreight

Family Centered Birth, Inc.--Who are we? We are a group of persons who have joined together because of a shared personal interest and commitment to family-centered maternity care. We are concerned with the physical, mental, emotional and social aspects of family-oriented maternity care--with primary emphasis on self-responsibility. Our primary goal is to establish an alternative maternity care center here in Juneau.

The concept of a birth center perhaps needs some clarification. For Family-Centered Birth, Inc., the following provisions must be included:

Our Birth Center will:

- 1) provide comprehensive maternity care to low-medical risk women in a home-like, out-of-hospital setting.
- 2) view Birth as a safe, family-centered, and personally meaningful event.
- 3) regard the prospective parents as being primarily responsible for the event of birth; encourage this role.
- 4) provide information, explanation, and education on all aspects of pregnancy, birth, and becoming a parent.
- 5) lower health care costs for child-bearing families.
- 6) seek to uphold a philosophy of non-intervention in birth.

We are very much in the planning stages at this time, but would like to give you a general idea of the make-up of a birth center in Juneau. Therefore we have attached a rudimentary outline of our plans.

## Birth Center Plans

(tentative as of Jan. 1981)

- 1) Services: Comprehensive maternity care (prenatal, labor and birth, Post-partum)  
Education opportunities (classes, discussions, library)  
Referral of high risk medical cases to a physician  
Routine lab work  
Newborn and infant check-ups  
Family planning
- 2) Physical Plans: The birth center will be located within a short drive of Bartlett Memorial Hospital (about 5 minutes). The center would provide a clean, home-like setting with safety back-up equipment and sufficient space for examination rooms, birthing rooms, living room, group meeting room, office, bathrooms, laundry, and kitchen facilities.
- 3) Staffing: The birth center will be directed by a certified nurse-midwife. Other staff would include consulting physician(s), nurses, and/or midwives. Volunteers for reception, clerical, and teaching will be solicited. The board of directors will take an active role with administration.
- 4) Equipment: General Furnishings and birth supplies; oxygen, resuscitation equipment, emergency drugs, radiant heated bassinet, external fetal monitor, IV equipment with blood expanders.
- 5) Clientele: Rigorous screening and referral of any high-risk pregnancy to a physician at any point of pregnancy, labor, or birth. Controlled caseloads to provide personalized and quality maternity care.
- 6) Support Services: We will seek outside services for the following:  
Emergency during labor and birth-Bartlett Memorial Hospital  
Extensive Lab Work-B.M.H.  
Physician back-up in case of transfer to BMH.  
Physician available for 24-hour telephone consultation  
Transportation by private car or van will always be present for emergency transfer.
- 7) Finances: The birth center will be private, non-profit.  
Clients will be charged for services rendered. Bills can also be worked off if prior arrangements are made.  
Third party reimbursement will be sought (legislation required right now)  
Monies available from state or local sources will be explored.

Family-Centered Birth, Inc. • 1670 Evergreen • Juneau, Alaska 99801 • tele: 526-3236

Any inquiries about our plans are welcome. We are looking for support, volunteers, a residence, and advice. Write or call.

state  
hospital  
association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790  
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

SB 237

President  
Dorothy Barling Hoane  
Catherine Cannon Hovstad  
Kathleen

President Elect  
Tom Minger  
President Emerita  
Faylene

Secretary/Treasurer  
Rae Farnham  
Alaska Hospital & Medical  
Center  
Anchorage

Communication Director  
Al Cooper  
President's Hospital  
Anchorage

Executive Director  
Dennis L. DeWitt  
Juneau

March 25, 1981

TO: Senator Charlie Parr  
FROM: Dennis L. DeWitt, Executive Director  
SUBJECT: Average Maternity Charge at Alaska Hospitals

The attached reflects a telephone survey of Alaska State Hospital Association members asking the cost of a routine maternity stay. Average daily service charge in Alaska is approximately \$200.00 so the figures would be adjusted by at least that should the stay be more or less than 3 days.

I hope that this is helpful to you in your deliberations.

FACILITY	AVERAGE MATERNITY COST	Maternity cost of
Alaska Hospital / Anchorage Birthing Center	900.00 - average	
Alaska Hospital	1,500.00 - 3 Days	
Bartlett (Juneau)	800.00	
Central Peninsula (Soldotna)	550.00	
Cordova	1,500.00 - 3 Days	
Fairbanks	1,000.00 - 3 Days	
Faith (Clemson)	850.00 - 3 Days	
Ketchikan	1,300.00 - 24 Hours	
Kodiak	600.00	
North Star (Homer)	1,700.00 - 3 Days includes Doctor	
Petersburg	550.00 - 24 Hours	
Yukon-Charley (Nikolai)	1,200.00 - 2 or 3 Days	
Seward	800.00 - 2 Days	
Sitka	1,100.00 - 2 Days	
South Peninsula (Homer)	550.00 - 24 Hours	
Valdez	1,000.00 - 2 Days	



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service  
Region VIII

Federal Office Building  
1961 Stout Street  
Denver CO 80204

SB 237  
April 8, 1981

Ms. Rocky Weller  
Senate H.E.S.S. Committee  
Pouch 5  
Juneau, Alaska 99811

Dear Ms. Weller:

As per our telephone conversation, I am sending you materials regarding home births. The first is a discussion which appeared in the University of Colorado Department of Pediatrics newsletter (Vol. 1, No. 2) with three references cited.

The second is a publication of the Michigan Department of Public Health on parental perspectives of home births.

I hope this information will be of help to you.

Sincerely,

Audrey H. Nora, M.D., M.P.H.  
Regional Program Consultant,  
Maternal and Child Health

Enclosures

Home delivery is one of the most emotion-packed questions confronting perinatal medicine today in this country. It is currently estimated by the American College of Obstetrics and Gynecology that 1% of all deliveries in the United States today are accomplished away from a hospital. The reasons for this increased interest in home birth stems from a number of factors. More and more women today and entire families for that matter, feel that the normal course of labor and delivery in a hospital setting is far from the happy family-oriented event that childbirth is supposed to be. A quick walk through most of the labor and delivery suites in American hospitals would certainly confirm this. Many women view home delivery as a way of circumventing the emotion and physical discomforts often encountered in hospital birth. Another growing problem in the Denver area is the reluctance of Oriental immigrants, specifically Vietnamese and Laotian, to come to the hospital for delivery. One question many of these women express is a fear of being forced to deliver by Caesarean section if they come to the hospital. Also relevant to them is the fact that most deliveries in their country of origin are

accomplished in something other than a hospital setting. Whatever the reason for the increasing incidence of home birth may be, the primary question that has to be addressed is simply - Is it safe? If in fact it is deemed to be unsafe, then the other question of whether or not parents have the right to make that decision for the infant must be raised. Another question in connection with this is simply - If it is felt by the medical community at large to be an unsafe procedure, then who is to be held liable if in fact a major complication should occur? In San Luis Obispo, California, a lay midwife was recently indicted on felony charges for practicing medicine without a license and second degree murder in connection with the death of a newborn infant following delivery at home. (Reference 1)

In answering these two questions, I feel it is safe to say that most neonatologists in this community feel in fact that home delivery is not safe. I certainly support this feeling and would go one step further in saying that people who assist in such home deliveries should in fact be held liable under the law if complications occur that would not have occurred had the infant been delivered in an appropriate setting.

Literature can be found today which can support whichever side of the question you choose to be on. A study on home delivery published in the British Journal of Obstetrics & Gynecology in 1977 would seem to confirm my suspicions regarding the increased hazard to the infant if he is born at home. (Reference 2) On the other hand, the Institute for Childbirth and Family Research in Berkeley, California, recently reported in the Journal of Reproductive Medicine the outcome of a series of over 1,000 home births which showed no significant increase in perinatal mortality. It is important when looking at this study, however, to recognize the fact that this was a self-selected medical screen of a very low risk population with medical facility back-up. In 1978 the American College of Obstetrics and Gynecology published in their Newsletter the results of an inquiry to various states concerning their perinatal mortality for inhospital and out-of-hospital deliveries. The four states who were able to record accurate data were Iowa, California, Oklahoma and Kansas. Their figures concerned the years 1975-76. In all four cases there was at least a doubling of perinatal mortality among infants born out of hospital. In fact, in the state of Kansas perinatal mortality jumped from 19.9/1,000 for inhospital deliveries to 103.7/1,000 for out-of-hospital deliveries. This represents a 500% difference in perinatal outcome. In 1976 the Vital Records Division of the State of Colorado was able to identify 296 non-hospital deliveries. There were 11 infant deaths among that group, showing an infant mortality of 37.2/1,000 as opposed to the overall inhospital delivery mortality of 13.0/1,000. It is obvious that the argument is endless. The more liberal of our citizenry in this matter complains that we are violating the rights of parents by interfering in their choice as to where and under what circumstances to bring their children into the world. Quite often our counter-argument that they have no right to make the decision concerning their unborn child's wellbeing falls on deaf ears. The consensus of cold facts, however, indicates that perinatal mortality increases in both low and high risk populations who choose to deliver in a non-hospital environment. An interesting point that we have recently noticed at DGH also indicates that certain forms of perinatal morbidity increase in addition to mortality. With the increase in numbers of Laotian and Vietnamese babies who are born at home and then brought to the hospital, we are finding an alarming increase in hyperviscosity among these infants. In looking at the same population who choose to deliver in the hospital, this problem has no greater incidence than that among the other populations that we serve.

In summary, I would say that the statement of the Maternal & Child Health Committee of the State Medical Society released in 1978 was perhaps one of the more sane

statements regarding this subject. The statement is as follows:

Whereas the mortality rate of home deliveries is three times greater when compared with hospital deliveries in 1976, and whereas it is impossible to predict an uncomplicated labor, delivery and neonatal resuscitation, and whereas practitioners who have attended out-of-hospital deliveries have experienced undesirable if not potentially fatal complications, and whereas anyone undertaking obstetrical care does so with the implied goal of a successful outcome for both mother and baby, now therefore be it resolved that until further data are available, the home is not the preferred place for delivery because of the sufficiently increased risk it poses for the mother and infant, and be it further resolved that a major priority of the Colorado Medical Society should be to make all information relative to risks of home deliveries available to those persons interested in such a way they can make a rational decision, and be it further resolved that the members of the Colorado Medical Society should strive to make in-hospital obstetrical care a non-illness, family-oriented experience.

The last sentence of the State Medical Society's statement cannot be emphasized too strongly. By making every attempt to render childbirth a time of joy for the parents and family in the hospital, most of the problems we have been discussing can in all probability be circumvented.

#### References

1. American Med. News. August 11, 1978, p. 11.
  2. Brit. Jnl. Obs. Gyn. 84:6, 401-411.
  3. Jnl. of Rep. Med. 19:5, 281-290.
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STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

ALABAMA

(Professions and Businesses 4.34-19-1-.34-19-10)

NURSE-MIDWIFE

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.

Definition:

Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.

PROFESSIONAL MIDWIFE

Requirements

Limitations on Practice

Special Statutory Provisions

Definition:

An individual who has received formal professional training as a midwife.

LAY MIDWIFE

Requirements

Limitations on Practice

Special Statutory Provisions

Definition:

Individual who practices as a midwife but has not received formal professional training.

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

Requirements

Definition:

Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.

Limitations on Practice

Practice supervised by physician or surgeon (physician's presence not required); case 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 abortion

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

Requirements

Definition:

An individual who has received formal professional training as a midwife.

Limitations on Practice

Special Statutory Provisions

LAY MIDWIFE

Requirements

Definition:

An individual who practices as a midwife but has not received formal professional training.

