SB
747
2/3

3924 E. 8th Ave #2
Anchorage, Alaska 99504
March 7, 1982

Senate and House Health, Education, and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like you to vote in favor of Senate bill #747, regarding the legelization of midwives and the establishment of a midwifery board. Homebirths and having midwives present at births is a part of our heritage. Although this practice had diminished in the recent past, it is on the rise again. I feel it is a beautiful way to bring a child into this world as opposed to being plugged into a machine and being injected with drugs at birth in a hospital.

The federal government recognizes midwives and uses them in Alaska at Elmendorf AFB, the Alaska Native Hospital, and throughout the State. With proper management midwifery can be a useful and rewarding program for our state, as it is for the federal government.

I realize that persons in the medical profession will lobby against this bill but their's are selfish -monetary- interests. Please vote as the common people in Alaska would have you represent them, in favor of midwifery in Alaska.

Sincerely,

Thomas Malone

Karen Malone

cc: Charles Parr
Terry Stimson
Mike Coletta
Vic Fisher
Tim Kelly

Alaska State Legislature

House of Representatives

Representative Ken Fanning

Official Business

JUNE—DECEMBER
Box 80929
College, AK 99708
Ph. 907-479-4234

WHILE IN SESSION:
Pouch V
State Capitol
Juneau, Alaska 99811
Ph. 907-465-4833

M E M O R A N D U M

TO: Senator Charlie Parr
Chairman, Senate HESS Committee

FROM: Representative Ken Fanning

DATE: April 9, 1982

RE: SB 747

Attached is a copy of a letter I received from Al Rushing, the President of B.A.B.E. (Better Alaskan Birth Experiences). In the letter, he expressed dissatisfaction with both the House and Senate HESS committees as he had specifically requested notification of hearings on this legislation, and he has not been so informed.

I would simply like to request on his behalf that he receive adequate notice of any additional hearings your committee may hold on this bill.

Thank you for your cooperation.

Paid for By Private Funds

BETTER ALASKAN BIRTH EXPERIENCES
P.O. Box 4-381, Anchorage, Alaska 99509
(907) 279-9117

look at current draft of bill – fill me in

March 26, 1982

Reps Ken Fanning & Dick Randolph
Alaska State Legislature
Pouch V, Juneau 99811

MAR 3 1 1982

Dear Reps Fanning & Randolph

I received today, your letter giving me opinion of SB 747 (and SSHB 11). Sitton – Carney →

I hope that you are continuing to keep abreast of the tremendous quantity of input supporting this legislation from families and individuals of Alaska. They are sincerely concerned about the protection of their right to choose freely what pregnancy care they utilize, as well as birth setting and birth attendant. From your letter and what I understand and know of your legislative philosophy, as well as Rep. Dick Randolph's I believe you and he each have mutual support for this basic human freedom.

I hope that you will however maintain an open and objective attitude and look into the current situation confronting us in Alaska. Here in the Anchorage area (and in other areas) couples choosing the home as a birth setting are being any access to routine lab work

there is absolutely NO reasonable explanation for this practice! Families choosing home birth have been unable to find any avenue for obtaining this very basic procedure. Lab work, is NOT medical care, irregardless of what individuals of the medical system may believe! Why is it that the current licensed medical/surgical hospital monopoly finds it necessary to maintain this non-competitive system? Why is it that SB 237 (introduced last session) had portions which would have made it illegal for anyone to have utilized the services of anyone, other than physicians at childbirth?

I believe that it is easy to see that

1) physicians are opposed to attending home births and most will not attend such births, therefore
2) by outlawing assistance of others at birth
   a) birth becomes less safe and/or
   b) people will be forced to go to hospitals for care

SB 237, the parts relating to childbirth, were effectively eliminated when the public found out of the bill. This speaks loudly of peoples interest and concern in regarding free choice of birth alternatives.

Hospitals as well as physicians currently have a virtual ~~stamp~~ "stamp of approval" from our State and yet react by attacking people seeking birth alternatives.

We have no protections currently - People are being harrassed, intimidated, threatened and denied

access to basic lab work as well as open access to other services that we would all assume are and should be available to all desiring them.

Instead what we have is a powerful private interest group - physicians - denying this access. These are the same individuals that profess to have as their only interest the health and welfare of ~~other~~ our mothers and infants! Is this reasonable? How does this unethical treatment (possibly illegal) benefit mothers and infants?

When we've sought legal opinions we've been told that lay midwives and home birth couples are in effect "non-persons" - that without legislation to "legitamize" their choices and midwifery, that these people will not obtain justice in our State's legal system!

Please look into this more fully. I am rather knowledgeable on this entire issue and would welcome the opportunity to discuss this with anyone sincerely concerned.

I was also rather displeased to say the least to find out late Tuesday night that the House HESS Committee was having their hearing on SSHB 11. To add to this Friday afternoon I was informed that the Senate HESS Committee's hearing was being held that day! I have provided input on this bill and the problems we are encountering for quite some while now and have continued to request to be informed of

any and all hearings regarding this legislation. As he stated I was informed of neither. I would have done my best to have come down to Juneau for direct testimony, questioning and input but was not notified. As is I have expended a lot of personal time and expense to correct a very unjust and unnecessary set of circumstances.

I am disgusted presently - I have been working within the system I do not feel the system has been working fairly.

If I can be of assistance regarding the subject please contact me.

Sincerely,
Al Rushing
President B.A.B.E.

P.S. BABE is composed of individuals supporting ~~free~~ access to alternatives in birthing, and providing childbirth education. We have approximately 500 or more individuals which support BABE's goals through their memberships.

I also have direct contact with childbirth educators of other groups, as well as the majority of all lay midwives practicing in Alaska.

PSS Short of a complete and total revamping of the current physician - hospital medical system I feel this legislation is ~~perhaps~~ the only effective means of protecting these peoples' freedoms.

Letter to Rushing
DRAFT
[illegible]

April 16, 1982

Al Rushing
P.O. Box 4-381
Anchorage, AK 99509

Dear Al:

Today we received a letter from Ken Fanning with a copy of your letter of March 26, 1982. I have to say that I am very distressed at your implications that the Senate HESS Committee has excluded you from testifying on SB 747. Ginger Baim and myself have worked for months on this project, have spoken to you at length on several occasions, have provided your written information and research to our legislators, have searched for legal opinions on midwifery, have lobbied the medical community and state departments on behalf of the midwives and have carefully rewritten this bill again and again to insure its passage.

I'm sure you must remember the video teleconference we had in March in which you were a participant. You must also be aware that Committee meeting schedules are developed a minimum of 5 days in advance, are published in the newspaper, and are available at all Legislative Information Offices. In addition, I know you have had weekly contact with Ginger and I feel you have little reason to suggest to other legislators that we have undermined your rights as a citizen to have input in the legislative process.

Sincerely,

Nancy Deitrick
Senate Aide

ND:sr

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

May 18, 1981

MEMORANDUM

TO: Representative Terry Martin

FROM: Betty Barton
Research Staff

RE: Funding Alternatives to Abortion
Research Request No. 81-116 (Additional Information)

As a component of your request on alternatives for women encountering problem pregnancies, you asked for information on the amount of State expenditures for abortion-related services costs. In a previous memorandum, we indicated that information regarding abortion-related expenditures under the State's public assistance program had been compiled for processing and analysis. We recently learned from Jeff Hubbard, who is responsible for the project at the Department of Health and Social Services, that the information will not be available until mid-June.

Consequently, we are only able to provide you with data concerning expenditures reimbursed to physicians for abortion-related costs under the Medicaid and General Relief Medical programs. From July 1979 to October 1980, there were 268 abortions reported with $81,434 reimbursed to physicians. According to Jeff Hubbard, between 14 and 20 public assistance clients per month received abortions with physician costs averaging $300 per case. This does not take into account hospital costs or pharmacy expenditures.

We are sorry that we were unable to obtain additional information for you at this time. When the Department of Health and Social Services has completed its analysis, we will forward a copy to your office.

BB/bf

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

April 24, 1981

MEMORANDUM

TO: Representative Terry Martin

FROM: Betty Barton BB
Research Staff

RE: Funding Alternatives to Abortion - Research Design
Research Request No. 81-116

The purpose of this memorandum is to present a suggested design for your research request regarding funding alternatives to abortion. You have asked that we address the level of service available to unmarried or economically disadvantaged women with pregnancies they wish to carry to term, and that we determine how the State can better meet the needs of these women. To fulfill your request, we have determined that our assistance might best be provided in a 5 to 7 page memorandum presented in two parts: 1) An identification of current gaps in services available to pregnant women; and 2) A discussion of innovative programs to assist unmarried or disadvantaged pregnant women.

Gaps in Service Coverage to Pregnant Women

In submitting this research request on your behalf, Bill Moffat has commented that current State programs may be providing a disproportionate level of assistance to women seeking abortions compared to the services available to those women who wish to carry their pregnancies to term. He has asked that we research this subject to determine the amount of State dollars that are spent both directly and indirectly on abortion-related costs. Our preliminary research has indicated that much of this data is unavailable. Although data on some of the direct assistance is available, such as medicaid funding for abortions, many costs cannot be isolated within a specific problem category.[1] Costs borne by the State for counselling services, for example, may be attributable to a variety of counselling needs ranging from family conflicts

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[1] The Department of Health and Social Services' Division of Public Assistance, is in the process of compiling data for physician, hospital and pharmacy expenditures attributed to abortion-related costs in the Medicaid and General Relief Medical programs. According to Bob Ogden, a deadline of May 15 has been established for the data compilation.

to economic difficulties. Counselling administered to the client for a problem pregnancy may be a service that overlaps with a number of other counselling services.

Taking this into consideration, we have revised this component of your request in an effort to establish a subject feasible for research which will accommodate your needs. We suggest a review of the Public Assistance program to determine what services are currently extended to eligible clients in need of pregnancy-related services. To the extent that cost data is available, we will be happy to provide it.

Program Innovations in Assistance to Pregnant Women

This section will introduce several concepts in the areas of social services, medical assistance, and education/information services for the disadvantaged or unmarried pregnant woman, which could be considered for program development in Alaska. To research this subject, we will first contact other states to review innovative programs that may have been implemented elsewhere in the U.S. Additionally, we will review selected programs in Alaska to determine whether the needs of pregnant women could be accommodated through the expansion of existing programs. We have tentatively identified the following concepts for study:

Maternity Homes/Birth Centers. Some unmarried pregnant women may choose not to bear a child due to the stigma of illegitimacy which they fear they will encounter during pregnancy. Traditionally, the response to this problem has been the establishment of unwed mothers' homes where women could live until their childbirth. For the most part, these homes for unwed mothers have been developed in an institutional setting. We will explore this area to determine what innovations are being considered to establish more humanistic settings for unmarried pregnant women. This might include, for example, any efforts that are being made to allow young women to continue their education during pregnancy.

Public Information Program. Some pregnant women may be unaware of the services currently available to them, e.g., adoption programs or pre and postnatal care programs. This segment of our research will explore potential solutions to increasing women's awareness of the availability of services.

Grants and Loans Programs to Individuals and Agencies. Economic considerations may cause some women to abort rather than bear a child. A grants and loans program could be extended to eligible women who have no other funding assistance for their pregnancy needs. These grants could be established in recognition of the special needs of pregnant women and could be extended to cover such costs as maternity clothing.

In turn, a grants and loans program could be established for eligible not-for-profit organizations to augment services provided to pregnant clients.

We hope this research design will meet your needs. We anticipate completing the second part of this research for you by May 1. The first segment, concerning existing service coverage to pregnant women, should be finished no later than May 8.

BB/bf

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

May 12, 1981

MEMORANDUM

TO: Representative Terry Martin

FROM: Betty Barton
Research Staff

RE: Funding Alternatives to Abortions
Research Request 81-116

You have asked for information concerning funding alternatives to abortion. This memorandum explores possible options for expanding the State's role in assistance to pregnant women. For the purposes of this memorandum, we are limiting our focus to those women who may be contemplating abortion because of the socio-economic problems associated with carrying their pregnancies to term. Consequently, we will address the service needs of the client who is experiencing a so called "problem pregnancy." You have also asked for information concerning the level of State expenditures for abortion-related costs; we will respond to this part of your request in a separate memorandum.

Our research is based upon telephone interviews with service providers located both in-state and out-of-state. To gain an understanding of the current service needs and problems for pregnant women in Alaska, we have contacted agency representatives of several Anchorage-based programs: Ms. Pat Petit and Ms. Jo Brosamer, co-directors of Birthright in Anchorage; Lt. Gene Ragan, director of Booth Memorial Home; and Ms. Norma Jean Elgas, an information and referral worker for the Anchorage Women's Resource Center. We have also contacted Mr. John Pugh, Mr. Dwayne Peeples and Mr. Gordon Landis of the State Department of Health and Social Services. To attain a perspective on programs outside of Alaska, we contacted Mrs. Lore Maier, executive director and cofounder of Alternatives to Abortion International; Ms. Maxine Cunningham, program analyst for the U.S. Department of Health and Human Services' Office of Adolescent Pregnancy Programs; Ms. Winnie Schoefer, director of Concern for Health Options; Ms. Ann Grey, editor of the Maternal and Child Health Legislative Alert Newsletter; and Ms. Susan Harding, co-director of the Addison County Parent/Child Center in Middlebury, Vermont.

STATEMENT OF PROBLEM

In the U.S., approximately 249,000 single women and girls under the age of 20 gave birth to children in 1978. This figure represents a significant increase above the figure of 199,000 in 1970, and is nearly three times greater than in 1960 when 91,700 births were recorded. According to an article in Today's Education, approximately 1 out of 18 girls will experience childbirth before she reaches the age of eighteen. Many of these girls will encounter problems during their pregnancies as a result of their young ages, economic status, or other socio-economic factors.

In Alaska, 12 per cent of the births are to women between 15 and 19 years, 37 per cent of whom are unmarried. The reported average age of a client at Booth Memorial Home, the only residential care facility for pregnant women in the Anchorage area, is 16.5 years although the range in ages is between 13 and 18 years. However, many of the women in Alaska who encounter problems are married and are older, according to staff at Birthright. Typically, these women may be experiencing financial problems or family difficulties concerning their unborn children. Generally, however, pregnancy clients are adolescents, financially needy, and lacking in employment skills. At Booth Memorial Home, between 30 and 50 per cent of the residents have become pregnant as a result of incest.

To illustrate, the complexities of the service needs of many clients, Pat Petit of Birthright described a recent case involving a pregnant 16 year old girl. The girl had no knowledge of childbirth from even a conceptual standpoint and did not speak or understand English.

SERVICE NEEDS FOR PROBLEM PREGNANCY CLIENTS IN ALASKA

Resource persons we contacted identified four problem areas regarding the current level of care available to women with problem pregnancies in the state:

- Shortage of emergency housing and foster home facilities;

- Inaccessibility of medical care;

- Inadequate public assistance programs;

- Deficient postnatal care services.

Emergency Housing and Foster Home Facilities

In the Anchorage area, a woman with a problem pregnancy has few available options for housing: She may stay in one of the 3 bedrooms at Birthright; she may stay within a foster home if one can be located for her; she may stay at the Booth Memorial Home if she is in the custody of the State (or if she has the financial resources to pay for her care); or, if she has been physically abused, she may seek emergency housing at McKinnell Emergency Lodge for Women (for a period not to exceed 30 days). If her family conditions allow it, she can remain within her own home, receiving necessary intervention services on an outpatient basis. For many of the women, however, remaining at home is not a feasible option.

More commonly, according to Booth and Birthright staff, women are placed on waiting lists until housing arrangements can be made available. Currently Booth Memorial Home is maintaining a waiting list of about 15 names and will be unable to provide space for another 6 months. Birthright, which is serving about 50 clients monthly, is able to house only 3 clients and is maintaining a list of 5 women in need of shelter. To the extent possible, Birthright staff arrange for temporary housing in private homes but as Pat Petit noted, "It is generally difficult to find someone who is willing to house a girl who may have been recently released from Ridgeview [Correctional Center] for theft and prostitution."

Inaccessibility of Medical Care

There is no available source for low-cost prenatal care in the Anchorage area. Several years ago, staff at the Neighborhood Health Center in Anchorage attempted to provide prenatal care at a cost determined by the client's ability to pay. However, the Center's staff were unsuccessful in finding the resources to provide a physician licensed to practice obstetrics. In an effort to work around the problem, the Center at one point adopted an operational policy where clients received prenatal care at the Center and were advised to go to hospital emergency rooms for their deliveries as hospital admittance staff will not refuse treatment of the financially needy.[1] The Center's policy was unfavorably received by the medical community and, consequently, was gradually discontinued. Prenatal care is no longer provided at the Center.

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[1] Pat Petit, co-director of Birthright, emphasized that emergency room deliveries may not be a wise alternative for a high-risk pregnancy. Research suggests that there is an added risk in terms of increased maternal-child morbidity and mortality rates in emergency room deliveries.

According to the staff at Birthright, prenatal care and delivery costs currently range between $800 and $1,000 for physician's fees and between $1,500 and $2,000 for hospital costs. Obstetricians in the Anchorage area require payment in advance for prenatal care; the cost for the first visit ranges from $100 to $200 with subsequent visits carrying a lesser fee. Agency representatives have noted that the payment provisions of the medical community preclude many pregnant women from seeking prenatal treatment. Staff at Birthright noted that there are a large number of women, who while unable to qualify for Medicaid and General Relief Medical programs, cannot afford the costs of obstetrical care.

Medicaid and General Relief Medical assistance present an added difficulty for many pregnant women. According to Duane Peebles of the State Department of Health and Social Services, some members of the medical community are unwilling to accept public assistance patients because of delays in reimbursement for services and insufficient compensation for the true costs of providing treatments. According to Jo Brosamer, only one obstetrician in the Anchorage area routinely accepts Medicaid or Medical patients; two obstetricians occasionally admit public assistance clients; the remaining members of the obstetrical community rarely accept such patients, and when so doing, some physicians often treat their assistance as donated services rather than seek reimbursement from public assistance programs.

Postnatal Service Needs

Our research indicates that several postnatal service needs are currently unmet. Ms. Norma Jean Elgas of the Anchorage Women's Resource Center has noted that although pregnant women and their families have a number of alternatives for counseling and support services before childbirth, there are no regularly available resources for these women's postnatal needs. As an example, Ms. Elgas cited the absence of counselling services in parenting skills. Adolescent-aged parents often lack the maturity and experience to understand the responsibilities inherent in childbirth. To illustrate, Susan Harding, co-director of the Addison County Parent/Child Center in Vermont, spoke of a young couple in her program who left their five-month old baby in his highchair all day. The couple considered themselves to be exemplary parents, not recognizing that by depriving him of the opportunity to lie on his back and stomach, they were creating the potential for permanent developmental disabilities. Ms. Harding has found that parenting problems in general do not begin to surface until the newness and excitement of a new baby have subsided. As a result, Ms. Harding's program offers classes and support groups in parenting to couples and single parents until their children are 3 years of age. She believes that the front-end costs of this service will result in a proportionately larger cost-savings in the

long term by diminishing the need for educational programs and social services at a later time.

An additional area of postnatal services which appears to be lacking is in employment placement and vocational training. According to Birthright staff, the majority of their clients lack the vocational skills and job histories which would make them employable. Professionals regard employment training to be an important area so that women without financial resources may become economically capable of caring for themselves and their children without requiring further public assistance.

Inadequate Public Assistance

Under current law, socially and economically deprived pregnant women are entitled to medical assistance when they meet eligibility criteria established under the State's Aid to Families with Dependent Children and General Relief programs. Eligibility is determined, in part, by assessing the amount of income and financial resources available to a woman in her home. Consequently, if a woman is living with a non-needy parent or relative, she may be denied eligibility because of the parent's or relative's perceived abilities to pay for her care. Some professionals noted to us that pregnancy-related costs are often regarded as a special category of expenditure frequently not included in a family's personal budget or health insurance plan. Some individuals believe that this occasionally results in women moving out of their family homes in order to gain eligibility for State-provided medical care. This aspect of the public assistance program is viewed by some professionals as a disincentive for family solidarity that can create additional stress for the pregnant woman.

AFDC once provided cash assistance to eligible pregnant women, but this was discontinued several years ago. Under current law, some pregnant women are entitled to financial assistance under the State's General Relief program's regular guidelines. However, some individuals we contacted regard this source of financial assistance to be insufficient, noting that pregnant women generally encounter significant increases in their cost-of-living due to added needs precipitated by their condition. An article in a December 18, 1980 issue of the New York Times addressed the "rising costs of having a baby" and cited examples of special needs affected by inflationary costs, including: maternity clothing, transportation services and fuel, infant accessories, and food to satisfy the increased nutritional needs of a woman and her child. According to Anchorage agency representatives, women experiencing problem pregnancies would be greatly assisted by the expanded availability of financial assistance programs.

POTENTIAL OPTIONS FOR THE STATE IN PROVIDING SERVICES

Our research has indicated that pregnancy programs outside Alaska traditionally have been offered primarily by federal and private non-profit organizations. In turn, funds for these programs generally appear to come from private donations and from federal, rather than state, sources. Dr. Sharon Alexander of the National Association of State Boards of Education has noted the absence of State policy regarding the service needs of women with problem pregnancies, attributing it in part to the inherent problems that limit a state's effectiveness in providing a comprehensive program of services. As examples of these deficiencies, she cited the absence of systematic data collection regarding this target population, impairing a state's abilities to identify service needs and to develop policy. Dr. Alexander also noted that categorical funding aimed directly at problem pregnancy services is rare. An article in Children Today elaborates:

> Frequently, state agencies have not developed policies in this area because the target population has been subsumed in other programs which already have policies in place. Often, too, the staff members responsible for this issue are far removed from the agency's policymaking level which diminishes the potential for change in agency policies.[2]

In the course of our research, we learned of no states that have assumed an active role in the development and implementation of comprehensive services for categorically designated problem pregnancy clients. As a result, if policymakers are to consider various means for the State of Alaska to expand its service capabilities in this area, it appears that they cannot look to other states for direction. Nonetheless, as a result of our conversations with agency representatives located both inside and outside the state, we were able to identify some program concepts that could be developed within Alaska in order to fill current gaps in service.

Prematernal Home/Birth Center

As a response to the combined problems of insufficient emergency housing and inaccessibility of medical care, the State could explore the feasibility of establishing a prematernal home and birth center

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[2] Carlos Salguero, "Adolescent Pregnancy: A Report on ACYF-Funded Research and Demonstration Projects," Children Today, November-December 1980, p. 35.

facility. This type of structure could be established for the purpose of providing low-cost housing and medical care to eligible women. However, the facility could also be made available to other women on a fee basis if it was determined that a larger population group could benefit from the availability of a center.

Such a facility could be free-standing, unaffiliated with an existing hospital or social services organization; or it could be appended to an existing program. According to Lt. Ragan of Booth Home in Anchorage, several prematernal homes and birth centers have been effectively established by other Booth Memorial Homes in the United States (for example in Portland, Oregon).

Beyond its essential provision of shelter, the prematernal home is an effective means of offering a built-in support group for pregnant women who often share common problems. Additionally, a prematernal home is a useful means of providing educational programs in nutrition, parenting skills, and other prenatal instruction.

The design of the facility would depend on the functions and the population it was serving. It might serve a statewide, regional or local population.

Parent/Child Program

A State-supported comprehensive program in parenting could also be developed. Although each child is born with his own potential for physical, social, and cognitive development, research suggests that a child's chances for reaching his maximum potential may be strongly linked to his early childhood environment and the parent-child relationship that he experiences during childhood.

Family Focus, Inc., a private non-profit organization in Chicago, was established in 1976 to demonstrate the effectiveness of providing community-based support services to expectant parents and to parents of young children. The organization has established a number of parent/child centers within Illinois, each of which is designed to fill a gap in services for families. Programs maintain a low operational budget by relying heavily on existing community services and the use of trained volunteers for program staffing. Additionally, Family Focus programs utilize parents who are participating in the program for assistance in fund-raising, program planning, and special projects. This also provides opportunities for the parents to develop and exercise leadership skills.

One Family Focus program, called "Our Place," is geared toward teenage parents and pregnant adolescents. Located in Evanston, Illinois, Our Place is a drop-in center that provides comprehensive social,

medical, educational, and vocational services to the community's adolescent population. The center offers a childcare program as well as recreation, fellowship, and education in responsible parenting.

Grants and Loans Program to Private Non-Profit Organizations

In 1978, the federal Office of Adolescent Pregnancy Programs was established under the Health Services and Centers Amendments of 1978 (P.L.95-626). Title VI of the legislation provided for funds to be granted to public and private non-profit agencies to assist in establishing networks of community-based services for "adolescents at risk of unintended pregnancies, pregnancies, pregnant teenagers and adolescent parents." Under the provisions of the legislation, grantees were required to provide certain basic services, including: pregnancy testing, maternity counseling, prenatal and postnatal health care, pediatric care, family planning services, referral to appropriate educational or vocational training programs, and adoption counseling and referral services. Federal staff anticipate that if the Office is refunded it will include additional program emphasis in family support services and alternatives to abortion.

Conceivably, if State policymakers determined the concept to be feasible, the State of Alaska could develop a similar program within the Executive Branch. This type of program could make financial resources available to private, nonprofit organizations within the state that are currently providing services to clients.[3]

Expanded Maternal/Child Health Programs

Under Title V of the Social Security Act, the State of Alaska receives two Maternal and Child Health grants through the federal Health Services Administration: The Improved Pregnancy Outcome Program and the Maternal and Infant Care Program. The Improved Pregnancy Outcome Program includes a statewide program for the development of early prenatal educational curricula and, on a local basis, a pilot program in Fairbanks for social educational, and medical assistance for pregnant women. Through the Fairbanks-based program, women may receive:

- counseling and care referral services;
- prenatal education; and
- medical care assistance.

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[3] Legal research may be required to determine if there are any State limitations on providing financial assistance to nonprofit organizations having a religious affiliation.

Medical assistance is provided to clients based on a sliding scale determined by family size and income. Coverage is extended as a payment of last-resort after all other sources of third-party coverage have been exhausted. Duane Peebles of the State Department of Health and Social Services commented that the program generally seems to pick up those women whose incomes are slightly above the Medicaid eligibility requirements.

The second Maternal and Child Health grant program in the State is located in Juneau. The Maternal and Infant Care Project is similar to the Fairbanks-based program with one notable exception. The Juneau program provides medical assistance for women for labor and delivery costs while the Fairbanks program, due to federal regulatory restrictions, is unable to offer compensation for inpatient services.

Although services under these programs may be extended to all pregnant clients, the program is primarily designed for women with medical/social risks. Consequently, while any woman may receive screening services, financial assistance is based upon factors such as age and income.

State policymakers might consider assuming financial responsibility for these programs and expanding their service outreach capabilities to communities other than Fairbanks and Juneau. According to Duane Peebles, funding for the Improved Pregnancy Outcome Project is scheduled to lapse September 30, 1982. In light of the Reagan administration's budget proposals and block grant approach, the prospects for continued funding of the project's $400,000 annual budget are somewhat uncertain.

Paternity Outreach Programs

In single parent settings, the responsibilities of child rearing can become very demanding. Pressures often are compounded when the parent is an adolescent, unwed mother. In an effort to alleviate the responsibilities borne by a single parent and to create a more natural setting for the child, some State and local governments are emphasizing program development to promote the participation of the other parent financially and socially.

An example of such a program is the Memphis Paternity Outreach Project in Tennessee. The purpose of the program is to enable the children of unmarried mothers to be legitimized and thereby eligible for support benefits. Through the program, a representative of the juvenile court visits every hospitalized, unmarried mother after the birth of her child, at which time the representative explains the process required to establish a legal relationship between the father and the child. A mother who decides to accept the paternity service signs an application and the process is handled in the same manner as other paternity cases.

Since the program's inception in August 1979, program representatives estimate that about 75 percent of the paternity cases where the father can be located, result in an agreement without reluctance on the part of the father to establish a parental relationship with his child. As a result of the program, it is possible for support to begin in some instances shortly after the mother and child are released from the hoospital.

Expanded Educational and Vocational Training Programs

Many couples and single parents are apprehensive about carrying a pregnancy to term because of the economic hardships which may be experienced after the child is born. Generally, this apprehension exists because of the deficient educational and vocational background of the parent which seriously limits the prospects for employability and self-sufficiency. Because of this, many professionals believe that state pregnancy assistance programs must include educational and vocational training programs for couples encountering problem pregnancies.

The Addison County Parent/Child Center in Vermont places extensive emphasis on the long-range vocational needs of its clients. Over 65 percent of the Center's participants return to school or seek educational or vocational training after the delivery of their children. According to Susan Harding, co-director of the Center, the program attributes part of its effectiveness to the individualized nature of the services established for the women as well as the program's tight coordination and utilization of existing services. Much emphasis is also placed on preliminary skills development; e.g., if poor reading skills are inhibiting a client's ability to develop office skills, volunteers are assigned to the woman to tutor her in her reading. Additionally, staff at the Addison County Center try to tailor job development to new parenting roles.

An example of an educational program designed for pregnant adolescents is the Family Learning Center, which was established in New Brunswick, New Jersey in 1969 to counter a significant pregnancy-related drop-out rate in the public schools. The program is provided in a separate building from the public school and is offered to any pregnant adolescent woman.[4] The program offers a comprehensive educational and health program that stresses nutrition, weekly physical check-ups, frequent consultation with guidance counselors, teachers, as well as the attending physician and clincial staff, and on-going counseling

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[4] Women have the option of attending the Family Learning Center of remaining in the regular public school programs.

and participation in support groups. Beyond the regular academic schedule, each student receives instruction in family life education, maternal and child health, and physical education.

CONCLUSION

The information presented in this memorandum is intended to represent only a sampling of program ideas and concepts which could be explored at the State level to ease the social and economic problems that may accompany pregnancy. A number of related services such as expanded adoption services and additional education programs, have not been addressed in our research but could, of course, alleviate some of the problems associated with unwanted pregnancies.

****

We hope this information has assisted you. Please let us know if we can provide you with additional research on this subject. We will be transmitting a second memorandum to you shortly on State expenditures for abortion-related services.

BB/bf

MEMORANDUM State of Alaska

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

Thur: Harry Treager, Director
Occupational Licensing

From: WILSON L. CONDON
ATTORNEY GENERAL

By:

Sarah T. Kavasharov
Assistant Attorney General

DATE: February 6, 1981

FILE NO: J-66-298-81

TELEPHONE NO: 465-3690

SUBJECT: Medical Board Inquiries Re Lay Midwives

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

CSSB 747

page 1. lines 28-29

Delete: (b)

page 2, line 9

three members shall be licensed under this chapter or eligible to receive licensure under AS 08.69.050 (1) - (3), one of which will be a certified nurse midwife.

delete following sentence to line 13

line 14: One person shall be a person with no financial interest in a health care facility. delete the rest of the sentence.

page 2, line 21: change his to their (SEXUAL PRONOUNS)

page 8, line 14

Insert: (4) ensure that each infant is screened in accordance with AS 18.15.200

page 8, line 13:

We need a clause in (3) which states that the consulting physician is not liable for the treatment of the midwife.

page 9, line 7

(3) "sponsor" means a physician licensed to practice in the state or exempted from licensure under AS , or a midwife licensed to practice in the state and authorized to act as sponsor by the board.

AS 08.64.370 (1)

soldotna — 4 ✓

dillingham 4 ✓

fairbanks 1 ✓

homer 6 ✓

mat-su 6.

Saal Boyer - bill should provide access to lab tests

Hall - need back-up. Midwife spends more time w/ mother than drs. Enough trained midwives to teach? More infections in hosp.

Schrage - scope is scope of nurse-midwife. Take more time to train lay under bill than for nurse to get trained as midwife.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Outcomes of Elective Home Births: A Series of 1,146 Cases*

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Institute for Childbirth and Family Research
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Medical records of 1,146 elective home births from five home delivery services in northern California were reviewed. Three of the services consisted of family physicians and nurses, whereas two consisted of lay midwives without immediate physician supervision. Rates of medical complications in both groups were low. Perinatal morbidity and mortality were lower than California averages. Fifteen premature infants (1.3%) were delivered successfully. Apgar scores were high. Four infants (0.3%) were neurologically abnormal at follow-up. The perinatal mortality rate was 9.5 per 1,000 total births. There were no maternal deaths.

These figures demonstrate that in a self-selected, medically screened, low-risk population, home delivery with medical facility back-up can be a reasonable alternative to hospital delievery. Possible reasons for the good results obtained are cited.

Key words: Home birth, midwife, family physicians, perinatal mortali[illegible], infant morbidity.

INTRODUCTION

A steady increase has been noted in recent years in the incidence of home delivery in certain California counties and presumably in other areas of the country as well. For the past five years, registered out-of-hospital births in California have increased steadily, at the rate of 0.1% a year.[11] This rise has been decried by some members of the medical community while supported by others. Many highly emotional statements have been made by both sides without data to support either position. This study is an attempt to provide such data on 1,146 planned home deliveries conducted by five home delivery services in northern California. One similar study has been published to date—that of Hazell,[6] which was a sociodemographic study and did not emphasize medical outcomes.

METHODS

Sources of Data

Medical charts from five home delivery services in northern California were reviewed. The five services included three physician groups: (1) a rural-based family practice in western Marin County (Point Reyes Station) composed of three family physicians and three registered nurses, performing both home and hospital deliveries since 1970 as part of a comprehensive family practice; (2) an urban-based (Mill Valley) family practice of two physicians and two registered nurses—one a maternity nurse practitioner—in practice since 1973; and (3) an urban-based (Berkeley) group consisting of one physician (whose training had been in pediatrics/neonatology) and two registered nurses, affiliated with a woman's health cooperative in Berkeley. This last group did not have hospital privileges and performed only home deliveries, referring women requiring hospital care to local obstetricians; they had been functioning since early 1974. The lay midwife groups consisted of (1) 10 lay midwives from Santa Cruz County, functioning in both urban and rural settings without immediate medical supervision and with limited medical backup, performing births since 1971, and (2) a rural lay midwife from Sonoma County, California, with good physician back-up, performing

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births since 1970. (In the latter service, records had been kept only for the last 171 of her estimated 500 deliveries during a five-year time span.)

All records until April 1975 were reviewed by one of us (L.E.M.). They were adequately detailed regarding prenatal care, intrapartum and postpartum events and infant and maternal follow-up. The groups represented the following percentages of the total sample: (1) the Point Reyes physician group, 40.4%; (2) the Mill Valley physician group, 11.2%; (3) the Berkeley physician group, 7.6%; (4) the Santa Cruz County midwives group, 30.8%; (5) the Sonoma County midwife, 10.0%.

The lay midwife from Sonoma County began her midwifery activities accidentally, while visiting a friend in labor. Others learned she had attended a birth and asked her to be at their deliveries until she eventually developed a reputation as a midwife. Her training was self acquired through reading and experience. The Santa Cruz midwives began functioning in much the same fashion, becoming midwives to meet an experienced need in the community and educating themselves through discussion groups, experience and reading. Their average fee per birth was $35.00, so their motivation was clearly not monetary. Typically, they were women who had had an unattended home delivery and had decided to help other women avoid this predicament.

The Sonoma County midwife had good medical back-up through physicians (mainly family practice residents) at the Community Hospital of Santa Rosa, who, although unwilling to attend home deliveries, were willing to discuss problems over the telephone and handle complicated deliveries in the hospital. The Santa Cruz group had poor medical back-up and was not able to obtain telephone consultation. They were often criticized heavily and condemned when bringing women who needed hospital care to the hospital and few supportive physicians to whom they could refer women with complications. Laboring women in the Sonoma area were occasionally as far as one hour from a hospital, although the usual distance was approximately 15 minutes. Laboring women in the Santa Cruz area were occasionally as far as 45 minutes from a hospital but usually ranged from 5 to 15 minutes.

Transport facilities for both lay midwife groups consisted of the midwife's car without any specialized support equipment. Equipment present at deliveries with the lay midwives was also minimal and typically consisted of a bulb syringe, sterile guaze, sterile gloves, a fetoscope, blood pressure cuff, urine dipsticks for testing for acetones, glucose and protein, a portable scale and little else. Their mode of operation has been described by Lang.[9]

The physician services brought a home delivery kit with them to births. Typically the nurse would attend the labor from its inception, and the physician would arrive during the second stage for primigravidae and first stage for multigravidae. The physician kit included IV equipment, oxytocin and methergine for use after delivery, other emergency drugs and forceps to use if necessary as well as suture supplies. (However, there was no intravenous oxytocin or forceps used at home in this series.) The only equipment or drugs not present in their kit and usually present in the hospital was whole blood. (A complete list of supplies is available on request.) The transport vehicle for the physician groups was also the car belonging to the birth attendant. For the Point Reyes group, the closest hospital was 20 miles. For the Berkeley and Mill Valley groups, the distance from a hospital was usually 5 to 10 minutes.

Prenatal care was essentially the same for all groups and did not deviate from the standards recommended by the American College of Obstetricians and Gynecologists with regard to frequency of visits, laboratory tests and clinical assessment. The lay midwife groups required a minimum of two visits to a physician, at which times clinical pelvimetry, Rh status, blood type, rubella titer, hemoglobin, hematocrit, VDRL and gonorrhea culture were determined. Nutrition, the avoidance of prenatal medication and the psychosocial aspects of pregnancy were stressed more than is typically done in prenatal care, and visits usually lasted 20 to 30 minutes for the physician groups, involving discussions with the nurse and then the doctor. For the lay midwife group, the visits were typically 30 to 60 minutes. Three women had no prenatal care and first presented themselves in labor.

There was no limiting of weight gain. It was felt that every woman should gain at least 20 to 30 pounds during pregnancy, and the average weight gain was in the 30- to 35-pound range. Women with chronic medical disease were encouraged to seek a hospital birth, as were women who remained anemic. The threat of a hospital birth usually increased patients' willingness to use iron-containing preparations, and, as a result, the number of women with hemoglobins

of less than 11.0 gm% giving birth at home was minimal (less than 1%).

Intrapartum care was essentially similar among the groups. The lay midwife groups did not perform breech or twin deliveries at home. The physician groups did so on occasion, but only after explaining the problems inherent in such deliveries. After 1973, the usual policy was to recommend cesarean section to women with low breech scores (Zatuchni-Andros breech score) and to attend women with breech scores indicating safe vaginal delivery at home if the women so desired and requested. (Since the completion of this study, the lay midwives have begun attending some breech deliveries at home because of parents' dissatisfaction with the rising incidence of cesarean sections in breech presentation.)

Labor prolongation, of itself, was not treated as a complication requiring hospitalization. Uterine inertia was often treated initially with buccal oxytocin by the physician group at home, and if results were not forthcoming, the woman was transported to the hospital for IV oxytocin. Prolongation of the second stage of labor also was not treated as a complication; indeed, most of the practitioners felt that a slower second stage with little pushing by the mother (often extending two to three hours) was preferable to a shorter second stage (less than two hours) characterized by an intense pushing effort by the mother. Patients with second stage *arrest*, however, if not responsive to buccal ocytocin over a one- to two-hour period, were transported to the hospital for forceps delivery. The midwives were unable to administer oxytocin and consequently sent more of their patients to the hospital for dystocia.

Both groups monitored the fetal heart rate closely throughout the first and second stage, using a fetal stethoscope or Doppler ultrasound fetoscope, and felt that any significant drop in heart rate requiring intervention would be noticed. Blood pressures were checked approximately every one to two hours during labor. Fetal heart tones were checked as often as after every contraction during second stage if some variability had been noted or if the mother was pushing particularly hard but usually were checked every 15 minutes during second stage and every 25 to 40 minutes during first stage, depending on the character of the labor and the fetal heart rate pattern. The fetal heart was occasionally listened to through a contraction and for some time afterwards to determine the presence of any abnormal patterns.

Meconium staining without fetal heart rate irregularities was not treated. (Meconium staining *with* fetal heart rate irregularities was cause for hospitalization, and the infants, with one exception, were treated with intubation and lavage.) Prolonged rupture of membranes in a term-sized infant was followed but not treated unless necessary. It was felt that if the mother did not show signs of amnionitis and had a good socioeconomic and nutritional background, intervention was not necessary within 24 hours. If labor had not begun by 24 hours, induction was usually undertaken in the hospital.