Limitations on Practice

Special Statutory Provisions

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CONNECTICUT

(377.20-75)

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CONNECTICUT (377.20-75)
<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	Requirements	Graduate of school of midwifery.
	Limitations on Practice	Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drug instruments, nor perform version or attempt to remove adherent placenta. Shall not attend a woman in labor until after seventh month of gestation.
	Special Statutory Provisions	Examination required for licensing.
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

FLORIDA

(30.485.011 - 30.485.091)

<u>NURSE-MIDWIFE</u>	Requirements	
<p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>PROFESSIONAL MIDWIFE</u> <u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	<p>Diploma from school for midwives; sponsorship by two practicing physicians; ability to read manual intelligently and write legibly (this may be waived).</p>
	<p>Limitations on Practice</p>	<p>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.</p>
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u> <u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	<p>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; sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived).</p>
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
	<p>Requirements</p>	<p>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* *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 it necessary to require proficiency in English.</p>
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> Individual who practices as a midwife but has not received formal professional training.</p>	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	<p>(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.</p>
	<p>Requirements</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MARYLAND

(Art. 43.82-94)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Certified by American College of Nurse-Midwives as a nurse-midwife.</p>
	<p>Limitations on Practice</p>	<p>Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion.</p>
	<p>Special Statutory Provisions</p>	<p>Person who is not 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.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> Individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	<p>Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included).</p>

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MINNESOTA

(148.30 - 148.32)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Certificate in nurse-midwifery from the American College of Nurse-Midwives.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

NEW JERSEY

(45:10)

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		NEW JERSEY (45:10)
<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	Requirements	Certificate from school of midwifery, or maternity hospital granted after 1800 hours 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.
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

OHIO

(4731.30-4731.34)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u>                  Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Diploma from college for nurse-midwives</p>
	<p>Limitations on Practice</p>	<p>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.</p>
	<p>Special Statutory Provisions</p>	<p>Examination may be required.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u>                  An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u>                  An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

UTAH

(58-44-1 - 58-44-11)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	<p>Completed approved certified nurse-midwifery education program.</p>
	<p>Limitations on Practice</p>	<p>Under this act, may also provide normal gynecological services.</p>
	<p>Special Statutory Provisions</p>	<p>Establishes committee to supervise practice of nurse-midwifery. Examination required by Act does not affect rights of parents to deliver their baby, where, when, how and with whom they choose regardless of certification.</p>
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

WASHINGTON

(18.50.090 - 18.50.110)

<p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u> Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
<p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u> An individual who has received formal professional training as a midwife.</p>	<p>Requirements</p>	<p>Diploma from legally incorporated school on midwifery in good standing, granted after least 2 courses of instruction of at least seven months each in different calendar year. Diploma from foreign institution on midwifery of equal requirements.</p>
	<p>Limitations on Practice</p>	<p>Shall not prescribe any drugs or medicine except some household remedy.</p>
<p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u> An individual who practices as a midwife but has not received formal professional training.</p>	<p>Requirements</p>	
	<p>Limitations on Practice</p>	
	<p>Special Statutory Provisions</p>	<p>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.</p>

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

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

# MEMORANDUM

# State of Alaska

TO: Pete Jeans  
Deputy Commissioner  
Department of Commerce &  
Economic Development

DATE: February 6, 1981

FILE NO: J-66-298-81

TELEPHONE NO: 465-3690

Thru: Harry Treager, Director  
Occupational Licensing

SUBJECT: Medical Board Inquiries Re  
Lay Midwives

From: WILSON L. COYDON  
ATTORNEY GENERAL

By:   
Sarah T. Kavasharov  
Assistant Attorney General

You have asked for clarification of conflicting opinions from this office on the question whether or not assisting at child birth constitutes the practice of medicine. The answer is, that while we might attempt to stretch the definition of the practice of medicine in the current law to cover assistance at child birth, it would be better to seek a revision of the statute.

The proposed amendment of AS 08.64.170 and AS 08.64.380(2) along with the new section 369 in the medical bill being introduced this session will cover actual assistance at child birth. Prenatal counselling already comes within the definition of the practice of registered nursing in AS 08.68.410(8) of the nursing bill which is also being introduced this session. We believe that passing these amendments is the best solution to the problem of regulation of prenatal care or assistance at child birth and should cover at least the major problems. If you have further questions on the issue, please contact our office again. We believe, also, that any further regulation of this area should be discussed jointly with the Board of Nursing.

STK:wjp

Readers  
Digest  
March '81

A sharp increase in the number of Caesarean sections has raised new questions—and concerns—about this “emergency” procedure

## Too Many Caesarean Births?

By JOHN J. FRIED

FOR ELAINE ADAMS the first warning that she would not have a natural childbirth came shortly after her estimated “due date.” She visited her obstetrician for her regular Wednesday appointment, and he told her that two weeks overdue was too much. They could induce labor, he suggested, rather than wait until the baby became too big and risk a difficult birth. He added that inducing labor now would help to avoid the possibility of a Caesarean birth. Reluctantly, Adams decided to take her doctor’s advice.

In the hospital she was given a drug to bring on labor. For ten hours very little happened. Then, as the dinner hour approached, the doctor told her she would need a Caesarean section, an operation in which the

baby is surgically delivered through the abdomen. Adams asked for a few more hours of labor, but the physician advised against it and ordered her prepared for surgery.

Elaine Adams’s story is not unusual. Tens of thousands of women are finding themselves confronted by the possibility of a Caesarean delivery. At the end of the 1960s, only 5.5 percent of births in the United States were Caesarean. Today that rate has tripled—and in some hospitals it is as high as 32 percent.

Many women arrive at hospitals unprepared for the sequence of events that can propel them into this major surgery. First, a fetal monitoring machine (which can be misinterpreted) calls attention to some seeming liability or risk. The doctor may order drugs to regulate

and/or accelerate labor. If this results in inadequate or distorted labor, a Caesarean is called for, and the woman, exhausted from hours of labor, submits.

Many, like Elaine Adams, are disappointed about being rushed into it without proper knowledge. "In the delivery room," she told me, "strapped down for the operation, I felt angry and trapped. Later, I was in pain from surgery, while others who had had normal births were bouncing out of bed and nursing their babies right away."

"Bikini" Surgery. Just a few years ago, Elaine Adams's story would have been unusual. Women across the country, after a long struggle against medical convention, had managed to force obstetricians and hospitals to accept a host of different childbirth methods: delivery without drugs; labor assisted by husbands; even births at home, aided by midwives instead of doctors. But now, the obstetrical pendulum has swung back with a vengeance.

To many medical experts, the return of the Caesarean is a return to rational birthing. Caesarean sections, they feel, are responsible for America's decreasing infant-mortality rate. This procedure spares the premature or low-weight baby, as well as the breech baby born buttocks or feet first, from the rigors of vaginal birth. "Ten to 15 years ago, a baby weighing less than three pounds ran a high risk of dying."

\*So named because Julius Caesar is supposed to have entered the world in this fashion.

says Dr. Charles Brinkman, chief of obstetrics at the University of California at Los Angeles Medical Center. "Now, in our hospital, 60 percent of the babies who weigh two pounds or the babies who weigh two pounds, or even less, survive."

Caesareans have also soared in popularity because physicians feel more at ease with the procedure. Today, many Caesareans are performed through a "bikini" cut—a small incision across the lower part of the belly, just above the pubic hairline—instead of a longer, lengthwise incision beginning just above the pubic area and extending well up over the abdomen. And instead of the general anesthesia used formerly, more than half of C-sections are now done with a spinal anesthetic that allows the mother to stay awake.

Yet the increase in the use of the technique has spawned anger and concern among many women. "There is so much emphasis on the natural experience that you feel cheated if you have a Caesarean," says Tracy Campbell, who went through a surgical birth. "Some women feel, 'I did something wrong. I ate too much. I breathed the wrong way. I am not a woman because I didn't actually give birth.'"

Almost 27 percent of the increase in the Caesarean rate can be traced to repeat C-sections—surgical deliveries in women who have undergone the procedure before. However, many physicians and the National Institutes of Health Task Force on Caesarean Childbirth point out that the adage "Once a C-section, always a C-

section" need not hold sway. The risk that an old C-section scar will rupture during a subsequent vaginal labor is small, especially in women who had bikini cuts.

**No Evidence.** Some doctors also feel that obstetricians are too quick to opt for a Caesarean because, with busy practices, they find it inconvenient to allow birth to come of its own volition. Thus, rather than wait out a slowly progressing labor, they will do a C-section. "A lot of people out there practice aggressive obstetrics," says a leading Los Angeles obstetrician who does not want to be identified. "They hurry things along when they shouldn't."

Many doctors believe, as well, that the procedure is a legal safeguard. Obstetricians rank fourth among physicians who are specialists as targets of malpractice suits. "The climate is such that if the physician has done a Caesarean he has done everything he can," says Dr. Thomas Garite, associate medical director for perinatology at Long Beach (Calif.) Memorial Hospital Medical Center. "If he tolerates a long vaginal birth and gets a damaged baby, it is more likely to be attributed to the physician's not doing enough." In the late 1960s and early 1970s, he adds, poor birth outcomes—including cerebral palsy, depression and neurological damage—were blamed on longer hours of labor. "So doctors won't tolerate long labors anymore," Dr. Garite says.

However, the contention that C-sections diminish the incidence of

cerebral palsy and other neurological problems among normal-weight babies carried to term is now a controversial question among obstetricians. The Task Force on Caesarean Childbirth could find no compelling evidence that babies born by C-section fare better than their vaginally delivered brothers and sisters.

Moreover, some experts believe that the obstetrician may even contribute to inefficient labor—one of the indicators used to rationalize Caesarean section—by using drugs to induce birth. "Birth is like plucking an apple off a tree," says Dr. Calvin Hobel, professor of obstetrics and gynecology at Harbor-U.C.L.A. Medical Center in Torrance, Calif. "If the apple is ripe, it will just fall off. But if you start too soon, it's like trying to pluck a green apple. You might break the branch. If you try to induce the patient before everything is ripe, you can get into trouble, and you may wind up doing a Caesarean section."

**Backing Off.** In a substantial number of births, the obstetrician who feels that labor is not progressing well is abetted by an electronic fetal monitor. Once the membranes have ruptured, the doctor will place two fingers in the woman's vagina, and the fingertips will touch the baby's head. Then he will pass a thin plastic-and-wire tube up into the vagina, and twist a coiled wire at the tip of the tube into the baby's scalp. Once this electrode is in place, an electronic digital readout

on a monitoring machine continuously flashes the baby's heartbeat. Ideally used, the fetal monitor can tell the obstetrician if the birth process is causing the child to suffer because his brain is not receiving enough blood and oxygen.

But the monitor itself has become a focus of controversy. Some obstetricians lack expertise in interpreting the signals. Moreover, the monitor is prone to readings that indicate problems where none exist.

In the late 1970s Dr. David Banta, a physician now with the Office of Technology Assessment in Washington, D.C., and Dr. Stephen Thacker of the Centers for Disease Control in Atlanta prepared a report on fetal monitoring for the Department of Health and Human Services. "We estimated that half of the increase in C-sections over the last ten years could be attributed to the monitoring," Dr. Banta says. "And essentially, most of those Caesareans were needless."

The goal, say some medical experts, should then be to lessen the impact of the fetal monitor. "There is no question that there has been a tremendous benefit from the increase in the Caesarean-section rate and that there have been benefits from fetal monitoring," says Dr. Hobel. "But now the question is: how much can you back off from fetal monitoring and Caesareans and maintain the success we have had in reducing infant mortality? Can we reduce the Caesarean-section rate from 25 to 10 percent and maintain

good outcomes? I think we can."

**Mitigating the Effects.** One reason for reducing the Caesarean-section rate is simple economics: the rocketing number of surgical births has brought immense financial burdens. In Southern California, for example, the average physician charges about \$750 for a vaginal birth—but about \$1000 for a Caesarean section. The Task Force report says that a normal birth will mean a two- or three-day stay in the hospital, but for a repeat Caesarean it will be about six days, with a net additional cost of over \$2000.

Obstetrics experts believe that in some cases the surgery may actually be harmful to the baby. Caesarean delivery is recommended to rescue a baby unable to withstand prolonged birthing. Although 20th-century technology makes it possible to determine fetal maturity, these methods are not always used or correctly applied. As a result, a scheduled Caesarean performed because the baby is allegedly overdue can bring forth a premature child subject to dangerous respiratory problems.

Caesarean sections take a physiological toll on the mother as well. In one study in New York, 25 percent of the women who had Caesareans suffered complications, including lung problems and adverse reactions to anesthetic, compared with only 15 percent for women who delivered vaginally. And the risk that a Caesarean mother will develop a pelvic

## READER'S DIGEST

infection is 7 to 20 times greater.

Such postoperative complications may simply mean more time in the hospital. But in some cases the adverse reactions can increase the risk of death. "In 1978 the maternal death rate in vaginal deliveries was 9.6 per 100,000," reports Dr. Diana Petitti of California's Kaiser-Permanente group. "But for women who had C-sections, it was 40 per 100,000, or four times greater."

Women who have undergone Caesareans seem even more concerned with the psychological hurt that follows the procedure. In many hospitals the woman is not allowed to hold her child immediately after birth. "I saw my son only briefly after he was born," says Sandy Hambeck, a young Californian. "And I still feel the trauma of not being able to hold him and nurse him."

While the hurt is real, however, psychologists say they find no persuasive evidence that Caesarean mothers suffer deep or long-lasting psychological damage. "We found that Caesarean mothers often tend to be more involved with their children," says Tiffany Field of the University of Miami School of Medicine.

Moreover, women who have had Caesareans agree that negative psychological effects can be mitigated if the woman—and her husband—retain a sense of control over their

birthing experience. Groups formed to help women suggest that:

- A pregnant woman should learn as much as she can about Caesareans so that, if the possibility arises, she will be prepared for the decisions that must be made.

- If told during labor that a Caesarean might be done, a woman should question the physician closely. "Don't accept the doctor's saying this is the only way the baby is going to be born," says Tracey Campbell, now a Caesarean-birth educator. "Find out what the problem is, whether there is something wrong with the placenta, the cord, the contractions. Have your questions ready before you go into labor, and have your husband there with you to hear the answers."

- If a woman is having a second baby after having had one by Caesarean, she may want to find a doctor who will allow a trial vaginal labor. She shouldn't agree to a scheduled Caesarean, unless her medical condition makes it imperative. Even so, she is entitled to a second opinion.

- The mother-to-be should shop carefully for a physician, and ask him what the Caesarean percentage is at the hospital where he practices. She should also ask what his own and his partners' is. "If he says, 'If that is a concern, maybe you don't want to see me,'" Campbell notes, "then maybe you don't."



**T**HE FULL SITUATION has created another excuse for being late to work:  
"Got my pant leg caught in the bicycle chain, boss."

—Wendell Trigg, Jan. 10, 1980, p. 57



Staff photo by Bruce McKim

Susan Anemone checks the vital signs of a prospective mother at the Seattle Midwifery School/Home Maternity Service.

## Midwifery school helps with home-births advice

by Sheila Anne Feeney  
Times staff reporter

**G**ET "We're like snoops. Our role is to always look for something going wrong." Susan Anemone said of her vocation's curious nature.

Ms. Anemone, Margaret Mansfield, Susan Myers, and Susan Rivard are Washington state-licensed midwives who operate the non-profit Seattle Midwifery School and Maternity Service.

The service partially supports the school, and also provides the field training for students.

Rigorous, continuous screening of patients occurs continually to assure that the prospective mother is "low risk." Factors such as high blood pressure, anemia, bleeding, or malpresentation (breech or unusual birth), or even desiring a home birth for the wrong reasons, will prompt the partners to refer the client to a hospital.

The mother is speedily transferred to the hospital should a complication arise during labor, Ms. Anemone explained. This is evidence of the evolving nature of a midwife's role: the old-time, rural midwife, who once had to handle any problems that came along, has been replaced by urban specialists who handle only routine births, and refer more complicated cases to medical specialists.

Home births are less expensive (the service costs about \$500, plus mileage in some cases), however, offer women more control over the birth experience and the opportunity to have their loved ones present if they desire, Ms. Anemone said.

"This has to do with a different value system, with not being medicated and (also) having control over your own body," said Ms. Anemone. She added that the service also is a preferred alternative for women who want to be

attended by other women, and for those who dislike or fear hospitals for some reason.

Ms. Anemone said the midwife takes a back seat to the mother during the birth. "Our patients aren't sedated. They're well-prepared, with childbirth instruction."

While deliveries by midwives are a controversial topic in the medical profession, Ms. Anemone said non-nurse midwives have an advantage in a home birth because midwives trained entirely in hospitals can't be expected to do as well in a home setting.

She added that persons trained in hospitals with a variety of technology and machines at their disposal "do not develop the self-reliance and skills to know (their) limitations."

Ms. Anemone said the two-year-old school, which is independent of nursing school or hospital affiliations, is perhaps the only one of its kind in the country. Other midwifery (pronounced midwifery) schools exist, but generally are run in conjunction with, or subsequent to, a nursing program, Ms. Anemone said.

The school, which was established by Anemone, Mansfield, Myers and Rivard to train licensed midwives, accepts only six students at a time, and has a waiting list of as many as 300.

The service accepts applications from prospective mothers who would like a team of midwives (student midwives assist as part of their obstetrical training) to attend them.

Although the service has openings for pregnant women who would like to deliver at home, Ms. Anemone added emphatically that "we never tell people to have home births. They come to us after their decisions have been made."

Sept 11, 1977  
Seattle Times

## Giving birth: at home or in hospital?

Dear Dr. Solomon: My mother gave birth to all three of her children at home, while I had all of my children in a hospital. Now my daughter



**Dr. Neil  
Solomon**

says she plans to have her first child at home. Which would you recommend, hospital or at-home birth of a child? — Mrs. M.W.

Dear Mrs. W.: There are both pros and cons to giving birth in a hospital or at home. In the case of uncomplicated pregnancies, the evidence supporting one method or the other is not conclusive. Where complications do exist, however, a hospital setting is necessary.

Despite the recent publicity surrounding home births, they constitute only about 1 percent of all births in the United States. Those who champion this trend maintain that it provides psychological advantages to both mother and infant, as well as to any other children in the family. Some women complain that hospitals are cold and impersonal, restrict visiting unnecessarily, and interfere with the mothers' access to their babies following birth. The high cost of hospital care is another factor.

The opponents of home birth, on the other hand, say it poses unnecessary risks for both the mother and baby. While many complications of pregnancy can be foreseen prior to birth, some — such as severe hemorrhage — may not be. As Dr. G. David Adamson, an obstetrician at the Stanford University Medical Center, points out, although childbirth is not an illness, it does pose an increased risk to health.

Almost all physicians are of the opinion that women who give birth at home face risks they would be spared if they were in a hospital setting; yet, many women do give birth at home without difficulty. But concrete evidence pointing to the advisability of one over the other in uncomplicated pregnancies is still lacking.

# HOME BIRTH

## *An Alternative on Trial*

*By Linda Fitzgerald*

**F**rom my bed I could hear the sound of the midwife's knitting needles clicking as I rested between contractions. It had been a long and tedious labor and the strain was showing on everyone. My friend who had come to take photographs and be a labor coach lay half-asleep at the foot of the bed, my husband sat dozing beside me.

The words of my midwife drifted through my mind. "It takes a mature woman to have a home birth... After you give birth you will know you can do almost anything." She came and sat down next to me, offering me a look of understanding concern. "It hurts," I complained. "Yes I know."

she said. "But you can handle it." I gripped her hand and took my thousandth controlled breath.

Thirty-two hours after my first labor twinge, I knew the meaning of "good things come to those who wait," as a surprisingly pink, bushy little creature lay squirming on my breast. I had just climbed Annapurna and accepted the Nobel prize all in the course of little more than a day.

The birthing had not come easy but I had gotten what I wanted: to labor in my own bed and to have my baby be free from intervention and medication. I had been in control of the birth.

The desire of many women to regain control of their birth experiences created the alternative birth movement a decade ago. Although the obstetrical profession has responded by offering, in some hospitals, reduced obstetrical intervention, modified hospital routine, and alternative birthing centers, a segment of the population is choosing to have their babies at home.

In the mid-'60s, home birth was on the verge of becoming an anachronism. But during the past ten years, there has been a tremendous resurgence of interest, and a movement has developed and grown both in strength and numbers. New home birth organizations have formed, and the conferences are getting bigger.

The National Association of Parents and Professionals For Safe Alternatives in Childbirth reports that there has been a three-fold increase in the number of home births between 1973 and 1978, with hospital births declining from 99.3 percent to 98 percent during that period. In California and Oregon, home birth rates have doubled every year for several years and now represent 3 percent of all births in California, and 4 percent in Oregon.

With the renaissance of home birth, the midwife, the traditional home birth attendant, has been called back into active service. Although trained medical profession (physicians and certified nurse-midwives) do attend home births, it is the lay midwife who is present at the majority of home births. Lay midwives have acquired their skills by working with experienced midwives or doctors, studying obstetrical manuals, or by training in the few lay midwifery schools that exist. The California Department of Consumer Affairs estimates that over 400 lay midwives are practicing in that state with 9,000 babies born annually under their care.

In spite of the increasing demand for home birth, the medical establishment remains firmly opposed to its practice. The twenty-thousand-member American College of Obstetricians and Gynecologists (ACOG), home birth's most vocal critic, contends that "labor and delivery are potential hazards that require standards of safety which are provided in the hospital, and cannot be matched in the home situation." ACOG's former executive director, Warren Pearce, has been known to make statements to the press such as: "Home birth constitutes maternal trauma and child abuse."

It is under the banner of "safety" that the obstetrical establishment has successfully persuaded the media and the general public that home birth is a dangerous practice. Recently, ACOG released damaging statistics on home birth, which purportedly show that home birth poses a two to five times greater risk to the baby's life than hospital birth. Home birth advocates view the study as fraudulent, claiming that ACOG never released the raw data on which the study was based, and that the spurious statistics make no differentiation between planned and unplanned home births.

Home birth advocates point to the studies done by Dr. Louis Mehl as a more reliable indicator of the safety of home delivery. Dr. Mehl's study is one of the most extensive conducted to date, comparing more than a thousand midwife-attended home births with an equal number of hospital births over a six-year period. Mehl used matching criteria among the women to eliminate any significant differences between the two groups. Mehl's findings show that the number of infant deaths were similar in the two groups, but that the hospital group showed more complications of labor and delivery, birth injuries, and a greater incidence of hemorrhage in the mothers.



## Childbirth in the Courts

Home birth is not illegal in America. There are no laws in any state that outlaw the practice. However, the use of home birth attendants can be legislated. It is not illegal for parents to deliver their own baby in their home but should a friend or trained attendant assist in the birth in any way, she could be accused of practicing medicine without a license, or worse.

In California in recent years three midwives had serious charges leveled against them (two were charged with murder, and the other with a felony.)

*It is not illegal for parents to deliver their own baby, but should a friend or trained attendant assist, she could be charged with practicing medicine without a license...*

In the highly publicized case of Marianne Doshi, the judge's decision was a victory for home birth. The charges of second-degree murder and practicing medicine without a license for having attended the birth of a stillborn baby were unexpectedly dismissed by the judge (who was considered a conservative by the home birth advocates) with the words "I really feel that we have a segment of our society that wants to choose an alternative to what the California Medical Association, or the AMA, or the medical profession wants to provide as far as the birth of children goes. And I think these people probably have that right under our constitution. I hope the medical profession has enough maturity at this point—to say that there are alternative ways. I am convinced that had that child died in the hospital, we would have had a thousand doctors lined up between here and Los Angeles willing to testify that the doctors provided medical treatment according to the standard of care."

In another case, Jo Ann Ruiz, a midwife and registered nurse from El Dorado County, California, was indicted by a grand jury for practicing medicine without a license for having counseled a woman wanting a home birth, in prenatal care during her pregnancy. The charges against Jo Ann were ultimately dropped, the reason being, according to one doctor who attended her hearing, that "the community demanded charges."

But the most serious case still pending, that of Rosalie Tsipening, has been far more trying. Tsipening, a Monterey physical therapist, has been charged with first-degree murder for attending the birth of a stillborn baby in December of 1979. First degree murder, according to California statutes, indicates an act committed out of a "malignant and abandoned heart." Rosalie was arrested two days after the stillbirth and, with bail set at \$100,000, she was jailed for seven days. Her bail was finally reduced to \$25,000 and she was released.

At Rosalie's first pretrial hearing in February, the "first degree" was dropped from her murder charge but practicing medicine without a license and grand theft (for charging for her services) were added.

Rosalie Tsipening's right to a speedy trial has been violated by the prosecution's continual delays and postponements. All in all she has been scheduled for thirteen preliminary hearings—a

record for Madera County, where her case is being heard. So far, her legal fees have accumulated to \$30,000, and may run beyond \$50,000. Should Tarpenting be convicted, she could spend seven years or more in jail. Thus far, the causes of the stillbirth have not been fully determined, but according to an autopsy report, there were no indications of fetal distress during labor.

Rosalie's legal struggle has proved sobering for other midwives in the lay community. The unspoken legal rule of thumb appears to be: if a baby dies at home, the attending midwife will be charged with murder or a felony. If the baby dies in the hospital, it's an act of God.



Rosalie Tarpenting, charged with first-degree murder for attending the birth of a stillborn baby.

Karen Lang, a founding mother of the Santa Cruz Birth Center and midwife for twelve years, describes her own tenuous situation: "I know that all I have to do is go to a birth and have that baby not be alive when it's born, and within twenty-four hours, the police are going to walk into my house and look through my journals. My entire family will be subjected to the law" (In California, where lay midwifery is clearly illegal, if a midwife is arrested for a problem that occurs at a birth, and her children are with her at the time of the arrest, they could be taken to juvenile hall.)

Although midwives have been involved in most of the home birth court battles, doctors who have home birth practices are not immune from legal statutes. Most recently, Peter Kinn, an M.D. from Sitka, Alaska, was acquitted of the charge of "negligent homicide" for having attended the stillbirth of a baby born at home.

Home birth organizations, as well, have been subjected to legal pressures, as evidenced by the case of the State of Illinois vs. the Association for Childbirth at Home, International (ACHI).

This case began three years ago when Illinois ACHI leader Cat Feral came to the attention of the local medical community due to her role as counselor of expectant mothers. Stemming from a doctor's complaint, an investigation was begun by the Illinois attorney general, who served Cat Feral and the ACHI with two subpoenas asking for seventy-one items from the ACHI's birth records.