The midwives practiced perineal massage to prevent tearing, but the physicians typically did not. This was optimally done by the mother and father for the month prior to delivery and was done by the midwife during the last half of the second stage. It was not done consistenly by all parents and midwives, but the midwives felt it helped prevent lacerations during delivery.

Forceps deliveries were not conducted at home, and no analgesia or anesthesia was administered at home. If the latter was desired, hospital transport was necessary for the woman to receive it.

The room in which the delivery occured was kept warm, and the baby was given to the mother immediately after delivery to hold and nurse, with blankets placed around the infant to prevent heat loss. The umbilical cord was not clamped until it ceased pulsating except in Rh negative mothers, in whom it was clamped immediately after delivery. RhoGam was given to the Rh negative mothers within 48 hours. Silver nitrate was not applied routinely to the infants' eyes unless there had been a history of gonorrhea or one or both parents were unsure about the other. Most of the infants were fed only by the breast, without glucose or formula supplementation, and were fed ad lib.

Home visits were usually made each day for the first three postpartum days, and telephone contact was maintained with the couple. The infants were seen by the physicians at one week in their offices and again at four weeks. After that point, the recommendations for well child care of the American Academy of Pediatrics were observed. Midwives referred infants for newborn care to pediatricians or family physicians after the first week and continued to follow the infants themselves for various periods of time. All mothers had an examination from four to six weeks postpartum by a physician; results of

the examination were entered in the lay midwives' records.

Study Population

Hazell[6,7] has described the demographic characteristics of the home birth population in the San Francisco Bay Area in a study of 300 home deliveries from the socioanthropological standpoint. Her subjects overlapped to some extent with our sample and were derived from the same subject pool—San Francisco Bay Area couples planning home delivery. According to her study, 90% lived in typical American fashion, with the father gainfully employed and in a single family dwelling with one or two cars; they were not members of an ethnic minority, not on welfare and had no household servants. A general characteristic of the group was described as self-awareness, shown in a concern for nutrition, health food, ecology, humanistic psychology and a strong feeling for a natural birth process. Typically, the mother and father had both attended college, but neither had graduated. The fathers' occupations were noted to vary through the range of occupations present in the Bay Area—from auto mechanic to physician to homesteader. Only one-tenth were classified as "hip," in rebellion to "normal American values" and living in a variety of alternative styles.

In our study, patients of the lay midwives tended to belong more to the counter culture than did Hazell's population. In the physician groups, more professional couples were included. A detailed socioeconomic study on one of the lay midwife groups (the Sonoma County sample) is currently being coordinated by one of us (W.E.H.), and a psychological/developmental outcome study on a subsample of the Santa Cruz group is being analyzed by two of us (L.E.M. and G.H.P.).

Table I presents statistics on the selection of the study population. Only 4% of those women who requested a home delivery were screened out for medical reasons (including premature labor, [on some services] toxemia and underlying systemic disease). This low percentage would seem to indicate that women seeking home deliveries are a self-selected healthy group, probably knowledgeable about childbirth and the importance of nutrition in pregnancy. Nine women with previous fetal deaths were included in the home birth sample. Previous obstetric complications (with the exception of cesarean section) were not used as screening criteria because it was felt that they were iatrogenic to some extent.

TABLE I

HOME DELIVERY STUDY POPULATION

	Number	Percent
Contacted home delivery service	1,348	100.0
Screened out, medical dx	55	4.1
Decided against	147	10.9
Attempted home delivery	1,146	85.0
Taken to hospital	136	10.1
Completed home delivery	1,010	74.9
Attemped home delivery	1,146	100.0
Physicians	685	59.8
Midwives	461	40.2
Taken to hospital	136	11.9
Physicians	58*	5.1
Midwives	78*	6.8

*Patients hospitalized represented 8.5% of physicians' cases, 16.9% of midwives' cases.

Eleven percent of the women who considered home delivery decided against it for nonmedical reasons. This number was highest in the lay midwife groups and may have been related to a hesitation about giving birth without physician back-up. In the physician-directed services, a common reason cited for switching to a hospital birth was that Medicaid would cover only hospital deliveries.

TABLE II

CHARACTERISTICS OF MOTHERS

	Number	Percent	California 1973
Mother's age	1,146	100.0	100.0
<20	60	5.2	17.3
20-34	1,068	93.2	77.6
≥35	18	1.6	5.1
Parity	1,146	100.0	100.0
0	729	63.6	43.3
1	237	20.7	31.0
2	128	11.2	13.3
3	34	3.0	6.0
≥4	18	1.6	6.3
Prenatal care began	1,146	100.0	100.0
1st trimester	707	61.7	72.8
2nd trimester	362	31.6	20.2
3rd trimester	74	6.5	4.5
None	3	0.3	2.4*

*Includes prenatal care unknown.

TABLE III

CHARACTERISTICS OF PRESENTATION AND DELIVERY

	Number	Percent
Presentation	1,146	100.0
Vertex	1,125	98.2
Brow	[illegible]	(0.3)
Shoulder	(3)	(0.3)
Breech	21	1.8
Delivery	1,146	100.0
Cesarean	28	2.4
Vaginal	1,118	97.6
Analgesia, only	(14)	(1.2)
Anesthesia, only	(3)	(0.3)
Both	(6)	(0.5)
None	(1,095)	(95.5)
Oxytocin		
1st and 2nd stage labor	85	7.4
3rd stage labor	235	20.5
Low forceps	11	1.0
Mid forceps	6	0.5
Lacerations requiring repair	148	12.9
Episiotomies	89	7.8

Of the 1,146 women beginning labor at home with the intention of delivering there, 136 (11.9%) were sent to the hospital to complete their delivery for treatment of intrapartum (11%) or postpartum (0.9%) problems. Eighty-eight percent of the deliveries begun at home were completed there. Thus, of the initial set of women contacting the home delivery services, 75% successfully gave birth at home.

Four surviving infants required hospitalization for other than phototherapy within three days of delivery; a fifth was born very prematurely in the hospit[illegible] and remained there for one month.

Table II presents characteristics of the mothers and compares them to California statistics for 1973.[11] Over 90% were in the optimal childbearing age of 20 to 23 years, and the average was 24.9 years. There was a high number ([illegible]%) of primigravidae in this series and an incidence of grand multiparity of less than 1%. Virtually all the women were trained in childbirth classes such as Bradley or Lamaze. All women except one attempted breast feeding; for a variety of reasons, eight women were not successful.

RESULTS

Delivery: Home Sample

Statistics on the presentations and deliveries are given in Table III. Most of the deliveries were normal vertex presentations. Of the 21 women with breech presentations, 10 were delivered successfully by choice at home, and 11 were taken to the hospital. The last were all unexpected and with lay midwives.

One percent of the women studied had low forceps deliveries, 0.5% had midforceps deliveries and 2.4% were delivered by primary cesarean section. (The California cesarean section rate was 9.9% in 1973.[11] If, as the Mayo Clinic[1] found, half of the cesarean sections are repeats, then California's primary section rate would approximate 5%, or double the rate in this study.) The indications given for forceps and cesarean deliveries are listed in Table IV.

TABLE IV

INDICATIONS FOR C-SECTIONS AND FORCEPS DELIVERIES IN WOMEN BEGINNING LABOR AT HOME

	Number
Low forceps delivery	
Protracted descent	6
Arrest of descent	2
Dysfunctional labor	1
Brow presentation with arrest of descent	1
Fetal heart drop	1
	11
Mid forceps delivery	
Protracted descent	3
Arrest of descent	1
Dysfunctional labor	1
Fetal heart drop, occiput posterior presentation	1
C-sections	
Cephalopelvic disproportion	16
Failure to descend, occiput posterior presentation, relative CPD	6
Arrest of active phase dilation, fetal heart drop, cord 4× neck	1
Prolapsed cord	1
Breech with amnionitis	1
Psychotic reaction to labor	1
Acutely dropping fetal heart tones	1
Toxemia	1
	28

Lacerations requiring repair were lowest (4.4% and 5.7%) in the lay midwife groups and highest (40.2%) in the physician group with the shortest experience in performing home deliveries without episiotomies. Similarly, episiotomies were lower for the lay midwife groups than for the physician groups.

Analgesia and or anesthesia were used in only 2% of the vaginal deliveries. During the first and second stages of labor, 38 women (3.3%) received buccal oxytocin at home, whereas 47 women (4.1%) received IV oxytocin in the hospital. During the third stage of labor, 146 mothers had oxytocin at home and 89 in the hospital. Mean length of first stage was 10.2 hours for primigravidae and 4.6 hours for multigravidae; second stage means were 118 and 45 minutes, respectively.

Complications of labor and delivery of the home birth group are shown in Table V (individual women may be listed under more than one complication). Interestingly, the total percentages of complications were comparable for primigravidae and multigravidae (18%). The majority of the intrapartum problems involved first stage dystocia. However, the total incidence of protracted labor in this series is noticeably low when compared to that in the literature,[8] as are meconium staining and fetal heart irregularities.[3,8] There was no maternal hypotension prior to or during delivery.

The lay midwives took significantly more of their patients (16.9%) to the hospital than did the physician groups (8.5%). The former took more women to the hospital for induction for prolonged rupture of membranes, uterine inertia during the first stage of

TABLE V

COMPLICATIONS OF LABOR AND DELIVERY

(Individual women may be listed under more than one complication)

Primigravidae (N = 136/729 = 18.6%)				
Complication	Home	Hospital	Total	Percent*
Intrapartum				
Dystocia† 1st stage	27	34	61	8.4
Dystocia 2nd stage	10	14	24	3.3
CPD	0	23	23	3.2
Meconium stain, only	24	3	27	3.7
FHT ↓ (c, s meconium)	6	13	19	2.6
Hypertension	3	6	9	1.2
Hypertension	3	6	9	1.2
Brow presentation	1	2	3	0.4
Shoulder dystocia	1	1	2	0.3
Polyhydramnios	0	2	2	0.3
Other*	1	10	11	1.5
Total	73	108	181	
Postpartum				
Hemorrhage‡	1	3	4	0.5
Excessive PP bleed‡	11	7	18	2.5
Retained placenta	10	4	14	1.9
Endometritis	9	2	11	1.5
PP depression	0	4	4	0.5
Total	31	20	51	

*Single cases of oligohydramnios, amnionitis, toxemia, prolapsed cord, thrombophlebitis, placenta previa, abruptio placentae, dehydration, urinary tract infection, 2nd trimester bleed, precipitous labor.

Multigravidae (N = 78/417 = 18.7%)				
Complication	Home	Hospital	Total	Percent*
Intrapartum				
Dystocia 1st stage	2	12	14	3.4
Dystocia 2nd stage	4	9	13	3.1
Meconium stain, only	11	1	12	2.9
FHT ↓ (c, s meconium)	3	4	7	1.7
Precipitous labor	7	0	7	1.7
Other*	1	2	3	0.7
Total	28	28	56	
Postpartum				
Hemorrhage	4	1	5	1.2
Excessive PP bleed	9	4	13	3.1
Retained placenta	4	4	8	1.9
Endometritis	3	1	4	1.0
PP depression	0	1	1	0.2
Total	20	11	31	

*Single cases of CPD, shoulder dystocia, oligohydramnios.

*Percent complications per 729 primigravidae, 417 multigravidae.

†Dystocia as used in this table is defined as: prolonged or arrested 1st stage, failure to dilate; prolonged or arrested 2nd stage, failure to descend (as per Greenhill and Friedman[9]).

‡Hemorrhage is defined as more than 650 ml; excessive bleeding as "more than normal," including third-day postpartum bleeding.

TABLE VI

COMPLICATIONS OF LABOR AND DELIVERY

(Individual women may be listed under more than one complication)

Physicians (N = 134/685 = 19.6%)			Midwives (N = 80/461 = 17.4%)		
Complication	Number	Percent*	Complication	Number	Percent*
Intrapartum			Intrapartum		
Dystocia† 1st stage	47	6.9	Dystocia 1st stage	28	6.1
Dystocia 2nd stage	24	3.5	Dystocia 2nd stage	13	2.8
DPD	14	2.0	CPD	10	2.2
Meconium stain, only	28	4.1	Meconium stain, only	11	2.4
FHT ↓ (c, s meconium)	16	2.3	FHT ↓ (c, s meconium)	10	2.2
Hypertension	7	1.0	Hypertension	2	0.4
Brow presentation	2	0.3	Brow presentation	1	0.2
Shoulder dystocia	1	0.1	Shoulder dystocia	2	0.4
Polyhydramnios	1	0.1	Polyhydramnios	1	0.2
Oligohydramnios	1	0.1	Oligohydramnios	1	0.2
Precipitous labor	8	1.2	Precipitous labor	0	0.2
Other*	6	0.9	Other*	0	—
Total	155		Total	82	
Postpartum			Postpartum		
Hemorrhage†	5	0.7	Hemorrhage	4	0.9
Excessive bleeding†	19	2.8	Excessive bleeding	12	2.6
Retained placenta	15	2.2	Retained placenta	7	1.5
Endometritis	10	1.5	Endometritis	5	1.1
Depression	3	0.4	Depression	2	0.4
Total	52		Total	30	

*Single cases of amnionitis, placenta previa, abrupto placenta, dehydration, urinary tract infection, 2nd trimester bleeding.

†Percent complication for 685 MDs' patients, 465 midwives' patients. See Table V.

*Single cases of toxemia, prolapsed cord, thrombophlebitis.

labor, fear of completing the delivery at home, falling fetal heart rate, manual removal of placenta and treatment of postpartum hemorrhage. The physician groups used significantly more oxytocin after delivery of the placenta than did the midwives and reported more precipitous deliveries. Complications by midwives' and physicians' groups are shown in Table VI.

There were no maternal deaths.

Perinatal Outcome

Six sets of twins were delivered successfully at home, bringing the total number of births to 1,152.

Fifteen infants, including two sets of twins, weighed less than 2,501 grams at birth (1.3%). Most of them (11) were 2,250 grams and over. Fourteen of the low birthweight infants were born at home. One (1,332 grams) was born in the hospital after second trimester bleeding and remained there for a month. Two of the smaller babies (1,729 and 2,154 grams) were admitted to the hospital with mild respiratory distress syndrome.

As noted earlier, some mothers were medically screened out of the home delivery group because of premature labor. There were 20 such patients. If they are included, the total premature rate becomes 3.0%. (California's premature rate in 1973 for white women 20 to 29 was 5.3%.) All the low birthweight babies survived without other postnatal complications other than those mentioned above.

The average Apgar scores were high—8.9 and 9.7 at one and five minutes—and were usually assessed by a nurse or lay midwife who did not deliver the infant. Though the scores may be in-

TABLE VII

INFANT MORBIDITY

Condition	Number	Rate per 1,000 lb	Delivery	Complications	Outcome
Congenital defects	6	5.2			
PDA			Home	None	Repaired surgically at one year
Coarctation of aorta			Home	None	Repaired surgically at two years
Omphalocele			Home	None	Repaired surgically at 15 hours
Myelomeningocele, thoracic			Home	None	Mental and motor retardation at 18 months
Multiple minor anomalies			Hospital	HHT ↓, c-s	No mental or motor retardation at one year
Down's syndrome			Home	Meconium	Mental retardation
Cerebral palsy	2	1.7	Home	Meconium + + + FHT ↓	Motor retardation
			Home	None	Mild spastic with slow verbal development
Surgical conditions	2	1.7	Home	None	Pyloric stenosis repaired at five and eight days
Low birthweight	15	13.1	Hospital	2nd Tri Bleed	1,332 g, in hospital one month, no problem
			Home	None	1,729 g, in hospital two weeks, mild RDS
			Home	Breech	2,154 g, in hospital 12 days, mild RDS
		Others:	Home	None	No problems

flated, they probably are no more so than in the hospital, where the physician delivering the infant assesses the Apgar. Forty infants (3.5%) born both at home and in the hospital had one-minute Apgar scores of 4 to 6, and seven infants (0.6%) had one-minute Apgars of 3 or less and required resuscitation. (Drage and Berendes[2] found a 21% incidence of one-minute Apgar scores below 7.) Lack of drugs, both prenatally and intrapartum, may be associated with these relatively high scores.

Two other surviving infants were admitted to the hospital during the first three days—one for repair of an omphalocele and one who was the result of an unattended (the only one) delivery with gross meconium staining and fetal distress and who was taken to the hospital within 10 minutes after delivery, where intubation and lavage were *not* performed. This delivery was part of the lay midwife sample. Table VII describes the cases of infant morbidity and their outcome.

Four infants (0.3%) were neurologically abnormal at follow-up: two had cerebral palsy and two were mentally retarded. This finding compares favorably with the 1.7% incidence of neurologically abnormal infants at one year found by the National Institute of Neurological Diseases and Stroke.[10] A fifth was slow, albeit consistent, in developing and did not walk until 18 months.

In addition to those listed in Table VII, there were 21 cases (1.8%) of jaundice requiring phototherapy. Only a few not already in the hospital were admitted, for parents were able to rig up flourescent lights over bassinets at home. Three babies with failure to thrive were switched from breast to bottle feeding, with successful results. The average length of infant follow-up was 11.5 months. Some children are still being followed now at three to five years of age. Over 80% were followed at least six months.

The nine women with previous fetal deaths had no complications.

TABLE VIII

PERINATAL OUTCOME

	Number	Study rate	California rate — 1973
Total births*	1,152		
Live births*	1,147		
Fetal deaths	5	4.3	10.2
Neonatal deaths	6	5.2	10.3
Total perinatal deaths	11	9.5	20.3
Low birthweight (<2,501 g)	15	1.3%	6.4%

*Includes six sets of twins.

Fetal and perinatal death rates are based on 1,000 total births; neonatal death rates, on 1,000 live births.

TABLE IX

Causes of Perinatal Death

Age at death	Number	Delivery	Complications	Cause of death
5 months est. gest. age	1	Home	None	Rh incompatability, insisted on home delivery
35 weeks est. gest. age	2	Home	None	Intrauterine death, unknown cause
During labor	1	Hospital	Amnionitis, IUD in place	Overwhelming intrauterine sepsis
During labor	1	Home	None	Unknown cause
2 days	1	Hospital	None	Macrosomia, single umbilical artery, bilateral adrenal hemorrhage, numerous congenital anomalies
7 days	1	Home	None	Cystic fibrosis, meconium ilius, postoperative perotinitis and sepsis
7 days	1	Home	None	Coarctation of aorta
10 days	1	Home	None	Cor biloculare
2 weeks	1	Home	None	Sudden infant death syndrome
3 weeks	1	Home	None	After surgery for tetralogy of Fallot

Perinatal outcome rates and the causes of fetal and infant deaths are given in Tables VIII and IX. The perinatal mortality rate in this study is significantly lower (95% confidence interval) than the 20.3% rate for the state of California in 1973. The state's fetal death rate in that year for white women 20 to 29 was 8.2 per 1,000 total births as compared to 4.3 in the home birth series. Unfortunately, there is no comparable neonatal death rate available for this specific group.

There was no association in this series between length of first or second stage labor and the incidence of low Apgar scores at birth or other complications. Arrest of descent was weakly associated with somewhat lower Apgar scores, but this was also strongly associated with the use of forceps, and the total number of cases was too small to draw meaningful conclusions. There were 14 cases of prolonged rupture of membranes but no resultant infections in the infants.

The average cost of home deliveries in the physician-directed service was $325 for mother and baby; for the entire study population, $277. This was an all-inclusive rate, covering prenatal care, home visits postpartum and all necessary supplies. The average cost for total care with hospital delivery and three days' hospitalization was $1,450. This latter figure is low, for it does not include the additional fee for cesarean section. (Estimated figures for a normal vertex delivery in California hospitals in 1975 were $1,150 to 1,550.)

Discussion

This is a self-selected healthy group of women, screened for obvious problems and complications occurring during pregnancy, so the data presented here are not directly comparable to state statistics. Still, their outcomes are better than average and the complication rates lower than expected.

Generally, the response of physicians to home delivery has been negative. Many view home birth as an irresponsible risk to mother and child. They do not encourage or attend home deliveries, and many have refused to give prenatal care, advice or instruction to couples planning home birth.

There is a dichotomy in obstetric thinking today. There is the technological trend represented by high-risk obstetric units with fetal monitoring and readily available medical and surgical intervention, and there is the family-centered, natural childbirth trend represented in its extreme by couples planning home delivery without any medical support. Reducing the antagonism between these divergent poles would enhance care for women choosing hospital deliveries as well as for those choosing home deliveries.

More studies of this kind are needed before any conclusions can be drawn. However, evidence from this study population strongly suggests that home delivery is a safe alternative for medically screened, healthy women; they deserve adequate care for the delivery of their choice. This care would include prenatal care by a physician, child birth education and only necessary intervention by attendants. Hospitals should be encouraged to adopt those techniques of home birth that improve pregnancy outcome. These techniques would include perineal massage and gentle head delivery to avoid episiotomies and lacerations, choice of the use of analgesia and anesthesia and provision of a supportive, friendly and comfortable environment for labor and delivery.

Acknowledgment

Acknowledgment is gratefully made to Carol Madore and Deborah Wingard for their statistical and editorial assistance in the preparation of this manuscript.

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Address reprint requests to: Lewis E. Mehl, M.D., Director of Research, Institute for Childbirth and Family Research, 2522 Dana St., Suite 201, Berkeley, California 94704.

3924 E. 8th Ave #2
Anchorage, Alaska 99504
March 7, 1982

Senate and House Health, Education, and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like you to vote in favor of Senate bill #747, regarding the legelization of midwives and the establishment of a midwifery board. Homebirths and having midwives present at births is a part of our heritage. Although this practice had diminished in the recent past, it is on the rise again. I feel it is a beautiful way to bring a child into this world as opposed to being plugged into a machine and being injected with drugs at birth in a hospital.

The federal government recognizes midwives and uses them in Alaska at Elmendorf AFB, the Alaska Native Hospital, and throughout the State. With proper management midwifery can be a useful and rewarding program for our state, as it is for the federal government.

I realize that persons in the medical profession will lobby against this bill but their's are selfish -monetary- interests. Please vote as the common people in Alaska would have you represent them, in favor of midwifery in Alaska.

Sincerely,

Thomas Malone
Thomas Malone

Karen Malone
Karen Malone

cc: Charles Parr
Terry Stimson
Mike Coletta
Vic Fisher
Tim Kelly

Date 3-16-82
N.O.

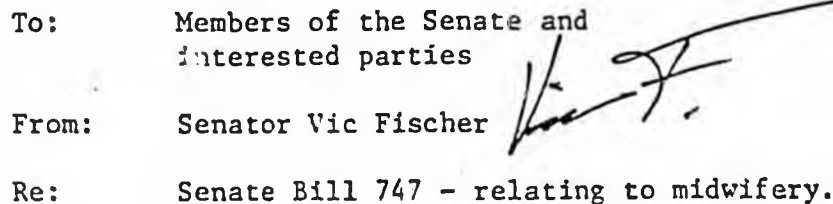
Alaska State Legislature

Senator Vic Fischer • Pouch V • Juneau, Alaska 99811 • (907) 465-4954

February 16, 1982

To: Members of the Senate and interested parties

From: Senator Vic Fischer



Re: Senate Bill 747 - relating to midwifery.

SB 747 creates a mechanism for voluntary licensing of "lay midwives through a board of midwifery under the Department of Commerce and Economic Development, Division of Occupational Licensing.

Introduced by request of individual midwives, childbirth educators, and health care providers, this bill is primarily concerned with providing a degree of consumer protection and information not available under current practice.

The traditional and cultural use of midwives and the demand for midwifery service, particularly for out of hospital births, is increasing in Alaska without adequate regulation and licensing. This bill provides a method of regulating midwifery in the public interest to assure that users of midwifery services are aware of the competency levels of their health care providers.

A key element in this bill is the concept of voluntary licensing. Regulatory boards are often accused of creating a "limited entry" in their field by refusing to grant licenses. This legislation creates a board of midwifery to test, regulate and license qualified midwives and makes it unlawful for a person to represent oneself as a licensed midwife or use any designation that implies that a person is licensed or certified by the state to act as a midwife. The bill does not, however, prohibit the practice of midwifery in the state without a license.

The concept is simple: the state has a legitimate interest in assuring that consumers of midwife services have the information available to make an informed choice of health care providers but should not hinder, prevent or interfere with consumers exercise of free choice in childbirth services.

SB 747 establishes experience and education levels for licensing, permits use of certain procedures and drugs by licensed midwives, requires ongoing education and experience, provides for apprenticeship training, and it requires midwives to keep statistical records available to the public. The bill establishes standards of practice and professional conduct and subjects licensed midwives to criminal penalties or suspension for violations of the provisions for licensure.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

COMMITTEE ON TRAUMA

GEORGE H. LONGENBAUGH, M.D., F.A.C.S.
Chairman, Alaska State Committee
Box 377
Sitka, Alaska 99835

March 25, 1982

The Honorable Charles Parr, Chairman
Health, Education and Social Services Committee
State Capitol
Pouch V
Juneau, Ak. 99811

Dear Senator Parr,

I would like to address the Committee regarding Senate Bill [illegible], an act relating to midwifery.

First of all, I am a graduate of the University of Colorado School of Medicine, with surgical residency in Baltimore. I came to Alaska in 1963 and was Chief of Surgery at Public Health Service Hospital, Mt. Edgecumbe, Alaska. I have been in private practice in Sitka since 1967, as well as consultant Chief of Surgery at the Mt. Edgecumbe Public Health Service Hospital since 1971. I am currently Chief of Staff at the Sitka Community Hospital and Chief of Surgery at Sitka Community Hospital.

During my years in Alaska, although I have not practiced obstetrics, I have, as surgeon in this small community, served as consultant and as the primary physician for most Caesarean sections performed during these years. I have also been active in Emergency Medical Services and served as medical advisor for the Southeast Regional [illegible] during the last several years and currently director of American College of Surgeons, Committee on Trauma, for the State of Alaska.

I believe that Senate Bill #747 is seriously flawed and its basic concept, that of licensing midwives who have not had medical training, encourages a pattern of obstetrical care which is certainly not in the best interest of survival for mother or infant. Delivery of children is certainly a natural process, and we realize that in the vast majority of deliveries is readily accomplished without a great deal of medical intervention. However, there is a significant percentage of mothers-to-be who at some point in their pregnancy have problems either immediately with their delivery or earlier. It is to this group of obstetrical patients that the encouragement of untrained attendants would do the greatest disservice. It seems to me that there are two factors involved in the management of the obstetrical patient that are often critical to the outcome of both mother and child.

1. The experience and training of the attendant.
2. The equipment and facility available to that attendant in the [illegible] there may be an unforeseen event.

In my role as consultant to various people practicing obstetrics over the years, it has certainly been apparent to me that the degree of training and experience is directly related to the complications encountered in the course of the delivery. I cannot believe that the attendance by an essentially untrained and minimally experienced person would have a significant influence on the presence of complications.

We here in the Sitka community have had some experience with home delivery, as at one time there was a physician here who promoted home delivery; however, the only neonatal death of a full term infant to occur in this community over the span of many years happened in association with a home delivery performed by a physician.

Again, I think that there is no question that the experience of the operator, including the facility and equipment available to him are factors in preventing various complications and death in the obstetrical practice. I believe that the licensing of minimally or untrained individuals to do deliveries would be a distinct disservice to the patients, as well as the society as a whole.

I appreciate this opportunity to submit this testimony for the consideration of your committee.

Sincerely,

George H. Tongenbaugh, M.D.

George H. Tongenbaugh, M.D., F.A.C.S.

GHT:ph

My name is Beth Cox and have lived in Sitka for 15 years. I am also President of our Local NAPSAC organization and a member of TCCA.

I urge the passage of SB 747 for one main reason. I believe childbirth is a natural physiological event and should be treated as such. This not always available in todays highly technological medical society.

I believe people should be allowed to have and chose safe alternatives in childbirth.

Midwifery is here to stay. You can outlaw midwifery but, you can't make it disappear.

The birthing parents don't care if a midwife is a nurse or not. They don't care if she is trained formally or informally. They just want her to be appropriately skilled, experienced and available by whatever means accomplished.

Pass this bill so that quality care will be available no matter where you choose to give birth.

From:
Beth Cox
Box 878
Sitka, AK.
(Page 1 of 1)

PAGE 1 OF
Carleen Stokes

Senator Charlie Parr

Hess Committee

Pouch V

Juneau, Alaska 99811

Senator Charlie Parr and all other legislators

Sir:

I am a mother, a mother-to-be and a childbirth educator in the Sitka area. I am in support of SB 747 "An Act Related to Midwifery". I know people in this area would like an alternative to the hospital births available. Many are forced to labor in crowded labor rooms, transfered to the one delivery room and on occasion returned to a room with a mother still in labor. How can one hope to have a good birthing and bonding experience under these conditions?

The medical community should be here to help everyone. When they refuse their services because a couple wants a home birth, they are not fulfilling their obligations.

Right now in Alaska, there is no way for the consumer to judge a midwifes ability. This bill would help do this and the way it does seems fair. Attending 20 births in Sitka would be very hard and considering most of alaska has a population less than this area. it is very limiting. However, if a person meets the standards excepted by the liscencing committee, then I would feel they are able to handle births.

A college education does not improve your value as a midwife. It is the experience and knowledge gained through actual birthing that makes a good midwife. Some people are born with a natural ability and desire to attend births. They may

spend their lives gaining knowledge and skill in this area alone. They would be able to meet the needs of the birthing community along with nurses, CNM and doctors.

I urge you to support SB 747.

Sincerely,

[illegible]

PAGE 1 of 1

Senator Charlie Farr
HESS Committee
Pouch V
Juneau, Alaska
99811

Senator Charlie Farr and all other Legislators

Sir:

I am in support of HB 747 "An Act Related to Midwifery".
I feel that pregnancy and childbirth is a natural physiological process and, in as much, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

From:
Bill Stokes
Box 1141
SITKA, AK.

For Senate HESS
PAGE 1 of 1

March 25, 1992

[illegible] Legislative Information Office
[illegible] Street
[illegible], AK 99835

Re: Senate Bill 747

Dear Sir:

I am for Senate Bill 747 and would like to see it go through. [illegible] safe alternatives in child birth and the licensing of [illegible] would aid this because the people coming into Alaska would have a way of judging the performance of our midwives.

Sincerely,

Drusilla Kennedy Palmer
Box 1990
Sitka, AK 99835

SITKA COMMUNITY HOSPITAL

P. O. Box 500 • Sitka, Alaska 99835 • (907) 747-3241

March 25, 1982

We, the undersigned, are unalterably opposed to SB 747. We strongly endorse the position of the Alaska Nurses' Association and urge you to vote NO on the licensure of lay midwives.

If this bill passes, the state is endorsing and encouraging lay midwifery, and in effect, telling the people of the state of Alaska that the licensed individual is well qualified. Without extensive education and experience requirements and defined standards of practice this piece of legislation only creates a false sence of security for the consumer.

Sheryl Johnson RN Director of Nursing — Sheryl Johnson

Patricia Gomez RN Head Nurse — Patricia Gomez

Susanne Fisher RN Staff nurse — Susanne Fisher

[illegible] RN — [illegible]

Peggy Keegan Campbell RN — Peggy Keegan Campbell

Jeanne [illegible] RN Inservice [illegible] — Jeanne [illegible]

Linda K. Cook RN OB Supervisor — Linda K. Cook

Jean M. Young RN — Jean M. Young

Dorothy A. [illegible] RN — Dorothy A. [illegible]

[illegible] — [illegible]

On next page

cc: Senator Charles Parr, Chairman, Health, Education and Social Services
Senator Terry Stimson
Senator Mike Colletta
Senator Vic Fischer
Senator Tim Kelly
Senator Dick Eliason
Rep. Ben Grussendorf

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FROM: ELAINE
TO: SUE
TARGET: LJH2 SUBJ: NAMES ON TELECOPY

PAGE 000

THE TELECOPIED MATERIAL ON "SITKA COMMUNITY HOSPITAL" LETTERHEAD IS SIGNED B

SHERYL JOHNSON, RN, DIRECTOR OF NURSING
PATRICIA GOMEZ, RN, HEAD NURSE
SUSANNE FILTEAU, RN, STAFF NURSE
RICHARD STAKLISTER (?), RN
PEGGY KEEGAN CAMPBELL, RN
JOANNE CLYDE, RN, INSERVICE C.S.C.H.
LINDA K. COOK, RN, O.R. SUPERVISOR
JEAN M. YOUNG, RN
DOROTHY A. DREIER, RN
DONNA HEBBELER, FNP

I WILL XEROX THE MESSAGE AND MAIL TO EACH LEGISLATOR COPIED; HOWEVER, PLEASE
GO AHEAD TO DISTRIBUTE TODAY PER REQUEST OF PEOPLE WHO BROUGHT IN THE MATERIA
THANKS.

Dear Senator Fisher,

As a mother of three small children; who were all born at home; and as an apprenticing midwife, I ask you to support Senate Bill 747 "an Act Relating to lay midwifery". I feel it adaquitly regulates midwifes with a certain standard of care, while providing for freedom of choice, which is the ultimate issue at stake. The only point I wish would be changed is that there has to be a qoata of births done to maintain licensure. Of my knowledge, there is no other health care proffesional who has to keep doing a certain number of procedures to be able to be licensed. Also the way Alakas communities are so small and spread out the chances of that many births going on all the time is slim. Another point is that the records to be kept by the midwife should be confindinial and not open for whoever to see. Other than thease points I feel the bill should be passed and I will give it my full support and urge you to give it yours.

Thank-you,

Cristina Lorance

Box 2671
Homer Alaska
99603
March 8, 1982

Dear Mr. Fischer—

As one of your female constituents I am well aware that Senate Bill 747 "An Act Relating to Lay Midwifery" may directly affect me. Should I become pregnant this bill will either limit my options for the birthing process, if defeated; or allow me the freedom of choice, if passed. In the event that I am able to deliver a child I would want to be able to do whatever I think best for my child and myself. Therefore I urge you to vote yes on Senate Bill 747. I consider it a lamentable fact that women today do not have the option of giving birth in a manner that our ancestors have done for most of our history. The importance of this bill is to give women a choice in how they want to manage their delivery and in what kind of environment they wish to welcome their child. I cannot stress enough the importance of women

maintaining their power of choice over such an important and personal matter.

Thank you for your sincere consideration of this matter.

Sincerely,
Joyce Day

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Senator Fischer,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening now in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

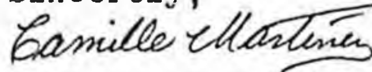
Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,



Camille Martinez

Alaska Nurses Association

~~529 Gold Street Room~~ 237 E. Third Avenue
~~Juneau, Alaska 99801~~ Anchorage, AK 99501

...a constituent of American Nurses' Association

March 18, 1982

The Honorable Vic Fischer, Senator
Member, Committee on Health, Education
and Social Services
Pouch V, MS 3100
Juneau, AK 99811

Dear Senator Fischer:

On behalf of the Alaska Nurses Association I would like to thank you for your support of SB 660 which will fund the Family Centered Birth, Inc. of Juneau. The Alaska Nurses Association heartily endorses this bill.

I hope that you will continue to support this bill when it comes to the floor. I look forward to working with you on health care issues in the future.

Sincerely,

ALASKA NURSES ASSOCIATION

Melinda Law

Melinda Law, RN
President

ML:m

cc: Margaret Crawford

1811 Southern Ave
Fairbanks, Alaska 99701
March 17, 1982

Mr. Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like to write in support of your bill introduced to the Senate S. Bill 747: "An Act relating to Midwifery."

This bill's passing is very important to me not only because of the licensing of midwives but because it is a freedom of choice issue. If we choose to sit idly by the bill wouldn't pass and all women would be forced to have their babies in hospitals. Childbirth is an emotional happening and often spiritual as well - hospitals seem to lack compassion at times in how you or I would prefer a childbirth in these aspects. After all, at Christmas we celebrate a Man's birth whose was the lowliest birth of all (- and certainly not the most sanitary!) and He survived it just fine.

I'm just one among many who support this bill. We can't hardly wait for it's passage. Thank-you for you work.

Sincerely,

Mrs. Wendy J. Hogan

Box 2906
Homer, Alaska 99603
March 17, 1982

Senator Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sen. Fischer:

I am writing concerning the proposed legislation on midwifery. Specifically, I urge your support of Senate Bill 747.

As a concerned citizen & parent, I believe consumer demand for the service of midwives will continue. To best serve the public, it is essential to establish licensing procedures & standards within which midwives would function. I believe Senate Bill 747 provides the most appropriate legislation. If passed, prospective parents would be in a better position to make a wise choice among midwives & other caregivers. Furthermore, it is my opinion that funding should be provided for a peer regulating board to govern the work of midwives.

Thank you for your consideration.

Sincerely,
Carol Hult
Carol Hult

cc: Charlie Parr
Brian Rogers
Albert Adams
Hugh Malone

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Ms. Baim,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

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Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

3-14-82

To Senator's Vic Fisher, Charlie Parr, and anyone else in-volved in the Senate Bill 747" an act relating to lay midwifery".

We are in favor of having lay midwifery because we feel that expectant parents should have a wide area of sources to choose from when considering how they want to have their children. (Sources ranging from doctors and hospitals, to nurse-midwifes and clinics, to lay midwifes and home births, ect.)

Lay midwifes have been delivering babies success-fully for many generation and we feel they have a

right to continue doing so as long as people like us want and need them to deliver our children in the place we feel most comfortable, our homes.

We have had two children. One with doctors, nurses and the hospital; the other at home with the help of a lay midwife. The hospital birth went very well as far as a successful delivery, but there were interruptions from nurses and doctors, other woman in labor, some screaming, everyone in a hurry; all this was very disturbing to us and made us feel that the birth of our child

was an impersonal experience for everyone but us. After the delivery our son was taken away from us for a couple of hours so he could be cleaned up, etc.

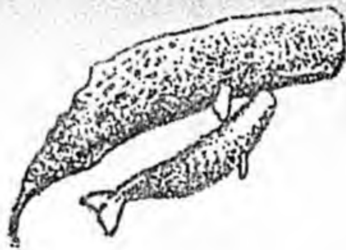
Our home birth was also a successful delivery but with the help of a understanding lay mid-wife and a well read husband involved. The experience was much more enjoyable. The lights were dim, low playing music, comfortable bed that I was used to, good friends to help and to take pictures, and just an all round relaxed atmosphere.

We were involved in all aspects of the birth and post natal care from cutting the cord to checking apgar score, to cleaning baby up, to nursing our little girl right after birth. It was wonderful.

We realize that not all deliveries are without complication, but most potential problems can be detected before the actual birth which would put those people in a high risk category for home births, and lay midwifes that we know will not deliver for anyone who is a high risk. They want what is best for our children too.

we are now expecting
our third child and are
definitely considering
another home birth. We
hope that lay-midwifery
will still be an option
available to us so that
we will have that choice
if we so choose.
Thank you for listening
to our opinions.

Susan L. Connor
+ Charles B. Connor



March 15, 1982

Dear legislature,

I am responding to Senate Bill 747 "An Act Relating to midwifery." I've in the past have sent in my suggested revisions for HB11 and see the changes reflected in SB 747. Although there are points I'm not comfortable with and am unclear about, I feel it's a bill that midwives and families can benefit from.

As a laymidwife, I have met much resistance and little support from the established medical system. I've been criticized for not having costly medical tools (I do not charge), lack of knowledge surrounding medical proceedures and the skills to use them (which if I did perform such a medical proceedure I face practicing medicine without license). Yet, it is these very people who aren't open enough to share and teach these skills and knowledge but make the charges if performed. I've been personally been pressured, blacklisted and verbally threatened to discontinue working with folks who seek me out. These folks do not want to birth with the medical system due to many reasons. Some reasons being cost, frontier spirit, non intervention, control and responsibility in decisions, comfortableness of their home environment, dislike of doctors and/or hospitals, feeling pregnancy and birth is a normal physiological process and not a medical proceedure or just their philosophy. By trying to eliminate laymidwives

will not stop home births. But enlarges the all ready existing gap for communication, screening for problems and medical availability when needed between care givers and families.

This gap could be lessened with this bill and all efforts should at least be made to not enlarge the gap. The established medical system is valuable and has its place, but need it control other forms of workable health care systems and philosophies? Isn't our constitution designed to protect its citizens from such an anarchy?