Included in the list of items were questions that challenge basic freedoms of individuals. The subpoena asked for the names and addresses of every parent the ACHI had trained; their phone numbers, birth dates, and work phones. Another question was phrased: "Where have the ACHI home birth series been offered in (a) Illinois, (b) the United States, (c) the world? State dates and leaders and addresses of each location."

When the ACHI refused to honor the subpoena, a lengthy court battle ensued, and the organization was charged with consumer fraud for certifying childbirth educators. The ACHI won the first battle on a technicality. The decision was appealed, dropped, and then reopened by the state. At present the case against the ACHI is being appealed to the Illinois Supreme Court.



### *The Source of the Conflict*

Throughout the history of childbirth, an antagonism has existed between female and male practitioners. The arguments given

*Suppression of female practitioners in the middle ages evolved into the witch trials, from which midwives emerged forever stigmatized...*

today against midwives practicing home birth have been reiterated by doctors for six hundred years. Charges of incompetence and inexperience were as common then as they are now.

In the middle ages, restrictions were first placed on midwives during the fourteenth century, when they were compelled (in England by law), to call on the barber/surgeon to perform difficult deliveries. Should a midwife be present at the birth of a stillborn or deformed child, she could be hung as a witch.

As Europe emerged from the Dark Ages, medicine was established as a profession, and physicians sent petitions to heads of state complaining about the "worthless and presumptuous women who were usurping the profession." Licensing laws were passed to prohibit all but university trained (male) physicians from practicing the healing arts. Sure doctors did not treat the peasantry, these laws were not observed in rural areas, which remained the stronghold of the midwife/female healer. To rid the profession of its competition, physicians enlisted the aid of church and state to help them eliminate female practitioners. The suppression evolved into the witch trials, at which doctors testified as medical experts to assist in determining if a midwife/female healer had caused an affliction to befall a peasant. Said

the church: "If a woman dare to cure without having studied (at a university) she is a witch and must die." When the trials tapered off in the 1600s, midwives emerged forever stigmatized as incompetent if not malevolent practitioners who had developed a deep and lasting resentment for the medical profession. The midwife's skills and techniques that had been called sorcery were now labeled medicine when performed by a doctor.

In the seventeenth and eighteenth centuries, doctors pressed for anti-midwife laws, blaming midwives for childbed fever. Midwives, in turn, charged doctors with commercialism and the misuse of their tools.

By the twentieth century, obstetrics had come to be a recognized surgical specialty in America, and midwifery a dying art. Although a study conducted by Johns Hopkins University in the early 1900s indicated that obstetricians were less competent at childbirth than midwives, doctors, in the name of science and the improvement of maternal and child health, convinced state after state to pass laws prohibiting or limiting the practice of midwifery.

The long-standing biases and rivalries between the two practitioners cannot be overlooked in the current dispute over home birth.

*Although a study conducted in the early 1900s indicated that obstetricians were less competent than midwives, doctors convinced state after state to pass laws limiting the practice of midwifery.*

If you were to ask most mainstream obstetricians why they oppose home birth, you would be likely to get a one-word, all-encompassing answer—safety. Citing the higher risk factor, it poses to mother and child, obstetricians will quote a long list of unforeseen, life-threatening complications that can arise in a matter of minutes in a seemingly normal, low-risk situation.

Having received their training in hospitals which are primarily centers for treating the sick, it is small wonder that physicians view childbirth as a potential hazard. In residency programs as a whole, normal labor and delivery are given very little consideration, being described as "unremarkable birth" in obstetrical textbooks. Most obstetricians have never seen a home birth, and many have had limited experience with unmedicated births. In conjunction with being educated in a system that shows too little respect for the normal process, young doctors are encouraged to disavow the healing instinct, and replace it with the frequent application of medical technology. This fosters a belief that high-intervention type obstetrics is the only way to get out a healthy baby.

Suzanne Arms, author of *Immaculate Deception*, a book that exposes the abuses of obstetrical intervention, described the uphill battle that the home birth movement is facing: "We are confronting an obstetrical establishment that is completely sold on high technology, has brought it lock, stock and barrel from the computer and aeronautics industries, and has failed to examine its motives in buying it."

The complicated system of technological checks and balances designed for the quick and easy hospital birth cannot be transferred to the home. Home birth would prove to be a time-consuming inconvenience and an unprofitable prospect for the



### One Doctor's Perspective

"I've been surprised and pleased to find that, given the current atmosphere around home birth, the opposition is not as rabid as it appears in public," says Dr. Stanley Sagov, a family practitioner in Cambridge, Massachusetts who offers home birth. Trained in South Africa, where it's a common practice, he says he began doing home births here rather naively: "People wanted birth at home and I didn't know that it was such a problem. I was not aware of and still am not aware of any statistical data that contradicts home birth on the grounds of safety in screened populations."

In spite of practicing in an area where the medical community as a whole frowns on home birth, Dr. Sagov says that, surprisingly, he feels supported in his practice. "We have made it a policy to be very public about our home birth practice. We write about it, talk about it, and let our colleagues know that we'd like to hear anything that might dissuade us from the practice."

"I find that obstetricians are often relatively uncritical of their own anti-home birth stance until they've had a chance to look at it in an unthreatened situation. I ask them when they last had an event in which it really would have made a difference not to be in a hospital, how often such events happen, and if policy should be made on the basis of such incidences."

obstetrician who is used to doing forty births a month in a central location.



*David Stewart (above) of NAPSAC says, "Home births represent an enormous threat to the system. Every home birth is a loss of an average of at least \$1,000..."*

David Stewart, the executive director of NAPSAC, believes that the medical establishment's resistance to home birth can be reduced to the profit motive. He writes in the spring edition of the "News From H.O.M.E." newsletter: "The most efficient way to gross a lot of money in maternity care, from the economic viewpoint of the doctor and the system, is to adopt the assembly-line model from industry, to force everyone into hospitals, and to coerce the birth process into set routines. This fact is apparently well known to hospital administrators, drug companies, medical device distributors and [some] medical doctors. While the cost effectiveness to the system is maximized by such a model, the cost effectiveness to families having babies is minimized, along with the minimization of kindness and humanity in childbirth."

Stewart has found that: "Home births represent an enormous economic threat to the system. Every home birth is a loss of an average of at least \$1,000. ... 10 percent home births in the United States represent a loss of at least \$5 billion every year." Stewart points out that doctors didn't object as strenuously to home birth until the last few years when upper and middle class couples adopted it. Says Stewart: "If ACOG can manage it, the battle of home versus hospital birth will not be fought over the facts — the facts are not in their favor. Power and politics are however. Hence it is via power and politics that they will seek to squelch home birth. Thus they will do by encouraging the harassment of doctors who sympathize with home birth, by seeking restrictive legislation limiting midwives — and by leveling child abuse charges against participants in home birth."

Sagov claims that an obstetrician would be hard pressed to find statistics for a strict in-hospital policy. "Birth is safe nowadays. On the basis of the data, there just doesn't seem to be a whole lot to talk about. All of the published data indicates that in screened low-risk populations the outcome is likely to be good whether one is at home or in the hospital."

In spite of the statistical data and the support he feels from his colleagues, he acknowledges that he is taking a very real, personal risk in doing home births. "We feel very vulnerable," he admits. "We feel that if there was a misadventure at home, especially a maternal death, there would be a slur cast on us for being home, even if we were completely above criticism technically. I think we would be hard pressed to find expert witnesses on our side to justify our choice of the home as a site. Though we have not let that deter us, we're afraid of it. It's a recurrent nightmare that something might happen that would be judged unavoidable if it happened in the hospital, but would incur a very harsh reaction from the medical profession if it happened at home."

Dr. Sagov feels that the question of home versus hospital is basically a straw issue, one which has come to encompass larger questions of freedom of choice and the right to self-determination. Though this has helped raise public debate, it ultimately clouds the real issue: finding ways to get together to make available the safest and most satisfying range of birthing choices.

He finds a sole focus on site to be one of the greatest obstacles. "If your orientation is that the home is the best place or vice versa, and you are not looking at the larger picture of what's really desired here — namely, satisfaction and safety for as many people as possible, then you're going to be spending your energies struggling with side issues and miss the point."

Birth can be a beautiful, meaningful experience wherever it happens. "I've seen people have just the most rich and transcendent experiences in the hospital in all sorts of circumstances, with Caesareans that they didn't anticipate, or having spontaneous vaginal deliveries that were with friends, other siblings and family members. They've been wonderful experiences where everyone has felt all of that excitement that makes us want to be a part of childbirth."

No matter how great an experience may be possible in a hospital setting, however, there will always be women who will choose home birth. Dr. Sagov says he wishes the obstetrical community would just accept this and get on with fulfilling their responsibilities as physicians providing safe care. "If our orientation as doctors is, 'How can we make it safe and how can we maximize consumer choice in a way consistent with our concerns for physical safety,' my own sense is that we can do a great deal that will relieve everyone's worries."

— P. T.



## Midwifery and the Law

The status of the law varies widely from state to state. Many states have no legislation or case laws covering midwifery. In some, the practice is considered illegitimate but not illegal. Other states make the practice clearly illegal. Lay midwives have been prosecuted in California, Kansas, Florida, Illinois and elsewhere.

Following is a cross section of how the individual states rate.

### The Western States

As a whole the west has a favorable midwifery and home birth climate. Oregon, Texas, and Utah are so-called free states, where there is no legislation governing the practice of midwifery, and midwives can openly practice without a license.

**Oregon:** The state attorney general has stated that as long as midwives use hygienic methods to insure the home birth will be clean and safe, there is no reason to regulate the practice. Oregon is a very progressive, individual-rights oriented state. Midwives can have a business license, charge for their services and advertise. Doctors are generally open to home birth and will do postpartum check-ups in the home if asked. Midwives can file birth and death certificates.

**California:** This state has one of the worst legal situations, but it has a strong home birth movement pushing for better legislation.

**Texas:** Texas has no regulations governing midwifery except in the border area near Mexico, where the local public health department supervises the practice of lay midwifery. Sixty percent of all births take place in the home.

**Utah:** Utah is a Mormon state and midwifery fits into their beliefs. A year ago nurse-midwifery legislation was passed which could have restricted rights of parents, but it was amended by pro-home birth legislation.

**Washington:** In Washington a midwife can practice without a license if she does not advertise or charge for her services. The state has recently revived old licensing laws for midwives. Midwives and state officials are in the process of updating the licensing procedures.

**Arizona:** Arizona is very similar to Washington where old midwifery licensing laws have been revived. The first midwifery exam was given a year ago.

**Alaska:** Allows home birth and midwifery, although a general preference is to have a physician.

### The Southern States

Most of the old licensing laws remain intact, although some have been updated. Some states require that public health departments supervise training, examining and licensing.

**Virginia:** There are two or three licensed midwives practicing in this state. License regulations are very restrictive. The public health department follows up on each delivery.

**Florida:** Under the old licensing act, a lay midwife must attend fifteen births under a doctor's supervision. If the doctor recommends her for a license and the county health department director agrees, she is eligible for the midwifery exam. In a 1975 decision in St. Augustine the 1931 Florida statutes for licensing lay midwives was declared unconstitutional, in the case of *Carole Baya*. If the decision is upheld in Florida's Supreme Court, Florida law will change.

**Kentucky and Tennessee:** Both states allow midwifery, especially nurse midwifery, with the Frontier Nursing Service.

**Arkansas:** Allows lay midwifery, but is phasing it out by not renewing licenses of those who have practiced for years.

## The Problem of Back-Up

The increasing difficulty of obtaining adequate back-up assistance from the medical community appears to be the most dangerous problem facing home birth in this country. The denial of back-up and prenatal care is the medical establishment's most effective means of penalizing midwives and women wanting home births. Midwives who have been practicing during the last decade report a gradual tightening up of doctors' attitudes toward home birth.

According to midwife Raven Lang, "Things are worse now, in a way, because twelve years ago, physicians didn't really know what home birth was all about, and they'd say, you can call on me if you need transportation or back-up. Now they are clear and precise, they do not want to be involved."

In Santa Cruz, California, as in parts of Illinois, Colorado and other states, midwives have reported that obstetricians have banded together and pressured their colleagues into refusing prenatal care and back-up to persons involved in or having a home birth. This is even a problem in Oregon and Washington, two states which have a favorable climate for home birth. Says Oregon midwife Shari Lauer, "I have to search for doctors to do back-up because they are filled with scare tactics from their peers." Lauer also claims that women who choose to come under a midwife's care, after having seen an obstetrician, are often in for a fight just to obtain the prenatal records that are legally hers.