Because of the choices available for the birth of my next child, we are having to seriously consider leaving our home and state. We are not comfortable with asking a midwife to place herself in a legal vulnerable position, doing the birth by ourselves nor going to the practioners that have been out right hostile to me.

I plea as a mother who has birthed at home, a worker who has worked labor/birth in hospitals, a woman who has been called on to stand by birthing families and a person who sincerely wants to be a credible helping citizen, for you to listen and provide for your people. I urge you to support and pass SB747.

Most Caringly,

Kathleen Stier
Box 1136
Homer, Alaska 99603

March 16, 1982

Dear Vic

Thank you for your letter, it was informative and appreciated. I have been encouraging my friends and clients to voice themselves about SB 747. I will be at the March 25 tele conference. I have some questions about the apprenticeship I hope to have explanned then. Enclosed are some copies of studies I thought you might find helpful. I would appreciate if you would be sure that copies of them get sent to supportive and key persons. Also I enclosed a booklet that I thought you may find interesting if not, amusing.

I understand the Alaska Hospital ass. has a lobbiest. How much pull and effect does this have? Do we (who have had to function underground with little or no pay) realistically have a change for the bill to pass against a established organization with $ behind them?

Thanks again, I would appreciate being kept posted. I seem to be the contact for this area and do share the news.

Warmly,

Kathleen Stier

SR A BOX 293 copies members
Anch. 99507

March 22, 1982

To Senator Charles Parr,

I am writing to you with great concern over senate bill 747 concerning the legalizing of midwives to perform homebirths in Alaska.

My son was born at home. I am talking about homebirth with good prenatal care and no forseen complications. I am talking about with good medical back-up. I must say, that is not simple in the case of unsupported midwifery by the medical community. This is the issue, Senator. I am so concerned about having the freedom to choose where to have our children, be it in the hospital or at our own homes with an attending midwife. In the case of homebirth it is vital to receive support from the medical profession in our community. It is for the safety of our children and ourselves. I could never believe anyone would intentionally ignore medical assistance for homebirth. There was so very much deep thought and caring over our birth choice. I received good prenatal care, but by no means aided in this with the medical community aware of my homebirth choice.

I am not some kind of a anti-hospital rebellion. I would be the first to commend our hospitals for all their help with births of our newborn and their efforts toward increasing natural childbirth in hospitals to higher risk mothers or simply mothers who choose to give birth in a hospital.

Please understand, Senator. Listen to my most sincere plea for legalizing midwifery. I believe it is very important to have medical support for this. I can see no way this would be possible with illegal midwifery existing in our community. I respect my freedom to speak up on something I feel so strongly about. Would it be fair to deny us safe alternative birth choices? Would it be fair to jeopardize the health of our unborn? I fear there would be increasing risks of pregnant mothers and unborn children.

Sincerely,

Mrs. Karen Casassa
Anchorage Resident

- PLEASE FORWARD TO ALL SENATORS INVOLVED WITH SENATE BILL 747 -

747

March 22-1982

Dear Senator Charles Parr,

and all other Legislators,

I support Senate Bill 747 which provides for voluntary licensure of lay midwives.

I believe that the choice of birth attendant belongs to parents. This bill will provide parents the opportunity to avail themselves of the services of a licensed midwife.

I believe it will protect both the parent and the midwife.

Sincerely,
Gail A. Dufresne
1433 I Street
Anchorage, Alaska 99501

3/19/82

This is to notify the appropriate parties that I am in favor of Senate Bill No. 747, after all, there must be some sort of regulation and protection of this area.

Sincerely:

Victor Sam R.N. S.N.

8936 Kimberlie ct
Anchorage AK 99504

3/19/82

Dear Sen Parr,
'and all other legislators'

As a father of two, one a very unpleasant hospital birth and the other a very rewarding and natural home birth, I strongly support SB747.
I firmly believe in the freedom to choose the setting for birth.
I want to encourage all of you to pass SB 747 and get home birth above ground where we can all have the opportunity to seek competent licenced care and alternitives. Thank you.

Sincerely
David R. Henderson
Box 573
Sitka, AK. 99835

Mar. 18, 1982

Dear Sen Parr,

and all other Legislators,

As a mother of two, one hosp. born, one home born, I strongly support SB 747. I charish my freedom to choose the setting in which I shall give birth. I wish to encourage you all to pass this Bill and get home birth above ground where we can all have the opportunity to seek competent licenced care.

Sincerely,

Cathie D. Henderson
Box 573
Sitka, AK.
99835

Box 1
Sutton AK 99674

March 16, 1982

To: Charlie Parr
Chairman of HESS Committee
and all other Legislatures

I am writing concerning Bill 747 dealing with legalization and certification of midwifery in Alaska.

I feel that it is the parents right to choose if they want a home birth or a hospital birth. I am currently three months pregnant and have chosen to have a home birth, if there are no complications. I have had a very difficult time finding a doctor to give me a prenatal blood test. I have been forced to go to one of the rural communities to obtain this. I feel that this rejection from the Open Door Clinic and some of the Doctors in Anchorage could be detramental to my health, my unborn babie's health and the health and well being of other pregnant women who choose to have home births.

I am expressing my concern about this issue and want to make it known the I feel midwifery in Alaska should be legalized.

Sincerely,

Aleta P. Stebbins

note: please distribute copies to Helen Beirne and Mike Beirne

3-14-83

DEAR MR. PARR,
& LEGISLATIVE MEMBERS OF THE SENATE —

I AM WRITING IN SUPPORT OF BILL # 747 CONCERNING THE REGULATION OF MIDWIVES HERE IN ALASKA. I AM VERY STRONGLY IN FAVOR OF THE BILL BECAUSE I BELIEVE IN THE OPTION TO CHOOSE A HOMEBIRTH & THUS RECOGNIZE THE NEED TO INSURE COMPETENCY IN THE UNIQUE INSTITUTION OF MIDWIFERY. I BELIEVE THIS CAN BE BEST ACHIEVED THROUGH THIS BILL. I BELIEVE THAT IF THE MIDWIVES HERE IN ANCHORAGE WERE SET UP TO REGULATE THEMSELVES, AS OTHER HEALTH PROFESSIONALS DO, THEY WILL BE ABLE TO SECURE A GREATER SUPPORT FROM THE MEDICAL FIELD, & THUS A GREATER INSURANCE OF SAFETY FOR THE MOTHER & CHILD. MY OPPINIONS ARE BASED ON PERSONAL BELIEFS, A POSSIBLE FUTURE PERSONAL-INTEREST, & ALSO A SEPARATE LOGICAL CONCLUSION. WHETHER HOMEBIRTHS/MIDWIFERY ARE LEGAL/NOT, REGULATED/NOT, RECEIVE A PHYSICIAN'S ACTIVE SUPPORT/NOT, THEY WILL CONTINUE TO EXIST. I BELIEVE THAT IS A FACT & THUS, SEPARATELY FROM MY OWN INTERESTS, BELIEVE THAT HOMEBIRTHING SHOULD BE MADE AS SAFE AS POSSIBLE. THE ONLY WAY TO DO THIS IS THROUGH REGULATION & THE BACKING OF THE MEDICAL FIELD, AND THE PASSING OF THIS BILL WOULD UNLOCK THE DOOR, SO TO SPEAK.

THANK-YOU,
ALLISON JAY

ALLISON JAY
2936 KIMBERLIE CT.
ANCH., AK. 99504

PH: 276-8926

1811 Southern Ave
Fairbanks, Alaska 99701
March 17, 1982

Mr. Charles Parr, Chair - Senate
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like to write to let you know that I support S. Bill 747: "An Act relating to Midwifery" introduced by Senator Vic Fischer.

I believe in freedom of choice in how we are to bear our children. And more people are turning to a more natural, homey setting - why should this be refused them? And yet if this bill, which would make sure midwives are licensed before attending births, is not passed it will surely restrict our freedom in this matter.

Please, don't be swayed by hospital lobbyists - many are money hungry, because homebirths are a threat to them, but doesn't freedom of choice - something our country is built on - mean more?

Thank-you for your consideration.

Sincerely,

Mrs. Wendy J. Hogan

1660 Garden
Anchorage, AK 99501
March 20, 1982

Charles Parr
HESS Chairman
Alaska State Legislature
Pouch V
Juneau, AK 99811

RE: Senate Bill 747

Dear Mr. Parr:

I am writing to encourage the senate to pass Bill 747 which concerns the practice of midwifery in Alaska. After reading it carefully, I believe the bill is a good one. It has the potential of becoming a model for other states, on this extremely personal issue of being able to choose ones own birth attendant and to be able to check their qualifications if one chooses a

licensed midwife. It also does not prohibit a woman from choosing someone other than a licensed midwife, i.e., her husband, to attend her labor and delivery.

I thank you for your influence on this matter.

Sincerely,
Jane Lupo

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Senator Parr,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening now in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

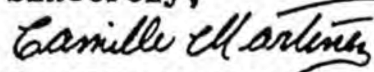
Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,



Camille Martinez

19 Mar. 82
PO Box 10183
Anch, Ak 99511

Senator Charlie Parr and
all legislators
Pouch V
Juneau, Ak 99811

Dear Sir:

I am a Registered Nurse & have worked in a variety of health care areas professionally. One of the problems I have noticed in the health care field is that of people from within the system assuming that they know what is best for individuals seeking health related services.

Specifically - I am in support of S.B. 747 People's rights to chose birth attendants & birth sites should be protected.

There is a growing number of people choosing home births & other health care options. I feel they should be assured access to whichever services & attendant they chose regardless of their reasons.

Sincerely
Dodie Matcho RN

POUCH V
JUNEAU, ALASKA 99811

MARCH 17, 1982

DEAR CHARLES PARR,

PLEASE SUPPORT SENATE BILL NO. 747 - "AN ACT RELATING TO MIDWIFERY." MY WIFE AND I ARE HAVING OUR 2ND MIDWIFE ASSISTED HOME BIRTH AND ENJOY HAVING THE CHOICE OF BIRTHING PROCEDURES. WE NEED YOUR SUPPORT. THANK YOU FOR YOUR TIME + HELP.

SINCERELY,
MARK LANE
Mark Lane
STAR RT. BOX 520
SEWARD, AK 99664

747

Gary & Carol Galbraith
P.O. Box 827
Cooper Landing, Alaska 99572
907 - 595-1226

3/8/82

Dear Charles Parr,

I am writing to let you know that I am in full support of the Senate Bill # 747 — An Act Relating to Midwifery.

I believe in the freedom of choice in deciding whether to have a hospital or homebirth, and the licensing of midwives is a crucial step toward providing the best and safest conditions for many women throughout Alaska.

It is very important that this bill passes, as more and more women, especially in Alaska, are choosing homebirth (which allows a more personal and fullfilling experience) over a hospital birth involving the use of sometimes needless medication, strict regulations and surgery.

I am speaking from experience, and can only hope that you, as a man, will try to understand my feelings and desires.

The only unsafe factor in the practice of midwifery (which is as old as the human race itself) is when laws prohibit them, and professional people do not support them in their endeavor to make a woman's birthing experience a more positive, family-oriented and meaningful experience.

We need midwives as well as doctors, and the two working together can bring about a more complementary and efficient service for the welfare of all concerned. (An excellent example of this is in The Netherlands and other European countries as well, who have a much lower infant mortality rate compared with the U.S.)

I hope you will "hear" what I'm saying and give the Senate Bill #747 your full support.

Sincerely yours,
Carol J. Galbraith

Senator Charlie Parr
HESS Committee
Pouch V
Juneau, Alaska
99811

Senator Charlie Parr and all other Legislators

Sir:

I am in support of SB 747 "An Act Related to Midwifery". I feel that pregnancy and childbirth is a natural physiological process and, in as much, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

Donald Ramsay
Shirley Ramsay

Star Rt. HPR
Sitka AK 99835

March 21, 1982

Senator Charlie Parr
HESS Committee
Pouch V
Juneau, Alaska
99811

Senator Charlie Parr and all other Legislators

Sir:

I am in support of SB 747 "An Act Related to Midwifery".
I feel that pregnancy and childbirth is a natural physiological process and, in as much, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

Beth Cox (Pres. SAFE-moms)
Local napsac group
Box 878
Sitka, AK
99835

747

Box 2671
Homer, Alaska 99603
March 13, 1982

Dear Mr. Parr,
As one of your female constituents I am well aware that Senate Bill 747 "An Act Relating to Lay Midwifery" may directly affect me. Should I become pregnant this bill will either limit my options for the birthing process, if defeated, or allow me the freedom of choice, if passed. Of course there is always the option of going outside the law, but in the case of complications that would be much too risky for me. In the event that I should be able to deliver a child I would want to be able to do whatever I think best for my child and for myself. Therefore I urge you to vote "yes" on Senate Bill 747. I consider it a lamentable fact that women today do not have the option of giving birth in a manner that our ancestors have used, and still remain within the law. The importance of this bill is to give women a choice in how they want to

manage their delivery and in What kind of environment they wish to welcome their child. I cannot stress enough the importance of women maintaining their power of choice over such an important and personal matter.

Thank you for your sincere consideration of this matter.

Sincerely,
Joyce Dey

CHARLIE PARR & ALL OTHER legislators:

My name is CHRIS Rushing and I PRACTICE AS A lay midwife in Anchorage ALASKA. I am strongly in favor of 747. (Senate Bill)

THESE ARE just some of my REASONS:

1) IN the North CAROLINA STUDY of 1981 the RESULTS SHOWED THAT unattended HOMEBIRTHS HAD A HIGHER INFANT mortality RATE than BIRTHS ATTENDED by the lay midwives. By making it difficult for folks to attain a selection OF lay midwives I believe more folks have their BIRTH unattended by a skilled attendant. People ARE going to CHOOSE HomeBirth even IF they ARE forced to do it themselves. By liscensing lay midwives it is not encouraging out of hospital birthing - the need for lay midwives is already there - it has existed AND persisted for centuries in spite of scorn and ridicule.

2) THE definition OF the word "MIDWIFE" IS someone THAT IS "with A woman." Doctors and nurses continuously TRY TO ANALYZE the lay MIDWIFE'S ROLE FROM A medical perspective. CAN they HANDLE this emergency - can they recognize this problem? etc. THE LAY MIDWIFE ATTENDS only normal births to give the couple moral support, companionship and to supervise the LABOR in SUCH A WAY that ALL minor and MAJOR ABNORMALITIES are recognized or at least suspected as early as possible. THIS does not require A medical BACKGROUND in my opinion. AS A Former registered nurse I can testify to the fact that A medical BACKGROUND WHERE ONE CONCENTRATES ON WHAT can go WRONG IS detrimental when APPROACHING normal CHILDBIRTH AT HOME.

Under the governing BOARD of liscensed MIDWIVES, exams can be given to ASCERTAIN the KNOWLEDGE of CANDIDATES in the AREA of normal CHILDBIRTH.

(3)

Licensing will not guarantee competency of lay midwives; the burden of responsibility will still be on the couple to determine the suitability of the individual. The practice of midwifery is not meant to challenge the advances in maternal child health nor intend to eliminate the vital role of the obstetrical specialist. Midwifery is the art of supporting and guiding a family through normal childbirth.

I want to see people's free choice upheld in childbirth - please support Senate Bill 747

Sincerely

Chris Rusting
1403 E 27th Ave
Anch, AK
99504

SRA BOX 1245
Anchorage AK 99507

Dear Senator Parr,

I hope you will do your best to see that Senate Bill 747 passes.

Midwives who work independently of medical doctors provide valuable and needed services to a growing number of Alaskans. Lay midwives are the only choice at the moment for Alaskans wanting to give birth at home. We need to protect their right to assist at childbirth and help mother and child to be in the best of health. The art of midwifery is regaining popularity after having been displaced by the medical technological management of childbirth. Each may have a very different approach and techniques, but both are needed.

Unfortunately an atmosphere of mutual distrust and lack of cooperation is developing between the medical community and lay midwives. It would be to everyone's benefit if we could reverse this polarizing trend and foster attitudes of respect and willingness to work together in the best interests of the client. Recognizing and regulating independent midwives by means of the liscencing system proposed in Senate Bill 747 is admirably suited to promoting this needed cooperation.

We know Alaskans especially value their independence,

their self reliance and freedom to choose. We are also in recent years experiencing a growing awareness of the need to assume greater individual responsibility for such things as health, and thus to relate to health professionals as resource people rather than authority figures.

We should encourage this consumer responsibility. An official liscencing system to assist the midwive's prospecive clients in judging thar competence, coupled with independent consumer education and referral programs, makes more sense today than restricting options and allowing the more powerful medical establishment to develop a monopoly of childbirth services, driving the lay midwife underground.

The usual argument of medical doctors against permitting lay midwives to assist at childbirth concerns their competency and the safety of their independent practice. That midwives have an <u>excellent</u> safety record, with or without the supervision of a physician, will be apparent to anyone who studies all the statistical evidence. It is very important, if one values truth and honesty, to be aware of how easily statistics can be manipulated to fit a particular bias, by omission and regrouping of certain measurements. We have some information focussed on Alaska, but plenty more from other states and especially foreign countries demonstrating the superior results of midwifery care for normal childbirth.

Essentially the difference between the midwives and the physician's methods of assistance at childbirth is a matter of attitude. The midwive sees her role as a support person, the M.D. tends to function as manager. Obstetricians can work wonders when health and life threatening situations develop, and midwives work best with healthy mothers. Both can learn from each other. Service improves with cooperation. Medical backup and good professional relations with hopital staff and M.D.'s are important for midwives. Obstetricians would be more efficient when not so overburdened with uncomplicated cases better handled by the midwives.

The issue of safety in childbirth can provoke some heated emotional arguments. All childbirth assistants who have their clients interests at heart are concerned with safety. Is the average obstetrician's view of the dangers of childbirth exaggerated? Medically trained professionals tend to favor strict control (doctors in charge of course) over who may assist at childbirth. How can such an obviously normal function of the human female come to be regarded as a process so fraught with danger that medical management is imperative in all cases? Medicine is a profession intended to help sick people. Medical training focusses on preparation for what _might_ go wrong. Emphasis on control and intervention is a response to the expectation that the birth process is likely

to malfunction at any times. This attitude may be quite appropriate to abnormal cases, however, normal Childbirth is not necessarily made any safer by this approach. In an atmosphere dominated by fear of what might go wrong, expectations of malfunctioning can become self fulfilling prophecies. Rather than stand by feeling helpless, waiting for the process to break down the temptation is to intervene. "Just in case" and "What if" influence decisions. Then the premature or unneccessary attempts to control the birth create their own problems. On the other hand, although confidence and faith support and enhance the birth process, it would be foolish to ignore danger signals. That is why cooperation, respect and good communication are so important between midwives and the medical professions. It certainly does NOT promote the safety of mother and child if physicians and midwives are afraid or unwilling to work together. Especially when one side or both sides are actively campaigning against the other. When motivated by competitive economic considerations none are likely to have their clients best interests at heart. We have to keep in mind that these are service professions.

Let us work to pass S.B. 747, and hope we are successful in estiblishing this needed cooperation.

Thank you

Sincerely,

Beryl J. Wardlaw

March 12, 1982

747

Dear Mr. Parr,

I am in favor of Senate Bill 747 as it is written now. I had my baby delivered at home with the help of a midwife. I knew her background and felt very good about her qualifications. But I am concerned that there are no regulations to guide the practice of midwifery. I know that at this time there aren't any guidelines in the State of Alaska for midwives. At the same time I feel that midwives should have control over their profession, as doctors have control over their profession, and as nurses have control of theirs.

It's time that the State of Alaska listens to the voices of people who want a choice in how and where they deliver their babies.

Sincerely,

Ann Rushing RN
276-8926
2936 Kimberlie Ct, Anch 99504

Dear Charles Parr & all other legislatures Mar. 10, '82

This letter is to express my support for SB #747 & HB#11

I think certification of midwives in this state is a very neccasary move. It will benefit everyone involved... the parent will know who they are getting to help them with their birth because ~~of~~ they will be able to check on their attendant's credentials. The midwife would have credentials, she could get insurance, she could be paid thru client's insurance, she could give better prenatal care with the cooperation of the medical feild. Plus the doctors & could stand to learn a few things like compassion & certain techniques that midwives use, that make them so special to so many expectant couples. Please pass these ~~bills~~ bills!

I would really like to see a teleconference happen ~~on~~ for this bill, it would be very beneficial for everyone. Please let me know if & when this is planned.

Thank you for your time

Sincerely,

Cathleen D. Horwitz
2601 Kona Lane
Anchorage, Ak.
99503

Dear Senator Fisher,

As a mother of three small children; who were all born at home; and as an apprenticing midwife, I ask you to support Senate Bill 747 "an Act Relating to lay midwifery". I feel it adaquetly regulates midwifes with a certain standard of care, while providing for freedom of choice, which is the ultimate issue at stake. The only point I wish would be changed is that there has to be a qota of births done to maintain licensure. To my knowledge, there is no other health care proffesional who has to keep doing a certain number of procedures to be able to be licensed. Also the way Alaskas communities are so small and spread out the chances of that many births going on all the time is slim. Another point is that the records to be kept by the midwife should be confindinial and not open for whoever to see. Other than these points I feel the bill should be passed and I will give it my full support and urge you to give it yours.

Thank-you,

Cristine Lorance

Box 2671
Homer Alaska
99603
March 8, 1982

Dear Mr. Fischer—

As one of your female constituents I am well aware that Senate Bill 747 "An Act Relating to Lay Midwifery" may directly affect me. Should I become pregnant this bill will either limit my options for the birthing process, if defeated, or allow me the freedom of choice, if passed. In the event that I am able to deliver a child I would want to be able to do whatever I think best for my child and myself. Therefore I urge you to vote yes on Senate Bill 747. I consider it a lamentable fact that women today do not have the option of giving birth in a manner that our ancestors have done for most of our history. The importance of this bill is to give women a choice in how they want to manage their delivery and in what kind of environment they wish to welcome their child. I cannot stress enough the importance of women

maintaining their power of choice over such an important and personal matter.

Thank you for your sincere consideration of this matter.

Sincerely,
Jayce Dey

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Senator Fischer,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

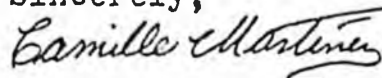
Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,



Camille Martinez

Alaska Nurses Association

237 E. Third Avenue
Anchorage, AK 99501

...a constituent of American Nurses' Association

March 18, 1982

The Honorable Vic Fischer, Senator
Member, Committee on Health, Education
and Social Services
Pouch V, MS 3100
Juneau, AK 99811

Dear Senator Fischer:

On behalf of the Alaska Nurses Association I would like to thank you for your support of SB 660 which will fund the Family Centered Birth, Inc. of Juneau. The Alaska Nurses Association heartily endorses this bill.

I hope that you will continue to support this bill when it comes to the floor. I look forward to working with you on health care issues in the future.

Sincerely,

ALASKA NURSES ASSOCIATION

Melinda Law

Melinda Law, RN
President

ML:m

cc: Margaret Crawford

1811 Southern Ave
Fairbanks, Alaska 99701
March 17, 1982

Mr. Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like to write in support of your bill introduced to the Senate S. Bill 747: "An Act relating to Midwifery." This bill's passing is very important to me not only because of the licensing of midwives but because it is a freedom of choice issue. If we choose to sit idly by the bill wouldn't pass and all women would be forced to have their babies in hospitals. Childbirth is an emotional happening and often spiritual as well — hospitals seem to lack compassion at times in how you or I would prefer a childbirth in these aspects. After all, at Christmas we celebrate a Man's birth whose was the lowliest birth of all (— and certainly not the most sanitary!) and He survived it just fine.

I'm just one among many who support this bill. We can't hardly wait for it's passage. Thank-you for you work.

Sincerely,

Mrs. Wendy J. Hogan

Box 2906
Homer, Alaska 99603
March 17, 1982

Senator Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sen. Fischer:

I am writing concerning the proposed legislation on midwifery. Specifically, I urge your support of Senate Bill 747.

As a concerned citizen & parent, I believe consumer demand for the service of midwives will continue. To best serve the public, it is essential to establish licensing procedures & standards within which midwives would function. I believe Senate Bill 747 provides the most appropriate legislation. If passed, prospective parents would be in a better position to make a wise choice among midwives & other caregivers. Furthermore, it is my opinion that funding should be provided for a peer regulating board to govern the work of midwives.

Thank you for your consideration.

Sincerely,

Carol Hulst

cc: Charlie Parr
Brian Rogers
Albert Adams
Hugh Malone

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Ms. Baim,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening now in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

3-14-82

To Senator's Vic Fisher, Charlie Parr, and anyone else involved in the Senate Bill 747 "an act relating to lay midwifery".

We are in favor of having lay midwifery because we feel that expectant parents should have a wide area of sources to choose from when considering how they want to have their children. (Sources ranging from doctors and hospitals, to nurse-midwifes and clinics, to lay midwifes and home births, ect.)

Lay midwifes have been delivering babies successfully for many generations and we feel they have a

Home Delivery and Neonatal Mortality in North Carolina

Claude A. Burnett III, MD, MPH; James A. Jones, MPH; Judith Rooks, CNM, MS, MPH; Chong Hwa Chen, MS; Carl W. Tyler, Jr, MD; C. Arden Miller, MD

• Neonatal mortality is examined by place and circumstances of delivery in North Carolina during 1974 through 1976 with attention given to home delivery. Planned home deliveries by lay-midwives resulted in three neonatal deaths per 1,000 live births; planned home deliveries without a lay-midwife, 30 neonatal deaths per 1,000 live births; and unplanned home deliveries, 120 neonatal deaths per 1,000 live births. The women whose babies were delivered by lay-midwives were screened in county health departments and found to be medically at low risk of complication, despite having demographic characteristics associated with high-risk of neonatal mortality. Conversely, the women delivered at home without known prenatal screening or a trained attendant had low-risk demographic characteristics but experienced a high rate of neonatal mortality. Planning, prenatal screening, and attendant-training were important in differentiating the risk of neonatal mortality in this uncontrolled, observational study.

(*JAMA* 1980;244:2741-2745)

SUMMARY reports of state vital statistics have traditionally classified births as occurring in-hospital and out-of-hospital. Fetal and infant mortality has also been reported using this differentiation. Being the best that is generally available, such information has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery. However, with increasing interest in home delivery, the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them. This article provides an analysis of neonatal mortality in North Carolina during 1974 through 1976, with attention given to the places and circumstances that characterized out-of-hospital deliveries.

In North Carolina, the proportion of infants born at home has declined from 76% in 1940, to less than 1% in 1975 (Figure). With this shift to hospital delivery, maternal mortality fell from 50/10,000 live births in 1940 to 3/10,000 live births in 1975, a decline of 94%. Neonatal mortality also declined 61%, from 33/1,000 live births in 1940 to 13/1,000 live births in 1975. Neonatal mortality remained more than 40 times that of maternal mortality in 1975, despite nearly universal hospitalization for childbirth.

Most of the medical profession advocates hospital delivery and views home delivery as a regressive step that would reverse the historical improvement in the safety of childbirth. Most women choose to deliver in a hospital where physicians are able to intervene effectively in emergencies, many of which cannot be anticipated with even the best prenatal care. However, an increasing number of women prefer delivery at home in order to be among familiar people and surroundings, to avoid the perceived risks of highly technical medical care, and to reduce cost.

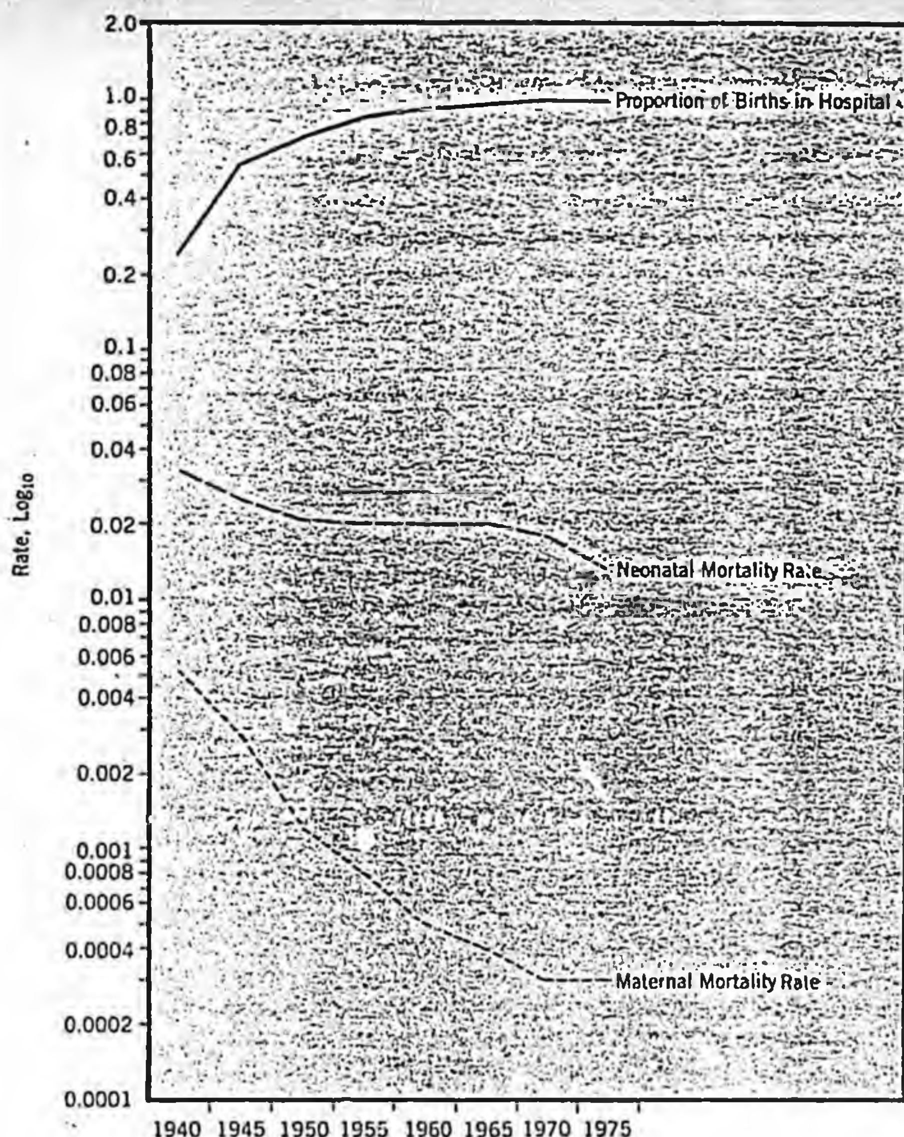
Lay-midwives legally attend home deliveries in some counties of North Carolina. The practice of these lay-midwives is regulated by county health departments. Prenatal care involving physician-supervised screening for risk factors must be provided by the health department for each patient, and every home delivery by a lay-midwife must be approved in advance as low risk. Since 1964, no lay-midwife has been initially certified to practice in any North Carolina county. Those lay-midwives still practicing are gradually being phased out; 25 were issued a required yearly permit in 1974, eighteen in 1975, and fifteen in 1976.

MATERIALS AND METHODS

This study used neonatal death rates as a measure of the risk associated with the place and circumstances of birth. Vital records of live births and neonatal deaths registered in North Carolina for 1974 through 1976 constituted the initial source

From the Family Planning Evaluation Division, Center for Disease Control, Atlanta (Drs Burnett and Tyler and Ms Rooks); the Maternal and Child Health Branch, Division of Health Services, State of North Carolina, Raleigh (Mr Jones); the Department of Biostatistics, Emory University, Atlanta (Ms Chen); and the Department of Maternal and Child Health, School of Public Health, University of North Carolina, Chapel Hill (Dr Miller). Dr Burnett is currently director, Northeast Health District, Georgia Department of Human Resources, Athens. Ms Rooks is currently expert consultant with the Office of the Surgeon General, Washington, DC.

Reprint requests to Northeast Health District, 408 N Milledge Ave, Athens, GA 30601 (Dr Burnett).



Proportion of births in hospital, neonatal mortality rate, and maternal mortality rate, North Carolina, 1940 to 1975.

of information. Birth records were coded as occurring in a hospital, in a clinic or office, enroute to a hospital, or at home. Infant death records are routinely linked with their corresponding birth records in North Carolina, making it possible to determine mortality by birth characteristics.

To estimate the risk of neonatal mortality associated with the circumstances of home delivery, the 1,296 home deliveries occurring in North Carolina during 1974 through 1976 were classified by both their planning status and the attendant present. If a home delivery was chosen and a healthy infant anticipated, it was classified as planned.

Emphasis was placed on determining the planning status of those home deliveries that resulted in neonatal death. Misclassification of a small number of these deaths would have had a notable effect on reported neonatal mortality rates. Therefore, these deaths were individually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery.

Two simplifying assumptions were made in classifying all home deliveries by planning status. We assumed that all home deliveries attended by a lay-midwife were planned. This assumption was justified for two reasons. First, for a lay-midwife to receive a permit to attend a home delivery, a pregnant woman had to be approved by a health department as being at low risk of complications. This was considered evidence of careful planning. Second, a lay-midwife would probably not attend an unplanned home delivery and report it on the birth certificate because of the risk of permit revocation.

Our second assumption was that home deliveries of infants weighing 2,000 g or less at birth and not attended by a lay-midwife were precipitate and unplanned. There were 51 such deliveries. These may have been planned but were classified as unplanned. However, no such assumption was made in the classification of the neonatal deaths that followed home delivery. Therefore, any classification error introduced by the second assumption would have increased the apparent neonatal mortality rate of home deliveries classified as planned and not attended by a lay-midwife, and decreased the apparent neonatal mortality rate of home deliveries classified as unplanned.

In June 1976, birth certificate copies of the remaining unclassified home deliveries were sent to the health department of the county of residence of the mother. A brief questionnaire accompanied each certificate requesting that health department staff determine the reason for home delivery and identify the attendant present. Four reasons for home delivery were provided: precipitate, intended, failure to plan for health care, and unknown. Field work by county health department staff was necessary when no detailed record described the circumstances of the birth.

RESULTS

Births Associated With Home Delivery.—Table 1 shows a classification of all 1,296 home deliveries for 1974 through 1976. Seventy-two percent of home deliveries were classified as planned. Of these, 768 were attended by lay-midwives and were assumed to be planned; 166 were classified by questionnaire as "intended" and were therefore considered planned. Of the 166 home deliveries classified as "intended," 57% occurred by preference, 26% were for economic reasons, 8% were for religious reasons, and 9% were for other or unknown reasons.

Nineteen percent of home deliveries were classified as unplanned. The 51 infants born at home, attended by other than a lay-midwife, and weighing 2,000 g or less were assumed to be precipitate, unplanned home deliveries. An additional 199 were classified by questionnaire as either "precipitate" or "failure to plan for health care" and were also considered unplanned.

Neonatal Deaths Associated With Home Delivery.—The planning status of the home deliveries that resulted in neonatal death is shown in Table 2. Of the 36 neonatal deaths associated with home delivery during the three years, six (17%) followed planned home delivery, and 30 (83%) followed unplanned home delivery.

Table 1.—Planning Status of All Home Deliveries*

	No.	%
Planned	934	72
Lay-midwife (assumed planned)	768	
Classified by questionnaire	166	
Unplanned	250	19
Birth weight ≤2,000 g (assumed unplanned)	51	
Classified by questionnaire	199	
Unknown	112	9
Total	1,296	100

*North Carolina, 1974 through 1976.

Table 2.—Neonatal Mortality by Planning Status of Home Deliveries*

	Deaths, No. (%)	Births	Rate†
Planned	6(17)	934	6
Infant normal	3(8)		
Congenital anomaly	3(8)		
Unplanned	30(83)	250	120
Precipitate	23(64)		
No alternative	2(6)		
Suspected homicide or neglect	5(14)		
Total	36(100)	1,184	30

*North Carolina, 1974 through 1976.
†Neonatal deaths per 1,000 live births.

Table 3.—Neonatal Mortality by Place and Circumstances of Delivery*

	Deaths	Births	Rate†
Home—planned, attendant physician	0	55‡	0
Home—planned, attendant lay-midwife	3	768	4
Hospital	2,805	242,245	12
Clinic or office	15	949	16
Home—planned, attendant not physician or lay-midwife	3	100‡	30
Enroute	12	177	68
Home—unplanned	30	250‡	120
Total	2,868	244,544	12

*North Carolina, 1974 through 1976.
†Neonatal deaths per 1,000 live births
‡Excludes 112 home deliveries with unknown planning status and 11 planned home deliveries with unknown attendant.

Six neonatal deaths occurred following planned home delivery. In three instances, a trained attendant was not present; in three others, delivered by lay-midwives, death was attributed to congenital anomalies.

Two of the 30 unplanned home deliveries resulting in death were classified as "unplanned—no alternative." Allegedly, one mother, who delivered a 2,800-g infant at eight months, went to a hospital but was turned away for lack of funds. The other, who delivered a 1,400-g infant at seven months, reportedly had been told not to go to the hospital without payment in hand. We concluded that these home deliveries were not intended.

Five of the 30 unplanned home deliveries resulting in death were classified as "unplanned—suspected homicide or neglect." Three involved unwed teenaged mothers charged with homicide. Of the two remaining deaths, one infant was found drowned in a canal and the other was grossly neglected. These home deliveries were judged to be either precipitate or intended without preparation for a healthy infant.

Neonatal Mortality Rates Associated With Home Delivery.—Home deliveries, without regard to their planning status, were associated with a neonatal mortality rate of 30 per 1,000 live births. However, when subdivided by their planning status (Table 2), a different picture emerged. The neonatal mortality of planned home deliveries was 6/1,000, while that of unplanned home deliveries was 120/1,000. The relative risk of unplanned home deliveries was 20 times that of planned home deliveries.

The planning status of 112 home deliveries remained unknown following the questionnaire survey. If these had been planned, the neonatal mortality rate of planned home deliveries would still have been 6/1,000. If all of these home deliveries had been unplanned, the neonatal mortality rate of unplanned home deliveries would have been 83 rather than 120 per 1,000.

The effect of possible classification error introduced by the assumption that the home deliveries of 51 infants weighing 2,000 g or less and not attended by a lay-midwife were precipitate and unplanned can be similarly examined. If all 51 home deliveries had been planned, the neonatal mortality rate of planned home deliveries would still have been 6/1,000; the neonatal mortality rate of unplanned home deliveries would have been 151/1,000.

Table 3 shows all neonatal deaths for the three-year period by place and circumstances of delivery, in rank order from the lowest to the highest neonatal mortality rate. The 112 home deliveries with unknown planning status and 11 planned home deliveries with an unknown attendant are not included in the births column or in the denominators of the neonatal mortality rates. The rates ranged from zero neonatal deaths for planned home deliveries attended by a physician, to 120 neonatal deaths per 1,000 unplanned home deliveries. Planned home deliveries, prenatally screened as low risk and attended by lay-midwives, were associated with a neonatal mortality rate of 4/1,000 live births. However, all three deaths following delivery by lay-midwives were associated with congenital anomalies and may not have been preventable.

Hospital deliveries, including high-risk pregnancies and low-birth-weight infants, were associated with a neonatal mortality rate of 12/1,000 live births. After excluding infants weighing 2,000 g or less at birth, the neonatal mortality rate for hospital deliveries was 7/1,000, while that for lay-midwife home deliveries remained 4/1,000. This difference was not statistically significant.

Three groups of home deliveries can be distinguished from Table 3: (1) unplanned; (2) planned without known medical screening and without a trained attendant; and (3) planned, selected based on medical screening, and with at least a minimally experienced attendant (grouping home deliveries by physicians and lay-midwives together). Group 1 had 4 times (95% confidence limits 1.4 to 11.4) the

Table 4.—Percent Distribution of Births by Selected Maternal Characteristics*

	Home Lay-Midwife, %	All Deliveries, %	Neonatal Mortality Rate† All Deliveries
Age, yr			
<20	40	24	14
20-24	34	35	11
25+	26	41	10
Race			
White	4	69	10
Nonwhite	96	31	15
Marital status			
Married	56	84	10
Unmarried	44	16	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	288
2,001-2,500	6	5	24
2,501-3,000	20	18	5
>3,000	74	74	2
N	467	159,333	...

*Home deliveries by lay-midwives vs all deliveries, and neonatal mortality rate for all deliveries North Carolina, 1975 through 1976.

†Neonatal deaths per 1,000 live births.

neonatal mortality rate of group 2. Group 2 had 8 times (95% confidence limits, 2.2 to 31.3) the neonatal mortality rate of group 3.

Lay-Midwife Deliveries.—Table 4 compares the maternal characteristics of the 467 women delivered by lay-midwives with all 159,333 deliveries occurring in North Carolina during 1975 and 1976. The table also shows the neonatal mortality rate for all deliveries relative to maternal characteristics. The distributions for the demographic variables of age, race, marital status, and education reveal a preponderance of mothers in high-risk categories among lay-midwife home deliveries compared with all deliveries. The women attended by lay-midwives were more likely to be young, black, unmarried, and less educated than the average woman who delivered in the state. Despite their high-risk demographic profile, these women had a relatively low-risk medical profile. None of their infants weighed 2,000 g or less, and their neonatal mortality rate was one third that for all deliveries.

Planned Home Deliveries Without a Trained Attendant.—Contrasted with women delivered by lay-midwives, women who delivered without a trained attendant had a low-risk demographic profile: 5% were younger than 20 years, 78% were white, 90% were married, and 48% were educated beyond high school. While they were at high risk with respect to prenatal care (38% with two or less prenatal visits), their deliveries were at low risk with respect to infant birth weight (only 2% of the infants weighing 2,000 g or less). Even with these favorable characteristics, their neonatal mortality rate was eight times that of lay-midwife home deliveries.

COMMENT

This study showed that the outcome of delivery varied importantly by both the place and circumstances of delivery. In-hospital vs out-of-hospital classification does not adequately group births by risk of neonatal mortality. Even more specific designation of the place of birth does not suffice to describe risk. Deliveries occurring at home ranged from lowest to highest risk of neonatal mortality depending on planning and the attendant present.

Medically selected women delivered at home by lay-midwives were at high demographic but low medical risk. The screening process carried out through physician-supervised prenatal care at local health departments was apparently effective.

In contrast, planned home deliveries without known medical screening and without a trained attendant resulted in high neonatal mortality despite their low-risk demographic profile. Having less prenatal care and not having a trained attendant at delivery appears to have lessened the demographic advantage for this group and predisposed their infants to higher mortality.

Unplanned home deliveries were associated with neonatal mortality even higher than deliveries en route to the hospital, although the difference was not statistically significant. After analyzing 100 consecutive cases of unattended home deliveries in England, Fraser[1] 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[7] and later Levy et al[3] 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[4] 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, Kessner et al[5] in New York and Dott and Fort[6] 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.[7] Second, lay-midwives practicing in North Carolina during the study were initially certified in 1964 or before and had at least ten years' experience with home deliveries.

Despite including all births in a three-year period, the number of home deliveries in this study remained small. There were so few neonatal deaths that the neonatal mortality rates of subgroups of home deliveries could be substantially altered by the addition or reclassification of several neonatal deaths. The findings need testing where home delivery is more common.

Retrospective classification of birth regarding intent to deliver in the place and circumstances in which delivery actually occurred is difficult at best. Intended home deliveries followed by neonatal death may have been misclassified as precipitate and unplanned. Women who chose home delivery but developed a problem during labor may have gone to the hospital to deliver. Hospitals are appropriately the intended place for most high-risk deliveries. This fact confounds comparison of the neonatal mortality of hospital and home deliveries.

Some home births may not have been reported to state registrars, especially if the infant died. Possibly such underreporting was more frequent in planned home deliveries when a preventable death caused guilt feelings. However, because lay-midwives need a permit for each home delivery and have a reputation to maintain, such underreporting is probably less likely than for home deliveries that did not come to the attention of the health department before delivery.

In conclusion, there has been a dramatic shift from home to hospital delivery in the last 40 years in North Carolina. The potential risk of delivery at home may be unacceptable to most women. However, some women still prefer or economically need an alternative to a high cost physician-hospital delivery. Indeed, cost and preference accounted for more than three fourths of the reasons for the dangerous planned home deliveries not attended by a physician or lay-midwife.

Poor women in some rural areas are still experiencing high levels of preventable neonatal mortality because of lack of medical attention. To extend adequate prenatal and delivery services to these women, economically realistic alternatives should be developed before existing traditional services are phased out. For prenatally screened low-risk women, delivery by a trained nurse-midwife under physician supervision, perhaps in a birthing center with hospital backup, may have a cost advantage over physician-hospital delivery without unacceptable risk of maternal or neonatal mortality. Whatever program a community develops, monitoring the quality of prenatal care, adequately identifying high-risk pregnancies, and training competent birth attendants all require the knowledge, expertise, and support of the medical community.

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STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU ALASKA 99811
907-465-3600

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M April 8, 1982

SUBJECT: Laboratory testing for women planning home births. (SB 747)

TO: Senator Charles H. Parr

FROM: Tamara Brandt Cook
Legislative Counsel

You have asked in general what liability a physician might incur by authorizing laboratory tests for a woman who is planning a home birth, assuming the physician does not render any other medical service to the woman related to the pregnancy or birth.

Under general principals of tort law, a physician would be liable for injuries resulting from the negligent performance of a medical service. Negligent conduct is conduct that violates the actor's duty of care, a duty to act with the amount of care that a reasonably prudent person (in this case, a reasonably prudent physician) would use under similar circumstances. Swenson Trucking and Excavating, Inc. v. Truckweld Equipment Co., 604 P.2d 1113 (Alaska 1980) Among the elements necessary to make out a claim for relief based on negligence is a reasonably close causal connection between the conduct and the resulting injury, that is "proximate cause". Sharp v. Fairbanks North Star Borough, 569 P.2d 178 (Alaska 1977) A causal connection is not deemed to be a legal cause of injury unless it is a substantial factor in bringing about the harm. Ketchikan Gateway Borough v. Saling, 604 P.2d 590 (Alaska 1979)

Applying these principals to the situation posed by your question is difficult since each case of alleged negligence is decided upon the particular facts of that case. Some fact situations that could result in liability on the part of a physician who orders laboratory tests include:

1. failure to order the correct test or all the tests that are necessary;

2. improper interpretation of the test results;

3. if during the process of authorizing the tests the physician examines the patient, failure to discover a condition needing treatment or posing a hazard or, if the condition is discovered, failure to inform the patient of the need for treatment or of the hazard posed.

However, in any fact situation the conduct of the physician must be a proximate cause of the injury before the physician may be held liable. The physician would not be liable for problems experienced during a home birth that are not connected to the service rendered by the physician in authorizing the laboratory tests.

You have asked whether a laboratory must have the authorization of a physician before it may test a medical sample. Nothing in the statutes forbids a laboratory from conducting tests without the authorization of a physician. AS 18.05.-040(a)(17) requires the commissioner of health and social services to adopt regulations for the voluntary certification of laboratories that perform diagnostic analyses on specimens from persons "submitted by licensed physicians and nurses for analysis". However, nothing in the statute appears to preclude the laboratory from performing tests on specimens submitted by other persons as well. A certification process for laboratories is established in 7 AAC 27.360, and the regulations contain no requirement that the laboratory only accept samples from physicians. AS 18.15.150 requires any person permitted by law to attend a pregnant woman but not permitted to take a blood sample to have the sample taken by a physician and to submit the sample for testing for syphilis. Since this provision requires a person other than a physician to submit a sample to a laboratory, it would make little sense for the laboratory to be precluded from testing the sample. On the other hand, a private laboratory is not required by law to accept all samples for testing.

I hope this answers your questions. If you have a specific situation in mind, please let me know and I will look into the matter further.

TBC:jdn

STATE OF ARIZONA

DEPARTMENT OF HEALTH SERVICES

ARTICLE 2. LICENSING OF MIDWIFERY

R9-16-200. Reserved

R9-16-201. Minimum qualifications

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

Historical Note

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

R9-16-202. Renewal application

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

Historical Note

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

R9-16-203. Course of instruction

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

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

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

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

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

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

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

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

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

Historical Note

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

R9-16-204. Qualifying examination

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

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

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

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

Historical Note

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

R9-16-205. Responsibilities of the midwife

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

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

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

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

1. Maternal conditions:

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

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

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

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

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

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

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

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

Historical Note

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

R9-16-206. Reports

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

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

Historical Note

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

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

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

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

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

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

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

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

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

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

Historical Note

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

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

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

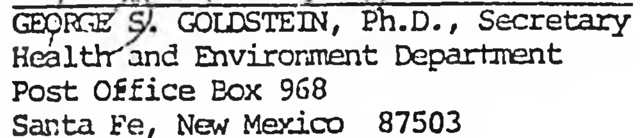
FILE CATEGORY:
REGULATION NO.: HED-80-3A (HSD)
ORIGINATOR: Health Services Division

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

REASONS FOR ADOPTION:

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

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



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

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Health and Environment Department
Health Services Division
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Santa Fe, New Mexico 87503

HED-80-3A(HSD)

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

General Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPLICABILITY

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

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

201.01. prenatal supervision and counseling;

201.02. preparation for childbirth;

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

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

REGISTRATION OF LAY MIDWIVES

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

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

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

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

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

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

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

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

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

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

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

302.02.07. Fee as prescribed by the Division.

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

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

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

303.01. An application to sit the next qualifying examination;

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

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

303.04. Evidence of satisfactory completion of required clinical experience;

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

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

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

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

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

303.10. Fee as prescribed by the Division.

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

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

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

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

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

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

307.03. Renewal fee as prescribed by the Division.

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

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

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

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

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

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

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

310.05. Submitting renewal fee as prescribed by the Division.

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

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

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

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

500.01. Dereliction of any duty imposed by law;

500.02. Incompetence;

500.03. Conviction of a felony;

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

500.05. Practicing under a false name or alias;

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

500.07. Obtaining any fee by fraud or misrepresentation;

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

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

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

500.11. Permitting another to use his registration;

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

500.13. Violating any of the provisions of these regulations.

EDUCATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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702.01.02. Normal growth and development of fetus and placenta;

702.01.03. Normal progress of pregnancy, labor and delivery;

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

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

702.01.06. Prenatal nutrition.

702.02. Patient teaching;

702.03. Special requirements of home delivery;

702.04. Risk factors in pregnancy;

702.05. Terminology used in the practice of lay midwifery;

702.06. Normal newborn characteristics and possible problems including anomalies;

702.07. Care of the newborn; and

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

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

703.01. Evaluation of judgment to cover areas of:

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

703.01.02. Recognition and treatment of emergency situations

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

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

704.01. Temperature, pulse, and respiration

704.02. Blood pressure

704.03. Fetal heart tones

704.04. Abdominal palpation

704.05. Cervical dilatation

704.06. Fetal position

704.07. Measurement of fundal height

704.08. Exam for edema

DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

819.02. Develops edema of the face and hands.

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

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

819.05. Develops glucosuria or proteinuria.

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819.06. Has symptoms of vaginitis.

819.07. Has symptoms of urinary tract infection.

819.08. Has vaginal bleeding before os.

819.09. Has premature rupture of membranes.

819.10. Noted decrease in or cessation of fetal movement.

819.11. Has inappropriate gestational size.

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

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

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

819.15. Has polyhydramnios or oligohydramnios.

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

819.17. Is found to be Rh negative.

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

819.19. Is 36 years of age or older.

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

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

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

820.03. Develops proteinuria.

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

820.05. Develops respiratory distress.

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

820.07. Has ruptured membranes without onset of labor after 12 hours.

820.08. Has bleeding prior to delivery.

820.09. Has meconium stained amniotic fluid.

820.10. Has a presenting part other than a vertex.

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

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

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

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

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

820.16. Has retained placental fragments or membranes.

820.17. Desires medical consultation or transfer.

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

821.01. Has a second, third or fourth degree laceration.

821.02. Has uterine atony.

821.03. Bleeds in an amount greater than normal lochial flow.

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821.04. Does not void within 6 hours of birth.

821.05. Develops a fever greater than 100°F. 38°C on any 2 of the first 10 days postpartum excluding the first 24 hours.

821.06. Develops foul smelling lochia.

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

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

822.02. Has any obvious anomaly.

822.03. Develops grunting respirations, retractions or cyanosis.

822.04. Has cardiac irregularities

822.05. Has a pale, cyanotic or grey color.

822.06. Has an abnormal cry.

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

822.08. Shows signs of prematurity, dysmaturity or postmaturity.

822.09. Has meconium staining.

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

822.11. Is lethargic or does not nurse well.

822.12. Has edema.

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

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

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

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

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

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

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

900.05. Has a history of third trimester bleeding.

900.06. Has a history of thrombophlebitis or pulmonary embolism.

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

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

900.09. Has a contracted pelvis.

900.10. Has severe psychiatric illness or a history of psychiatric illness in the 6 month per [illegible] prior to pregnancy.

900.11. Is addicted to narcotics or other drugs.

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

900.13. Has a multiple gestation.

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

900.15. Has a gestation beyond 42 weeks by dates.

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

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

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

900.19. Has pre-eclampsia.

900.20. Has a parity greater than 5.

900.21. Is 17 years of age or younger.

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

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

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

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

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

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

SUPERVISION BY DIVISION

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

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

1000.02. One certified nurse midwife;

1000.03. Two regularly registered lay midwives;

1000.04. One member at large.

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

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

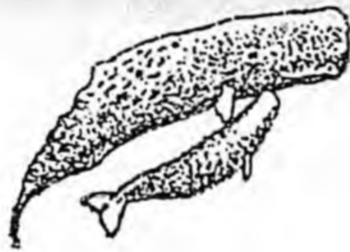
1002. MORTALITY: IMMEDIATE REPORTING: The registered lay midwife must report within 48 hours to the Health Services Division any fetal, neonatal or maternal mortality in patients she has cared for or any major morbidity as outlined in the section Prohibitions and Limitations of Practice.

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

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

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

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



March 15, 1982

Dear legislature,

I am responding to Senate Bill 747 "An Act Relating to mid-wifery." I've in the past have sent in my suggested revisions for HB11 and see the changes reflected in SB 747. Although there are points I'm not comfortable with and am unclear about, I feel it's a bill that midwives and families can benefit from.

As a lay midwife, I have met much resistance and little support from the established medical system. I've been criticized for not having costly medical tools (I do not charge), lack of knowledge surrounding medical proceedures and the skills to use them (which if I did perform such a medical proceedure I face practicing medicine without license). Yet, it is these very people who aren't open enough to share and teach these skills and knowledge but make the charges if performed. I've been personally been pressured, blacklisted and verbally threatened to discontinue working with folks who seek me out. These folks do not want to birth with the medical system due to many reasons. Some reasons being cost, frontier spirit, non intervention, control and responsibility in decisions, comfortableness of their home environment, dislike of doctors and/or hospitals, feeling pregnancy and birth is a normal physiological process and not a medical proceedure or just their philosophy. By trying to eliminate lay midwives

will not stop home births. But enlarges the all ready existing gap for communication, screening for problems and medical availability when needed between care givers and families.

This gap could be lessened with this bill and all efforts should at least be made to not enlarge the gap. The established medical system is valuable and has its place, but need it control other forms of workable health care systems and philosophies? Isn't our constitution designed to protect its citizens from such an anarchy?

Because of the choices available for the birth of my next child, we are having to seriously consider leaving our home and state. We are not comfortable with asking a midwife to place herself in a legal vulnerable position, doing the birth by ourselves nor going to the practioners that have been out right hostile to me.

I plea as a mother who has birthed at home, a worker who has worked labor/birth in hospitals, a woman who has been called on to stand by birthing families and a person who sincerely wants to be a credible helping citizen, for you to listen and provide for your people. I urge you to support and pass SB147.

Most Caringly,

Kathleen Stier
Box 1136
Homer, Alaska 99603

March 16, 1982

Dear Vic

Thank you for your letter, it was informative and appreciated. I have been encouraging my friends and clients to voice themselves about SB 747. I will be at the March 25 tele conference. I have some questions about the apprenticeship I hope to have explanned then. Enclosed are some copies of studies I thought you might find helpful. I would appreciate if you would be sure that copies of them get sent to supportive and key persons. Also I enclosed a booklet that I thought you may find interesting if not amusing.

I understand the Alaska Hospital Ass. has a lobbiest. How much pull and effect does this have? Do we (who have had to function underground with little or no pay) realistically have a change for the bill to pass against a established organization with $ behind them?

Thanks again, I would appreciate being kept posted. I seem to be the contact for this area and do share the news.

Warmly,

Kathleen Stier

We were involved in all aspects of the birth and post natal care from cutting the cord to checking apgar score, to cleaning baby up, to nursing our little girl right after birth. It was wonderful.

We realize that not all deliveries are without complication, but most potential problems can be detected before the actual birth which would put those people in a high risk category for home births, and lay midwifes that we know will not deliver for anyone who is a high risk. They want what is best for our children too.

was an impersonal experience for everyone but us. After the delivery our son was taken away from us for a couple of hours so he could be cleaned up, etc.

Our home birth was also a successful delivery but with the help of a understanding lay mid-wife and a well read husband involved. The experience was much more enjoyable. The lights were dim, low playing music, comfortable bed that I was used to, good friends to help and to take pictures, and just an all round relaxed atmosphere.

right to continue doing so as long as people like us want and need them to deliver our children in the place we feel most comfortable, our homes.

We have had two children. One with doctors, nurses and the hospital, the other at home with the help of a lay midwife. The hospital birth went very well as far as a successful delivery, but there were interruptions from nurses and doctors, other women in labor, some screaming, everyone in a hurry; all this was very disturbing to us and made us feel that the birth of our child

We are now expecting our third child and are definitely considering another home birth. We hope that lay-midwifery will still be an option available to us so that we will have the choice if we so choose.

Thanks you for listening to our opinions.

Susan L. Connor

+ Charles B. Connor

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

TO: Representative Joe McKinnon January 14, 1980

FROM: Christine Johnson, Research Analyst CEJ
House Research Agency

THROUGH: Duncan L. Read, Director
House Research Agency

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

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

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

CJ/bf
Encl.s

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	Practice supervised by physician or surgeon (physician's presence not required); 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 abortions.
	Special Statutory Provisions	Requirements for censure are left up to appropriate boards and committees. In general, California's statutes establish the confines of the practice.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

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

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

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MARYLAND (Art.43.82-94)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certified by American College of Nurse-Midwives as a nurse-midwife.
	Limitations on Practice	Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion.
	Special Statutory Provisions	Person who isnot licensed midwife may practice under the personal and direct supervision of a physician. Subtitle does not restrict physician or person volunteering service in an emergency.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included).

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

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		NEW JERSEY (45:10)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Certificate from school of midwifery, or maternity hospital granted after 1800 hours of instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician.
	Limitations on Practice	Shall not perform criminal abortion. Normal labor cases. only.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

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

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

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

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

TO: Senate HESS Committee members

FROM: Nancy Deitrick

RE: Video Teleconference

The video teleconference for SB 747 "An act relating to Midwifery" on March 25, 3:00 p.m. to 5:00 p.m. is in room 423 of the Capitol building.

Following the video portion of the teleconference, we will be switching to audio for all sites.

A video teleconference is completely scheduled before the conference starts, and there are many people wishing to speak. Testimony has been limited to three minutes, and for this reason members are being requested to limit questions to participants as much as possible.

The conference will open with Charlie Parr introducing the committee members and giving a brief summary of the bill. We will then go to Fairbanks(35 min.), Sitka(35 min.) and Anchorage(45+ min.). Sitka is set up only to receive video, so all sites will be viewing the committee during their testimony. Fairbanks and Anchorage will be viewing the committee during their testimony, with other sites seeing the person testifying. The name of the person testifying will be on the television screen.

Bethel had to be dropped from the video portion because of technical problems.

DO NOT wear a white shirt!

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

March 27, 1981

MEMORANDUM

TO: Representative Tony Vaska

FROM: Leslie Longenbaugh LL
Research Staff

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

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

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

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

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

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

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

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

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

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

LL/dp

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

March 31, 1981

MEMORANDUM

TO: Representative Tony Vaska

FROM: Leslie Longenbaugh
Research Staff

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

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

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

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

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

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

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

---

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

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

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

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

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

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

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

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

4. Does Oregon keep a register of lay midwives?

There is no list of midwives compiled by the state.

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

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

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

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

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

LL/dp

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March 31, 1981

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March 3, 1982

To: Representative Pat Carney, Chair
House Finance Subcommittee

From: Representatives Brian Rogers
and Tony Vaska

Prepared
By: Ginger Baim, Aide to
Senator Vic Fischer

Re: CS SS House Bill 11 and Senate Bill 747

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

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

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

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

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

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

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

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

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

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

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

levels of midwives attending homebirths.

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

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

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

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50399
Fairbanks, Alaska 99701
(907) 456-3029

Pouch V
Juneau, Alaska 99811
(907) 465-4907

March 2, 1982

Dr. William Bell
Box 194
Homer, Alaska 99603

Dear Dr. Bell:

Thank you for sending me copies of your letter of February 17 to Rep. Hugh Malone (lay midwives) and of February 19 to Sen. Mike Colletta (naturopaths).

Let me deal with the lay midwife issue first. Last year the Medical Board proposed a revision of the medical practice act which gave the Board authority to regulate lay midwives. My committee received almost 200 irate messages and letters opposing such regulation. When we held a teleconference on the bill there was another outcry. Dr. Jeffrey Partnow, President of the Board, was present and heard the opposition.

Witnesses said that: Childbirth is a natural process, not an illness; that they wanted their children born at home but could find no doctors willing to do home deliveries; that regulation of midwives was a power or money grab by doctors; and some claimed to have had trouble with the doctor/hospital birth and no trouble with the midwife/home birth.

As a result of the reaction the midwifery section was removed from the bill. Rep. Brian Rogers had a bill (HB 11) on midwifery in the House, and the Senate HESS Committee felt treating the subject separately would avoid jeopardizing the medical practice act. I can assure you that we will deal carefully with the subject.

The HESS Committee has now had a teleconference and a hearing on the naturopath bill. Nearly all testimony so far has been in favor. Witnesses have made the following points: They should have the right to be treated by naturopathic means if that is their preference, presently in order to exercise this right they must make an expensive trip to the lower 48, and finally they want naturopaths licensed to do only what those practitioners are trained and qualified to do.

Again, I think the Committee will move carefully. We are all laymen and we are all accustomed to listening to expert--but

conflicting--testimony. We will look at fairly recent statutes from other states and will attempt to learn what the experience has been in states which do license naturopaths.

Thank you again for your letters.

Sincerely,

Charles H. Parr

CHP:bk

cc: Senator Colletta
Representative Malone

Copies members packets.

FAIRBANKS INTERNAL MEDICINE
and
DIAGNOSTIC CENTER, INC.
1919 LATHROP STREET
FAIRBANKS, ALASKA 99701

(907) 452-4769

INTERNAL MEDICINE
WILLIAM H. DOOLITTLE, M.D. F.A.C.P.
JEFFREY A. PARTNOW, M.D.

INTERNAL MEDICINE, HEMATOLOGY & ONCOLOGY
J. MICHAEL CARROLL, M.D.

INTERNAL MEDICINE & AVIATION MEDICINE
DAVID S. GRAUMAN, M.D. F.A.C.P.

April 13, 1981

Senator Charles Parr
Pouch V
Juneau, AK 99811

Dear Senator Parr:

Please allow me to express thanks, both from the Medical Board and especially from myself personally, for the courtesy shown by your Committee in allowing me to testify on SB 237 last week. As I indicated on the plane, I was quite nervous about my appearance, having never done such a thing before, and the good auspices with which I was received were greatly appreciated.

Please also extend my thanks to Senators Stimson, Fischer, and Kelly.

The day after meeting with you, I spent a few hours with Doctor Spence at the Department of Public Health talking over the "obstetrical controversy". Should you or Senator Fischer decide to introduce separate statute concerning this, there are several points that I would like to make. As you are aware by now, I am speaking only as an individual who has devoted a fair amount of thought to the situation.

(1) As you correctly identified, there are two aspects to the problem. The first deals with home deliveries versus deliveries elsewhere, and I personally feel that this is probably a matter of personal preference and is certainly not anything tha the State should legislate out of existence. Needless to say, I feel that there should be some medical screening somewhere along the line to minimize, insofar as possible, any predictable medical problems. The second aspect of the problem is that of layman providers. This is clearly a thornier issue.

(2) I feel strongly that all individuals providing obstetrical services on any sort of on-going basis ought to be "licensed" or "authorized". Inasmuch as there is no centralized certifying body, it will prove difficult to set up any kind of consistent procedure concerning training and qualifications. Those people without formal training who have had a good deal of prior experience, will be particularly difficult to evaluate.

(3) The testimony expressed at the Hearing, while nearly unanimous and obviously quite impassioned and vociferous, clearly represents a minority point of view as cursory examination of Vital Statistic Records would bear out. In looking at the relevant statistics for Juneau in 1979, the last year for which records are available, it would appear that the instance of home delivery is between 3 and 5%. I am at a loss to explain the apathy shown by virtually all members of the majority viewpoint during the hearing.

(4) I feel that there must be some statutory (or regulatory) insistence on a mode of communication in the event of medical problems. I feel that there should be some formalized, prearranged communication mechanism rather than haphazard communication at the time that an emergency becomes apparent.

(5) For purposes of maintaining good Vital Statistics, there must be some insistence that a birth certificate be completed regardless of the location of birth. Dr. Spence indicates that perhaps 50% of home births are currently going unrecorded.

(6) Careful review of the relevant statutes and regulations dealing with nurse-midwives (advanced nurse practitioners) ought to be made to insure non-discrimination.

(7) In order to foster communication between the "medical establishment" and lay providers, there should be some specific statutory exemption from liability for physician or nurse midwife collaborators.

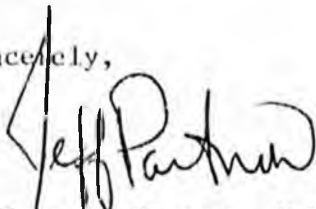
(8) Medical screening could be provided either by physicians or through the Department of Public Health.

(9) There is clearly a need for a massive public education campaign to outline the scope of potential services, high risk versus low risk pregnancies, etc.

(10) I continue to have strong personal feelings that the practice of medicine comprises a good deal more than treating "illnesses and conditions". The delivery of obstetrical care seems to me to be a part of the practice of medicine, and as such, is I feel a legitimate area of concern for the Medical Board. As I have stated, the Board is willing to tackle this difficult area if this is the desire of the Legislature. I would, however, be more than pleased to see someone else shoulder this particular burden.

At the risk of sounding like a stuck record, I would like to reiterate that I personally nor the Medical Board as a whole have any particular ax to grind in this matter other than the insurance of the provision insofar as feasible of adequate health care to the citizens of Alaska. I would be more than pleased to provide whatever input I can to you in any future deliberations concerning this matter.

Sincerely,



Jeffrey A. Partnow, M.D.
Chairman
State Medical Board

JAP/co

MSG 82-00010762 PRTY 1 02/26/82 18:28:47 ORIG: LM00 IN= 0011 OUT= 015
FROM: MARTIE/MATSU TO: JUNEAU INFORMATION .
TARGET: LJH2 SUBJ: P.O.M. PAGE 00

TO: SEN PARR, CHAIR SEN. HESS

FROM: JOE AND VIOLET REDINGTON
KNIK RD. BOX 5460
WASILLA 99687
(H) 376 5562, (W) 376 4256

617

RE: SB 617

WE ARE DEFINITELY IN FAVOR OF SB 617 FOR THE VOACTIONAL AND AGRICULTURAL TECHNICAL SCHOOL AT MAT SU COMMUNITY COLLEGE.

MR. CHARLIE PARR, CHAIRMAN
HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
POUCH V
JUNEAU, ALASKA

DEAR MR. PARR,

I WOULD LIKE TO ADVISE YOU OF MY STRONG SUPPORT OF S.B. #747- AN ACT RELATING TO MIDWIFERY. WE NEED THE HELP OF LAY MIDWIVES IN THIS STATE. COULD YOU PLEASE SET UP A TELE-CONFERENCE SO THAT PEOPLE IN BRISTOL BAY CAN PARTICIPATE IN THE HEARINGS? THANK YOU.
SINCERELY,

CAMILLE MARTINZ

TO: SENATOR PARR

FROM: MARELLA JAVIER
7600 DELAIR #162
ANCHORAGE 99504 (H) 333-5736

I SUPPORT SB 747 AND WOULD APPRECIATE YOUR ARRANGING A TELECONFERENCE ON THIS BILL.

TO: SENATOR PARR

FROM: LESLIE BRECKE
7800 DEBARR #431
ANCHORAGE 99504 338-3252

I SUPPORT SB 747 AND WOULD LIKE TO REQUEST A TELECONFERENCE ON IT. THANK YOU FOR YOUR ATTENTION TO THIS MATTER.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE - UPDATE

I. REQUEST
Bill/Resolution No. SB 747
Title An Act relating to midwifery.
Requested by Senator Fischer Date 2-11-82

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

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		27.9	27.9	27.9	27.9	27.9
200 TRAVEL		9.4	10.3	11.4	12.5	13.7
300 CONTRACTUAL		16.0	17.4	18.9	20.6	22.4
400 COMMODITIES		.5	.5	.5	.5	.5
500 EQUIPMENT		2.8				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		56.6	56.1	58.7	61.5	64.5

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		56.6	56.1	58.7	61.5	64.5
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

PERSONAL SERVICES - FY'82 salary schedule and benefits.
1 Licensing Examiner I, range 12, gen.govt., 12 mos. 27.9

TRAVEL - 10% inflation factor projected.
Board of Midwifery, 5 members(anticipate 1-Anch, 1-Fbks, 1-Southeast, 1-Kenai area, and 1-Nome area); 3 meetings per year (1 ea. in Anch, Fbks, & S.E), travel costs plus 3 days per diem @$80/day $6,000.00

Department staff: 1-licensing examiner to attend meetings of the Board of Midwifery, travel costs plus per diem 1,200.00
1-regulations specialist to hold hearings and assist board in promulgation of regulations, travel and per diem 1,200.00
1-investigator, travel and per diem costs to investigate complaints concerning lay midwifery; average 1 trip every 4 months @$200/trip plus per diem @ $80/day 1,000.00

IV. DATE March 25, 1982 PREPARED BY Marjorie Odland
AGENCY Division of Occupational Licensing
PHONE 465-2535

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

33-001 (Rev. 12/81)

CONTRACTUAL - 9% inflation factor projected.

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

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

Average 6 hour days:

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

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

Rental Space - 1 licensing examiner position: 60 sq.ft X $1.70 X 12 mos.= 1.2

COMMODITIES

General supplies needed by licensing examiner such as tapes for meetings, file folders, paper etc. .5

EQUIPMENT - one time cost in FY'83.

1 desk, double pedestal 60" x 30"	426.92
1 chair, posture without arms (contour)	170.57
1 typewriter, correcting selectric, dual pitch	1,028.81
1 typewriter table	101.92
1 credenza, 90" x 62"	470.90
1 side chair	95.15
2 file cabinets, 4 drawer legal	505.20
	$2,799.48

A GUIDE TO DOCUMENTING A LOCAL PROGRAM

THE CHILD WELFARE RESOURCE INFORMATION EXCHANGE

A Project of

The Children's Bureau
Administration For Children, Youth and Families
Office of Human Development Services
U.S. Department of Health, Education, and Welfare

Prepared by

Mott-McDonald Associates, Inc.
2011 Eye Street, N.W.
Washington, DC 20006

Contract #DHEW-105-76-1130
December 1979

Department of Health and Human Services
Office of Human Development Services
Administration for Children, Youth and Families
WASHINGTON, D.C. 20201

June 24, 1980

Dear Colleague:

From October, 1976 through December, 1979, the Children's Bureau supported an innovative demonstration of technology transfer called the Child Welfare Resource Information Exchange. The goal of the Exchange was to promote the transfer of program and technological developments and knowledge related to services for children at risk with a primary focus on child welfare services. The Exchange provided technical assistance in the replication and implementation of programs, methodologies and materials to improve practice. The child welfare community was kept informed by a bi-monthly bulletin and through the dissemination of program abstracts which provided details on the features of an exemplary program. These two forms of knowledge dissemination and utilization have been well received by child welfare planners, administrators, practioners, and academicians.

To provide continuity after the Child Welfare Resource Information Exchange completes its close-out activities the Children's Bureau has entered into a cooperative arrangement with Project Share to assume some of its knowledge dissemination and utilization functions.

Project Share is an information clearinghouse sponsored by the Department of Health and Human Services to provide significant information to help improve the management of human services. Project Share acquires, announces, and makes available documents; analyzes and synthesizes these documents; provides computerized literature searches of its data base; and produces and disseminates many monographs and bibliographies on topics of current interest to its users. A quarterly Journal of Human Services Abstracts will be disseminated to interested users. This publication will serve a function similiar to the abstract updates formerly sent out by the Exchange.

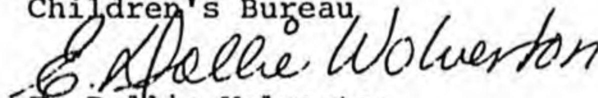
As indicated in the last issue of the Bulletin there are forty National and Regional resource centers that also can assist you. In the near future we expect to develop additional resources relating to Indian Child Welfare and home-based services. We are pleased to have worked with you in achieving information dissemination leading to program improvement and advancement.

Enclosed for your information are two publications of the Exchange which have not been previously disseminated: A Guide To Documenting A Local Program: revised; Suicide Among Children and Youth: A Guide For The People Around Them.

We also take this opportunity to express our appreciation and commendation to Paul Mott and the staff of the Exchange who successfully demonstrated different approaches to social change.

Sincerely,

Charles P. Gershenson
Director, Program Development and Innovation Division
Children's Bureau



E. Dollie Wolverton
Project Officer
Program Planning and Innovation Specialist

Enclosures

A GUIDE TO DOCUMENTING
A LOCAL PROGRAM

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INTRODUCTION

The purposes of the Child Welfare Resource Information Exchange (Exchange) are to identify scuccessful child welfare programs and practices, and to stimulate, or assist in, the transfer of successful programs/practices to other settings. The resource collection includes operating manuals, handbooks, program descriptions, research studies, state-of-the-art surveys, planning and management tools, and training materials such as curricula, teaching manuals, and student workbooks.

In order to be included in the Exchange, programs/practices must be of benefit to the child welfare field, reflect sound principles of services delivery, have proven results, and possess a high potential for replication. To determine whether potential resources meet these criteria they are evaluated by both Exchange staff and outside reviewers for conceptual soundness, positive evaluative results, and replicability.

The transfers of programs/practices are accomplished through the publication of a bimonthly bulletin and monthly abstracts which permit interested parties to receive more in-depth information directly from the resource developers. On-site consultation services are provided to assist in the adaptation or replication of selected programs.

The assessment of a potential resource for inclusion in the Exchange and the facilitation of the transfer of selected resources require comprehensive documentation of the program/practice. The Exchange staff has found that there are many high quality programs which have not been documented adequately to share with the child welfare field. In addition to making it easier to have a successful program/practice included in the Exchange, adequate program documentation may be beneficial to an agency in other ways, i.e., in efforts to secure program funding, or as a tool in the program planning or evaluation process. The purpose of this guide is to assist child welfare program managers in the documentation of their program efforts by providing both a recommended process and format.

Section I of this guide provides a general discussion of the documentation process, with suggestions for "how to" document a program. Section II presents the recommended format to be used in the preparation of the documentation report. The Appendix provides a sample of the completed documentation of an adoption program, prepared by a member of the Exchange staff.

One final note of introduction. The documentation effort can provide a useful assessment of where your program is, where it's been, and where you would like it to go. Our suggestion is to use the documentation process for redefining and solidifying your program goals, for evaluating its strengths and weaknesses, and for initiating constructive communication among program staff.

SECTION I. THE DOCUMENTATION PROCESS

Program documentation may consume a considerable amount of time, depending upon the size and complexity of the program, and the documentor's familiarity with the program itself. However, the documentation process itself is not complicated.

A. Documentation: Who, How Much Time, Benefit, and Assistance

Answers to several key questions may be useful in considering the costs of undertaking the documentation effort:

- Who is the best person to carry out the documentation effort?
  Our experience indicates that a person knowledgeable with the full range of program functions, services, and operations is the best person to conduct the documentation effort. That person may be a current or past employee, or may be an outsider familiar with the program.

- How much time will it take to conduct this documentation effort?
  We have found that the time required to complete the documentation effort in the format suggested varies considerably from the more complex to the less comprehensive program. For example, the sample found in Appendix A required approximately 120 hours for an Exchange staff member to complete. The cooperation of program staff and the degree to which supportive documents are readily available will have a major impact on time spent in the effort.

- How can this documentation effort help the program?
  Those groups that have completed the documentation effort suggest that it is well worth the time invested. Many point to the increased understanding of the program mission and long-range goals that the involvement in the process can bring; others suggest the completed document has been helpful in gaining increased public understanding and financial support.

B. The Documentation Process: The Major Activities

The process consists of three major activities:

- Information collection;
- Analysis and synthesis of information; and
- Writing the report.

1. Information Collection

The principal sources of information for the documentation effort should be the program's written materials and conversations with program staff. Additionally, the documentor's personal observations of the program's operations can be a valuable source of information.

Written materials may include data sheets, annual reports, funding applications, advertising brochures, operating manuals, case records, and budget documents. The written information should be initially reviewed with an eye toward obtaining a fundamental understanding of the program's operations.

The understanding of the program operations, obtained from the review of the written materials, should be tested and expanded through interviews with key program staff. The documentor should be prepared to engage in informal discussions with these program staff, and be prepared to ask knowledgeable questions concerning the gaps found in the written information.

Personal observations of all phases of the program's operations will provide additional information, and/or raise questions which may not have been previously answered by either the written materials or the initial interviews with program staff. A useful method for observing program operations is to "walk through" all steps of the services program, from intake to case closing or aftercare, from program planning to program evaluation.

2. Analysis and Synthesis of Information

As information is collected, it should be organized into the various sections specified in Section II below. The major categories will be: program environment, program management, program operations (services), and program evaluation.

The analysis of information should seek to assure that there is consistency and continuity among all aspects of the program presented. For example, the documentor will want to assure that all components of the program are reflected in the budget, and that there is a means of providing sufficient data from which a services plan could be developed by the reader of the report.

The synthesis of information, in addition to condensing the material and making it easily understood, may include the development of flow charts, organizational diagrams and other useful graphics, which can be further explained by narrative descriptions.

3. Writing the Report

The documentation report may be written following the format outlined in this guide. (Unlike the sample appended to this manual, you may prefer to single space your final document to cut down on reproduction costs.) The style may be formal or informal, but in any case, the report should be concise (as long as it needs to be, but no longer) and easily understood. Professional jargon should be minimized.

At all stages of its development, the report should be reviewed by key program staff for both accuracy and readability. The finished report should have the approval of the program director before it is sent outside the agency.

C. General Considerations

1. Examples taken from the real-life experiences of your program and its users will be helpful in supporting and making your documentation live. Examples may be a case study of a successful user, interagency cooperative activities, creative ventures, etc.

2. There are many cases in which a picture is worth a thousand words. For example, pictures or diagrams have been found useful in depicting a program's setting and physical plant, its structure, the stages of a user's interaction with an agency, the steps in the planning and management processes, etc.

3. Statistics are an important means by which one can substantiate a program's successes. Statistical charts may be useful in presenting population characteristics of the community served, length of time in the program, follow-up success rate, etc.

4. Evaluation of your program efforts in meeting its objectives is an important consideration in "selling" the success of your program's work to the reader. Both subjective and objective measures may be indicated as clarification of these successes. Evaluative feedback from many sources--users, the community, staff, in addition to the more formal means--might be useful.

5. Wherever possible, a clear "how to" approach is helpful in indicating program accomplishments. To those reading your document, process is every bit as important as output or outcomes. Likewise, approaches that were tried and subsequently rejected may be as useful as those which were successful. Remember that the aim is to provide specific information--including all the learning experiences gained--to others interested in pursuing similar program activities.

SECTION II. THE DOCUMENTATION REPORT FORMAT

This section provides a format for the organization of the documentation report. The suggested content for each element of the report is described. This format is recommended for use in the documentation of all types of child welfare programs. However, the documentor should feel free to add or delete information as required to best describe the specifics of the program to be documented. The documentor should also interpret the subheadings of the program components in a manner which is most suitable for the specific program being documented. This may mean certain sub-elements may best be combined or eliminated to more accurately describe the program.