Lauer does all of her own prenatal care, and receives emergency help from doctors on a good Samaritan basis. For her clients in Washington, she has only two doctors who will back her up. She reports that, in one instance, she had to drive a woman needing a Caesarean section out of her own city (population 100,000) to a rural area forty minutes away to get emergency care. Said midwife Raven Lang about the situation in her area: "There is no back-up except from other midwives. If you have to go to the hospital, it's take who you get."



Tonya Brooks, head of the Association for Childbirth at Home, International.

This "put back" state of affairs can prove to be dangerous in some circumstances. Two Kentucky midwives, having to transport a laboring woman with a prolapsed cord, were greeted at the hospital by an uncooperative staff of medical personnel, who paid little attention to their repeated pleas for a surgeon to do a Caesarean section. As one midwife struggled for half an hour to keep the baby's head off its cord, she was told there was no surgeon in the whole county, and they would just have to wait. The midwives put the woman back in the ambulance and drove

to another hospital, twenty minutes away, where the woman was finally given a C-section.

*"If a doctor delivers at home and there is a poor outcome, ... no one will testify in his defense."*

Tonya Brooks, head of the ACHI, calls the back-up situation a "national scandal." Says Tonya, "In the last fourteen years, I have not seen improvement in back-up. Everywhere we make strides, there are other hospitals that are nasty about it."

Suzanne Arms believes that in refusing prenatal care to women wanting a home birth, and by cutting off back-up to midwives, doctors are hoping, in effect, to prove that out-of-hospital birth and the use of midwives is a dangerous practice.

Physicians justify their reluctance to provide back-up by citing the legal risks that could arise with their assistance. In a recent *Los Angeles Times* article on home birth, a Santa Barbara physician complained about midwives bringing in patients in emergencies. "The physician who tries to bail that situation out is the one who has to go to court if there's a suit, because he's the one who has the insurance. The lay midwife doesn't have the insurance." Although there are few, if any, instances where doctors have been prosecuted under such circumstances, they are in the letter of the law legally responsible for the welfare of whomever they treat. In a state like California, malpractice lawsuits are a prominent fear. Says an obstetrician who backs up home births but refuses to attend them: "If a doctor delivers at home and there is a poor outcome, whether or not there could have been anything that could have been done about it in a hospital, that doctor's name is on the line, no one will testify in his defense."

Doctors with the courage or conviction to attend home births often find malpractice insurance hard to come by. ACHI President Tonya Brooks explained, "In the United States now, insurance companies often will not give malpractice insurance to physicians who do home deliveries or will raise the rates so high for those physicians that they are prohibitive."

Norcal Mutual, the insurance company of Northern California physicians, informed its clients two years ago that doctors attending home births would no longer be covered by malpractice insurance. "The lack of insurance can mean an end to a doctor's hospital privileges, thus limiting his or her ability to provide emergency care. Doctors wanting to maintain a home birth practice will find it necessary to meet clear of the physician-united barriers that put restraints on their right to practice at their homes."



## Midwives Unite

Increased harassment, concurrent with increased demand for their services and the desire to upgrade their education, has pushed midwives to band together. They are becoming better organized, with grassroots support groups often turning into strong organizations complete with newsletters, bulletins, and t-shirts. Many midwives are coming to believe that public involvement and legal action are necessary skills that must be learned if the age-old practice is to survive.

Some midwives, who have come to the practice from a personal point of view, at last think involvement in politics is appropriate.

## Midwest

**Illinois:** Presently has an archaic licensing system for certified nurse midwives and lay midwives, and requires the presence of a physician. New legislation has been proposed and is in the lengthy hearing-debate stages.

**Wisconsin:** Recently passed legislation allowing home births under lay midwives.

**Ohio:** Allows home births under lay midwives and physicians.

## East

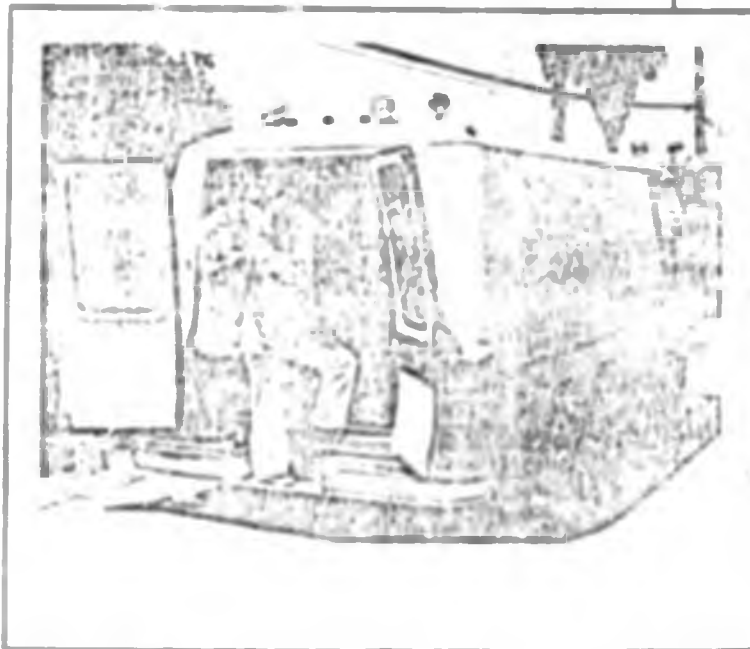
**New Jersey:** The attorney general has proposed regulations that would allow only hospital births, doing away with midwifery in the state.

**Maryland and Washington D.C.:** Both allow the practice of midwifery and nurse midwifery.

**Maine:** Allows the practice of lay and nurse midwifery.

**Massachusetts:** Lay midwives may attend home births without a physician.

**Connecticut:** State legislators, nurse-midwives and lay midwives are working to replace the old licensure board with a safe certification process and to have medical back-up assured.



The Baby buggy, a fully equipped paramedical vehicle, stands outside a home nurse-midwives from the A. R. E. clinic in Phoenix, Arizona do home births.

## Tools for Birth

### Lay Midwifery Schools

The Seattle Midwifery School, 1624 44th Ave., Seattle WA 98122

The Maternity Center of El Paso, Texas  
Association for Childbirth at Home, P.O. Box 1214, Corona CA 92701

The Woman-Care Midwifery Program, Santa Cruz CA

There is also training available for nurse midwives at Georgetown University, Yale University and one or two other medical schools.

### Home Birth Organizations

The Association for Childbirth at Home, International (ACHI), P.O. Box 1219, Cerritos CA 90701: Third largest childbirth organization in the United States. The ACHI is also an international training and research organization that has trained over 800 childbirth educators and 10,000 couples.

NAPSAC, P.O. Box 267, Marble Hill MO 63764: NAPSAC publishes a directory of alternative childbirth issues, and has compiled data on home birth.

Informed Home Birth, P.O. Box 788, Boulder CO 80306: sponsors midwifery workshops.

Home Oriented Maternity Experience, 311 New York Avenue, Tacoma Park, Washington DC 20012: A national consumer group with branches in at least twenty states. H.O.M.E. publishes a list of 1,500 birth attendants throughout the U.S. and a book titled *A Comprehensive Guide to Home Birth*, also a quarterly newsletter, "News From H.O.M.E."

Peace and Home Association of Wichita, MaryEllen Jordan, 2730 Thistle, Rose Hill KS 67133. A group working for midwifery legislation in Kansas.

International Childbirth Education Association, P.O. Box 20852, Milwaukee WI 53220: The biggest childbirth education association.

Washington State Midwifery Council, Ann Younis, 1512 Langridge Ave., Olympia WA 98502

The California Association of Midwives, P.O. Box 3306, San Jose CA 95116: A group of a hundred and fifty practicing home birth attendants including lay midwives, nurse midwives, and licensed physicians who are working to get midwifery legislation passed, provide guidelines for midwifery, and working for midwifery concerns.

The American Foundation for Maternal and Child Health, 251 Nottingham Way, Hillside NJ 07035

The Farm Midwives, 152 Drake Lane, Summertown TN 38485

New Mexico Lay Midwives Association, Box 2104, Taos NM 87571

Family Birth Associates, Arlington VA

Maine Arrow to Alternatives in Childbirth Care, c/o Arnel Walton, RFD 1, Box 74, Durham ME 04432

Birth Options, 1492 River Road, Teaneck NJ 07666

Institute of Feminine Arts, P.O. Box 2774 East Side Station, Santa Cruz CA 94062

Home Opportunities for the Pregnancy Experience, P.O. Box 78, Wauconda IL 60084

C-Soc., Inc., 140 Valley Rd., Needham MA 02192: Nancy Weather Cohen founded this organization for two purposes: to offer support to women who have undergone Cesarean sections and to begin for their future birth options.

### Home Birth Supplies:

Birth Center, P.O. Box 603, Summit City CA 94389: provides a list of least-expensive suppliers of birth equipment.

Mountaincrest Birthings & options, 1644 S. Downing, Denver CO 80210: Carries dispensable home birth kits and midwife supplies.

Home of St. Augustine, RFD 1, Box 12, St. Augustine FL 32086: Carries home birth kits.

are, but as Raven Lang says, "You can say, well, I don't believe us that [politics] and meanwhile you're getting handcuffed and taken off to jail—you get politicized fast."

According to California registered nurse and midwife Mickey Selwin: "It's very difficult for midwives to be good practitioners and good politicians at the same time. Babies come first. Every time we try to get organized and set a meeting, the people aren't there, and it's for good reasons. We need people who know how to organize, and that's a skill most midwives don't have."

Getting together on basic issues and arriving at standards for their profession is a hurdle that lay midwives have yet to jump. Paramount among their concerns are issues involving training and legalization. Many fear that in order to practice legally, they will be obligated to receive their training in a hospital under the supervision of doctors, and be transformed in the process into medical technicians. Raven Lang is of the opinion that if midwives become state-approved practitioners, they will lose the art of serving women in childbirth. Says Raven: "If everyone is certified, midwives are not going to make beds and take home the laundry, and bring the dinner the next day."

In training lay midwives, she teaches them to trust their God-given instincts, rather than focus entirely on acquired medical skills. She thinks hospital training should be limited, and that a midwife can gain most of her knowledge by watching normal births.

The consensus among the lay community appears to be that basic emergency training is essential, but that abnormal conditions in birth should be taught primarily by midwives, with some hospital training interspersed with normal home births.

The concept of "spiritual midwifery" may have been misunderstood by a segment of midwives, who interpret it to mean that the atmosphere created at a birth is of greater importance than technical skills. ACHI Vice President Linda Bennett takes issue with this point of view, contending that it is imperative that safety be given top priority in the home birth situation. Says Bennett: "You cannot jump over the physiological concerns and say, 'well I'll just skip all that.' You are not free to handle the emotional and spiritual aspects of birth until the physical ones are handled."

Establishing protocols and guidelines has been difficult for the community of midwives. At the heart of the matter is the question of what really constitutes a midwife's responsibilities. Susanne Arms and others in the home birth movement have proposed a tiered system of midwifery practice, a sort of career ladder whereby a midwife could train to practice at a certain level of expertise. Should she want to practice at another level, she could take additional training. "I hope lay midwives set their standards for themselves and that the state uses the one when it comes to writing the law," says Arms. "If midwives don't do it, the state is going to do it, under pressure from the mainstream medical community and national lobbying groups."

If their practice is to be regulated, the majority of midwives would want to see a control board composed primarily of their peers, with representatives from the medical community. California midwife Karen Chelak explained the problem. "The midwives have great fears of having an organization like the A.M.A. ruling us. We don't want to get so powerful without the community that we are endangering people around and denying what we're right to what we have."

But many midwives believe that standard setting is necessary. As Susanne Arms says, "I think anybody practicing and all wants to practice to a certain standard and wants to know if the state achieved the best facilities."

Lani Rosenberger, a member of the California Association of Midwives, explains that her organization would like to see certification of lay midwives as a protection for the public: a practitioner's certificate would show she had gone through a specific training program, or had otherwise demonstrated proficiency in her work.

At present, the CAM, one of the best-organized midwife groups, is working to define the lay community's goals. Through networking and lobbying efforts, they are preparing to take on the California Medical Association's lobby in order to get midwifery legislation passed.

Midwifery legislation is now being written or is coming up for consideration in a number of states. California, at this point, probably has the best chance of getting favorable legislation passed. If the adage is true, "As California goes, so goes the country," the hope is that in the next ten years other states will follow suit. Two bills in the past made it halfway through the legislative process in California, the most recent having been defeated by only one vote in subcommittee. In the four hours of testimony on the Midwifery Practice Act, only the California Medical Association and the local chapter of ACOG argued against the bill.

In trying to gain support for and push through the next piece of legislation, the CAM will switch its focus from debating health and safety with physicians, which has proved to be a no-win situation, to placing the emphasis on the right of consumers to choose the type of health care they want.