The recommended format is as follows:

A. Title Page; Table of Contents; Table of Exhibits

B. Introduction

The introduction should present a preview of the documentation report through a general description of its content.

C. Program Summary

The program summary should be a concise (one-to two-page) description of the program, serving as a preview to the entire contents of the document. It should include a review of the program's history and identification of the sponsoring agency, organization, or individual. Also included should be a short description of the population served, the services provided, and the sources of funding.

D. Program Components

For the purposes of the documentation effort, program descriptions may be broken down into the following three components: Program Environment, Program Management, and Program Operations (Services).

1. Program environment

The program environment component should provide a description of the physical, social, and philosophic environment within which the program functions. The following information should be included in this subsection.

a. A description of the political, social or economic circumstances which affect program development and ongoing operations.

In many instances a program has been developed in response to a penetrating problem recognized by current political, social or economic circumstances. For example, the need for a new program may have been caused by the cutback in funding available for a previously provided service. Or, an increased emphasis on the provision of child protective services may have been occasioned by the reporting of the tragic death of an abused child.

b. <u>A description of the characteristics of the program's setting</u>.

Such a description is important because a program designed to serve a rural poor population may have an entirely different set of needs than does a program in a metropolitan, middle-income community. Therefore, adaptation would be required for the transfer of a program from one setting to another; or replication may be totally prohibited due to the program setting.

c. <u>A description of the population served</u>.

The reasoning for the inclusion of this information is essentially the same as that for the general demographic information. The description of the specific problems of the persons served by the program being documented is necessary for the reader to determine whether replication or modification is necessary and/or appropriate.

d. <u>A description of the philosophy guiding the program's operations</u>.

The philosophic base upon which a program is constructed is an important consideration to the success of the effort, and, therefore, critical for the reader. An example of program philosophy is the belief that it is best to serve children in their own homes rather than placing them in foster care, or that older or physically handicapped children should be freed for adoption rather than maintained in institutional settings.

e. <u>A description of the program's goals</u>.

Goal statements should be a restatement of the program's philosophy in more concise and action-oriented terms. An example of a goal statement may be "to develop or improve the ability of parents to care for children in their own homes."

f. <u>A general description of other resources serving the same client group and the documented program's relationship to them</u>.

A program will always have a limited range of services, sometimes very specialized ones. The program's effectiveness may be a direct result of its users' access to a comprehensive array of other services. It is useful to describe the program's relationship to other available private and public resources such as public assistance, child welfare services, health, mental health, etc., and the types of relationships (contractual, source of referral, cooperative agreements, etc.) that have developed.

2. Program Management

The program management component should provide a description of the program's governance mechanism, its organizational structure, funding, and the management tools used to control program operations.

a. Governance

If the program is a private, not-for-profit, or proprietary agency, a description of the structure, its Board, advisory committees, and their roles in the operation of the program should be included. For example, it may be significant to the operation of the program that the Director does not have responsibility for fund raising, if this function is performed by the Board's Development Committee. For a program in the public sector, the relationship of the program to the government funding source could be significant.

b. Organizational structure

Provide an organization chart, depicting all significant aspects of the program. (See page A-9 for an example.) Provide a description of each staff member's role in the functioning of the program and the qualifications required for each position.

c. Funding and budget

Indicate the amounts and sources of funding for all components of the program's operations. Provide a description for all major budget items, such as the following:

- Personnel (includes paid staff and volunteers);
- Indirect Labor Costs;
- Rent or Building Purchases;
- Furniture and Equipment; and
- Travel.

d. Management Tools

Describe the means used to maintain fiscal and program accountability. For example, an agency may have an automated management information system, utilize management by objectives, or use program planning and budget (PPB) techniques. Append all forms which are used in these processes.

3. Program operations (services)

In most instances the program operations or services component will be the heart of the documentation. This section should provide a description of both the process for the delivery of services to users and the services themselves.

The service delivery process should be described with a case flow chart (See Figure 1 for an example) and an accompanying narrative description of each step in the process. For most programs, this will include most of the elements in Figure 1; however, considerably more detail is possible, and the arrangement of elements will vary from program to program.

a. Intake

The means used by which persons come to the attention of the program and how their needs for services are determined. Sub-elements of intake are:

(1) Outreach

The means used the the program to make its services known and the provision of easy access to them. Examples of outreach techniques are the use of the media for advertising and the maintenance of active media for advertising and the maintenance of active liaison relationships with the schools, courts, hospitals, and other social welfare service providers.

(2) Case screening

The process used to determine whether a person is eligible for the services provided by the program. A description of the screening process should include a restatement of the eligibility criteria. Forms used should be appended.

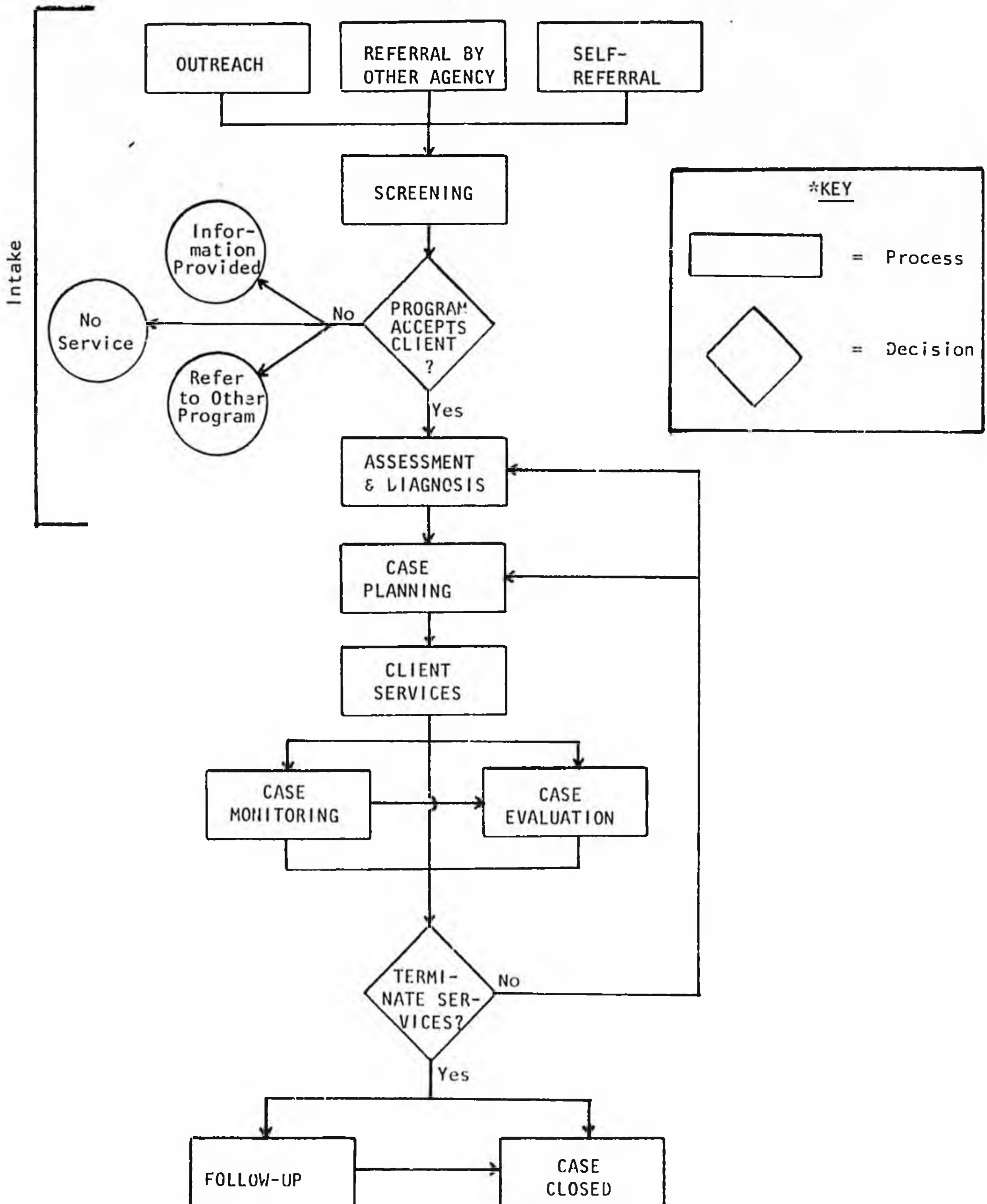
(3) Information and referral (I&R)

The means, in addition to the outreach efforts, by which the program provides information to the public and other service providers about its services, and the means by which referrals to appropriate resources are made for receipt of services not provided by the program.

(4) Case assessment & diagnosis

The process used by the program to obtain a determination of user needs. Emphasis should be given to the role of staff and outside consultants in the assessment and diagnostic processes. Written materials used should be appended.

FIGURE 1: SAMPLE CASE FLOW



b. Case planning

Activities designed to match user needs with a purposeful plan for the receipt of services designed to meet the identified needs should be described. The description should include the means used to set case objectives, service contracts between the user and the program (if used), and a discussion of the role the user plays in case planning. Forms used should be appended.

c. User services

Those activities designed to prevent, solve, or ameliorate user needs through the conduct of the user service plan and the meeting of the case objectives should be presented. Services should be described in terms of the staff who provide the service, the nature of the service and the staff time invested in the provision of the service. Where there are multiple services provided, each one should be described individually, along with the means used for coordinating them to achieve the case objectives. Step-by-step procedures should be described insofar as possible.

d. Case monitoring

This is the on-going process for determining that services are being provided in accordance with the case plan. The description should state how the provisions of services are monitored. Tracking mechanisms, manual or computerized, should be described where used. Forms used should be appended.

e. Case evaluation

The process of determining whether the objectives of the case plan have been met should be described in terms of the means of evaluation (staffing, periodic records review, etc.) used and the data generated on the program's generic effectiveness. Forms used should be appended.

f. Termination of services

The description of the process used to close a case should include both the criteria used for case closings and the means used to terminate services. Data on closed cases (successes vs. non-successes) should be provided.

g. Follow-up services

Follow-up services are the periodic check-up to determine if the services provided have had the desired effect (i.e. how is the person doing?). The description should state the means, frequency, and length of time the program tracks the case once it has been closed.

Throughout the write-up of the operations/services component the documentor should take care to record which staff are responsible for conducting the various functions. Copies of all pertinent forms and written procedures utilized in the operations/services process should be described in the narrative of this section and provided in an Appendix.

E. Program Evaluation

The documentation process itself is not expected to be an evaluation; however, it should report the results of any efforts offering an indication of the program's level of success. This section should include any or all of the following:

1. Formal evaluation

If any formal evaluation of the program has been conducted, the name of the evaluator, the date of the study, and the significant results should be indicated. Charts, statistics, and a narrative summary from the evaluation would be helpful.

2. Case disposition data

Even if no formal evaluation has been carried out, most agencies can compile data indicating client progress over the program's history. How many clients were served? Of those provided services, how many are currently receiving them and how many have been terminated? Of those terminated, how many were successfully placed, diverted or mainstreamed? What were the problems preventing success? How many showed significant improvement, slight improvement, no improvement, or regression? Etc.

3. Success in meeting program goals

Your program should be able to make a statement on the degree to which it has succeeded in meeting the stated goals of the program. This can be accomplished if the program goals are further delineated into measurable objective statements.

4. Testimony

Quotations from current and past clients, community members, referral agencies, etc. can be offered to assist in substantiating a program's claim to success. Results from evaluative questionnaires can be tabulated, and incisive comments quoted. Testimonial letters can be included in an appendix.

5. Replication

If the program's techniques or services have been replicated or adapted by other agencies, or if interest in the program has been indicated through journals, national reports on exemplary programs, etc., this should be indicated.

6. Directions for the future

Finally, the evaluation section may provide the director's, staff's, or documentor's assessment of future activities. In addition, if the program is part of a larger service network, recommendations can be made about how the entire network might be improved. Are there local, state, or federal policies which might be altered to provide strengthened support to service for clients? Do services need to be coordinated on a larger geographic scale or strengthened within the current network? Etc.

APPENDIX

Sample Documentation Report

THE TRESSLER-LUTHERAN SERVICES ASSOCIATES
ADOPTION PROGRAM

Tressler-Lutheran Services Associates
York, Pennsylvania

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SECTION I. INTRODUCTION

This report describes the Adoption Program of the Tressler-Lutheran Services Associates (T-LSA). It is organized into the following three sections.

Section I - Program Summary provides an overall description of the program's organizational structure and purposes.

Section II - Program Components provides a detailed description of all phases of the operation of the Adoption Program. The first subsection describes the physical and philosophic environment in which the program operates. The second subsection provides a full description of all phases of the program's management. The third subsection describes each component of the program's services and their delivery.

Section III - Program Evaluation presents information on the results achieved by the program and its effectiveness.

SECTION II. PROGRAM SUMMARY

Tressler-Lutheran Service Associates (T-LSA) is the multi-service, non-profit operational arm of two separate Lutheran Church-related social services agencies. T-LSA was formed in 1972 as the result of an agreement between Tressler-Lutheran Home for Children (TLHC) and Lutheran Social Services - Central Pennsylvania Region (LSS-CPR). Under terms of the agreement, T-LSA was incorporated to provide all of those services formerly provided by these two agencies, and currently operates under the joint control of TLHC and LSS-CPR.

T-LSA provides a variety of services including individual and family counseling; personal growth and enrichment services; specialized foster care services for adjudicated youth; refugee resettlement, nursery and day-care services; the operation and management of nursing homes and retirement centers; and the adoptive placement of children with special needs. Prior to the 1971 merger of the agencies both also provided traditional adoption services. However, in 1972 the adoption program was redefined, and the focus shifted to the present emphasis on the adoptive placement of children with special needs.

The T-LSA Adoption Program currently is a home-finding program specializing in adoptive placements for children with specialized needs. The program is the "placement arm" for other agencies and generally has no children directly within its custody. Adoption program staff also perform an advocacy function by demonstrating to other agencies that there are families willing and able to adopt children with special needs. Additionally, to help ensure a low rate of disrupted adoptive placements, a broad range of preparation and supportive services are provided to prospective and finalized adoptive families. The program's services are intended to form a continuum from inquiry to follow-up after obtaining the final adoption decree.

SECTION III. PROGRAM COMPONENTS

This section provides a description of the components of the T-LSA Adoption Program. The components are categorized under the following headings: Program Environment, Program Management, and Program Operations (Services).

A. Program Environment

1. Circumstances which affected program development and functioning. The special needs focus of the adoption program was developed because of:

- The recognition of the problems of "waiting children," i.e. those children legally free to be adopted, or those who could be freed for adoption but who remain in foster care placements; and
- The decline in the number of healthy, white infants available for adoption.

2. Characteristics of the services area. The T-LSA Adoption Program operates in twenty-six counties of Pennsylvania, and the states of Maryland and Delaware, as well as the District of Columbia. The Pennsylvania counties serviced are predominately rural, with the largest city within the area being Harrisburg, the State Capital. The other large urban centers within the service area are Baltimore, Maryland; Wilmington,Delaware; and Washington, D.C.

The T-LSA Adoption Program is headquartered in York, Pennsylvania, with branch offices in Williamsport and Altoona.

3. Population served. The T-LSA Adoption Program provides home-finding and adoptive placements for children with special needs. Special needs children are defined as those children legally free to be adopted who are:

- Over the age of eight;
- Family or sibling groups of two or more children;
- Black children, and children of mixed racial parentage;
- Children with medical, emotional or mental disabilities; and
- Children from developing countries.

4. Program philosophy. The Adoption Program utilizes a client-centered approach. The basic assumption is that potential adoptive parents can make the best decisions regarding their interests, strengths, and limitations. Adoptive parents are encouraged to evaluate their own capacities, research other available resources, and then select the children they feel will fit best into their homes. The agency holds no preconceived concept of what makes a family acceptable. It focuses on the needs of the children and the capabilities of each family to provide the emotional resources necessary to care for special needs children.

Adoptable children who have physcial disabilities or are of mixed racial heritage are not considered to be "hard-to-place," but rather are considered to have "special needs" which may require greater efforts to find adoptive families with the love, concern and capacity to accept and work with their special circumstances.

Both parents and children can best be served by positive, supportive services. The role of the social worker in the Adoption Program is to help educate the family in the skills that can be used to meet the needs of the children it adopts, and to provide post-adoptive services to support the placement.

This client-centered approach focuses on self determination, an educational process of building on already existing parental skills, self-assessment of strengths and weaknesses, and the ability of the clients to be the primary active decision-makers in the building of their families through adoption. It is the belief of the agency that the program's various service components which support this philosophy reduce the disruption rate even with children who have special needs by making adoption realistic for the adoptive parents.

The Program operates with the belief that it is the responsibility of the community to provide families for its children and, therefore, it works toward reeducating the community with reference to its perception of special needs children.

5. Program goals. The goals of the adoption program are as follows:

- To find permanent, loving homes for institutionalized and foster children with special needs;
- To provide a method for helping adoptive parents to evaluate their capacities and to provide them with additional parenting skills;

- To provide supportive post-adoptive services to families;
- To enable people to become the best parents they are capable of becoming; and
- To broaden public awareness of the needs of waiting children and to advocate on their behalf.

6. Other resources serving the same population, and the program's relationship to those resources. The staff of the Adoption Program maintain regular contact with approximately 100 agencies for the purpose of cooperative home-finding and placement, the sharing of knowledge and experience, and for observing the trends and services in the placement of children with special needs. Concentrated contacts are maintained with approximately 40 agencies throughout the U.S. and Canada, as well as with several international adoption agencies. T-LSA staff work with these agencies, as well as with courts and regulatory bodies.

T-LSA uses existing adoption exchange services to facilitate the placement of available children. Some of these exchanges are as follows:

- ARENA (Adoption Resource Exchange of North America - Child Welfare League of America);
- PACE (Pennsylvania Adoption Cooperative Effort);
- Delaware Valley Adoption Council;
- The CAP book;
- New York State Adoption Exchange; and
- Adoption Exchanges in Texas, Arizona, Virginia, and Indiana.

Additionally, adoption exchange books are used to provide prospective adoptive parents with information on available children.

Upon request, the T-LSA Adoption Program staff provide consultation services to any of the agencies with which the program maintains control. The Director has conducted training workshops for adoption personnel and has made numerous presentations on the Adoption Program to agencies throughout the country.

B. Program Management

1. Governance. T-LSA is the operational arm of two church-affiliated social services agencies: Tressler-Lutheran Home for Children (TLHC), and Lutheran Social Services - Central Pennsylvania Region (LSS-CPR). Both of these agencies are incorporated, nonprofit agencies. Each of them maintains its own assets and elects its own Board of Directors.

The TLHC Board of Directors is elected by the Executive Boards of the Central Pennsylvania and Maryland Synods of the Lutheran Church in America. There are seventeen members of the board. Eleven members are elected by the Central Pennsylvania Synod; four members are elected by the Maryland Synod; the President of each Synod, or a Presidential designee, serves as an *ex officio* member of the TLHC Board.

The LSS-CPR Board of Directors consists of 16 persons elected by the Board of the Central Pennsylvania Synod of the Lutheran Church in America. The Synod President or a designee serves as an *ex officio* member of the LSS-CPR Board.

The Executive Committees of both TLHC and LSS-CPR consist of five members each. These two Executive Committees serve as the formal Board of the Tressler-Lutheran Service Associates (T-LSA), the operational corporation.

To oversee the operations of T-LSA, the Boards of T-LHC and LSS-CPR meet jointly three times a year. The T-LSA Board meets six times each year.

The central point of executive responsibility for the operation of all three agencies --TLH, LSS-CPR, and T-LSA --is the President, who simultaneously serves as the chief executive officer of all three groups. The staff of T-LSA is ultimately responsible to the President, under the authority of the T-LSA Board of Directors.

2. Organizational structure. Figure 1 is a chart of the overall organizational structure of T-LSA. The two major divisions of services are Church and Community Services, and Residential Services. Each division is headed by an executive.

Under the Executive for Church and Community Services the two service subunits are Counseling and Education, and Children and Youth Services. The Adoption Program is one of four service units under Children and Youth Services; the others are the Community Treatment Program, the Child Advocacy Program, and the Administration for Interagency Relationships Planning.

FIGURE 1

ORGANIZATIONAL STRUCTURE: TRESSLER-LUTHERAN SERVICES ASSOCIATES

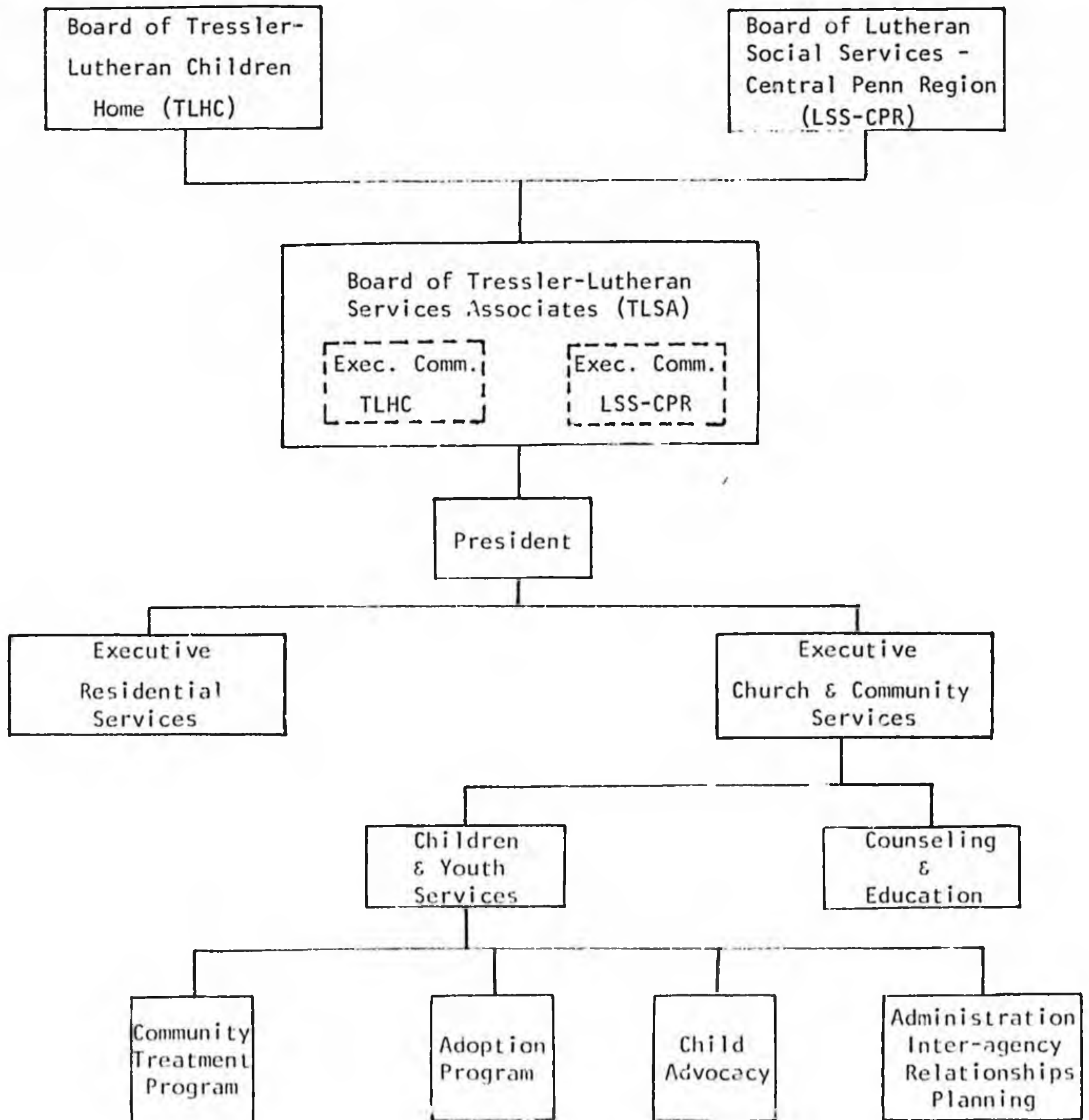


Figure 1-A is a chart of the organizational structure of the Adoption Program.

The staff of the Adoption Program work out of three locations: York, Williamsport, and Altoona, Pennsylvania.

The York office is the main office, and the staff there consists of the Administrator of Children and Youth Services, under whom the Adoption Program operates; the Director of the Adoption Program; an adoption specialist; and a secretary. The Williamsport office consists of two adoption specialists and a clerk/typist. The Altoona office is staffed by an adoption specialist from the Williamsport office on a part-time basis.

The Administrator of Children and Youth Services is responsible for interagency coordination and general services planning. He also supervises three service programs--the Community Treatment Program, which provides foster care, counseling, tutoring and case management to adjudicated youth; the Child Advocacy Program; and the Adoption Program.

The Director of the Adoption Program, in addition to carrying out administrative responsibilities, conducts study groups, provides casework service attends adoptive parent meetings, provides counseling, makes home visits, edits the newsletters, conducts study training workshops throughout the country, and provides consultation to other agencies upon request. A unique strength of the Program is that the Director is an adoptive parent, and can provide an adoptive parent's perspective to the delivery of professional services.

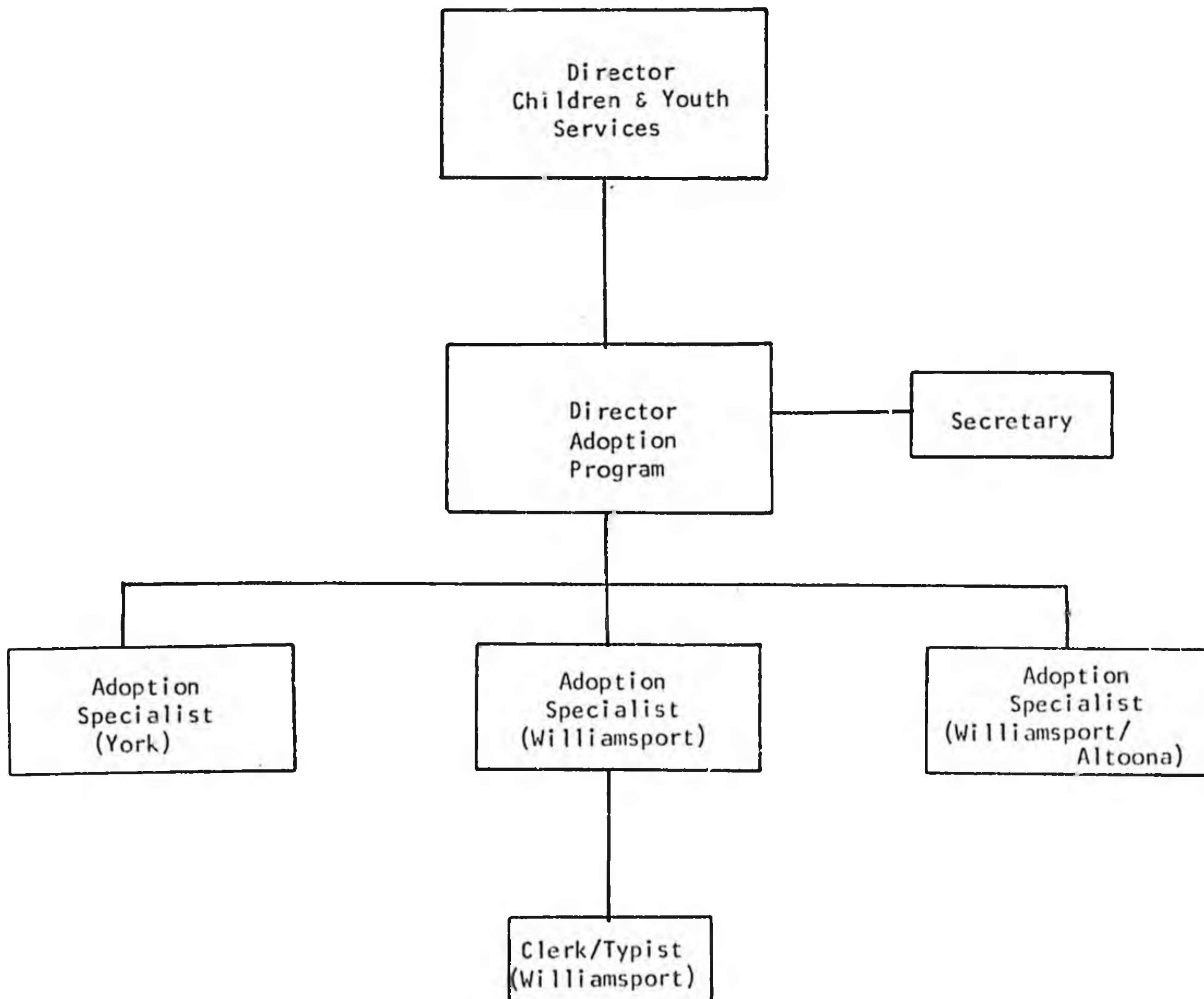
The adoption specialists conduct study groups, provide casework services to the adoptive families, respond to adoption inquiries, and make presentations on adoption to interested groups and organizations.

The secretary performs clerical tasks, maintains records, provides responses to telephone requests, and types material for the newsletters.

All professional staff members are required to have at least a B.A. and it is preferred that they be working towards attaining a Master's Degree in Social Work, or a related degree. The Director of the Adoption Program is an accredited social worker.

FIGURE 1A

ORGANIZATIONAL STRUCTURE: T-LSA ADOPTION PROGRAM



In addition to the formal educational requirements, the program seeks to employ persons who have a sensitivity for the realities of adoption from the perspective of the parent.

Although not depicted on the organization chart, three adoptive parents are being currently trained to co-lead adoption study sessions for prospective adoptive parents.

3. Budget and funding. Figure 2, below, is a presentation of the Adoption Program budget for FY 1980:

FIGURE 2

INCOME

Fee Income:

Consultation	*$ 500*
*Adoption Study Fees **	*42,500*
Education	*300*
Workshop	*4,000*
Third Party Reimbursement	*12,000*
Other Fees	*1,000*
Total Fee Income:	*60,300*

Grants:

Tressler-Lutheran Home for Children	*95,659*
Total Grants:	*95,659*

Contributions:

General Contributions	*1,000*
Total Contributions:	*1,000*

Non-Operating Income:

Books (re-sale to clients)	*330*
Total Non-Operating Income:	*330*
Total Income:	*$157,289*

EXPENSES

Salaries:

Administrators	*21,293*
Professional	*47,241*
Clerical	*15,783*
Total Salaries:	*84,317*

Benefits & Taxes:

Group Medical Insurance	*1,968*

	Group Life Insurance	552
	Pension	6,746
	Worker's Compensation	784
	FICA Agency Expense	5,168
	State Unemployment Tax	828
	Total Benefits & Taxes	16,046
Staff Support:		
	Mileage	7,300
	Other Travel Costs	1,800
	Meetings/Conferences	1,200
	Memberships & Dues	150
	Books/subscriptions	270
	In-Service Training	500
	Miscellaneous Staff Costs	100
	Total Staff Support:	11,320
Physical Plant Operations:		
	Rent-Facility	4,376
	Insurance	400
	Maintenance & Repairs-Building	240
	Maintenance & Repairs-Equipment	640
	Lease-Equipment	1,800
	Total Physical Plant Operations:	7,456
Purchased Services:		
	Legal	1,000
	Consultant	300
	Clerical	400
	Counselor	1,600
	Psychiatrist	200
	Total Purchased Services:	3,500
Service Operations:		
	Telephone	10,050
	Postage	4,500
	Printing	3,850
	Promotional Material	150
	Miscellaneous Services	150
	Total Service Operations:	18,700
Supplies:		
	Office Supplies	3,500
	Books for Re-Sale to Clients	330
	Non-Capitalized Equipment	100
	Custodial Supplies	60
	Program Supplies	110

	Food Supplies	170
	Kitchen Supplies	60
	Other Supplies	50
	Total Supplies:	4,380
Capital Purchases:		
	Capital Purchases	2,395
	Funded Depreciation	550
	Total Capital Purchases:	2,945
Costs Transferred IN:		
	Allocated General & Administrative Costs	6,623
	Allocated Church & Community Services Costs	3,036
	Other Allocated Costs	9,651
	Total Costs Transferred IN:	19,310
	Total Expenditures:	$157,289

*Fees for services.

The agency charges an application fee and an adoption study fee.

The fee schedules are flexible and revised on a regular basis in regard to the cost of adoption services. Specific fees for adoptive applicants are determined through discussion with the applicants in conjunction with the current fee schedule and their financial circumstances. Other costs, such as transportation of children, or fees of cooperating agencies, may also be incurred.

Whenever possible, agencies having custody of children placed by the Adoption Program are asked to pay a placement fee based upon the actual cost of services provided. These may include: recruitment, study, supervision, and post-placement services. T-LSA believes that no child should be denied placement because of a prospective family's inability to pay a fee, or the lack of a placement fee from another agency.

C. Program Operations (Services)

1. Intake. The Adoption Program's intake process consists of those mechanisms used to contact prospective adoptive parents (Outreach and the Provision of Information) and to determine the interest of prospective adoptive parents in adopting a special needs child (Screening).

a. Outreach (Recruitment). During the early stages of the Adoption Program, radio announcements, newspaper advertisements, television interviews, and presentations to church groups and other interested organizations were used to publicize the need for adoptive parents.

However, since 1972 no formalized recruitment effort has been necessary. The primary recruitment technique has been adoptive families' demonstration of the workability of adoption in their own communities. These families prove the potential of adoption in their daily lives, leading other families to be encouraged to adopt by observing these successful examples. People who have been turned away by more traditional agencies tell others of their success through T-LSA, and a snowball effect occurs. The agency's acceptance of different life styles encourages some people to apply who may have feared rejection.

The agency and P.A.C.O., the Adoptive Parent Organization (See page A-25), work together to provide informational meetings in different geographic areas. These sessions provide opportunities for potential applicants to learn more about the realities of the adoption of children with special needs and to interact with experienced adoptive parents.

There have also been a number of newspaper articles, feature stories, and special local programs which have dealt with adoption and the services of T-LSA in recent years, but these were not initiated by the agency.

b. Information. Staff respond to all written and telephone inquiries about the program. A newsletter called "The Adoption Scene" is mailed to everyone who inquires about adoption. It contains information on the current availability of children and a description of agency services. An Interest Registration Form is attached to each of these newsletters. (See Exhibit A)

c. Screening. The initial means of screening prospective applicants is provided through use of the Interest Registration Form (Exhibit B). This form provides a statement of the applicant's interests in adopting a special needs child and serves as the basic information source for selecting applicants to be processed for the adoption of available children. Some of the items on the form are discussed below.

(1) Age. There are no set criteria for chronological age. However, the following factors are considered:

Minimum: The age of the applicant should be sufficent to establish reasonable maturity and ability to accept the responsibilities of parenthood. It is considered in conjunction with emotional stability and any legal requirements.

Maximum: The importance of an applicant's physical health, comparative age with the potential adoptee, and his/her flexibility of ideas and attitudes related to parenting are considered, rather than chronological age.

(2) Marital Status. Single applicants, as well as married couples, may apply for adoption. The program accepts a wide variety of life styles as potentially providing appropriate families for children. Verification of marital status is required, and previous marriages ending in divorce are evaluated in light of subsequent adjustments.

(3) Family Composition. Potential adoptive families are not categorically excluded because of the number of children already in the family. In fact, the staff has found that large families often provide good homes for children simply because the adopted child doesn't have to "be everything" and will not have to be the center of attention. The number of children placed in a family is determined primarily by the interest of the applicants based on their own assessment of financial capability, general health, stamina, and capacity for parenting.

(4) Health. General physical and mental health should be such that it enables the applicants to meet the challenge of parenthood.

(5) Income. No set level of financial assets or resources is required. T-LSA does not use the criteria of income or occupation as screening devices (e.g., a family with a yearly income of $4,000 has had children successfully placed). However, there should be a reasonable relationship between a family's earning power and its financial stability: the level of income should be adequate to cover basic family needs.

(6) Housing. Housing may be owned or rented as long as living space and sanitation can provide a clean and comfortable home for children.

2. Assessment and planning. The assessment and planning processes are combined. Assessments and planning of cases consist of Adoption Rap Sessions and the Study Process.

a. Adoption rap sessions. These meetings are held periodically in various parts of the service territory. People who are waiting for a group study session are invited to attend, and agency staff and adoptive parents lead the discussions. Interaction with "successful" adoptive parents enables

applicants to more realistically evaluate their own motivations, awareness, strengths, and commitment. T-LSA has found that applicants often become more flexible in the types of children they feel they can parent through adoption after participating in these sessions. The Interest Registration Forms are available at these meetings, and applicants have the opportunity to make necessary changes in stating the types of children they want to adopt.

Seven of these sessions were held during 1978 and one was televised by Maryland Public Broadcasting. It was shown on a nationwide syndicated program called "Consumer Survival Kit."

b. Study process. A realistic preparation for adoptive parenthood is developed through the use of various concepts such as parent effectiveness training, values clarification, and transactional analysis. Participants in each of the study group series are chosen on the basis of their interests outlined on the Interest Registration Form and the needs of available children. Approximately one hundred adoptive applicant families participate in the process each year.

Five to seven couples and/or single applicants meet for a series of nine sessions. This group method was initiated so that adoptive parents would not feel isolated during the adoption process, and to allow applicants to challenge, support, and encourage each other. Interaction within a group setting has been shown to reveal greater insight into parenting capacities and attitudes than individual sessions. In addition, applicants can be processed more quickly in groups, resulting in more homes for the waiting children.

Throughout the sessions, the emphasis is on educating parents to meet the needs of the children. T-LSA encourages the development of an honest relationship between the adoption worker and the client; therefore the process is conducted in a nonjudgmental atmosphere. The philosophy is that as the adoption workers become acquainted with the adoptive families, the applicants get to know themselves better. They

become aware of the children available for adoption and come to terms with their coping capacity, their strengths and their weaknesses. The prospective parents are assisted in questioning their capabilities and limitations, and, if necessary, removing themselves from the adoption process. Adoptive applicants who complete the study process have the responsibility and opportunity to select the children they want to adopt, instead of the worker making the choice for them.

The components of the study process are:

(1) Informational meeting. Prospective parents, selected to attend the study process based on their interests and the needs of the available children, meet to discuss basic information about adoption and agency policies. Application forms (See Exhibit C) are distributed, and the series of study sessions begins when these forms are returned with the application fees.

(2) Panel presentations. Two sessions, entitled "Parenting the Child Who is a Challenge," feature panel presentations by parents who have already adopted special needs children. The purpose of the panels is to present the realities of adopting challenging children. The panel discusses problems encountered before and after placement and topics such as stealing, running away, foul language, and bed-wetting. The presentations provide the applicants with an opportunity to discuss their own feelings about these realities before the actual adoption of a special needs child. The panel also discusses issues such as: What do prospective adoptive parents need to know about themselves before adopting an older child? How much experience should they have had with children? How committed are they to making the placement work?

(3) Group sessions. A six-session parent-child communication course focuses on values clarification, transactional analysis, and parent effectiveness training. During these meetings the social worker can get to know the applicants individually, and the applicants can gain self-awareness and insight. Tools and skills which they might need in meeting the challenges of adopting special needs children are also presented. The emphasis is on the social worker and applicants working together to increase the opportunity for a successful placement.

Part of the study process involves the completion of a number of assignments such as writing autobiographies, completing health forms, and providing "thought sheets." The "feeling autobiographies" provide answers to questions about attitudes and expectations. Thought sheets have questions such as "How would you handle a child who couldn't trust you or couldn't establish a close bond?" and "What would you do if this child became a disruptive influence on your marriage?" Basically the applicants write their own life studies instead of the social worker doing it for them.

The parent-child communication course is based on discussions about the individuals themselves and includes selected transactional analysis concepts which are explained and practiced in the non-threatening group atmosphere. The group is encouraged to evaluate the concepts presented and to provide examples of them in the daily conduct of their own lives. This approach to the study process provides a learning and growing experience for all involved. Through this open, informal approach the social worker can gain a feeling for the applicant's ability to parent or to improve his/her parenting techniques.

(4) Visit to an adoptive family. The prospective parent is linked with a family that has adopted a child of approximately the same age and characteristics that the applicant is requesting. The applicant visits the family and has the opportunity to obtain an even more realistic view of the adoption experience. The experienced adoptive family advises the agency staff on their impressions of the applicant's capabilities. This visit often results in a long-term linkage between the prospective parents and the host adoptive family.

(5) Individual interviews. The social worker also conducts an individual session with each applicant to further obtain an accurate picture of the prospective parent's background, philosophies, interests, self-image, etc. This is also an opportunity to discuss further any concerns the applicant or worker may have.

(6) Situational groups. Upon completion of the study process, new applicants are assigned to one or more "situational" or "special interest" groups depending on the age, variety, and number of children for which they have applied. These groups are composed of both adoptive families and people waiting to adopt. Attendance is voluntary, but participants have found that the groups provide an excellent atmosphere for "reality testing." Social, cultural, and educational sessions allow prospective parents to help determine whether they will be comfortable parenting those children for which they have applied. The situational groups at present include Korean, Vietnamese, Single Parent, Older Children and Siblings, Large Families (over 5 children), Inter-racial Adoption, Mexican-American, North American Indian, and Children with Medical Problems. Many people participate in several groups concurrently.

3. Services. The primary services of the T-LSA Adoption Program are the situation groups, placement, the operation of a twenty-four hour hotline, the conduct of a teen therapy group, and the provision of counseling services to adoptive families, when needed.

a. Situational groups. These groups (described in 2. b. (6) above) enable families to discuss similar challenges in a group setting. They also relate to issues of their children's heritage and culture and sponsor family activities. Additionally, they provide an opportunity for prospective adoptive parents to get a "feel" for the experience of adopting a special needs child.

b. Placement procedures. During the study process, the applicants have the opportunity to review information on available children provided by adoption exchange books and other agencies and to identify children they are interested in adopting. If an applicant expresses serious interest in a particular child or children, the staff requests complete background information from the agency having custody. The applicant studies it, discusses it with the staff, and consults doctors and community resources regarding the child's problem areas. By having the prospective parent do the groundwork instead of the social worker, T-LSA believes that the applicant develops an increased commitment, thereby increasing the potential for a successful adoption. At the same time the family study is sent to the referral agency. The study includes the autobiography, health form, references, "thought sheets," and a summary and recommendations from the social worker.

The placement decision is a tri-level one made by the applicant, T-LSA, and the referral agency. The agency with custody makes the final determination.

If all parties decide to proceed with the placement, specific arrangements are made. This may include a pre-placement visit to the child's home. This is not always a prerequisite and is usually determined according to the needs of the child and/or the agency having custody. T-LSA believes that it is difficult to determine in a short visit whether the placement will be successful. Through its experiences over the years, the agency has found that preadoptive visitations are of minimal value in determining the appropriateness or success of adoptive placements. In fact, many of the placements accomplished during the program's existence have been made without preplacement visits. It is believed that the most essential element to successful adoptive placements is not the visitation, but rather the adequate preparation of the child and of the potential parents.

If there is a placement that must be expedited because of a child's needs, the staff does not necessarily wait until the completion of the group study process before placing the child. The staff will work with the adoptive parents independently of the group sessions to facilitate the completion of the study. However, the family participates concurrently in the group study sessions.

As cited above, the primary responsibility for preparing a child for adoption rests with the agency having custody. However, one element of this preparation is provided by the adoptive parents through T-LSA. Each family is advised to develop a scrapbook reflecting family composition, their home, community, pets, hobbies, family activities, and other interests. These scrapbooks are shared with the child through his/her foster care worker to enable him/her to begin to identify with the family in advance of a visitation or direct placement. T-LSA provides these scrapbooks to the agency with custody for their preparation work with the child.

T-LSA also encourages the agencies with custody to have adoptive children maintain personal scrapbooks throughout their time in foster care and to carry them into adoptive placement. The staff believes that this aids children in maintaining their identification and strengthening their self concept.

c. PACO listening ear. A twenty-four hour hotline provides a crisis intervention function. This service is provided by trained adoptive parent volunteers in various locations throughout the twenty-six county area served. These volunteers give parent-to-parent support and also make reports and referrals to the professional staff. T-LSA has found that many adoptive families of special needs children do not have relatives and friends who support their decision to adopt these children. The Listening Ear provides this support as well as an emergency linkage with professional services.

d. Teen group. A therapy group composed of adopted teenagers enables these youth to deal with present conflicts as well as with years of repressed problems. T-LSA provides staff for these sessions.

e. Counseling. The staff provides counseling for the families and adoptive children as needed. Referrals are also made to other community resources and to other adoptive families for support.

4. Monitoring. Placements are monitored through follow-up visits, and the submission of "sharing sheets" by the adoptive family.

a. Follow-up visits. The agency staff is available to assist the family during the period between placement and the finalization of adoption (at least six months), as well as after finalization. A worker is assigned to have a minimum of three visits during this supervisory period prior to finalization. The staff encourages and expects the adoptive family to let them know when problems occur. Preventive and/or crisis therapy is suggested and provided when applicable.

b. Sharing Sheets. Families who have not finalized their adoptions send the agency monthly "sharing sheets" which let the staff know how the placements are progressing and the areas of success or difficulty they are experiencing. If staff are needed for guidance or if counseling is required, the family is contacted immediately. (See Exhibit D)

5. Case evaluation. By state law, program staff are required to make a minimum of three contacts with the family after the adoptive placement is made. Staff use these visits, as well a other supportive services provided, to evaluate whether the placement cceeding.

6. Case termination. In effect there are no formalized termination of service procedures, as the program maintains ongoing contact with adoptive parents as long as necessary after the finalization of the adoption.

7. Follow-up. The follow-up services provided after the finalization of the adoption consist of visits to the home, the operation of an adoptive parents organization, the provision of counseling services, the operation of a 24 hour hotline, and the publication of the newsletters.

a. Follow-up visits. The follow-up visits as described in C.4.a. above continue after the finalization of the adoption.

b. Adoptive parents organization. Parents of Adoptive Children Organization (P.A.C.O.) provides a structure for the supportive relationships which adoptive parents need. T-LSA believes that adoptive parent organizations can make a significant contribution to programs involving the placement of available children through recruitment,education, and mutual support, and that agencies and adoptive parent groups should work cooperatively for these purposes. PACO is an integral part of the T-LSA Adoption Program.

The Adoption Program provides staff resources in development, coordination, and program planning for parent groups affiliated with the organization. Examples of the programs conducted by the group are seminars on sex education, child development and childrearing; legal information about adoption, wills, and insurance policies; and a session on voluntary and involuntary termination of parental rights. Family events in which children participate are also held. In addition to attending social and educational meetings, the members receive a bimonthly newsletter (See Exhibit F) which contains information about upcoming events, agendas for meetings, current legislation, reports from national conferences, information on current issues, letters from readers, a list of recent placements, and descriptions of adoption resources.

PACO groups are organized in specific geographic areas, and there are also subgroups composed of parents who have adopted children with similar special needs. Current subgroups are available for those who have adopted older children, siblings, Korean and Vietnamese children, children of Black and Black-White parentage, Mexican American and Native American children, and children with medical and physical disabilities. These groups meet periodically for programs related to their respective needs and interests. Some families may belong to several of the subgroups depending upon the types of children they have adopted.

PACO also provides interest free financial support to adoptive families for such needs as transportation costs, dental care, etc. The organization does not charge dues but instead conducts moneymaking activities such as parties, dances, and fairs.

PACO chats are small group sessions held in people's homes at which information on available children is shared and concerns of adoptive parents are addressed. T-LSA staff are present at these meetings. Prospective adoptive parents are also invited to attend these meetings if they have an Interest Registration Form on file with T-LSA.

c. Counseling services. The counseling services described in subsection C.3.e. are also provided as a follow-up service.

d. Twenty-four hour hotline. See subsection C.3.c.

e. Publications. Several newsletters are provided on a regular basis to keep families advised of social and educational programs, to inform them of available children, and to share current adoption issues.

- "Because We Care So Much" is a bi-monthly newsletter for families who have adopted five or more children. This is currently mailed to more than 850 adoptive families throughout the United States and in several other countries. This newsletter serves as a linkage for sharing concerns, challenges and the joys of large families.
- Every family, approved and waiting for a child, receives a monthly newsletter, "We Wait Too," which focuses on available children. (See Appendix F).
- "Children and Adoptive Parents" is a bi-monthly publication with a circulation of approximately 1,800 adoptive families and agencies. (See Appendix E).

SECTION IV. RESULTS AND EVALUATION

In the less than nine years that the Adoption Program has been in operation, more than 1,000 children with special needs have been placed in permanent homes. The annual placement statistics since the development of the specialized program are as follows:

Year	Placements
1972	98
1973	94
1974	99
1975	299*
1976	119
1977	121
1978	146
1979	80 (through July, 1979)
Total	1,056

*Included over 200 children placed during the emergency airlift after the fall of South Vietnam; of this number, 96 were placed through other agencies with T-LSA having custody.

From January 1972 through December 19/8, the number of children with handicaps who have been placed is 217. Other special needs children were members of sibling groups and those over the age of twelve. The following chart indicates the number of children placed by characteristic for 1976, 1977, and 1978.

	1976	1977	1978	1979 (through July 1979)
Over age twelve	12	22	18	11
Members of sibling groups	18	44	32	16
Mentally retarded	2	5	4	3
Emotionally disturbed	8	22	20	14
Slow learner	11	--	12	12
Auditory difficulty	1	--	1	2
Visual impairment	3	1	5	7
Cerebral palsy	3	2	5	1
Downs syndrome	--	4	5	--
Heart defect	--	1	--	--
Drug baby	--	1	--	--
Cleft palate	--	1	--	--
Gerodoma Osteodipplastica	--	1	--	--

	1976	1977	1978	1979 (through July 1979)
Hydrocephalic	--	--	3	--
High medical risk	--	--	3	--
Severe speech problem	--	--	1	--
Incest child	--	--	1	--
Deformities	--	--	1	--
Spinobifida	--	--	1	--
Epileptic	--	--	2	--
Sexually active	--	--	2	--
Severe skin problems	--	--	1	--
Orthopedic problems	--	--	1	5
Other medical problems	--	--	--	9

For these same years the following chart depicts the number of children placed according to race or native country:

	1976	1977	1978	1979 (through July 1979)
White (USA)	63	39	59	34
Black (USA)	12	12	5	6
Black/White (USA)	13	14	9	11
Korean	20	23	24	12
Vietnamese	--	8	2	--
Native American	18	13	35	11
Puerto Rico	4	2	--	--
Philippines	4	--	2	--
Indian/Black	1	1	--	--
Chinese	1	--	--	--
Dominican Republic	2	1	--	--
Mexican/American	--	2	--	1
India	--	2	--	--
Cambodian	--	2	--	--
East Indian	--	1	4	1
Columbia	--	--	--	3
Peru	--	--	--	1

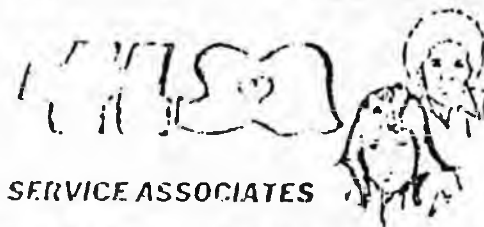
The greatest number of children (847) were placed when the program had only two full-time adoption workers conducting the family studies. The disruption rate has been very low (5% overall) and most of these children were replaced with T-LSA families. The staff credits the client-centered approach for the low disruption rate and for the agency being able to meet the needs of many waiting children and adoptive parents. The self-assessment of strengths and weaknesses, the educational process of building on already existing parental skills, and the ability of prospective parents to be the primary decision-makers, all contribute to making adoption realistic for adoptive parents. The provision of multi-faceted post-adoption support services also adds to successful placements.

The success of the program can also be attested to by the fact that many other agencies are now incorporating the techniques employed by T-LSA. At the inception of the program in 1972, the exclusive placement of special needs children and the non-traditional T-LSA approach were unique to the field of adoption. However, due to the decrease in the number of healthy, white infants available for adoption, agencies have had to change their attitudes and redesign their programs.

To help these agencies adjust to the recent trend toward placing special needs children, the Director of the Adoption Program has made numerous presentations on client-centered adoption, the group study process, and supportive services. (See Exhibit G for letters from agencies attending presentations and workshops). Children Unlimited, an adoption agency in Columbia, South Carolina which places special needs children, has modeled its program of education and post-placement services on the T-LSA program.

T-LSA has also been selected as an exemplary agency in the successful placement of developmentally disabled children by the North American Center on Adoption, Inc.

the adoption scene at T-LSA



A REPORT ON ADOPTION FROM TRESSLER-LUTHERAN SERVICE ASSOCIATES

There are children everywhere. Some are eating cotton candy, others are being given rides throughout the grove of trees in a tractor-drawn wagon, and still others are being costumed as Indians.

The scene looks very much like a huge family reunion or perhaps a Sunday School picnic, except that, upon closer observation, one might note that many of the children are handicapped or biracial or of Indo-chinese or Canadian-Indian descent.

But there's something even more special about this September Sunday gathering in Jacobus, York County: Practically all of the children are adopted.

The get-together is the annual York-area PACO (Parents of Adopted Children Organization) picnic, and that first, tentative description of the affair as a family reunion is not an inappropriate one.

Because of organizations like PACO and events like its yearly picnic, many adoptive parents say they feel as though they're part of a large, widely scattered family.

That feeling is one of the many unique aspects of Tressler-Lutheran Serveice Associates' adoption program.

At the very heart of that uniqueness is the fact that in 1972 the program was reorganized exclusively to place "special needs" children, those formerly (and unfortunately) labeled "hard to place." **Discontinued completely was the placement of healthy, young white children and white infants.**

What produces the special needs of the children T-LSA places is that they are black, biracial, or from a foreign country; or they are between the ages of eight and 18; or they have physical, emotional, or mental disabilities; or they are to be placed along with a varying number of their brothers and sisters. (T-LSA has placed with one family a "sibling group" of seven children!)

The program, operating in 26 Pennsylvania counties (the territory of the LCA's Central Pennsylvania Synod), has the function of preparing and then representing prospective adoptive parents to agencies in whose care children are placed prior to being adopted.

Rather than providing care to these children awaiting adoption, T-LSA instead serves as an "adoption broker," bringing together special needs children and loving families.

Immediately apparent to anyone who has conceived of adoption as the fulfillment of a childless couple's needs by providing them with a healthy white infant is the fact that the nature of adoption has changed markedly: While the core of T-LSA's program is its work with adoptive parents, and while the adoption procedure is oriented toward these parents, the entire focus of adoption is on ministering to the needs of children.

As the nature of adoption has changed, so too has the manner in which children are adopted. And T-LSA has had a lot to do with that change.

The entire transition began in the late 1960s when fewer healthy white infants were becoming available for adoption. For some time prior to that Tressler staff had been doing some adoption work with special needs kids.

As a result of that work the program was redesigned entirely toward the placement of special needs children.

The traditional approach to adoption had been to have a social worker interview a prospective adoptive couple three or four times in an office. The social worker obtained information on the couple's background and usually made a home visit. Then, if they were "approved," a child was selected for them.

The group approach utilized by T-LSA is much better, say both adoption staff workers and adoptive parents.

"You feel a lot more at ease and are able to learn more," relates one York County adoptive parent. And the group sessions allow people to "reveal more of themselves than they ever would in an office interview with a social worker." They also are able to gauge their strengths and weaknesses and to work on overcoming the weaknessess.

Typically, six to eight couples or single parents meet for eight or nine weeks, usually in the home of a staff member or a church parlor or other informal setting.

At those sessions, they share feelings, experiences, expectations, and fears. And they get a chance to talk with families who already have children similar to those they are contemplating adopting. The adoptive parents are as frank and open as possible, both to acknowledge the challenges of adoption and to aid group participants in learning if adoption is for them.

At the sessions prospective adopters also study information about children available for adoption, helping them and staff members to identify the type of child they would like and feel capable of rearing.

To reach this stage in the adoption process, prospective parents first file an "interest registration form" with the agency. Then, when periodic "adoption rap sessions" are scheduled in various areas, those people are invited to attend.

In accordance with the availability of children and staff resources, applicants — about 100 of them each year — are selected to participate in the adoption study process, which consists largely of the group sessions.

In addition, participants must complete "feeling" autobiographies.

These autobiographies are an additional way in which applicants can sort out their feelings on adoption, children, parenthood, and related topics.

During the study process an adoption unit staff member visits with the applicants, and, following completion of the group sessions, the prospective adoptive parents must visit the home of an adoptive family, usually with children similar to those they want to adopt. The family then files a report on the visit so that any problems can be worked out between the applicants and staff members.

Finally, if the prospective parents and staff members believe that the family is ready to adopt a child, the applicants are registered with adoption exchanges.

Sometimes, a child is placed with them relatively quickly; however, most placements take at least several months and some longer.

As part of its service to children, T-LSA carries the major cost of the program. This money represents a significant portion of the interest from the endowment fund of the Tressler Lutheran Home for Children.

Prospective adoptive parents pay an application fee and an adoption study fee, based on the actual cost of service and levied on a sliding scale in accordance with the applicants' ability to pay. These fees, however, seldom cover the cost of service provided by the agency.

T-LSA adoption services do not stop with the placement of the child. For the first six months following placement, staff maintain contact with the family, visiting them and providing whatever support is necessary.

But support comes from other sources as well. First, the adoptive families themselves provide support to one another.

Second, organizations like PACO - one of the largest adoptive parents organizations in North America -- and its various "subgroups" (for example, groups for families with Korean children) can be a [illegible] to adoptive parents.

And, third, there are the T-LSA adoption newsletters, one of them designed just for families with five or more children, another for families waiting for a child.

What lies ahead for the adoption program?

Staff members cite the continuous evolution of adoption study guidelines, parent-training skills, and increased participation in support groups like PACO as part of the program's future.

But whatever is ahead, you can be sure of one thing, its origin: As the bumper sticker pasted on the rear of many adoptive families' cars proclaims, Adoption Starts in Loving Hearts.

Tressler-Lutheran Service Associates (T-LSA) provides a program of specialized adoption services including: the processing of applications for the adoption of children with special needs; community education regarding the needs of children available for adoption; and a variety of group and supportive services for adoptive families.

Applications for adoption may be received from potential adoptive parents residing in a twenty-six county area in Central Pennsylvania, which coincides with the territory of the Central Pennsylvania Synod of the Lutheran Church in America. These counties include:

Adams	Clearfield	Franklin	Lebanon	Perry
Bedford	Clinton	Fulton	Lycoming	Snyder
Blair	Columbia	Huntingdon	Mifflin	Somerset
Cambria	Cumberland	Juniata	Montour	Tioga
Centre	Dauphin	Lancaster	Northumberland	Union
				York

The Adoption Program is based in the York office and staff persons assigned to the program operate from the Williamsport and Altoona offices.

While the adoption scene is constantly changing, there have been several constant and significant trends in the past few years.

- more people have become interested in adoption as a means of having or expanding their families.
- fewer white infants and very young white children have become available for adoption because of more effective birth control measures, abortion, and many more unwed mothers raising their children.
- agencies and courts have increased their efforts to place the thousands of children with special needs, who had previously been considered hard-to-place.
- many children with special needs who are considered to be the "available children" are being placed in permanent adoptive homes.

INTEREST REGISTRATION FORM

The Interest Registration Form is designed to provide the agency with a concise statement of the applicants' interests in adoption. Applicants complete and return the form. This form serves as a basic information source for selecting applicants to be processed for the adoption of available children. Completion of the form does not imply any obligation on the part of the applicant or the agency. Changes on Interest Registration Forms may be made by writing or phoning the office with which you are registered.

Applicants are accepted for an adoption study according to the availability of children. T-LSA is constantly in touch with other adoption and child-serving agencies, with adoption exchanges in various states, and the Adoption Resource Exchange of North America (ARENA). Consequently, we learn of the types of children in greatest need at that particular time. Because we gear our service primarily to the needs of the available children, some potential adoptive parents may be registered for many months. Others may be processed within a short period of time. There is a greater possibility of studying and placing with those who have sincerely expressed a broad range of interest and flexibility on their Interest Registration forms.

CAUCASIAN INFANTS

The T-LSA Adoption Program **does not place** healthy, white infants. There is a "shortage" of such children for adoption and other agencies have long waiting lists. In fact, today it is almost impossible to locate any healthy, white children under the age of eight for adoption. We feel that these are not the children most in need of our services.

AVAILABLE CHILDREN

The following summaries present a concise reflection of the availability of children in the descriptive categories we generally use in the program.

OLDER CHILDREN (ages 8 to 18)
Many children are available for adoption in these age ranges. They come from a wide variety of backgrounds and experiences. All need the love and security of permanent homes.

MEXICAN-AMERICAN
Several years ago, we placed many Mexican American infants. In the past few years, we have placed no Mexican-American infants because the agencies in the Southwest have discovered that these children can be placed for adoption in their local communities. However, we have placed older Mexican American children and sibling groups.

SIBLING GROUPS (any family group of two or more brothers and/or sisters)
This is one of the most available categories of children. Generally, they are over the age of eight. The larger groups (more than two) are in the greatest need of adoptive families.

AMERICAN INDIAN (Native American)
Tribal laws now strictly limit adoption except by Indian families. The only exceptions likely to occur are for sibling groups of two over the age of ten or for sibling groups of three or more of all ages, also teenagers and children with medical limitations. Most of these children are from Canada.

BLACK & BI-RACIAL (Black-White)
Many children are available from within this broad grouping. Black and bi-racial infants are not as available as older children and sibling groups.

While T-LSA makes inter-racial placements, we **strongly encourage black applicants.** Thousands of children wait for black or white homes. **We suggest that black applicants indicate this on their Interest Registration Forms because the need is so great for black families to adopt waiting children.**

KOREAN
T-LSA has worked cooperatively with the Holt Adoption Program in placing youngsters from Korea, Thailand, and the Philippines. The availability of young Korean children is not limited to families who have previously submitted an application to Holt.

INTERCOUNTRY ADOPTION
Many children in other countries, particularly the developing countries, are in need of permanent adoptive families. However, the complexity of adoption requirements in some countries and difficulty in achieving international agreements on adoption make it very difficult, if not impossible, to obtain those children for adoption. When, and if, such arrangements are made, we expect to be able to work cooperatively with international agencies for this purpose. Persons interested in intercountry adoption should attach a separate note to the Interest Registration Form, stating their interests.

MEDICAL, EMOTIONAL AND PHYSICAL LIMITATIONS
Children with a wide range of medical and emotional needs are available. Some children may be retarded or only moderately limited in their potential. Their need for love and permanence is critical.

ADOPTION RAP SESSIONS
Adoption Rap Sessions are scheduled periodically. Everyone who has an Interest Registration Form on file at our office will receive an invitation to sessions as appropriate. Agency representatives and panels of adoptive parents are available at each of the sessions to discuss the current "Adoption Scene".

THE ADOPTION PROCEDURE
The procedure for adopting a child through T-LSA involves the following major steps:

1. Initial inquiry and completion of an Interest Registration Form.
2. **Selection of applicants for the adoption study process according to the availability of children and staff resources.** As the agency is made aware of available children, applicants are selected for study on the basis of their interests outlined on the Interest Registration Form and the greatest needs of waiting children. Invitations to enter the study process are then extended to the applicants who can be processed in a group (approximately six couples). (We generally have about 300 applications on file and are able to study approximately 100 applicants per year.)
3. Attendance at an informational meeting for those selected for the study group. At that time, basic information is discussed about adoption and the agency policies. Application forms are distributed at this meeting.
4. Remittance of the application form to the agency with the application fee (for those who wish to proceed with the adoption study.)
5. Attendance at a series of group meetings scheduled with the applicants. The primary purpose of these meetings is to enable the social worker to get to know the applicants as potential adoptive parents. This is also a time for increased self-awareness and insight on the part of the applicants. Individual interviews may be arranged as appropriate. Approximately ten sessions are involved.
6. Completion of the study process. The social worker and applicants make a decision regarding the readiness of the applicants for adoption and the study is then written. Material contained in the study is treated in a confidential manner and records are maintained in accordance with requirements of the Pennsylvania Department of Public Welfare.
7. Registration of processed applicants with appropriate adoption exchanges. Other efforts are also taken to make these potential adoptive homes available for waiting children.
8. Completion of initial home visit. The worker visits the home prior to placement to complete a descriptive summary.
9. Placement of a child with the family. (Timing cannot be accurately predicted). There is a period of at least six

months before the adoption can be finalized in court. This may be a period of adjustment for the whole family.

10. Follow up visits. The agency staff is available to assist the family during this time as well as after finalization.

THE COST OF ADOPTION

An application fee and an adoption study fee are charged by the agency. As a voluntary, non-profit, social service organization, the agency has established a fee schedule to enable the adoptive family to share in the costs of service. The actual fee is determined with the applicants according to a sliding fee scale and their respective financial circumstances. These fees are based on the actual cost of adoption services to the agency. However, as already noted, the agency has traditionally carried the major costs of the program.

Attorney fees and court costs are handled between the adoptive parents and their attorney.

Other costs, such as transportation of children or fees of cooperating agencies may be incurred. These costs vary with each situation and are worked out on an individual basis.

P.A.C.O.

An organization for adoptive families, P.A.C.O. (Parents and Adopted Children Organization) provides services and advocacy for children in partnership with the T-LSA Adoption Program. This organization holds educational and social programs and functions throughout the T-LSA service territory. Local PACO groups are organized in specific geographic area.

Special groups are available for those who have adopted older children; siblings; Korean and Vietnamese children; children of black and black-white parentage; Mexican-American and Native American children; and children with medical and physical disabilities.

T-LSA ADOPTION OFFICES:

- ☐ 25 W. Springettsbury Ave. - York, PA 17403 - (717) 845-9113
- ☐ 221 W. Fourth St. - Williamsport, PA 17701 - (717) 322-7873
- ☐ 1200 - 11th. [illegible] - Altoona, PA 16601 - (814) 944-5355

For other helpful information on adoption including books and subscriptions to "Adoptalk", contact: The North American Council on Adoptable Children, Inc., 250 E. Blaine, Riverside, CA 92507 Phone. 714-682-5364.

When T-LSA receives your completed Interest Registration Form this will be acknowledged by letter. You will receive an invitation to attend one of a series of Adoption Rap Sessions when they are scheduled. Because of the heavy work load and the very large list of registered applicants, **you will not be contacted by the agency until your application may be accepted for further processing or to be notified of the Rap Sessions or PACO Chats.**

EXHIBIT B

INTEREST REGISTRATION FORM

Name: (Please Print) ______________________ Date: ______________

Street Address: ______________________ Phone & Area Code: ______________

City: ______________ County: ______________ State: ________ Zip: ______________

We are interested in the adoption of children with special needs as indicated below. Please be aware of this interest and notify us when you can process our application or help us in any other way.

1. *Number of children we would like to adopt now: ______________*
2. *Ages or age range we are interested in: ______________*
3. *We feel we could adopt the following special needs children:*
   - *( ) Children of Black parentage*
   - *( ) Older Caucasian (white) children (age 7 to 18)*
   - *( ) Mexican-American children (older than 5 years)*
   - *( ) Family group - more than one child*
   - *( ) Children of mixed Black-White parentage*
   - *( ) Native American children*
   - *( ) Caucasian children (age 0 to 7 or 8) with limitations*
   - *( ) Intercountry children (as available)*

Physical, Mental and Emotional Limitations:

( ) Cleft palate	*( ) Heart defect*	*( ) Brain damage*
( ) Hearing loss	*( ) Cystic fibrosis*	*( ) Missing arm or leg*
( ) Speech impairment	*( ) Cerebral palsy*	*( ) Hyperactivity*
( ) Mental retardation	*( ) Spina Bifida*	*( ) Sight loss*
( ) Burns	*( ) Learning Disabilities*	*( ) Hydrocephalus*

( ) Other disability (please specify):

( ) *( )* *( )*

** Other types of special needs we could accept: ______________________*

Our family currently consists of: Man (age) ________ Woman (age) ________

Children (list age and sex) ______________________

Other members of immediate family: ______________________

( ) Adoption study group sessions are generally scheduled in the evening. If you could not possibly attend evening sessions, please check here.

( ) I am unmarried and would like to adopt.

( ) If you are Black, kindly indicate this, since there is such a need for Black homes.

T-LSA encourages your registration with other agencies wherever possible. For those interested in Intercountry Adoption, it is necessary to register with resource programs. (A listing will be sent upon request). If you are registered with another agency, please identify that agency. ______________________

Signatures of applicants: ______________________

Please return to the designated area office: ____York ____Williamsport ____Altoona

Note: Your registration may be changed at any time by notifying this office.

** Use reverse side for additional comments.*

11/78

EXHIBIT C

ADOPTION SERVICES UNIT
Division of Family and Child Services
Tressler-Lutheran Service Associates

APPLICATION FORM

1. IDENTIFICATION

Last name of applicant: . ______________________ Date ____________

Address: ____________ / ____________ / ________ / ________ / ________
Street / City / County / State / Zip

Telephone: (Area Code & Number) ______________________

	MALE	FEMALE
First, Middle & Maiden Name		
Birthdate/Birthplace		
Education:		
Religious Denomination:		
Name of Clergyman:		
Address of Clergyman:		

2. EMPLOYMENT

Occupation:		
Present Employer:		
How long with this employer?		
Approximate yearly salary:		

3. MARITAL STATUS

Married ( ), Never Married ( ), Divorced ( ), Widowed ( )

Date & Place of Marriage: ______________________

Previous Marriage? (Dates & names of previous spouse, how and when terminated and, if divorced, who initiated) ______________________

4. FAMILY STATUS:

Names of Children	Birthdates	"Homemade" or Adopted

Names of others in home	Ages	Relationship

EXHIBIT C (cont.)

5. Have you ever had any professional counseling for an emotional problem? ________ If so, please explain. ________

6. Have you ever been convicted of any charge other than a minor traffic violation? ______ If so, please explain: ________

7. Have you ever made application for adoption to another agency? ________
If so, please indicate: Name of agency, location, results of your contact.
____
Is that application still active? ________

8. Have you previously applied for adoption through this agency? ________
If so, please indicate: when, location agency office, results of that application. ________

9. Your attorney for the adoption procedure (It is not necessary to select an attorney until after a child is placed in your home).

Name: ________
Address: ________ Zip: ________
Telephone: ________

10. Your physicians (or physicians)

Name: ________ ________
Address: ________ ________
Telephone: ________ ________

11. References (List three references, not related to you, who have known you for at least several years)

NAMES	ADDRESSES	PHONE NO.

12. Reason for adoption (Please state briefly your reasons for wanting to adopt child.) ________

If you are unable to have children born to you, are there medical reasons? ________. Have you been given a medical opinion on this? ______ By whom? ________ When? ________ What was the diagnosis? ________

13. Child desired to adopt (Please specify the type of child you are desiring to adopt at this time: age; number of children; ethnic background; handicaps; etc.) ______

______

______

______

14. How long have you lived at your present address? ______
Previous Addresses (List previous addresses if you have resided at your present address for less than five years)

ADDRESSES	DATES
______	From: ______ To: ______
______	From: ______ To: ______

15. Directions for reaching your home (Clearly describe the easiest way to reach your home by car from the office where your application is being processed) ______

______

______

______

______

Signature of applicants: ______

______

Note:
Information contained in this application is held in confidence by the agency. Kindly return this application to the agency representative noted below:

( ) Mrs. Barbara Tremitiere
Adoption Services Unit
Tressler-Lutheran Service Assoc.
25 W. Springettsbury Ave.
York, Pennsylvania 17403

( ) Miss Lois Eckels
Adoption Services Unit
Tressler-Lutheran Service Assoc.
221 W. Fourth St.
Williamsport, Pennsylvania 17701

( ) Ms. Winnie Goings
Lutheran Children & Family Service
2900 Queen Lane
Philadelphia, Pennsylvania 19129

EXHIBIT D

TRESSLER-LUTHERAN SERVICE ASSOCIATES

For Work With Older Children in Placement

"Sharing Sheet"

CHILD'S NAME: ______________________ *DATE:* ______________________

FAMILY NAME: ______________________

GENERAL ADJUSTMENT: *(Give examples)*

SCHOOL ADJUSTMENT: *(Give examples)*

ADJUSTMENT TO FAMILY MEMBERS:

AREAS OF SUCCESS:

AREAS THAT NEED IMPROVEMENT:

FEELINGS OF ADOPTIVE PARENTS:

AREAS WHERE EITHER CHILD OR ADOPTIVE PARENT NEED PROFESSIONAL HELP:

PLEASE CONTACT US BEFORE NEXT REPORT IS DUE: *YES*__________ *NO*__________

Revised
T-LSA 1978

EXHIBIT D (cont.)

SESSION VI

CONTENT: PET - PROBLEM SOLVING FAMILY COUNCIL - also INDIAN FAMILY FANTASY

ENCLOSURE: (For use later) Sharing Sheets

OBJECTIVES:

To summarize PET and see how it all fits together.

To help people "feel as an adopted child might feel and work through those feelings.

To evaluate, and set up future contact through PACO and T-LSA.

After Placement

- *"Sharing Sheets"*
- *Supervisory Visits*
- *Staff Counseling and Support*
- *Referral to Other Resources*
- *Preventive and Crisis Therapy*
- *Special Interest Groups*
- *"Listening Ear"*
- *"PACO Chat"*

T-LSA views adoption services as a continuum - from inquiry through and beyond the formal adoption process - for as long as a family may need identifiable service.

"How can we say we've done our share,

When everywhere we look, the children are there!"

BTT

Revised
T-LSA 1978

A NEWSLETTER FOR ADOPTIVE FAMILIES

SEPTEMBER - OCTOBER 1978

Finally, all the kids are back in school....time to take a breather from a hectic summer! Placements continue to happen at a rapid rate. We are so thankful to all of you, our adoptive families, for opening your homes and hearts so readily to these little ones!

Placements:

From our Williamsport Office:

The Lynn family of Northumberland County received their bi-racial daughter. She joins her 7-year-old Vietnamese brother and 10-year-old biological brother.

The Foster family of Clearfield County recently received their 3-month-old Caucasian Downs Syndrome son. He joins his 9-year-old Canadian Indian sister, his 2-year-old Downs Syndrome brother and his 6-year-old biological brother.

The Anderson family of Lycoming County received their 9-year-old Caucasian daughter. She and her 5 sisters will sure keep their Mom and Dad busy!

The Williams family of Lycoming County received their 8-year-old Caucasian son.

The Bryan family of Lycoming County received their infant son. Mr. Bryan is busy decorating and making rugs for the nursery.

The Sorens family of Bucks County received their 14-month-old son from India.

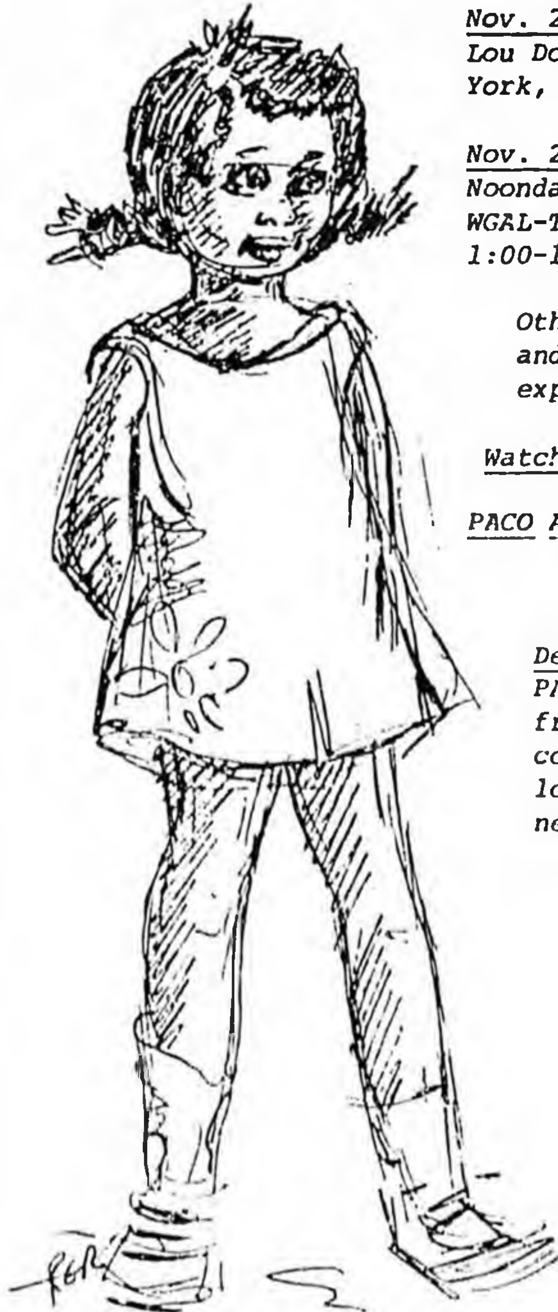
The Evans family of Lycoming County received their 14-month-old son from India. Both boys (Sorens and Evans) were thought to have heart problems, but upon arrival it was good news to learn that both boys only have heart murmurs.

The Bilger family of Snyder County received their 3-year-old Caucasian daughter. She joins her 3 siblings including a Vietnamese brother, Song.

Parents of Adopted Children Organization

A COMMUNITY SERVICE OF TRESSLER LUTHERAN SERVICE ASSOCIATES

ADOPTION WEEK 1978 IS THANKSGIVING WEEK!!!!! While we all "meditate" on the year gone by, and all the children who now have homes, let us also think ahead to 1979. If each of our families, through news media, personal contact, etc., could help one waiting child to find a home in 1979, what a wonderful year it would be! (Let's put special concentration on the teens, the handicapped, and the BOYS!)



Nov. 20 - PACO members on Lou Doolittle Show, WSBA-TV, York, 1:00-1:30

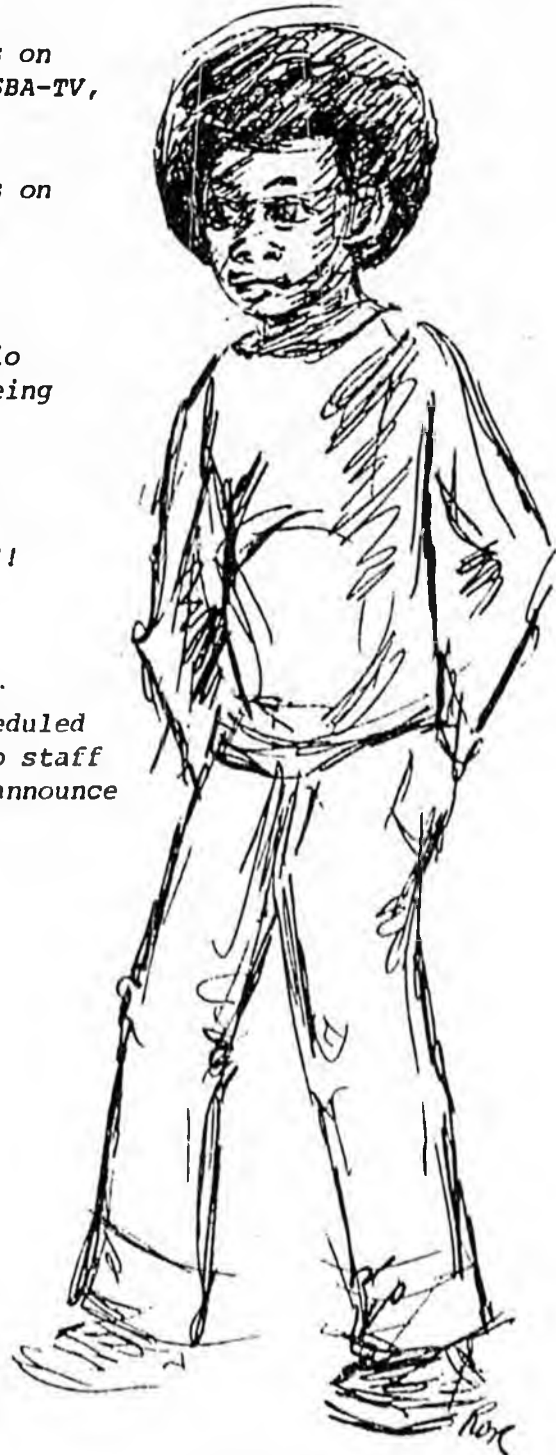
Nov. 21 - PACO members on Noonday On Eight Show, WGAL-TV, Lancaster, 1:00-1:30

Other possible Radio and TV spots are being explored!