Although she supports efforts to legalize midwifery, ACHI Vice President Linda Bennett cautions that the standards set by licensing do not necessarily guarantee competency, as has been clearly demonstrated in the case of medical peer review boards. "The key," says Linda, "is informed health-care consumers." Parents must decide what constitutes a good midwife.

The home birth movement is in the process of gaining control over parents' rights to a free choice concerning where, how and with whom birth should be experienced. It is in the hands of the parents that the future of that free choice now lies. The medical establishment will respond accordingly, if it is faced with a determined segment of society that demands home birth as an option. Changes that have occurred so far in childbirth have come about because of consumer demand. Midwives will be at the forefront of the home birth controversy, but without the parents they cannot bring about the changes that are necessary to continue. Says midwife Abbey Selwin, "In the United States, where money speaks louder than words, consumer demand is ultimately the loudest voice."

"The home birth situation today is not hopeless at all," concludes Suzanne Arms. "It is as demanding a situation as the Vietnam war was, where you literally had to drop out of the system in order for the system to change. All the movement has is the decision-making power of the women themselves. All they have is the power in people's feet to walk out and say 'Hell no, we won't go.' As long as there are people to keep alive the knowledge that birth can be a wonderful, magical event, you will never drive it underground."



Linda Fitzgerald, a California licensed nurse-midwife with over 20 years home birth experience, is active in the West Coast home birth movement.

## Books

*Immediate Deception* by Suzanne Arms, (Bantam, \$2.50). The seminal book on the childbirth revolution, it exposed the abuses of medical technology.

*Commonsense Childbirth* by Lester D. Hazell Berkley Publishing Corp., \$2.95). One of the most comprehensive home birth guides. She provides an excellent description of labor and delivery in the home birth situation.

*Childbirth at Home* by Marion Sousa (Prentice-Hall, \$7.95). Explains why home birth is a good alternative to hospital birth, and also contains a superb chapter on complications in labor.

*Birth at Home* by Sheila Kitzinger (Oxford University Press, \$11.95). The most up-to-date guide to birthing at home, it contains valuable information on arranging a home birth and the safety factors involved.

*The Birth Book* by Raven Lang (Available from Science and Behaviour Books, Inc., P.O. Box 11457, Palo Alto CA 94306, \$7.95). One of the first books on home birth to appear, it helped kick off the home birth movement and has many birth stories of interest.

## Newsletters, Bookstores and Films

Birth Notes, the ACHI Journal, P.O. Box 1219, Centos CA 90701.

Birth Family Health Bookstore, 3440 B West Orange Avenue, Anaheim CA 92804. Comprehensive list of books on birth and health related issues. Also has t-shirts, calendars, and other items.

Birthing, c/o Box 415, Winona Lake IN 46790.

The California Association of Midwives Newsletter, c/o Claudia, P.O. Box 512, Penngrove CA 94951.

The Federal Monitor, 710 Bullsneck Rd., Drawer Q, McLean VA 22101. A newsletter on legislative and regulatory activities relating to the health of women and children.

Mothering, Dept. W, P.O. Box 2046, Albuquerque, NM 87103.

The Practicing Midwife, 136 Drake Lane, Summertown TN 38483 (The newsletter of the Farm midwives).

The Penny Press, 1100 24th Ave. E. Seattle WA 98112. Carries pamphlets on obstetrical information.

Birth and Life Handouts, P.O. Box 70423, Seattle WA 98107. Offers a comprehensive selection of books on pregnancy, child birth, and early childcare, as well as offering IMPRINTS, a quarterly newsletter.

Midwifery and home birth t-shirts, Janice Ashworth, 8200 Oak Ave., Ben Lomond CA 95005.

Cinema Media, 2335 West Foster Ave., Chicago IL 60625. Carries a wide range of childbirth films including some on midwives and home birth.

News from HOME, 511 New York Ave., Takoma Park, Washington DC 20012 (newsletter of HOME) offers information and the Andrea baby pack, a front carrier for nursing infants.

NAPSAC and ACHI, listed in Organizations, publish good newsletters.

Other sources include the Women's Health Care Collective which publishes the book *Our Bodies, Our Lives* among others, local chapters of La Leche League, local family practice physicians, and local bookstores that focus on women and women.

# THE Caesarean Epidemic

*Who's Having This Baby, Anyway—You Or The Doctor?*

By Gena Corea

Photograph by I'main Hill

**D**on't go to the hospital," Julie Olsen tried to warn her pregnant sister, Laurie, when she heard that, though Laurie's labor had not yet begun, her membranes had ruptured. Too late. Laurie had left.

Independently, Kathie, another sister, attempted to reach Laurie to tell her: "Don't let them give you Pitocin." But by that time, the Pitocin drip had already been started.

Karla, eldest of the four sisters, also tried to protect Laurie that day—the day Laurie's first baby, Jesse, was born—delivered by Caesarean section.

Laurie is in a close family with an extraordinary mother, Tillie Olsen, author of the feminist classic, *Tell Me A Little*, and more recently, *Silences*. Laurie's father, Jack Olsen, teaches labor history and is a former union organizer. The work of the three elder daughters is concerned with childbirth and feminist health. Perhaps these are reasons why they understood, and were especially outraged by, what happened to Laurie.

A policy researcher and a writer who at one time worked with *The Feminist Press*, Laurie is the youngest Olsen daughter. When she became pregnant, she and her husband, Michael Margulis, a musician, began voraciously reading books and articles on childbirth. They took Bradley method childbirth classes and talked extensively with midwives. Though they would have preferred a midwife-attended delivery, they felt confident they could handle the birth in the hospital facilities offered by their health plan. After all, they were prepared and Laurie was in excellent health.

Laurie's waters broke at five a.m. and three hours later, on July 25, 1979, she and Michael were at their hospital in Oakland, California.

The doctor there told them that the hospital had a policy on ruptured membranes: the baby must be delivered within 24 hours because of the danger of infection. The membranes of the "bag of waters" that surround a fetus protect it from any bacteria that might come up the vagina and into the uterus. So if Laurie's labor did not begin soon, the doctors wanted to induce it intravenously by giving her Pitocin, a drug that stimulates uterine contractions.

By 10 a.m. Laurie was hooked up to an electronic fetal monitor (EFM) and an intravenous feeding tube. She was lying on her back in deference to the machine's needs and could hardly move. The EFM made Laurie uncomfortable. The EFM, a key part of this story, is a large machine which is wheeled to the bedside of a woman in labor. An audio device, a screen like that of an oscilloscope and a steadily unrolling paper tape record the heartbeat of the fetus and the strength of the mother's contractions.

At 11 a.m., the resident physician came in and said that Laurie's labor would be induced by Pitocin. "It's policy," she explained.

Laurie and Michael decided not to enter into an adversarial relationship with the doctors. They did not want to fight alone against the hospital, especially when they were not confident they knew enough to challenge its policy. But for all their awareness of the complexities of birth, they were not prepared with practical alternatives when the hospital's rules began to work against them.

If Laurie and Michael could have gone to a medical library, this is what they would have found:

In order to avoid the danger of infection associated with

# Engineering A Caesarean

SCENARIO NO. 1: "We're going to make your contractions more effective," the doctor announces to the woman in early labor. He ruptures her membranes prematurely. Then he orders the nurse to give the woman Pitocin.

The Pitocin-induced contractions come much stronger and more frequently than normal ones. Each contraction cuts off the oxygen supply to the baby. During natural labor, the baby has time to "catch its breath," but between the artificial contractions, the baby has less time to get oxygen. This causes fetal distress, an indication for Caesarean delivery.

Dr. Peter Dunn writes in the British medical journal *The Lancet*: "The increase in Caesarean section following failed induction is well known."

*Variation:* When the doctor ruptures the membranes, the fluid in which the umbilical cord floats spills out of the sac. The cord drops down before the baby's head does and is squeezed, blocking off the baby's oxygen supply. This condition, a prolapsed umbilical cord, is a severe complication. Emergency Caesarean follows.

SCENARIO NO. 2: The doctor inserts the internal electronic fetal monitor (EFM) into the woman's body. Piercing the scalp of the baby, he attaches an electrode to its head. The procedure frightens the woman. Later, she feels uneasy at the strange sounds issuing from the machine. Or she may panic when, as frequently happens, the EFM malfunctions and records "fetal distress," which later turns out not to have been there. In her fright, her body releases catecholamines, a substance which can lead to a slowdown of the baby's heart rate and a lowered fetal blood pressure. This reduces the baby's oxygen supply and brings on fetal distress.

*Variation:* Wired up to the monitoring machine, the woman cannot walk around. The immobility, along with the supine position she is obliged to take in deference to the machine's needs, results in "supine hypotension," a condition which involves lowered blood pressure. With less blood getting to the fetus, its oxygen supply is reduced. Later, the woman's supine position leads to compression of the umbilical cord. In order to rescue the distressed fetus, the doctor calls for a Caesarean.

SCENARIO NO. 3: A nurse shaves off the laboring woman's pubic hair and gives her an enema. The doctor inserts an I.V. into her arm and the EFM through her vagina. Strangers (residents and medical students) repeatedly give her vaginal exams, sometimes when she is in the middle of a contraction. These procedures frighten the woman, and the fear stops her labor.

The doctor gives her Pitocin to force the resumption of labor. The Pitocin-induced contractions go out of control. The doctor administers another drug to stop the contractions. Later, he restarts labor again with Pitocin. The woman gets very tired and discouraged. She loses all confidence in the ability of her body to bear her child. With more drugs, the doctor slows the contractions. Then he diagnoses "failure to progress" and does a Caesarean. The woman is grateful.

*Variation:* The Pitocin-induced contractions remain in control but are much more painful than natural ones. The doctor gives the woman pain-relieving drugs. He does not explain that the drugs can slow labor and lead to a condition called "uterine dysfunction." Eventually, he sections the woman for "dystocia" (impaired labor), or "failure to progress." □

the breaking of the waters, or premature rupture of the membrane (PROM), midwives and conservative obstetricians refrain from examining the woman vaginally with their hands. It is just such examinations that could lead to infections.) They take the woman's temperature frequently. Only if a sign of infection develops do they intervene in the birth.

The more aggressive doctor-in-control approach to PROM calls for delivery of the baby within 24 to 48 hours of rupture through induction of labor with drugs. If that fails, the doctor performs a Caesarean.

About 15 years ago, the time limit following PROM was 72 hours. Then, in some hospitals, it dropped to 48 hours. Now, in some places, it is only 12 hours.

In 1979, Dr. Kenneth Kappy and colleagues from the Tufts University School of Medicine Affiliated Hospital in Boston reported on their own work practicing the conservative approach to PROM. If there were no signs of infection, they waited while the women went into labor spontaneously. They did not examine such women manually.

Of 166 women studied who had babies under 37 weeks gestation, more than half waited longer than a day, and 19 percent went longer than seven days, before labor began. One woman waited 58 days. Despite the higher potential for infection at delivery, there was no significant illness among mothers, and no deaths among them or their babies.

## LOSING THE WAR

*At the hospital, Pitocin dripped steadily into Laurie's vein. The contractions came on strong and suddenly. Unlike normal contractions, there was no buildup to them. Laurie concentrated on her breathing exercises and Michael supported her intently. They felt good about the labor. They felt they could handle the experience.*

When Karla, Laurie's eldest sister, learned of the induction, she was worried. Karla, who teaches exercises to pregnant women, knew that labor induction was frequently the prelude to Caesarean section.

She called the hospital several times and finally reached Michael. "What is the hospital doing to Laurie?" she asked, frantically. "Try to get her off the Pitocin. Try to walk her around to bring on her labor."

Instead, the doctors upped Laurie's dose of Pitocin. At one point, the baby's heartbeat accelerated too much. The drug was stopped for a while.

Laurie's parents, Michael's parents and an 18-year-old niece, Enckel, arrived at the hospital in the afternoon. Hospital rules allowed only Michael in the labor room, but 67-year-old Tillie half-charmed, half-sneaked her way to her daughter's side.

It was the electronic fetal monitor she saw first. The machine's presence filled the room. At a time when Laurie needed to concentrate on what was happening inside her body, her attention, and that of everyone in the room, was diverted to the machine. Laurie and Michael were staring directly at it, their eyes glued to the graph that showed every tiny variation in the beat of their child's heart.

Tillie Olsen did not let herself feel her outrage over that machine until later. She had come to be of use. She immediately set to work putting pressure against Laurie's back to relieve some pain. The labor, she saw, was arhythmic. It was

not labor as Tillie had both experienced and observed it.

Labor wasn't going well, Jack Olsen told his daughter Kathie over the telephone. Laurie wasn't dilating. Kathie called sister Julie. "Let's go to her," she said.

As they set off in the car for the two-hour drive to the hospital, Julie said, "Well, do you want to know the scenario?"

"What do you mean?" Kathie asked.

"They're going to have her hooked up to the fetal monitor by the time we get there. They may let her off the Pitocin for as much as two hours. And at one o'clock in the morning, she'll be having a C-section."

Kathie laughed. "Julie, how can you say that?"

"They change shifts at midnight. The Pitocin is going to fowl her up so seriously that she won't be able to go into active labor. They'll realize that late in the evening. They'll wait for the next shift to operate."

Julie's analysis of the ordeal her sister would go through at the birthing proved not far wrong. Many observers, like Julie, have noted that people seem to be undergoing more Caesarean sections these days. But it is not until you start examining statistics that you see how sudden and extreme a trend it is. As recently as 1968, the overall rate for Caesareans in the United States was only 5.0 percent. By 1978, that had shot up to an estimated 13.9 percent. And in some hospitals today, the C-section rate has reached 25 percent of live births.

This leap in the rate of C-sections comes at a time when women are winning many battles in their struggle to regain control over childbirth, a normal process which physicians have defined as a medical event. In many parts of the country, women have won the right to give birth in a conscious state, without heavy medication; the right to bear their children in an upright position rather than flat on their backs, bound to delivery tables; the right to give birth in the presence of a loved one rather than totally among strangers; and the right to see and hold and nurse their babies immediately after birth. All these changes center childbirth on the woman; Caesareans put it back in the hands of the doctors.

## THE DOCTOR AS GOD

From the figures alone it seems clear that the C-section delivery is no longer being used as an emergency birth method to save the life of mother or child. Rather, the demands of birth technology and the medical technocracy are now taking precedence over the best interests of mother and infant. As one critic of the rise in Caesareans put it, "The mother is 100 percent out of control of the birthing, and the obstetrician is absolutely in charge. The Caesarean is the obstetrician's last opportunity to play God."

Changing terminology reflects this. "The chief of ob-gyn [obstetrics and gynecology] won't let us answer the phone 'Labor and Delivery' anymore," says obstetric nurse Betty Wood of Vanderbilt Hospital in Nashville, Tennessee. "We have to say 'Fetal Intensive Care Unit.'"

Indeed, so enthusiastic are some doctors about doing Caesareans that they talk as if there were something wrong with women who want to have their babies the old-fashioned way. "It may well be that during the next 40 years the allowing of a vaginal delivery or attempted vaginal delivery

Four obstetricians suggest in an article that an "occult reason" may lie behind a woman's refusal of a Caesarean.

may need to be justified in each particular instance," write Drs. John Sutherst and Barbara Case in the April 1975 issue of the British journal *Clinics in Obstetrics and Gynaecology*. And in an American journal last year, in an article entitled "The Fetal Right to Live," four Israeli obstetricians suggest that an "occult reason" may lie behind a woman's refusal of a Caesarean section. "It is probably that the patient hopes to be freed in this way of an undesired pregnancy," they write. Other possible reasons for this strange reluctance to undergo a C-section, the doctors speculate, may be "fear of surgery, prejudice, ignorance, difficulty with the language or inadequate rapport between doctor and patient."

Physicians refer to C-section deliveries as "from above" and vaginal deliveries as "from below." Dr. Helen Marieskind, author of a report prepared for the Department of Health, Education and Welfare (HEW), relates that while she was conducting interviews for her study on the rising Caesarean rate, obstetricians repeatedly asked her: "What's so great about delivering from below, anyway?"

To be sure, there are sometimes valid medical reasons for "delivery from above." An estimated seven percent of the Caesareans now being performed are for conditions that endanger the baby's life, such as *placenta previa*, in which the placenta covers the opening to the birth canal; or *abruptio placentae*, in which it tears from the uterine wall, cutting off the baby's oxygen supply. But these are unusual birthing conditions and have been rare throughout history. As recently as 1965, doctors who exceeded a five-percent C-section rate were generally suspected of gross incompetence. For, though Caesareans can save lives, they also can pose serious risks to the mother. Some are these:

- Death during childbirth. Caesareans, like any form of surgery, occasionally can result in fatal complications.
- Inevitable separation of the infant and mother after delivery. This can lead to difficulties in emotional bonding between mother and child and in breast-feeding.
- Pain, gas, weakness and difficulty in movement after surgery. According to one report, half of the women who undergo a C-section suffer serious side effects like hemorrhage and infection.
- Infection of the respiratory or genitourinary tract. In one study, Caesarean mothers had a 20.4-percent rate of uterine infection after birth, while mothers who delivered vaginally had only a 1.4-percent rate of uterine infection.

To sum it up, a C-section is *major* surgery. "People have the idea that a Caesarean is a simple little operation," says Dr. J. R. McTannany, chief of obstetrics at Community General Hospital in Reading, Pennsylvania. "But it's a

major operation. There are all sorts of complications and problems than can develop." The risks present with any operation—*anesthesia effects, shock and hemorrhage, emotional trauma*—are inherent with a Caesarean. Should hemorrhage occur, there are then complications associated with the necessary blood transfusions—*hepatitis or other, adverse transfusion reactions*. And, during surgery, doctor-induced injury to organs near the womb is possible. There is also a disfiguring scar left from the operation, depression and a sense of failure, all of which would not otherwise be associated with the birth of a child.

For the infant, there are different hazards:

- Respiratory Distress Syndrome and hyaline membrane disease. Both of these lung problems are more frequently

found in infants delivered by C-section than by normal birth. C-section infants also have more mucus in their lungs, leading to the conclusion that there is something about the normal labor process, not thoroughly understood, that clears a baby's lungs.

- Drug reactions. From Pitocin, used to induce labor, to pain-killers to anesthesia, the long-term effects of drugs on a newborn infant are not well known. They look worse with every passing study. More and more women refuse to subject their fetuses to the damaging effects of caffeine, alcohol or nicotine, only to have their about-to-be-born children bombarded with pharmaceuticals which the women never even heard of before labor began. A study in the British medical journal *The Lancet* found that infants born after a Pitocin-augmented labor were six times as likely to be admitted to intensive-care nurseries as infants whose mothers had not been given Pitocin.

The key to resisting a Caesarean is understanding how the operations are engineered by doctors and grasping exactly when those rare occasions do occur when a C-section is necessary to save lives. If you are a pregnant woman or think you might ever become one (or are the husband, friend or lover of a pregnant woman), you should be informed (see box, page 35). If you are giving birth in a hospital, be sure to have a well-informed ally with you who can argue with the doctors if it turns out to be necessary.



Chart by David Jacobs. Photo by Dwight Sorenson

### THE SCENARIO ENDS

At the hospital, nurses came in, checked Laurie and warned her that her cervix was not dilating enough. She was not "progressing in labor."

Tilje Olsen was aware of the intimidating atmosphere in the labor area. Time and again, the nurses and doctors entered the room, looked first at the machine, examined Laurie, called attention to her failure to dilate and said they were going to increase the Pitocin.

Each time, Laurie and Michael questioned the need for a larger dose. Each time, doctors asserted it was essential.

Right after one of the examinations, a nurse who had been gentle with Laurie came to check the Pitocin. It looked like the flow was blocked. The nurse pugged the bottle. Large doses of Pitocin sped into Laurie's vein, she had a massive contraction lasting what seemed to be between five and ten minutes.

The baby's heartbeat on the electronic fetal monitor dropped from 160 beats per minute to 40. Within seconds, the room filled with doctors and nurses. They cut off the Pitocin and gave Laurie another drug to stop the contraction.

The doctors said Laurie might have to have a Caesarean. It was an emergency. Michael could not be present. But the baby's heartbeat was beginning to climb again. Michael said no. They would accept a Caesarean only if it were absolutely necessary.

All right, the doctors said, losing some of their urgency. But Laurie and Michael would have to sign a consent form in case a Caesarean was necessary later.

The doctors brought the form. Michael read it to Laurie between contractions. As he went through the long list of things that could go wrong and things the doctor had a right to do during surgery, they felt increasingly powerless to resist

the hospital and its authority. One provision on the form gave the doctors authority to remove any of Laurie's organs when they opened her up to do the Caesarean.

They did not want to sign it, but Laurie was in labor, in pain, exhausted. They did not know exactly how to word what they were willing to sign. Should they cross out some items or write in qualifications?

They decided: we cannot deal with this now. What is happening now is labor, getting through the labor. They set the form aside. Tillie pressed against her daughter's back to try to ease the pain of the contractions.

In the waiting room, Julie Olsen watched a man she had not seen before make a phone call. His wife was having a Caesarean. According to Julie's count, there were five births going on at the hospital that night. Four were Caesareans.

At midnight the doctors announced that a Caesarean was probably necessary for Laurie. They said, "You're only five centimeters dilated and you've been in labor for 13 hours. You're going to be exhausted with another 13 hours of this. Your baby is probably not going to make it because he's in distress already."

Laurie knew it was wrong to assume that because it took her 13 hours to get to five centimeters, it would take her another 13 to get to ten. Natural labors do not work that way. She could be at ten centimeters in another hour or two. But maybe artificially induced labor was different. Maybe the baby was in danger.

A doctor said, "Let's give it another hour."

Tillie watched Laurie and the doctor. Laurie, exhausted and in pain, was bargaining not to be put out, bargaining to be conscious during the birth and to preserve her right to have Michael with her.

Laurie went into surgery at 1:30 a.m. She kept saying to herself, "Laurie, your baby is being born." But she could not pay attention to the birth. She could not even look over at Jesse, her new son. She was vomiting severely now, from the anesthetic.

Sister Julie's scenario of the engineered C-section had been off by only ten minutes.

**R**ecovery from the C-section shocked Laurie. She had no idea she would be so sick, so debilitated by the surgery. She was in great pain. In her hospital room, several television sets blared on different stations, and nurses left ringing bells unanswered for what seemed like hours. It was so difficult to rest that she checked out of the hospital after three days, "against medical advice." It was seven weeks before she felt she had her body back.

As her strength returned, Laurie felt angrier and angrier about the Caesarean. Some of the reasons for her anger seemed trivial to her. Like the scar. The realization that she had a tremendous scar for the rest of her life. It itched. It hurt. She felt it disfigured her.

Other reasons seemed more important. Many of the hospital procedures, she thought, probably created the need for the Caesarean. As the doctors acknowledged, the drug-induced labor put extra stress on the baby and, through the abnormal contractions, on her.

She was angry, too, with the way people reacted to her Caesarean. They treated her as though she had had less than a birth. They pitied her. Their comments made her feel terrible about herself. Women said, "How awful that you had

**W**hy are physicians— who once saw the knife as a last resort—so anxious to wheel American mothers into the operating room?

to miss the thrill of pushing your baby out of your body." She began to feel she had missed out on a terribly important occasion in life. But at the same time, this feeling became mixed with another: she found herself feistily defending her experience. She wanted people to know that, Caesarean or not, it was still a birth.

## FOR A PRICE

Laurie Olsen's story is one of many thousands. The rising Caesarean rate, as yet, shows no signs of leveling off. What has changed over the last ten years to push the C-section rate higher? Why are physicians—who once viewed birth by knife as a technique of last resort—now so anxious to wheel American mothers-to-be into the operating room?

There are many reasons, all interrelated. Dr. Helen Marieskind, in her study *An Evaluation of Caesarean Section in the United States*, has given the most complete picture of the problem. (Anyone interested should read her findings, available from Clara Schiffer, Room 723, E-2, Hubert H. Humphrey Building, Washington, D.C. 20201.)

One reason for the increase in C-sections is greed. In 1963, the ratio of live births to obstetricians was 261 to 1. By 1975, the number of births had dropped as the number of obstetricians increased, and the ratio shrank to 145 births to one ob-gyn. Yet, astonishingly, the after-tax income of ob-gyns as a group rose dramatically, passing the median incomes of even general surgeons and psychiatrists, to establish the field as the highest-paid medical specialty.

"This is a remarkable accomplishment in view of the dramatically falling birth rate," observes Dr. C. Arden Miller, a public health physician at the University of North Carolina. "It seems to me," Miller adds, "that in order for those obstetricians to maintain that sort of livelihood, they are forced to resort to more expensive and elaborate technologies, of which, I think, Caesarean section is one." (The cost of a Caesarean—including increased physician fee and hospital stay—is about three times greater than the cost of a vaginal delivery.)

A study by Dr. Andrew Fleck, director of the Division of Maternal and Child Health in New York State's Department of Health, shows widely diverse Caesarean section rates around New York state—from two percent in one hospital to 22 percent in another.

"What we've been able to show is that Caesarean section is a provider attribute and not an attribute of the woman," Fleck explained in an interview. "If you go to a doctor who likes to do Caesarean sections, you're going to get sectioned. In other words, snake-bite poisoning is a function of the kind

# A Feeling Of Being Raped

**BETH SHEARER, Boston, Massachusetts:** The first thing I said to the doctor when he told me I was going to have a Caesarean was, "You're not going to put me to sleep are you?"