Watch and Listen for

PACO ADOPTION WEEK!!!!!

Dec. 5 - Lancaster PACO Chat (Re-scheduled from Oct. 3 due to staff conflicts) Will announce location in next newsletter.



Feb. 1979

PACO VALENTINE PARTY !!

A special super event for the whole family, to be held for the second year at the York YWCA. We will have the swimming pool,etc. for a great party! Mark your calendar now! Details coming soon!

Mar. 24, 1979

PACO DANCE !!!!

This annual event will be held in March instead of May this year so more of you will be able to attend! Mark your calendar now...details coming soon!

EXHIBIT E (cont.)
- 3 -

PACO Board of York, the Parent Group of all of our PACO chapters, shares the following important announcement:

Anyone wishing to serve on the PACO Board of Directors and anyone wishing to nominate anyone on the PACO Board of Directors (individual or couples) should submit their name to:

PACO
Tressler-Lutheran Service Associates
25 West Springettsbury Ave.
York, PA 17403

as soon as possible. The ballots will be going out in November to all PACO members to vote on board members according to our by-laws for the next two-year term. Duties will start January 1, 1979.

One-half of the Board will be elected every year. This way we will have experienced people working with those who do not have experience.

PACO Board President - Ron Lentz

****

By-laws are now being sent out to all of our PACO Presidents, and will be run for all of you in our next PACO newsletter. We want to thank the present PACO Board, who, under the leadership of the Wileys and the Lentzes, finally got us some by-laws! It has been a long, hard pull!

CHILDREN OF THE MONTH:

Jimmy is one year old. He is a hydrocephalic child who spent his first four months in the hospital with a shunt. He has none now. Jimmy comes from a family with superior intelligence. He is a "risk" child, as his intelligence is unknown. Subsidy is possible. Jimmy is Caucasian. Would he fit into your home?

Tommy, also Caucasian, is 6. He is considered to be a disturbed child, although he is not a problem in school. His intelligence is at least average, and he is described as a "beautiful child". Problems include a high sexual awareness, possible exploration with other children, and "urinating anywhere". Could your family help and include him?

Sandy, Caucasian, age 12, is an attractive girl with mild CP. She also has had to have some plastic surgery and orthodontic work done. She prefers men to women, and is able to manipulate adults. Does your family have the strengths to meet her challenges? She needs a home very soon.

Todd and Tim, Caucasian brothers, aged 12 and 13, are behind in school due to frequent moves and early deprivation. It is thought that they are of average intelligence. They have some behavior difficulties, but nothing major. These beautiful, blonde boys badly need a family - before Christmas, they hope.

If you are interested, let me know! *Barb Tremitiere*
(717-845-9113)

AREA GROUP NEWS:

York Area: Many thanks to all who helped so much with our great PACO Fair. Special thanks to the Hambergers and Johnsons who put in so many hours of organizational work!

****

EXHIBIT F

WE WAIT TOO!!!

February Issue 1979

In the midst of winter, snow, etc., let's give some thought to more of the children who wait.

Sandy, a Black child born in 1975, is a beautiful child with an outgoing personality. Could she fit into your home?

Jessie, Caucasian girl born in 1966, has had too many placements for any young girl. Could you help her to grow up and achieve her full potential?

Debbie, Caucasian, born in 1962. Paralyzed from waist down due to abuse or fall, but gets around with braces and crutches and can care for herself. Wants so much to have a family of her own. A beautiful girl.

Warren (born 1969) and Wade (born 1967) are brothers, Caucasian, who need a loving home with a family who will "hang in there" with them. Is it yours? These boys are in Canada.

John Jairo, in South America, was born 9/76. He has had some problem areas, but it is felt that he is doing well now. Cost - about $2000.

We also have several more children from South America, aged 3 - 10 on referral. Most have some physical problems. Cost about $2000 per child.

We have some Korean children available also, including siblings (girl 12, boy 10), and a five-year-old boy with a slight hunch-back due to the after-effects of having had TB of the spine Cost is about $1600 per child.

Looks like we will also be getting some children on referral from India. They will be young with some medical problems. Cost will be about $2000.

Let us know of your interest in any of the above, and we will send more information.

So much to do; so many to place; so short a time before they grow up! If you want to be a part of their growing-up years, let us know!

Tressler-Lutheran Service Associates

York Office
Barb Tremitiere (717) 845-9113

Williamsport Office
Lois Eckels (717) 322-7873

EXHIBIT G

SPAULDING FOR CHILDREN

P.O. Box 337 • Phone [illegible] • Chelsea [illegible]

February 10, 1978

Ms. Barbara Tremitiere
Tressler -- Lutheran Service Association
25 W. Springettsburg Ave.
York, PA 17403

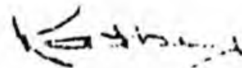
Dear Barb,

I just finished reading your newsletter and want to thank you for sending it along.

Also, I would like to extend my personal thanks to you for the workshop in Ann Arbor. It was a most enlightening and stimulating experience. You are doing a remarkable job and you had a most possitive influence on us.

Keep up the good work.

Sincerely



Kathleen M. Cavanagh
Director of Agency Development

KMC:kp

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

1717 WEST JEFFERSON • PHOENIX, ARIZONA • P.O. BOX 6123 85005

Bruce E. Babbitt
GOVERNOR

E.D. CROWLEY
ACTING DIRECTOR

May 15, 1978

Mr. William Tremitiere
Program Director
Tressler-Lutheran Services Association
25 West Springeptsbury Street
York, Pennsylvania 17403

Dear Bill:

Thank you for taking time from your busy schedule to participate in the Adopt Co-op/DES Conference on Adoption. Those who attended your sessions found them stimulating and thought-provoking. As we have active adoptive parents' organizations in Tucson and Phoenix; which have not been utilized by the public, I am hoping that your workshop will provide the impetus for these groups to be better utilized. I am also hopeful that the Bureau of Social Services will be able to secure funds to bring you and Barbara back to Arizona for more training in adoption, as training in this area is greatly needed.

I enjoyed the opportunity to get to know you and hear about the many creative approaches your agency has taken.

Sincerely,

Anna

Ms. Anna Arnold, M.S.W.
Special Assistant
to the Director

EXHIBIT G (cont.)

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF SOCIAL WORK
UNIVERSITY PARK
LOS ANGELES, CALIFORNIA 90007

April 17, 1978

Mr. William Tremitiere
Tressler-Lutheran Assoc., Inc.
York, Pennsylvania 17403

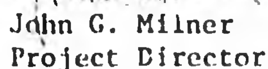
Dear Mr. Tremitiere:

Carol Williams and I wish to express our thanks to you for the excellent presentation you made to our North American Adoption Seminar members. Our group members continued their discussion of your program on the days that followed your being here and all agreed that you had contributed many new ideas and methods of practice. They too asked to have their appreciation expressed to you.

Payment from our university is somewhat slow and we regret this. The necessary request for payment has been sent to our payroll department.

I shall look forward to seeing you at the Arizona meeting.

Very sincerely,



John G. Milner
Project Director

JGM:cd

10 June 1981

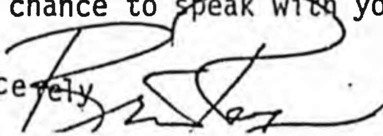
Dear Dr. Worrall,

Thank you for your letter of June 4th regarding lay midwives and House Bill 11.

My purpose in introducing this bill is simply to allow patients the ability to know more about the person or persons whom they choose as a birth attendent. I do not intend to limit in any way the right of a patient to choose their health care provider. Many states allow the practise of licensed lay-midwives and statistics show that even home births, when attended by a trained midwife (not necessarily a nurse) compare favorably with hospital births. Because of this, many doctors are willing to work with lay midwives and are supportive of this bill.

In any case, I appreciate your comments and hope to have the chance to speak with you about this bill in the future.

Sincerely



HB11

Fairbanks Clinic

1867 Airport Road • P.O. Box 1330 • Fairbanks, Alaska 99707 • (907) 452-1761

June 4, 1981

Representative Brian Rogers
Pouch V
Juneau, Alaska 99811

Dear Representative Rogers,

This is a word against lay midwives and Sponsor Substitute House Bill #11.

I am 56 years old, a physician, a certified and recertified obstetrician-gynecologist, a fellow of the American College of Surgeons, etc., etc. I have been practicing obstetrics-gynecology in Fairbanks since 1966. I no longer do much obstetrics.

Lay midwives (please do not use the term midwife without the qualifying words "lay" or "nurse". In qualifications they are worlds apart) do not have sufficient training to deliver babies, and the State of Alaska should not suggest they are qualified by recognizing them. The law should prohibit lay midwifery for a fee or renumeration of any kind.

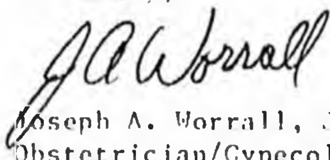
Practicing obstetrics is like flying an airplane. Things can go wrong at anytime, and when things go wrong, you want the best available talent at the controls to prevent disaster if at all possible. I have been out of medical school for 33 years, and I firmly believe this about delivering babies: To have a baby at home or in the bush is foolhardy and a form of child abuse.

Physicians will not cooperate with lay midwives, and patients who through ignorance go to a lay midwife will receive substandard care and will be at risk of unnecessary complications.

If you wish to promote <u>nurse</u> midwifery, this is a different matter, and I endorse encouragement of nurse midwifery in the State of Alaska.

You should beware of people who tell you that "obstetricians are not trained to handle normal birth". This is nonsense.

Sincerely,



Joseph A. Worrall, Jr., M.D.
Obstetrician/Gynecologist

JAW:jmc

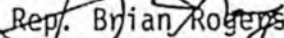
9 June 1981

Dear Dr. Brown,

Thank you very much for the information you sent regarding the practice of lay midwifery and information regarding home births in North Carolina. What you suggest is, indeed, a reasonable compromise and I hope to incorporate many of these ideas in House Bill 11 when we continue work on it next year. The bill is currently in the House Finance Committee where it will stay until we convene in 1982. I will be in contact with you again as soon as there is new information to pass on.

Thank you for your continuing attention to this legislation and for your help.

Sincerely,



Rep. Brian Rogers

HB11

Women and Children's Health Associates

Box 2101 Palmer, Alaska 99645

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

OBSTETRICS / GYNECOLOGY PEDIATRICS PREVENTIVE MEDICINE

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Receptionist

June 4, 1981

Representative Brian Rogers
Pouch V
Juneau, Alaska 99811

Dear Representative Rogers:

As a follow-up to my recent letter of May 26, 1981, I have attached a recent article which reviews some important work done on the home birth movement and neonatal mortality in North Carolina. The full text of the article in the Journal of the American Medical Association may be one which you might wish to review.

Most sincerely,

Carolyn Brown

carolyn V. Brown, M.D.

cVB/dd

Home Birth and Neonatal Mortality

A basic difficulty in assessing the safety of out-of-hospital compared with in-hospital births is that summary reports of state vital statistics seldom give details regarding the circumstances. Planned and attended home births are combined with those for which little or no care was provided, along with sudden births that occurred at home or en route to the hospital. Fetal and neonatal deaths are also reported using the same two general categories.

In a recent report in *JAMA, The Journal of the American Medical Association*, Dr. Claude A. Burnett and other researchers in North Carolina and Georgia point out that this summary information "has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery." With the growing interest in home births, however, "the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them."

Shift to Hospital Delivery

In 1940, they note, 76 percent of infants were born at home in North Carolina; the proportion had fallen to less than 1 percent as of 1975. "With this shift to hospital delivery, maternal mortality fell from 50 per 10,000 live births in 1940 to 3 per 10,000 live births in 1975, a decline of 94 percent. Neonatal mortality also declined 61 percent, from 33 per 1,000 live births in 1940 to 13 per 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."

Against this background of declining mortality, "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." At the same time, "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."

In evaluating risk associated with the place and circumstances of birth, the authors used data from North Carolina's vital statistics for the years 1974 through 1976. Birth records were coded as occurring in a hospital, in a clinic or office, en route to a hospital, or at home. Since infant death records are routinely linked with their birth records in the state, it was possible to determine mortality by birth characteristics.

The 1,296 home deliveries occurring in North Carolina during the study period were classified by both planning status and the attendant present. "If a home delivery was chosen and a healthy infant anticipated, it was classified as planned." For those home deliveries that resulted in neonatal death, the cases were "individually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery." — appropriate supervision.

Home Births Must be Approved

In some North Carolina counties, lay midwives legally attend home births. Their practice is regulated by county health departments; no new lay midwives have been licensed since 1964, and those still practicing are "gradually being phased out." Every home birth by a midwife must be approved in advance as low risk, and the health department must provide prenatal care involving physician-supervised screening for risk factors.

The authors assumed that all home births attended by a lay midwife were planned (since a permit is required), and that home deliveries of infants with birth weights less than 2,000 g and not attended by a lay midwife were unplanned. Unclassified home deliveries were followed up with questionnaires to county health departments, and those remaining unclassified were listed as unknown.

Planning Status Alters Statistics

Of the 1,296 births that occurred at home, 934 (72 percent) were classified as planned, 250 (19 percent) were considered unplanned or precipitate, and the remainder unknown. Of the planned home births, 768 were attended by lay midwives and 166 were classified by questionnaire as "intended" and therefore assumed to be planned. There were 36 neonatal deaths associated with home delivery; of these, six followed planned home delivery. In three of the six deaths, a trained attendant was not present; in the remaining three, attended by lay midwives, death was attributed to congenital anomalies.

Without regard to their planning status, home births were associated with a neonatal death rate of 30 per 1,000 live births. "However, when subdivided by their planning status, a different picture emerged. The neonatal mortality of planned home deliveries was 6 per 1,000, while that of unplanned home deliveries was 120 per 1,000. The relative risk of

unplanned home deliveries was 20 times that of planned home deliveries." Among prenatally screened home births attended by lay midwives, the rate was 4 per 1,000.

"Hospital deliveries, including high-risk pregnancies and low-birth-weight infants, were associated with a neonatal mortality rate of 12 per 1,000 live births. After excluding infants weighing 2,000 g or less at birth, the neonatal mortality rate for hospital deliveries was 7 per 1,000 while that for lay midwife home deliveries remained 4 per 1,000. This difference was not statistically significant."

Considering maternal characteristics, 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."

Low Risk No Guarantee

In contrast, women who gave birth without a trained attendant had a "low-risk demographic profile: 5 percent were younger than 20 years, 78 percent were white, 90 percent were married, and 48 percent were educated beyond high school." Additionally, their deliveries were at low risk with respect to infant birth weight. "Even with these favorable characteristics, their neonatal mortality rate was eight times that of lay midwife home deliveries."

The present study, say the authors, "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."

a Reasonable Compromise

Thus the screening program carried out through physician-supervised prenatal care for those women who planned on home birth with a lay midwife was "apparently effective." On the other hand, planned home births without medical screening and without a trained attendant resulted in high neonatal mortality despite the low-risk demographic profile. "Adequate prenatal care and provision of care appropriate to medical risk repeatedly has been associated with lower neonatal mortality."

(continued on back cover)

define

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HOME BIRTH AND NEONATAL MORTALITY

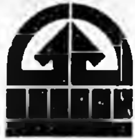
(continued from page 62)

As limiting factors, the authors note that the number of neonatal deaths was small; classification errors may have occurred, and births and neonatal deaths may have been underreported. Moreover, home delivery practices in North Carolina during the study period "were not necessarily representative" of those elsewhere. Home and hospital births attended by nurse-midwives were not represented, although they are "an increasing proportion of deliveries in other states." Finally, since the lay midwives were initially certified in 1964 or earlier, they had at least ten years of home birth experience at the time of the study. For all these reasons, "inferences regarding the safety of home births should await prospective controlled studies."

In conclusion, there has been a "dramatic shift" from hospital to home birth in the last 40 years in North Carolina. Nevertheless, "some women prefer or economically need an alternative to a high cost physician-hospital delivery." To extend adequate prenatal and birth services to poor women in rural areas, "economically realistic alternatives should be developed before existing traditional services are phased out." Whatever alternative 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."

Source

Claude A. Burnett III, MD, James A. Jones, MPH, Judith Rooks, CNM, Chong Hwa Chen, MS, Carl W. Tyler, Jr, MD, and C. Arden Miller, MD, "Home Delivery and Neonatal Mortality in North Carolina," *JAMA*, Dec 19, 1980 (Vol 244, No 24), p 2741



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House of Representatives

Executive Director
Earl S. Mackey

June 19, 1981

Nancy Deitrick
Senate Health & Social Services Committee
Pouch V, State Capitol
Juneau, AK 99811

Dear Ms. Deitrick,

In response to your request for information on licensing requirements for lay midwives in the states, I have enclosed a survey of state legislation pertaining to nurse-midwifery that includes some information on lay midwifery. The report, first published in 1976, has been updated to January 1980 in some areas. I also tried to contact the National Midwives Association, which should have additional information on lay midwifery, but have been unable to reach them by telephone. I will let you know about any relevant information that the Association is able to provide. Meanwhile, I hope that the enclosed survey will be useful. I also have copies of state legislation that I will be glad to send to you at your request.

If you have further questions or need additional information, please be sure to write or call. I will be happy to assist you.

Sincerely yours,

Bonnie Dolan

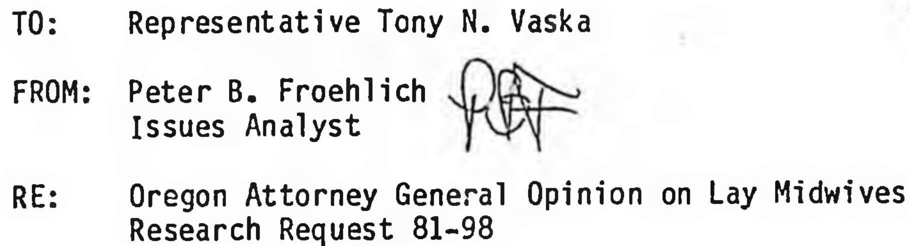
Bonnie Dolan
Senior Research Associate

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

April 21, 1981

MEMORANDUM



TO: Representative Tony N. Vaska

FROM: Peter B. Froehlich
Issues Analyst

RE: Oregon Attorney General Opinion on Lay Midwives
Research Request 81-98

Your staff has asked us to analyze a June 17, 1977 Oregon Attorney General's opinion concerning the practice of lay midwifery. This opinion was discussed in two memoranda to you, dated March 27 and March 31, 1981, from Leslie Longenbaugh of this office. The opinion itself was forwarded to you several days later.

In summary, our analysis of the opinion indicates that it is based on Oregon statutory language which is similar to Alaska statutory and regulatory language. A strong argument can be made, therefore, that an Alaska Attorney General opinion would be likely to reach the same conclusion as does the Oregon opinion.

The Oregon opinion addresses two questions: 1) whether a person in Oregon, other than a licensed physician or nurse, can legally be a midwife and assist at a normal childbirth; and 2) if so, whether the person (lay midwife) can legally administer medicine or perform an episiotomy. The first question was answered affirmatively and the second negatively by the Oregon Attorney General's office.

Permissibility of Lay Midwifery

The basis for the first answer that one could legally serve as a midwife without licensure as a physician or nurse hinges upon the explicit use of the word"midwife"in the Oregon statutes requiring the filing of birth certificates.

The Oregon statutes provide in pertinent part:

> 432.205 (1) a certificate of birth shall be filed with the local registrar or the registration district in which the birth occurred within the time prescribed by the division, by either the physician or midwife in attendance at the birth, or if not so attended, by one of the parents;.... (Emphasis added)

> 432.210 If neither of the parents of the newborn child, unattended by either physician or midwife, is able to prepare a birth certificate, the local registrar shall secure the necessary information for the preparation of a birth certificate from any person having knowledge of the birth. (Emphasis added)

A predecessor Oregon statute, adopted in 1905, also referred specifically to "midwives." The Oregon Board of Examination and Registration of Graduate Nurses was established six years later, in 1911, to license people who engage in the practice of nursing, without any mention of midwives or the functions they performed.

However, like the Alaska legislature, the Oregon legislature never defined the practice of nursing to specifically include midwifery and never required licensure of midwives. Thus, the Oregon opinion concludes that the Oregon legislature has recognized "midwifery as an occupation distinct from nursing" for which there has never been a licensing requirement imposed.

The Alaska statutes concerning birth certificates provide in part:

> Section 18.50.160 Birth Registration...
>
> (c) When a birth occurs outside an institution, the certificate shall be prepared and filed by one of the following in the indicated order of priority:
>
> (1) the physician in attendance at or immediately after the birth; or in his absence;
>
> (2) a person in attendance at or immediately after the birth; or in his absence;....
>
> Section 18.50.240 Fetal Death Registration...
>
> (b) The funeral director or person acting as the funeral director who first assumes custody of a fetus shall file the fetal death certificate. In his absence, the physician or other person in attendance at or after the delivery shall file the certificate of fetal death....

Although the word "midwife" is not currently used in either of these sections, nor indeed, in any other Alaska statute, the word is used in a 1960 regulation, 7AAC 05.370, adopted under AS 18.50.150.

> 7AAC 05.370 PERSON RESPONSIBLE FOR FILING... When a birth occurs outside an institution, the following shall be the order of responsibility for preparing and filing the certificate:

(1) physician in attendance;

(2) nurse in attendance;

(3) sub-registrar of village, if any;

(4) midwife or any other person in attendance (Emphasis added)

The broad language of the statutes (i.e., "person in attendance at the birth,") and the specific use of the word "midwife" in the regulations indicate that the practice of midwifery is recognized and permitted in Alaska, as in Oregon, as an occupation distinct from nursing. Likewise, just as in Oregon, there is no Alaska requirement that midwives be licensed. Furthermore, the word "midwife" was used in the Alaska statute requiring birth certificates from its first enactment in 1917 (§2 ch 35 SLA 1913) until it was rewritten more broadly in 1960 (§13 ch 18 SLA 1960) to include anyone attending a birth, and not only midwives. The Alaska Nurses Examining Board was not established until 1941 (ch 46 SLA 1941), and the practice of nursing was not defined until 1949 (§1 ch 28 SLA 1941). Neither enactment and none of the several subsequent amendments to the nurse licensing statutes has prohibited or mentioned midwifery directly or indirectly.

Scope of Lay Midwifery

The second part of the Oregon opinion concluded that lay midwives could not legally administer medication or perform episiotomies. This result was based on Oregon statutes and Attorney Generals' opinions which define the practice of medicine and of nursing to include performing surgery and administering medication respectively.

Alaska statutes clearly also include performing surgery such as episiotomies within the definition of the practice of medicine (AS 8.64. 3802(e)) and therefore, a license to practice medicine is required by AS 08.64.170(a). Performing surgery has been included in the statutory definition of the "practice of medicine" since the first Alaska Medical board was created in 1917 (§14 ch 8 SLA 1917).

The Alaska definition of the "practice of professional nursing" includes:

> ...the administration of medications and treatments prescribed by a licensed physician or dentist which require substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social science.... (Emphasis added) AS 8.68.410(5)

Thus, some medications can be legally administered only by licensed nurses, while other medications can be administered by anyone, including a lay midwife. Under the Alaska Administrative code, the

prescription eyedrops which prevent infant blindness due to maternal gonorrhea, must be placed in the eyes of newborn infants by a "physician, nurse, or certified (nurse) midwife." (7AAC 27.111) It is not perfectly clear that the eyedrops are medication that requires the type of "substantial specialized judgment" which, under AS 8.68.410(5) would mean they must be administered by a licensed nurse (or physician). Nonetheless, the Department of Health and Social Services eliminated in 1980 any remnant of doubt by adopting 7AAC 27.111 which requires in no uncertain terms that the drops be administered by a doctor or nurse. Therefore, anyone other than a physician or dentist who administers these eyedrops or any other prescribed medication which requires "substantial specialized judgment and skill" must be licensed as a nurse under AS 8.68.160.

In conclusion, Alaska law is very similar to Oregon law on this subject, and we believe that an Alaska Attorney General opinion would probably reach a result very similar to that of the Oregon opinion. Informal discussion with an Assistant Alaska Attorney General further confirms this supposition.

Please contact us if we can provide any further information or assistance. You may also wish to contact the Legal Services Division of the Legislative Affairs Agency concerning this subject.

PF/bf

STATE HEALTH NOTES

Midwifery

As the debate over the efficacy of traditional birthing practices continues, the midwifery movement appears to be gaining momentum in a number of legislatures. A new bill in **WASHINGTON** State (SHB 316), which has already passed the Senate, may serve as the model for the nation. SHB 316 updates Washington's 1917 licensure act regulating the practice of midwifery. It includes *midwife* in the definition of a health care provider, and creates a midwifery advisory committee consisting of one obstetrician, one physician, one certified nurse-midwife, three licensed midwives, and one public member. In addition, SHB 316 specifies the qualifications candidates must meet in order to take the licensure examination. These include: a minimum of three years of midwifery training, unless the candidate meets certain requirements; education in obstetrics, neonatal pediatrics, basic sciences and other specified subjects; observing fifty women in each of the prenatal, intrapartum and postpartum periods; and observing an additional fifty women in the intrapartum period.

The Health Policy Analysis Program at the University of Washington, Seattle, has published an extensive monograph on the state-of-the art of midwifery, nationwide and worldwide, covering such areas as the scope of the practice, education and training, credentialing, the question of independence, and other related issues and policy questions. The monograph's title is *Midwifery Outside of the Nursing Profession: The Current Debate in Washington*, ($6.00, 156 pp) and it may be obtained by calling (206) 543-3522.

Other states are also examining the midwifery option. **UTAH's** legislature, for example, passed a resolution to establish a study commission for a lay midwife program (SCR 8). A bill in the **NEW HAMPSHIRE** Legislature (HB 319) would establish an advisory committee to regulate lay midwives. **ARIZONA's** SB 1336 would set procedures and requirements for the licensure of midwives.

Nursing Legislation

While experts continue to argue over whether a nurse shortage actually exists, many states are convinced of its existence and are proposing a variety of legislative remedies. **NEW YORK**, for example, is considering legislation that would provide 600 additional scholarships annually for basic professional nursing education (A2220). **KANSAS** is considering legislation (SB 247) that would provide state financing of professional nursing education in public or private nonprofit hospital schools of nursing. Under this bill, each facility would receive up to $1,000 for each nursing student in the second or third year of a three-year program.

The **ARKANSAS** General Assembly has passed legislation (Act 54, SB 100) which authorizes the Board of Nursing to waive the educational requirements for licensure for practical nurse or psychiatric technician nurse, if the board determines the applicant is otherwise qualified. **MARYLAND's** HB 1349 would establish a scholarship program for retaining nurses in that state.

In a related issue, **TEXAS** (SB 532), **MASSACHUSETTS** (H 3444) and **MINNESOTA** (SF 688) are considering legislation that would provide for the registration of temporary nursing pools. **MINNESOTA's**

SF 688 requires nursing pool agencies to register with the Commissioner of Health. Further, the commissioner would establish minimum standards for the registration and operation of temporary nursing pools. A **WISCONSIN** bill (AB 16) would require the Department of Health and Social Services to set maximum rates nursing pools may charge for services reimbursable under Medicaid.

Abortion Legislation Increases

Restrictions on abortions have become a focus of legislative activity in a number of states. Many of the legislative proposals, while aimed at restricting or prohibiting abortions, make exceptions in instances where the life of the mother is in danger or in cases of rape, incest or fetal abnormality.

Several states, including **OKLAHOMA**, **RHODE ISLAND** and **ILLINOIS**, have introduced legislation that would make coverage for abortions available only as an optional rider to health insurance contracts, plans and policies. **NEBRASKA** has introduced a resolution (LR 27) to require that abortion coverage be an optional benefit under the state employee group health insurance plan, with coverage to be financed entirely by the employee.

The **NEBRASKA** legislature adopted an emergency act (A 125) which prohibits group insurance policies or HMOs paid for in part by public funds from including coverage of abortions. The act does not prohibit the insurer from providing special coverage for abortions so long as the costs are borne solely by the employee. **IOWA** is considering an approach (HF 650) similar to Nebraska's.

Other states, such as **NEW YORK** (AB 2162), **ALABAMA** (S 522) and **MICHIGAN** (HB 4179, SB 18), are considering legislation to eliminate coverage of abortions under their Medicaid programs. **TEXAS** and **OKLAHOMA** are debating bills (HB 1194 and HB 1257, respectively) which would restrict all public funds from paying for abortions.

Several recent court decisions have had a significant impact on the abortion issue. The **MASSACHUSETTS** Supreme Court, for example, ruled that the state must pay for all *medically necessary* abortions for welfare recipients. **CALIFORNIA's** Supreme Court went beyond the Massachusetts decision and ruled that the state must pay for abortions of welfare recipients if the state chooses to pay for the medical care of women desiring children.

The U.S. Supreme Court upheld **INDIANA's** law requiring that abortions in the second trimester of pregnancy be performed by physicians in hospitals. A few weeks earlier the Supreme Court declared state laws requiring parental consent for an abortion for an unmarried minor to be constitutional. In a similar action, the **MASSACHUSETTS** Supreme Court recently upheld a 1980 statute requiring parental consent for an abortion. While the statute requires the consent of both parents in the case of an unmarried minor, it does provide that if one or both parents do not consent, or if the minor refuses to seek her parents' consent, she can appeal to the supreme court of the state for a private hearing. The judge can approve an abortion on a finding that the minor is mature or that the abortion is in her best interest. Several states, including **OHIO** (H 92), **VERMONT** (S-123) and **MINNESOTA** (HF 399) have introduced legislation requiring parental approval before an abortion can be performed on an unmarried minor.

Protective Services for the Elderly

A number of states are debating potential solutions to the growing problem of elderly abuse. **WEST VIRGINIA**, for example, has introduced legislation that would provide protection for elderly persons, age 60 and older. SB 121 would require doctors, police officers, etc., to report to the State Department of Welfare suspected cases of abuse, neglect, exploitation, abandonment or cases in which elderly persons are in need of protective services. The department would subsequently be required to investigate the matter and when necessary, with the consent of the elderly person or his conservator, to provide whatever protective services the person may need. The Commissioner of Welfare would be given broad general authority to take all actions necessary to protect the health, safety and welfare of an elderly person unable to care for himself.

The **MASSACHUSETTS** Legislature is considering similar legislation (H 4112, S 640). Under these bills, all suspected cases of abuse and all deaths which result from abuse must be reported to the Department of Elder Affairs. Any death

which occurred as a result of abuse or neglect must also be reported to the district attorney. In addition, the department would be required to conduct an assessment and evaluation, and develop a service plan which may include such services as: 1) homemaker; 2) transportation; 3) legal assistance; 4) counseling; 5) emergency housing; and 6) emergency financial assistance.

A new statute in **WYOMING** establishes an Adult Protective Services program (Chapter 155, Laws of 1981, HB 49-A). Under this law, the Department of Health and Social Services (Division of Public Assistance and Social Services) is required to coordinate a protective services program to ensure that all disabled persons, age 16 and older, will have easy access to these services. In addition, the department is required to adopt regulations necessary to implement the program, as well as develop and maintain a statistical data system by type of referral and disposition.

Reports of crime and victimization of elderly persons have spurred **RHODE ISLAND** to consider legislation (H 5089) that requires housing authorities to provide 24-hour security guards to protect all older persons who reside in housing projects for the elderly.

To protect the rights of elderly persons in nursing homes, **MASSACHUSETTS** is debating legislation that would establish a nursing home ombudsman unit in the Department of Elder Affairs (H 617, H 3448). Under this proposal, the ombudsman would receive and investigate complaints against nursing homes and any agency that is responsible for regulating nursing home care.

ICFs/MR

States continue to demonstrate an interest in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). **NORTH DAKOTA** alone has introduced seven bills in this area. HB 1049, for example, would establish and appropriate funds for a revolving loan fund for the construction and renovation of ICFs/MR, while HCR 300 would direct the North Dakota Social Services Board to cover ICFs/MR services under Medicaid.

In **MAINE**, LD 299 would allow nonambulatory persons certified as being capable of following directions the option of residing in small normalized boarding care facilities without requiring these facilities to meet the requirements of the Institutional Occupancy Section of Maine's Life Safety Code.

A new study examining the experience of ICFs/MR throughout the country is available by calling or writing IHPP ($5.00).

Medigap Activity Continues

At least 25 states have introduced legislation this year aimed at regulating the sale of supplemental Medicare health insurance policies. Most of these so-called *Medigap* bills extend authority to the insurance commissioner in each state to issue new rules and regulations on minimum standards for policies and benefits, loss ratios, disclosure requirements, etc. **INDIANA**, for example, has passed legislation (HB 1878) which authorizes the insurance department to adopt rules to simplify terms and coverage of Medicare supplement policies. At least 15 bills introduced in legislatures across the country cite PL 96-265, which includes the Baucus Amendment, as one reason for the new legislation, and indicate the intention to bring the state into compliance with the federal law. The Baucus Amendment establishes, among other things, a voluntary certification program for Medicare supplementary policies effective July 1, 1982. States with an approved Medigap program in place by the 1982 deadline will be unaffected by the federal statute.

Because of the large amount of legislative and regulatory activity over the past two years surrounding this issue, preliminary figures indicate that a solid majority of states should be in compliance with Baucus by next year's deadline. The IHPP will be compiling an up-to-date summary of all state activities in this area within the next two months.

Medicaid Survey

IHPP has completed a 50-state survey of Medicaid cost-containment proposals. The survey lists, state by state, all legislative and executive proposals which would affect services, eligibility and reimbursement, as well as strategies for improving the administration and management of the program. The survey is current through May 1, 1981. Copies can be obtained by sending $2.00 to IHPP.

State Health Highlights

• A new statute in **ARKANSAS** (Act 380, laws 1981) directs all state agencies which administer funds for long-term care services to develop a coordinated and accessible network of long-term care and related community-based services by utilizing an interagency referral system.

• A new bill in the General Assembly of **NORTH CAROLINA** (HB 405) would direct the Secretary of the Department of Human Resources to consolidate all programs and services that serve the elderly into one unified program, emphasizing in-home care whenever possible. In addition, the bill would direct the Secretary to expand the Medicaid nursing home preadmission screening program.

• The **MINNESOTA** Legislature is considering a bill that would provide for a statewide program of subsidies to families who agree to provide home care and training to their minor dependants who are mentally retarded (HF 314, SF 408).

• **ALABAMA's** Legislature has directed the state Medicaid agency to exempt children, including newborns, who have had an EPSDT screening, from the state's 20-day annual limit on hospital days (Act 86, Laws 1981).

• A new report, *Better Health for Our Children: A National Strategy*, contains over 100 recommendations for improving the organization and financing of maternal and child health services. To obtain the four-volume report contact: Mimi Simms, Office of Maternal and Child Health, Public Health Service, (301) 443-2170.

• A bill now in the **WASHINGTON** Legislature legalizes the use of the drug DMSO (dimethyl sulfoxide). DMSO has not been approved by the federal Food and Drug Administration except for bladder infections. There are claims, however, that it may provide relief from arthritis and a variety of other ailments. **WASHINGTON's** HB 88 authorizes licensed practitioners to prescribe DMSO to a state resident, and authorizes licensed pharmacists to dispense DMSO with a prescription. In addition, the bill makes it lawful for DMSO to be manufactured in the state of Washington by licensed pharmacists.

• A new statute in **MAINE** (LD 914, chapter 271) creates an Environmental Health Program within the Department of Human Services, Bureau of Health. The program is authorized to develop and monitor the health of Maine's citizens, identify significant problems, particularly those related to environmental factors, and conduct and contract for investigations to ascertain whether or not particular problems are related to environmental factors.

• The **FLORIDA** House adopted a bill (HB 90) prohibiting disability insurance carriers from discriminating against persons exposed to DES.

• According to a recent study released by the **GEORGIA** Department of Human Resources, 30 percent of the mentally retarded residents in Georgia's institutions could be better served in a community setting. A lack of statewide residential services was cited as a major obstacle in moving these persons into community residences. Furthermore, the study, Project P.R.O. (Preparing for Residential Options), identified 1,212 mentally retarded individuals now living in the community who are in critical need of other residences. The study recommends placing both groups of persons in a variety of residential settings over a three-year period -- costing the state about $4 million for the first year and about $3.7 million for the second and third years.

STATE HEALTH NOTES

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UTAH STATE SENATE

SOPHIA C. BUCKMILLER
SECRETARY OF THE SENATE

317 STATE CAPITOL
SALT LAKE CITY, UTAH 84114
PHONE 328-8473, 328-5701

May 21, 1981

Ms. Nancy Deitrick
Research AnalystHealth, Education &
Social Services Committee
Alaska State Legislature
Pouch V - State Capitol
Juneau, Alaska 99811

Dear Ms. Deitrick:

In compliance with your request dated May 18, 1981, I have enclosed a copy of S.C.R. No. 8, INTERIM STUDY OF THE LAY MIDWIFE PROGRAM, by Senators Bangerter, Ferry and Farley.

If at any time our office can be of further help, it will be our pleasure to respond.

Respectfully,

Sophia C. Buckmiller

Sophia C. Buckmiller
Secretary, Utah State Senate

Encl:

INTERIM STUDY OF THE LAY MIDWIFE PROGRAM

1981

GENERAL SESSION

Enrolled Copy

S. C. R. No. 8

By Jack M. Bangerter
Miles 'Cap' Ferry
Frances Farley

A CONCURRENT RESOLUTION OF THE GENERAL SESSION OF THE 44TH LEGISLATURE OF THE STATE OF UTAH, THE GOVERNOR CONCURRING THEREIN; DIRECTING THE LEGISLATIVE MANAGMENT COMMITTEE TO ASSIGN TO AN APPROPRIATE INTERIM STUDY COMMITTEE THE DUTY [illegible] THE PRACTICE OF LAY MIDWIFERY IN THE STATE OF U AH.

Be it resolved by the Legislature of the State of Utah, the Governor concurring therein:

WHEREAS, there has been an increase in the number of lay midwives in the State of Utah;

WHEREAS, there has been an increase in the number of children delivered by midwives in the State of Utah;

WHEREAS, there has been concern about the training and certification of lay midwives;

WHEREAS, the legality of the practice of lay midwifery in the State of Utah is uncertain;

WHEREAS, the State of Utah is interested in the promotion of health care services for protection of people of the state.

NOW, THEREFORE, BE IT RESOLVED, by the General Session of the 44th Legislature of the State of Utah, the Governor concurring therein, that the Legislative Management Committee be directed to assign to the appropriate interim study committee the duty to study the practice of lay midwifery in the State of Utah.

BE IT FURTHER RESOLVED, that the existing program, during the interim, be supervised by the division of registration.

INTERIM STUDY OF THE LAY MIDWIFE PROGRAM

1981

GENERAL SESSION

Enrolled Copy

S. C. R. No. 8

By Jack M. Bangerter

Miles 'Cap' Ferry

Frances Farley

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INTERIM STUDY OF THE LAY MIDWIFE PROGRAM

1981

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Rick Slobitsky –

No cases involving mid-wives
Only case Dr. Rocey in Sitka
found innocent in court but
negligent in licensing hearing
and therefore elected to leave
State (Wash.) rather than
go with recommended changes

11:00 – Charlie
Collette 3732

MICA 274-9232 Anchorage
Mr. Oberson (?) Home delivery care.
Attitude of Dr. Newman is that it works
well in some parts of the world w/ mobile
units and readily available physicians.
Hasn't been any cases. Controversy
over Dr. Peter Rocey in Sitka – Dropped
his insurance. Not a formal underwriting
position but on basis of his being
under investigation. No legal precedent.

Nancy – Message from Charlie

①- Check (court building) around to find out how many cases (if any) where Drs. have been prosecuted in last few years (Re: Drs. delivering at home or mid wives – etc) –

library-3808

Dr. Rasey – Dept of Law

---

②. – call M.I.C.A. Corp. (this is an insur agency set up for doctors) – Re: any mal-practice liabilities (if any that were brought up – where doctors gave pre-natal care (x-Rays) — but the woman had a home delivery with a mid-wife – or doctor –

Nancy

For:

RCK 3620

Dan Hickey – 3428

— SB 747 - MIDWIFERY —

(1) Cathleen Horwitz
2601 Kona Lane
Anchorage, AK. 99503

(2) Kathy Dettinger
1628 ~~Main~~ Market St.
FBX, AK. 99701

(3) Theresa Rasin
8141 Country Woods
Anchorage, AK. 99502

(4) Al Rushing
1403 E. 27th
Anchorage AK. 99504

(5) Julie Ballard Gorham
S.R. 1552 Eagle River Road
Eagle River, AK. 99577

(6) Barbara + Harold Parker (MR. + MRS.)
P.O. Box 605 A.
Chugiak, Ak. 99657

March 25 Video T/C.