The anesthesiologist told me, "Let me know if you feel some discomfort." I didn't want to go to sleep because I was still hoping to feel and see my baby.

At one point I said, "It really hurts." The next thing I knew, with no warning and no explanation, there was a mask coming down on my face. I couldn't talk. It was over my head. I was trying not to breathe in.

I wanted to pull my hands up to shove the mask away, to get rid of it, to say, "I don't want to go to sleep. I'll take the pain." But when I went to lift my arms, they were tied down.

I thought, "I can't move! I'm going under." It was terrifying.

Finally, I shook my head vigorously and he took it off. But by that time, I was already very groggy.

Afterward, I thought that the feeling of powerlessness I had then may be the same feeling women have during rape.

**KATHY HERWALDT, Chicago, Illinois:** I wanted to be awake for the birth. But I was so spaced out during the contractions, I don't remember too much. They said they were going to do a general anesthesia, and I guess I said O.K. I must have.

Right before I went out—I remember this so clearly—the surgeons started talking about their weekends.

When I woke up in Recovery, someone said to me—it was a man's voice—"You have a girl." I was just coming out of the anesthesia. My eyes were still closed. And I said to myself, "I really don't give a hoot. I could care less if the baby lives or dies."

From that minute on, I was depressed. In the middle of the night, I woke up with a nightmare. It was about a pagan ritual. A male priest was holding a knife. Then he cut a baby.

After six weeks I went to see a psychiatrist. I said to her, "I had a feeling that I didn't want my daughter, but I also had a feeling that I didn't have my daughter either."

**EUNICE BRINKLEY, Plainfield, New Jersey:** Shortly after I arrived in the hospital room, the doctor entered. He said, "Let's get this over with before your husband comes in." I said, "What are you doing?" He said, "I'm breaking the bag of waters. This will improve the quality of the contractions."

The contractions tripled and quadrupled. I was shaking in the bed. It was the kind of pain that shoots through and vibrates in your body.

At about a quarter to six, I began to push. I was absolutely thrilled. It felt so good to push—almost orgasmic. I was having such a wonderful time pushing; then they announced that I was going to have a Caesarean.

I started hollering that I was *not* going to have a Caesarean. What could possibly be wrong? They said, "Mrs. Brinkley, your baby's heart rate is slightly affected. We classify him as distressed."

I said, "But I'm pushing! I'm having this baby now!"

No one responded to me. They just started carrying out a big rush and taking off all the monitoring wires and instruments and taking off all my clothes and shaving my stomach, and the whole time I was protesting.

I protested all the way as they rolled me through the hall—naked on the table—into the operating room. I protested up until the very moment they put me out with anesthesia.

of snake which bites you. The data in my report offers indirect evidence that the performance of a Caesarean section is unrelated to the woman's condition.

Convenience, as well as greed, may be a motivation of doctors who perform Caesareans frequently. One would expect first-time Caesareans, which are supposed to be emergency operations, to occur randomly around the clock. But when an associate in Fleck's office looked at the statistics of five New York hospitals in 1978, he found that 62 percent of the first-time Caesareans took place during working hours—between 7 a.m. and 6 p.m. Only 33 percent occurred between 6 p.m. and 7 a.m.

Some doctors, in fact, openly defend the practice of scheduling births at their convenience. Dr. R. E. Hall was quoted in a congressional hearing as having written to his fellow obstetricians: "It is high time we shed our shame over preferring to practice obstetrics in the daytime." And two British physicians argue the same thing in a recent article. "If planned induction for nonurgent reasons increases," write Drs. John Setherst and Barbara Case, "the work load of a busy maternal unit can, possibly, be spread evenly throughout the week. It might even be possible thereby to completely minimize the performance of Caesarean section at, for example, weekends or holidays, when medical staffing can be a difficult problem."

Just as the economics of delivering babies has changed since the beginning of the '70s, so too has the emphasis of birth shifted from physician concern over the mother's well-being to what could only be called a baby-as-product mentality on the part of the doctors. They argue that they are getting "better babies" with the increased use of Caesarean section, but when asked for evidence, they cannot point to studies that support their contentions that normal birth is in any way detrimental to infants.

Dr. Saul Lerner at the University of Massachusetts Medical School is a great believer in C-sections. He asserts that in 20 years, most women will deliver babies by surgery. Lerner is also one of the doctors who claim normal birth is a dangerous process for babies.

"There's a lot of force there," Lerner hypothesizes. "Babies can be battered by labor. Sometimes you get a 'football' baby, squeezed out of shape. That's not good for the baby. We're trying to avoid brain damage."

Lerner could supply no citations, however, for studies supporting his belief that C-sections could reduce the number of brain-damaged infants. The studies are, in fact, not on his side. Several recent studies indicate there is no evidence whatever that liberal use of the C-section has done anything to raise the mental performance of children. "Neither is there conclusive proof," the authors of a Brown University paper add, "that Caesarean section has been able to reduce the incidence of neurological disorders in our population."

A condition frequently mentioned by ob-gyns like Lerner, who believe normal birth can lead to brain damage or neurological difficulty, is that known as breech birth. A breech birth occurs when the baby is positioned to exit the womb in any way other than head-first. As many as four percent of births are breech deliveries. Though many ob-gyns now insist all breech births should be delivered by C-section, medical studies do not support this practice.

A retrospective review of 457 breech deliveries at the Medical Center Hospital in Burlington, Vermont, revealed no significant improvement in death and morbidity rates for breech babies delivered by C-section over those born vaginally. In some breech births, a C-section may be warranted, especially if the infant is of very low birth weight. But prevention may ultimately be the solution to the breech birth problem, not surgical intervention. One breech birth study found that a simple exercise performed twice daily by the mother actually changed the baby's position from breech to head-first in 88.7 percent of the women who tried it.

## TECHNO-CURE

The role of medical technology in the rising rate of Caesareans cannot be underestimated. The chief instrument of that technology—the machine that so dominated Laurie Olsen's birthing—is the electronic fetal monitor. With the EFM has come a "diagnosis" of something called "fetal distress" and a cure for the condition—Caesarean section. Before the fetal monitor took over the watchful role once performed by human beings, fetal distress was rare.

Most reports indicate that the fetal monitor gives a high number of false positives—indicating babies are distressed when they are not. Dr. H. David Banta and Dr. Stephen Thacker coauthored a federal report on the EFM. Banta and Thacker cite four studies which compared groups of EFM-monitored mothers with those monitored by nurses. The EFM group showed no benefit attributable to the machine. Banta and Thacker conclude that the "EFM has, if any, proven benefit not given by the regular auscultation [human monitoring with a stethoscope] and it is a costly and dangerous procedure."

Yet in a discussion of the EFM published in February 1978 in *Patient Care*, obstetricians agreed that it is advisable to monitor every mother in labor and that women who refuse the machine may be uninformed or simply selfish. Dr. Ronald Chez, professor of ob/gyn at Howard University College of Medicine said: "Our task is to help these patients recognize that they are introducing their own hedonism into a 12-hour event that may affect the 70-80 years of life of the infants they bear."

If the fetal monitor is mostly wrong, dangerous, expensive and uncomfortable to the mother, who must lie immobile during her labor, why is it used? Doctors most often cite the fear of malpractice suits as the chief reason. They are afraid that if they do not perform a C-section when a baby is actually distressed or when the operation is necessary for the mother's health, they will pay for it in court. Even physicians who do not believe in the EFM—and one, Dr. Albert Huerkamp, who authored a study which found that use of the monitor made no difference in fetal outcome—still use the machine because of a fear of lawsuits.

But Dr. Helen Maneskind thinks that, based on the findings of her HEW study, malpractice suits are not valid fears. "There have been one or two really whopping suits," she says. But she adds that most malpractice suits involving Caesareans relate to events that occurred during the C-section, not to a failure to perform the operation.

Maneskind also discovered that physicians are no longer being taught how to handle a complicated vaginal delivery, like a breech birth, without resorting to the knife. Others

admit they are now reliant on the fetal monitor for tuning into the fetus and birthing mother during labor, having lost the skill of manually listening to the baby's heartbeat. One ob/gyn said he felt "naked" now without the machine, even though he admitted that use of this machine has undoubtedly led to some unnecessary Caesareans. As with any technology, once physicians are hooked up to it, it is often difficult to kick—even if the hardware proves undesirable in the end.

## CHILD ABUSE

Ultimately, the justification for the rising Caesarean section rate rests on a devaluation of the woman and a glorification of the baby. Some physicians would have this view embodied in the legal code. The four Israeli obstetricians who authored the article "The Fetal Right to Life" declare that if a pregnant woman refuses to submit to a Caesarean section which the physician deems essential to save the fetal life, "the doctor

—Continued on page 42

## Stopping That Knife

THE EPIDEMIC of Caesarean sections will not go away until there are considerable changes in the power structure of American medicine. But in the meantime, there are some things you can do to avoid having an unnecessary C-section. One is to have a midwife attend your baby's birth. If, however, an obstetrician will be delivering your child, choose your doctor carefully and have some clear understanding with him or her *before* labor begins. "It's through this kind of direct political action—women taking the situation in their own hands—that the C-section rate is going to drop," says Dr. Sidney Wolfe, director of the Health Research Group in Washington, D.C.

Here are some questions to ask the doctor at the beginning of your pregnancy:

**QUESTION NO. 1:** What percentage of deliveries does he or she do by C-section? This is the most telling fact. "If it's over ten percent," says Wolfe, "then he or she is one of the doctors who is keeping the average up. Watch out." Other critics would set that percentage lower.

**QUESTION NO. 2:** What does the doctor feel are legitimate reasons for a Caesarean? If the physician answers that all breech deliveries, not just complicated ones, justify the operation, beware. Ditto if he or she says that all women who have had a Caesarean must have repeats for subsequent pregnancies. If you have had a previous C-section, you probably had a "lower-segment section," and this does not necessarily mean that you can never deliver vaginally.

**QUESTION NO. 3:** What does the doctor know about the policy of the hospital where you plan to deliver your baby? In what percentage of pregnancies does the hospital use the fetal monitor? If the answer is more than 20 percent, the chances are higher you will have a C-section. Also ask whether the hospital will allow patients to be conscious during the C-section and what its policy is on other medical problems, such as ruptured membranes.

**QUESTION NO. 4:** What is the physician's opinion on drugs used to induce labor and how long would he or she wait before starting labor induction? The drugs used for inducing labor are coming more and more into question. In the case of Laurie Olsen, they contributed to the need for a Caesarean section. □

# Caesarean Epidemic

—continued from page 35




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must be legally entitled to warn the woman that she is committing a felony."

Their article, which appeared in 1979 in *Obstetrics & Gynecology*, is published at the same time abortion opponents are using the fetal right-to-life argument to justify compulsory pregnancy. Such arguments turn the woman into mere housing for a fetus whose rights and personhood are given more value than the woman's, and in the name of whose welfare the woman's body can be manipulated, probed and invaded with impunity.

So today, while women are accused of murder for having abortions, some obstetricians are charging women with felonious behavior (for refusing Caesarean sections), hedonism and ignorance (for refusing the electronic fetal monitor) and child abuse (for resisting tech-

nological hospital deliveries and bearing their babies at home). "I think home birth is child abuse," Dr. Edward Hon, developer of the EFM, said in an interview. "If my daughter wanted to have a baby at home, I would say in no circumstances should that be done. I would tell her very plainly that she does not have the right to make that decision for the unborn child."

These arguments reduce the woman to a vessel, an object. That is the view women have been so forcefully challenging for the past ten years. As Tillie Olsen, who watched in suppressed rage the events leading up to her daughter's Caesarean section, observes: "The stunning rise in Caesareans at this particular time has a great deal to do with sexism fighting for its continuance."

Gena Corea writes frequently about medical subjects.

## NEW OFFERINGS

Roughly 800,000 people will read Gena Corea's "The Caesarean Epidemic" in this issue of *Mother Jones*. Eight hundred thousand is a lot of people, but it's only a fraction of those who should know what's happening in America's maternity wards. That's why we offer inexpensive reprints of this and other important *MJ* articles.

### The Caesarean Epidemic by Gena Corea (JULY 1980)

At a time when the movement toward more natural childbirth has won several victories, doctors are asserting their control over the birth process. The result: an incredible rise in the rate of surgical deliveries.

### Running in Reverse by Karen Branan (JULY 1980)

When Karen Branan's Ford Galaxie slipped from park into reverse and raced backward for two blocks, sideswiping five cars, she decided to do some digging. Every Ford owner in America should read what she learned.

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A visit from a deaf neighbor who needed assistance in making a phone call introduced the author to the unfamiliar, often misunderstood—and sometimes militant—world of the deaf.

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