Total Time: 2 hours + possible x-tra 10 min.
Segment Time (4 sites)

come up to video: | 0 minute | OPEN | JNU

VIDEO TO ALL SITES OF JNU COMMITTEE

Opening statements from the committee chairman. Welcome. Intros. [Brief statement of bill + positions]

count down and switch to: | 5 minutes | FIRST SITE | FBX

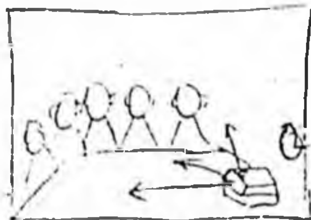
FBX VIDEO OUT TO ALL VIDEO SITES (FBX SEES JNU COMMITTEE) (ALL OTHERS SEE FBX WITNESS)

FAIRBANKS STATEMENTS TAKEN.

WITNESSES:

Sen. Parr thanks FBX, moves on to SIT.

switch to: | _ minutes | SECOND SITE | SIT



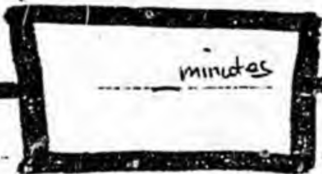
ALL VIDEO SITES RECEIVE JNU COMMITTEE LISTENING (AUDIO OF SITKA)

SITKA STATEMENTS TAKEN

WITNESSES:

Sen. Parr thanks Sitka ... on to 3rd

site change / same video



THIRD SITE BET

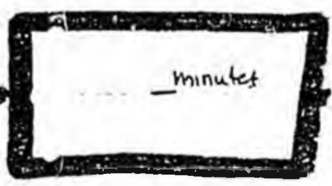
BETHEL STATEMENTS TAKEN

WITNESSES:

ALL VIDEO SITES RECIEVE JNU. committee listening (AUDIO OF BETHEL WITNESSES)

Sen. Parr thanks Bethel, on to Anchorage

count down and switch source to:



FOURTH SITE ANC.

ANCHORAGE WITNESSES TESTIFY

WITNESSES:

(ANCHORAGE SEES COMMITTEE ON THEIR MONITOR)
ALL SITES RECIEVE VIDEO OF ANCHORAGE WITNESSES
— ANCHORAGE VIDEO OUT TO ALL SITES —

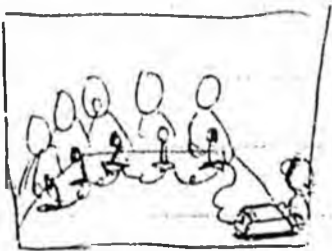
Sen. Parr thanks Anc / Summarizes

countdown and switch source to:

VIDEO CLOSE JNU

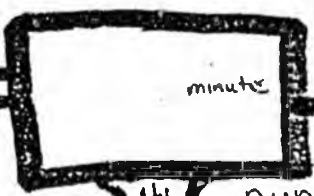
TRANSITION STATEMENTS FROM COMMITTEE / VIDEO TO AUDIO ONLY

Sen. Parr wraps up, summarizes, thanks participants & indicates future track of this bill in legislative process.
Sen. Parr reminds people that video portion [illegible] audio continues for another 1½ hours.



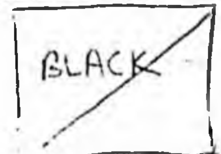
Sen Parr & committee to all sites.

Video countdown to BLACK / LTN continues.



REGULAR T/C

Sen. Parr or Moderator begins teleconference round robin.



VIDEO TRANSMISSION ENDS

AUDIO LTN/Teleconference until 7 pm. PST.

SENATE ENGROSSED COPY

State of Arizona
Senate
Thirty-fifth Legislature
First Regular Session
1981

SENATE BILL 1336

AN ACT

RELATING TO PUBLIC HEALTH AND SAFETY; EXEMPTING FROM LICENSURE AS MIDWIVES PERSONS ATTENDING WITHOUT COMPENSATION WOMEN IN CHILDBIRTH; PROVIDING FOR CERTAIN PROVISIONAL LICENSING, AND AMENDING SECTION 36-752, ARIZONA REVISED STATUTES.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-752, Arizona Revised Statutes, is amended to read:

36-752. Attendance at childbirth

A. A person attending women in childbirth~~, habitually or~~ for hire, shall~~, on and after July 1, 1957,~~ be:

1. A qualified physician;

2. A registered nurse certified by the Arizona state board of nursing as a qualified nurse-midwife;

3. Under the personal direction and supervision of a qualified physician; or,

4. A licensed midwife.

B. NOTHING IN THIS CHAPTER SHALL BE CONSTRUED TO PROHIBIT A PERSON NOT LICENSED UNDER THIS CHAPTER, WHO DOES NOT ACCEPT MONETARY COMPENSATION, FROM ATTENDING WOMEN IN CHILDBIRTH.

Sec. 2. Provisional licensees to practice midwifery

For a period of six months from the effective date of this act, the department of health services shall grant a provisional license to any applicant who passes an examination established by the department pursuant to title 36, chapter 6, article 7, Arizona Revised Statutes, and pays a fee of twenty-five dollars. The provisional license is valid for a period of one year from the date of issuance and is nonrenewable. Upon the expiration of the provisional license, the department of health services shall issue a license to the holder of a provisional license upon documentation of successful assistance in ~~a minimum of~~ at least five births and the payment of licensure fees pursuant to section 36-754, Arizona Revised Statutes.

midwives' licenses
FISCAL NOTE INDICATED

COVER SHEET

S.B. 1336
(Reference to Senate engrossed bill)

Struck everything after the enacting clause

Amended title to conform

Passed Senate, amended. Held in House.

STATE OF ARIZONA
35th LEGISLATURE
FIRST REGULAR SESSION

REFERENCE TITLE: midwives' licenses
FISCAL NOTE INDICATED

SENATE

SB 1336

Introduced
February 10, 1981

Referred on February 12, 1981

Rules

HEALTH, WELFARE & AGING

Introduced by
Senator Hardt; Representative Cooper

AN ACT

RELATING TO PUBLIC HEALTH AND SAFETY; PRESCRIBING QUALIFICATIONS, EXAMINATION AND LICENSURE FOR MIDWIVES; PRESCRIBING FEES; PRESCRIBING CONTINUING EDUCATION AS CONDITION FOR RENEWAL OF LICENSE; ESTABLISHING MIDWIFERY ADVISORY BOARD; AMENDING SECTIONS 36-753 THROUGH 36-755, ARIZONA REVISED STATUTES, AND AMENDING TITLE 36, CHAPTER 6, ARTICLE 7, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-755.01.

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Section 36-753, Arizona Revised Statutes, is amended to
3 read:
4 36-753. Application for examination for license as midwife;
5 qualifications; examination fee
6 A. A person who desires to obtain a license to practice midwifery
7 shall make written application to the director of the department of health
8 services, upon a form to be supplied by the director, ~~and~~ shall furnish
9 such information as may be required by the director, AND SHALL PAY AN
10 EXAMINATION FEE OF SEVENTY-FIVE DOLLARS.
11 B. TO BE ELIGIBLE FOR THE EXAMINATION GIVEN BY THE DEPARTMENT OF
12 HEALTH SERVICES, THE APPLICANT MUST SHOW EVIDENCE OF:
13 1. COMPLETION OF HIGH SCHOOL, OR ITS EQUIVALENT.
14 2. COMPLETION OF A MIDWIFE EDUCATION PROGRAM APPROVED BY THE
15 DIRECTOR.
16 Sec. 2. Section 36-754, Arizona Revised Statutes, is amended to
17 read:
18 36-754. Licensing of midwives; renewal of license; continuing
19 education; fees
20 A. The department of health services shall grant a midwife's
21 license to ~~a person meeting the qualifications prescribed by this article~~
22 ~~and payment of a fee of one dollar.~~ AN APPLICANT WHO PASSES THE
23 EXAMINATION AND PAYS THE INITIAL LICENSE FEE OF TWENTY-FIVE DOLLARS.

B. The license shall expire ~~July 1~~ ON DECEMBER 31 of ~~the following calendar~~ EACH year~~.~~, AND ~~A valid license~~ may be renewed ~~each succeeding year~~ upon ~~application to the director, without~~ payment of ~~a further~~ THE ANNUAL RENEWAL fee OF TEN DOLLARS AND UPON EVIDENCE OF COMPLETION OF EIGHT CREDIT HOURS OF CONTINUING EDUCATION APPROVED BY THE DIRECTOR OR HIS DESIGNEE.

C. A LICENSEE WHO FAILS TO RENEW A LICENSE WITHIN SIX MONTHS OF ITS EXPIRATION MUST APPLY AGAIN TO THE DEPARTMENT FOR AN ORIGINAL LICENSE AND TAKE THE EXAMINATION.

D. THE DEPARTMENT SHALL GRANT A LICENSE WITHOUT EXAMINATION TO A MIDWIFE HOLDING A CURRENT LICENSE GRANTED BY ANOTHER STATE WHICH HAS LICENSING REQUIREMENTS SUBSTANTIALLY IDENTICAL TO THOSE OF THIS STATE.

E. THE DEPARTMENT SHALL GRANT A LICENSE TO AN APPLICANT WHO HAS PRACTICED MIDWIFERY CONTINUOUSLY FOR THE FIVE YEARS PRECEDING THE APPLICATION, IN ANOTHER STATE WHICH DOES NOT REQUIRE LICENSURE, IF THE APPLICANT PASSES AN ORAL AND PRACTICAL EXAMINATION GIVEN BY THE DEPARTMENT AND PAYS THE APPROPRIATE FEES.

Sec. 3. Section 36-755, Arizona Revised Statutes, is amended to read:

36-755. Rule-making powers of director

A. The director may make such rules and amendments as may from time to time be deemed necessary for the proper administration and enforcement of this article.

B. The director shall, by regulation:

1. Provide reasonable regulations necessary to assure that any person holding a midwife license is free from communicable disease or diseases.

2. Define and describe, consistent with this article and the medical practice act and the laws of the state, the duties and limitations of the practice of midwifery.

3. Provide reasonable and necessary regulations to safeguard the health and safety of the mother and child.

~~4. Describe and define reasonable and necessary minimum qualifications for midwives, including:~~

~~(a) The ability to read and write.~~

~~(b) Knowledge of the fundamentals of hygiene.~~

~~(c) The ability to recognize abnormal conditions during labor.~~

~~(d) Knowledge of the laws of the state concerning reporting of births, prenatal blood tests, and of the regulations pertaining to midwifery.~~

4. PREPARE OR ADOPT AN EXAMINATION TESTING THE KNOWLEDGE OF APPLICANTS FOR A LICENSE.

Sec. 4. Title 36, chapter 6, article 7, Arizona Revised Statutes, is amended by adding section 36-755.01, to read:

36-755.01. Midwifery advisory board; membership; duties

A. THERE IS ESTABLISHED THE MIDWIFERY ADVISORY BOARD CONSISTING OF SEVEN MEMBERS APPOINTED BY THE GOVERNOR FOR A TERM OF THREE YEARS PURSUANT TO SECTION 38-211. MEMBERS ARE ELIGIBLE TO RECEIVE COMPENSATION PURSUANT TO SECTION 38-611.

1 B. TWO MEMBERS SHALL BE DOCTORS OF MEDICINE PRACTICING OBSTETRICS
2 AND GYNECOLOGY, TWO SHALL BE LICENSED MIDWIVES, ONE SHALL BE A REGISTERED
3 NURSE CERTIFIED AS A NURSE-MIDWIFE AND TWO SHALL BE PUBLIC MEMBERS NOT
4 ENGAGED IN HEALTH CARE.
5 C. THE BOARD SHALL ADVISE THE DIRECTOR OF THE DEPARTMENT OF HEALTH
6 SERVICES ON MATTERS PERTAINING TO THE PRACTICE OF MIDWIFERY AND THE
7 LICENSING OF MIDWIVES.
8 Sec. 5. Initial terms of members
9 Notwithstanding section 36-755.01, Arizona Revised Statutes, as
10 added by section 4 of this act, the initial terms of members are:
11 1. Two terms ending on the third Monday in January, 1984.
12 2. Three terms ending on the third Monday in January, 1985.
13 3. Two terms ending on the third Monday in January, 1986.
14 The governor shall make all subsequent appointments as prescribed by
15 statute.
16 Sec. 6. Current licensees
17 The department of health services shall renew a license to practice
18 midwifery to any person who on the effective date of this act holds a valid
19 license to practice midwifery in this state and who upon the expiration of
20 such license pays the required fee and shows evidence of having completed
21 the required hours of continuing education.
22 Sec. 7. Intent regarding termination
23 Notwithstanding the provisions of this act, the legislature intends
24 that, if the provisions of title 41, chapter 20, Arizona Revised Statutes,
25 operate to terminate an agency, any provisions regarding powers, duties,
26 functions or personnel added or amended by this act terminate on the date
27 of termination of the particular agency.
28 Sec. 8. Effective date
29 This act shall become effective on December 31, 1982.

SUMMARY
PERINATAL ADVISORY COMMITTEE MEETING
October 27, 1981

Members Attending: Lynda Collier
Jennifer Gleason
Sharon Gray
Jacqueline Greenman
Jack Jacob
Ralph Wells
Peggy Wilson
Elaine McKenzie
Agnes Nichols
Oliver Osborn
Joan Pelto
David Spence
Jeanne Wolf
Penny Chemilewski

Guests: Vernellia Randall, Maternal Child Health Nursing Coordinator, State of Alaska, Juneau
David Ottoson, Board Member, Family Centered Birth Inc., Juneau
Liz Gollogly, Lay Midwife, Fairbanks
Portia Kauffman, Chief, Health Facilities Certification Land Licensure, State of Alaska, Anchorage
Erwin S. Rabeau, Director, Division of Public Health, State of Alaska, Juneau

Staff: Liz Sappington, Health Educator
Carolyn Aoyama, Maternal Nurse Consultant
Dwayne Peeples, Project Coordinator

The Perinatal Advisory Committee met in the 5th Floor Conference Room of the Anchorage Department of Health and Environmental Protection Building review the draft prenatal education curriculum and to discuss alternative birthing in Alaska.

Activity Update

The committee was presented with a summary of activity progress for the period May 1, 1981 thru September 30, 1981.
(Committee Meeting Materials pp. 12-15)

Prenatal Education:

A draft of the prenatal education curriculum was completed in September and is scheduled to be reviewed by the committee during the October 23, 1981 meeting. Based upon the committee's comments, the curriculum will be revised and available for public review during December. In addition, the appropriate audio-visual materials to accompany the curriculum where previewed and purchased during June, July and August.

Prenatal Risk Forms:

Drafts of the three prenatal care forms (Risk Assessment, Patient Care and Patient Care Continuation) where completed and an outcome/follow-up form was drafted. It is anticipated that this fourth form will be field tested this winter and be revised for distribution by spring.

Maternal Transport System:

The committee was updated by Jack Jacob as to the development of the maternal transport and consultation systems. The perinatal hotline will be operational in December with 24 hour access to obstetricians and neonatologists. The system will not be based at the Providence Hospital as originally planned, but will be routed through McCaw Communications, Inc. switchboard via radio telephones to the consulting physicians.

Fairbanks Improved Pregnancy Project:

The project has continued with an average enrolled case load of 90 clients per month. A preliminary assessment of the client profile for the months of July and August indicates an increase in utilization of the project and cost per client of those receiving financial assistance. The increased cost is associated with a stronger focus on high risk women and the associated medical care.

Professional Continuing Education:

The committee met via teleconference on September 3, 1981 to develop a final recommendation concerning the purchase of the Nursing Child Assessment Satellite Training materials from the University of Washington. After considering the costs and the benefits, the committee recommended purchase of materials utilizing FY '81 funds. The first NCAST class is scheduled for October in Anchorage.

The Nurse Preceptorship Program at Providence Hospital has continued to train hospital nurses in neonatal care skills. During this period nurses from Elmendorf and Cordova hospitals participated in the program.

Federal FY '82 Plan and Grant Application:

The grant application was prepared in May based upon the priorities identified by the committee during the April 22, 1981 meeting. Notification of Award was received during the last week of September and the project received an additional $22,000 more than was originally anticipated. The additional funds were made available by the granting agency for the purposes of continuing the project coordinator's position full time and maintaining genetic counselling services through contract arrangements with the University of Washington.
(Committee Meeting Materials pp. 16-18).

Human Services Institutional Review Board:

Vernellia Randall, MCH Coordinator presented a request for volunteers to participate in a Human Services Review Board that would advise on a cervical cap study project. This study would be conducted at the Juneau Health Center Family Planning Clinic for a period of two years. The board's responsibility would be to assure that individuals using a cervical cap for contraception would have their rights protected and that the project was conducted in a safe manner.
(Committee Meeting Materials pp. 20-22)

Appendix I

ALTERNATIVE BIRTHING IN ALASKA

PREFACE

As follow-up to an expressed interest by the Perinatal Advisory Committee members concerning the issue of alternative birthing during the April 23, 1981 meeting, Carolyn Aoyama organized a presentation on the current birthing trends in Alaska. The presentation consisted of a general overview of the issue by Ms. Aoyama; a discussion of freestanding birthing centers by David Ottoson; and discription of lay midwife practice by Liz Gollogly.

INTRODUCTION

The debate over management of childbirth has intensified in recent years. Both professional and the lay public are increasingly scrutinizing traditional physician oriented and hospital based obstetrics. Serious questions as to the necessity, safety, dignity and cost of institutional maternity care are being asked. Critics charge that hospital obstetrics have become increasingly impersonal. They argue that many of the routine practices are more for the convenience of medical and hospital staffs than for the health and safety of mothers and their newborn. Many argue that these practices may even be harmful. At issue are such items as routine enemas, perineal shaving, IV's, restriction of food, fluids and mobility, separation of family members before and after birth, electronic fetal monitoring, multiple and often unsupporting attendants, the use of analgesics and the traditional lithotomy delivery position for birth. At issue also is the perceived attitude that pregnancy, labor and delivery are pathologically inclined events, that since birth is so inherently hazardous, it should only occur in the hospital.

Patients and professionals are also voicing serious concerns over aspects of medical obstetrical management of labor and delivery. The emphasis here is on aggressive management and excessive intervention. Many are particularly alarmed about the routine application of sophisticated technology in the absence of medical indication or in situtaions where its benefits have not been firmly established through rigorous scientific experimentation. Much of the controversy centers on the short and long term effects of obstetric medications, electronic fetal monitoring, elective induction, the routine or preventive use of forceps, and the cesarean section rate which doubled between 1971 and 1976.

A result of this controversy is that hospital based obstetrics has come to be viewed by many as insensitive to personal needs and obsessed with the use of sophisticated equipment. Since the early 1970's a small, but growing number of parents have sought and received maternity care outside of hospitals. This care has been obtained in the offices and clinics of practitioners, in free standing birth centers and in the home. After a steady decline over the past decades, the percentage of U.S. births occurring outside of hospitals has risen from a low of 0.6% in 1970 to 1.5% in 1977. The trend in Alaska according to the Bureau of Vital Statistics, shows that out of hospital rates have gradually increased from a 2.3% in 1977 to 3.3% in 1979. These rates

Review of the Draft Prenatal Education Materials:

Liz Sappington reviewed the prenatal education modules previously mailed to the committee. Each module was reviewed separately with verbal comment from the committee concerning the general content and philosophy of the curriculum. Written comments were also obtained that addressed specific points was requested to be forwarded to Ms. Sappington.

The committee's general comments on the draft modules are summarized as:

- include more graphics into the reading materials and simplify the vocabulary to reduce the reading level;
- utilize larger print and make the visual affect more attractive;
- utilize true-false questions in the workbook and condense the information;
- include a discussion of the effects of tobacco chewing;
- discussion of medical tests and procedures should be simplified;
- the reader should be referred to the health care provider for any questions concerning tests and procedures.

Alternative Birthing in Alaska:

Carolyn Aoyama presented a discussion of alternative birthing in Alaska as follow-up to an expressed interest of the committee members. The presentation focused on the three major types of alternative birthing; hospital based birthing rooms; free standing birthing centers; and home births. To provide input from those participating in alternative birthing, guest speakers where invited to discuss their activities. David Ottoson of Family Center Birthing Inc. of Juneau discussed free standing birthing centers and Liz Gollogly, a lay midwife discussed home births. A synopsis of the presentation is attached in the meeting summary appendix.

Proposed Birth Center Regulations:

Portia Kauffman, Chief, Certification and Licensure, requested that the Perinatal Committee review the draft proposed birth center regulations. A draft of the regulations was handed out to the committee and any comments the members may have could be forwarded to her office in Anchorage.

Public Comments

The floor was opened to allow for comments or questions from the audience. Several individuals had comments and questions concerning the alternative birthing presentation. Liz Gollogly and Carolyn Aoyama answered the comments concerning the type of practice experienced in lay midwifery and birthing center.

The committee decided to meet in the next three to four months, possibly in Juneau. Dwayne Peeples would be contacting committee members to determine the schedule depending upon prospective funding for next year's grant application.

must be interpreted with caution since many out of hospital births are not reported.

Hospital Birthing Rooms

To varying degrees, many hospitals have responded to consumer pressure for change by altering their policies and procedures. These modifications have ranged from simply permitting husbands into the delivery room to the creation of separate family centered maternity units staffed by nurse midwives or physicians where parents can have a substantial voice in their birth experience. It is still much too early to assess the impact that these changes in hospitals obstetrical practices will have on the prevalence of births outside the hospital.

Alaska's hospitals have responded to consumer's requests for family centered care with a variety of approaches. Fairbanks, Providence and Alaska hospitals have all initiated birthing rooms with policies directed at keeping the labor and delivery experience as safe, but as personally satisfying to the family as possible. Only low risk women can use these birthing rooms. Couples generally must take prenatal classes, a birthing room orientation class and have the written permission of the mother's and and baby's physician. At the client's request, technology is kept to a minimum and the mother is encouraged to take oral fluids, and labor and deliver in her position of choice. Newborns are not separated from their families after birth unles it is in need of special care. Mothers remain in the birthing room for about 4-12 hours postpartum with a nurse. If there is no contraindication, they are discharged from the birthing room directly home. Home visits are made by either the labor and delivery nurses or the public nurses within 24 to 72 hours postpartum. At that time, the nurse does a thorough maternal and neonatal physical assessment including PKU and drawing blood for the bilirubin level if necessary. The newborn is generally seen by the pediatrician by the 5th day of postpartum. Families seem well satisfied with the birthing room at Alaska hospital where they have conducted their own survey.

Birthing Centers

A second type of facility that has developed in response to consumer demand is the free standing birthing center. A birthing center can be defined as both a setting and a concept. The woman's and family's involvement in childbearing is enhanced. Birthing centers screen out high risk clients and only accept low risk women who aren't likely to have complications. Medical technology and aggressive management is minimized. The birthing center is free standing, in e.g., located and owned independent of the hospital. The basic goal of the birthing center is to foster childbirth as an experience in which the woman feels physically safe and psychologically secure and in in control of her labor, delivery and postpartum experience. The family is central to the experience and the free standing birthing center must be viewed, therefore, as an extension of the home rather than an extension of the hospital.

In the birthing center, the family usually makes the decisions (within safe limits) regarding the nature of the delivery. General anesthesia is never used and drugs for analgesia are used only upon request. Routine

Forceps-assisted delivery and cesarean section, pitocen induction, general or regional anesthesia beyond pudental block are not used. Decisions regarding labor position , lighting, and who will be with the mother during delivery are family decisions. If a particular medical procedure is considered advisable such as episiotomy, the patient is consulted first and her approval is required. At all times, the staff informs her of what they are doing and why. Typically the mother and infant are discharged within 12 hours of birth. Because the FBC is usually a fairly small operation, more tailored, less routinized care can be offered.

Since the free standing birth center is not part of a hospital, (although it is usually located near a hospital) it can only provide minimal emergency care of the newborn adn mother, including resuscitation of the newborn using oxygen intubation. IV's and plasma expanders are used for maternal hemorrhage. Because it does not have access to blood and is not capable of surgery, stringent criteria are used to screen against women likely to be at risk in labor and delivery. Typically less than 10% of their clients require transfer to a hospital.

The screening out of high risk women is the single most crucial element in assuring safety at birthing centers. The effectiveness of such screening techniques has been demonstrated by the fact that less than 10% of women who reach labor are transferred out of these centers. In the experiences reported to date there have been no postpartum emergency transfers. (MCA, New York, Oregon, McLammery).

There are four identifiable stages in pregnancy at which screening criteria must be developed and used. These correspond to Maternity Care Center Association's criteria. They are:

1. Early pregnancy screening criteria (e.g. BP or diabetes).

2. Antepartum referral criteria (problems discovered later in pregnancy but before labor, e.g., preclampsia).

3. Intrapartum transfer criteria (for problems discovered during labor prior to delivery e.g. prolapsed cord).

4. Postpartum transfer criteria (for problems with the mother or infant after delivery such as hemorrhage or respiratory distress).

Birthing Room /Free-standing Birth Center Charges

When compared to the charges for similar services in conventional OB units, birthing room and FBC charges range from 20% to 70% less.

A fiscal audit of Maternity Center Association (MCA) in New York for the years 1976 to 1977 by Blue Cross of Greater New York reported that charges for MCA were 37.6% of in hospital care barring complications. Also noted was the cost to the plan had the same family gone to the hospital, barring complications.

The primary reasons for the reduced charges are:

1. the elimination of charges for labor, deliver and recovery rooms
2. elimination of nursery charges
3. elimination of most drug and anesthesia charges
4. reduction in length of stay from 24 to 72 hours postpartum

In addition, birthing centers are oriented toward preventing costly complications through the use of careful screening criteria. Care during labor and delivery is constant and individualized with nearly 100% of that time spent in contact with professional staff. Traditional hospital oriented management cannot begin to provide such professional contact time.

Further economies are realized through utilization of non-hospital space as a setting for healthy normal childbearing while making reasonable allowances and arrangements for the safe care of clients with complications extensive, educational programs emphasizing nutrition, family relationships and self help. Self care responsible health habits are included in the charge. Unlimited telephone consultation is also available.

Family Centered Birth Inc.
David Ottoson

Family Centered Birth Inc. of Juneau is the only free standing birth center in Alaska. The center is governed by a board of directors and is not part of the hospital or physician practices in Juneau. It is a non-profit corporation which was organized by Juneau residents to develop an alternative to existing choices.

Members of the board obtained a grant from the Department of Health and Social Services for the purpose of assessing community need and support for a center; providing public education concerning the center's services; and obtaining consultation in developing the center. Presently, the corporation has obtained a facility and has hired a certified nurse midwife and expects to be open for business by midwinter of this year.

The birth center will offer a home-like environment for low risk women to obtain prenatal care, and education for labor and delivery. This care will be provided primarily by a certified nurse midwife with a physician on contract for back-up services. Transfer protocol will be arranged for urgent or emergency transport to the hospital which is less than 10 minutes away from the center.

The birth center is seeking no state or local governmental support, but will obtain it's funding from private loans and public contributions. The start-up cost of this type of service has been high. Although the board would like to purchase the building it is using, it will probably have to lease the space and medical equipment. It is anticipated that the center will be serving 75 families the first year and 166 the second year. Although there will be dependency on loans and contributions for the start-up cost, the center is projecting financial stability by the second year or operation.

Lay Midwifery

Lay midwives for my purpose here will be defined as individuals who attend women during childbirth outside of the hospital and outside of established medical obstetrics and nurse-midwifery. Those individuals vary widely in their training, experience and competence.

Unlike nurse midwives whose training standards and codes of professional practice are well established, lay midwifery does not yet have a strong professional or educational foundation. Few states have attempted to provide a regulatory framework for them and only a few states have taken steps to regulate the activities of lay midwives. Most states either have no statutes relating to midwives or have laws enacted in the early 1900's that have little relevance to modern standards of OB care.

In ongoing debate over the future of maternity services in the country, the most divisive issue is that of home birth. Despite a common perception that this occurred due to the activities of "counter culture types", religious sects and other "fringe groups", the available evidence indicates that the primary interest in birth at home is coming from certain middle class individuals who are seeking greater flexibility and control of their birth experiences than are allowed in hospitals or other institutional settings. In addition, another large segment of this group desires home birth for the family closeness and convenience of home. Care becomes centered on mother and child rather than the institution or physician.

Because home birth and lay midwifery represent such as a radical departure from the current norms of obstetrical practice, and since there has been little substantive research on these subjects, the controversy has been based as much on emotion and ideology as on objectivity.

My own assessment is that home birth and lay midwifery is neither safe or hazardous in and of themselves. Rather, it appears from the scientific literature that the outcome of childbirth at home with lay midwife attendants will be largely depended on the conditions under which the birth take place. While information is certainly limited, the study on Home Delivery and Neonatal Mortality in North Carolina, as well as Mehl's study of home birth in California, indicate that planned home birth utilizing trained midwives or other trained attendants could be a viable option in safe maternity care. There are several pre-requesites to a reasonable homebirth approach including: careful selection of cases to include only low risk pregnancies; a high level of parental responsibility and maturity; a suitable home environment; management of the pregnancy by skilled practitioner; and the ready availability of consultation and support services to handle complications and emergencies.

Lay midwives have experienced considerable difficulty in obtaining recognition and legitimacy. This is in large measure due to a lack of professional body which could set standards and accredit educational programs and determine the scope of midwifery practice. Although there are about ten training programs in the country, the limited information gathered suggests that, for the most part, they are loosely organized and vary widely in their

sponsorship, structure, teaching, orientation and stability. Moreover, none is accredited or otherwise endorsed by a public licensing body or private professional body. Therefore, quality of standards of instruction provided is impossible to measure. At present there are independent advocacy groups such as Washington State Midwifery Council that have formed to disseminate information and press for favorable legislation and regulatory policies.

The characteristics and practice patterns of midwives vary. Some are entirely self taught, having done little more than attending periodically and reading a book or two on the birth process. At the other end of the spectrum are those, like the European midwives, who have gone through several years of specialized training, including theoretical preparation and supervised clinical instruction. In between lies a variety of background and skills.

Practice patterns also differ. While some midwives conduct their activities completely separated from other established maternity care resources, others have developed working relationships with local providers that enable them to provide a higher standard of care.

The basic issue concerning lay midwives has to do with public safety and quality of care. A key argument used in the debate on where childbirth should occur and who can legally attend and care for the childbearing women involves the mortality rate. Proponents of hospital childbirth relate the decline of maternal and infant mortality rates to the medical technology and in-hospital delivery by highly trained and regulated practitioners. Many fear that a shift of childbearing from hospitals attended by physician back to the home and attended by unregulated personnel will result in increased morbidity and mortality.

Establishment of causal relationships using such observational data is fraught with difficulty. Interpreting and extrapolating trends without taking into account the improved health in population, decreased fertility rates, improvement of sanitation and housing as well as control of communicable diseases can only lead to confusing and erroneous conclusions.

The increased incidence of out-of-hospital births and the reporting of data on their safety has led home birth advocates to begin to conduct research into this area. Mehl et al. investigated the statistical outcomes of home delivery in California. The outcomes of birth attended by 6 groups consisting of combinations of lay midwives, nurse midwives and general practitioners were compared. The perinatal mortality rates for their study populations revealed significantly lower rates compared to the state as a whole.

For women who have been adequately screened for risk factors with reasonable consultation and referral, good outcomes are the rule. However, even in an apparently normal pregnancy, problems can and do occur so that a positive outcome can never be guaranteed. The interest, therefore, of public officials in the rising numbers of out-of-hospital births largely is due to the uncertain qualifications and competence of the lay attendants as well as the uncertain outcome of any birth.

Midwifery outside of nursing is beginning to gain legal status as a legitimate profession or trade. In Oregon, a recent opinion of the state's attorney general held that midwifery, independent of nursing, is within the scope fo the law so long as it excludes the performance of episiotomies or use of medications. In some states, courts have recognized midwifery as separate from nursing and in others they have concluded that childbirth is natural function and consequently midwifery does not constitute the practice of medicine (Oregon).

The majority of state midwifery provisions are remnants of the early 1900's. State governments have attempted to deal with the reality of midwifery outside the established maternity care system. In Arizona, Rhode Island, and New Mexico, action was initiated by their respective state health departments and state health agencies involves a qualifying exam, case reports by midwives and oversight by a professional advisory committee. Arizona's program was the first to be established in February of 1978, and state officials report a generally favorable experience in terms of safety factors and workability of the program.

The quality of obstetrical services is dependent upon competent clinical judgment, standards of care and integrated referral systems. While some states have taken initial steps to incorporate lay midwives into the medical system, Alaska presently has not followed this action. While the future of the lay midwife's role in Alaska's medical system is hard to predict, it can be assumed that the demand for their services and home births will continue.

In the State of Washington, a midwifery statute has passed in both the House and Senate and is now awaiting the Governor's signature to become law. Washington's Substitute House Bill No. 316 provides for a three-year training program and defines a specific subject area which must be included as basic. There are shorter training requirements for individuals with nursing backgrounds. Hospitals, clinics, birth centers or private residences are recognized as acceptable settings for clinical experience.

Lay MidWife and Homebirths in Alaska

Liz Gollogly

There are various lay midwives actively delivering newborns in Alaska with various backgrounds and types of practice. Liz Gollogly, a lay midwife presently practicing in Fairbanks was trained in Europe. The services she provides are prenatal care, home deliveries and postpartum care. Prospective clients seeking her services are initially screened to determine their medical risks and are informed as to what would be required for a home delivery. Those who are accepted are required to attend childbirth education classes, develop a transport plan to the hospital for emergency and make adequate preparation for the delivery. They are also encouraged to communicate with their physician as to their plans.

During the prenatal period, the clients are continually monitored for potential medical problems. The risking is continued throughout the prenatal period and during delivery. At any time when conditions warrant the patient is referred and transferred to the hospital for delivery.

Those who deliver at home do not receive anesthesiology or episiotomics. The newborn is assessed for the 1 and 5 minute APGAR and blood drawn for testing. The parents are encourage to see a physician with 24 to 48 hours for a complete medical check-up.

During the postpartum period, the clients are advised to the possible problems and are checked on during the first few days following birth. In addition, they are encouraged to call if any problems develop.

During a 20-month period, client outcome was monitored to evaluate practice. Of a total 62 requesting home births, 17 were screened out for medical or other reasons. Of the remaining 45, 9 were subsequently referred to the hospital for delivery. Of the 36 who began labor at home, 9 were transported to the hospital during the 1st, 2nd or 3rd stage of labor. Of the 9 who were transported to the hospital, 7 were primips. The total risk out during the prenatal and intrapartum period was 35, of which 24 were primips. As a result of these statistics, Liz Gollogly only accepts multips as her clients.

It was Ms. Gollogly's general conclusion that lay midwives need to be integrated into the medical community and their referrals to physicians should be accepted. In addition, clients who do have homebirths should not be discriminated against by physicians and hospitals.

Evaluation of Outcomes of Non-Nurse Midwives: Matched Comparisons with Physicians[1, 2]

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Introduction

The practice of midwifery and the attendance of home births by midwives are much discussed issues today. Equally discussed is the distinction between lay midwife and certified-nurse midwife. In this paper we shall attempt to evaluate the results of out-of-hospital practice by experienced non-nurse midwives.[1]

Opponents of possible licensing of non-nurse midwives center on several specific concerns:

1. Midwives may provide inferior care to that currently available.
2. Lower socioeconomic status women may be shunted to midwives in an effort to save funds.
3. Licensing midwives will be *de facto* approval of out-of-hospital delivery, which is not safe.

Proponents of legislation to license midwives argue that:

1. Trained, experienced midwives provide as high (if not higher) standard of care than that which is generally available, calling upon physicians for consultation and intervention in situations exceeding the depth of their skills. (Two concomitant issues arise here: first, the level of judgment

necessary to accomplish such a task and, second, the feasibility of creating risk groupings by screening.

2. The demand for midwives comes largely from middle- to upper-class women.
3. Midwives may be the best primary care provider for rural areas, provided expert obstetrical consultation is available.
4. Home birth and out-of-hospital birth can be safe alternatives for screened, selected women attended by trained, competent practitioners.

Summaries of the arguments of those opposed to the licensing of midwives can be found in Pearse (1976), Aubry (1976, 1977), Hibbard (1977), and International Medical News Service articles (1977a, 1977b). These arguments center on contentions that studies exist proving that home birth and midwives are unsafe (the two issues are usually considered concurrently). Aubry (1977a) presents birth certificate data from Oregon showing higher neonatal mortality rates among out-of-hospital deliveries from 1970 to 1975. Similar data are now available for Hawaii (Pearse, 1977) and California (Emrey, 1977). Without desiring to advocate for home delivery and midwives, we must point out that from a research methodology perspective these data merely obscure the basic issue. Two questions are not properly differentiated. The first is the more important: can screened,

selective women deliver at home with trained midwives without significant increases in risk? The second is less so: what are the overall incidences of complications for reported out-of-hospital deliveries? Currently, birth certificates do not differentiate between types of out-of-hospital delivery--home, taxicab, car, birth center, planned or unplanned. In addition, from the standpoint of cultural anthropology, home birth is a complex phenomenon. In conducting our initial study on home birth with midwives in Santa Cruz County, California (Mehl, Peterson, Shaw, & Creevy, 1975), we learned that only 25% of deliveries were reported to the State Health Department. Since then, we have found ranges of percentage reported from 20% to 100%, the least with unattended deliveries, the most with physician-attended deliveries. In one of our prospective experiences in Madison, Wisconsin, even with strong encouragement on the part of the birth attendants, only 60% of deliveries were reported within 6 months of delivery. The other sample-biasing effect is that abnormal deliveries or newborns needing medical attention or dying are all reported at the moment of contact with an established medical or legal institution. Emrey's (1977) contention that home-birth parents "bury their babies in the woods" is a non-scientific statement with no valid basis. It would be extremely difficult to conceal the outcome of a pregnancy in modern society. Thus, birth certificate data is not a

valid source of data on intentional home birth. In this regard, it is important to note that of Emrey's California out-of-hospital deaths, 65% were among infants weighing less than 2,500 grams. The planned home-delivery-population prematurity rate has been reported as 3.0% among several northern California home-birth services (Mehl, Peterson, Whitt, & Hawes, 1977). There were no neonatal deaths among these premature infants. Established home-birth services consistently report low neonatal mortality rates (Taylor, 1976; Epstein et al., 1977; Berman, 1977; Carson, Felton, Gloyd, Luehis, Mansfied, Mertz, Myers, & Rivard, 1977; White, 1976; Mehl et al., 1977; Estes, 1977).

While established services do report good outcomes, real problems exist in the practice of midwifery, which cannot be currently regulated. The California Department of Consumer Affairs estimates that 300 to 500 nonlicensed midwives are practicing in California (Krisman, 1977). Nancy Mills, a well-known lay midwife in Sonoma County, California, receives an average of 40 telephone calls weekly from women who want to be midwives. There are ample numbers of anecdotes about women who have seen one or two births and then called themselves midwives, only to encount complications they were not prepared to handle or could have avoided through adequate screening. The important question seems to be how to provide legislation which would permit the rise of competent midwives while prohibiting the practice of

inadequately trained midwives. Current prosecution has by nature centered on the most competent midwives (Mills, personal communication, 1976; Bowland vs. Municipal Court of Santa Cruz, 1975; Davis, personal communication, 1977; Richwald, personal communication, 1977; Carson et al., 1977). Responsible midwives become visible and vulnerable to prosecution by the act of being responsible. In accompanying their problem patients to the hospital during labor, in consulting with physicians regarding problem cases, and in arranging hospital and physician back-up, they improve the care of their clients and become known. To be known is to be vulnerable to prosecution. The dilemma is obvious.

In previous studies, we have compared two groups of women--a planned home group and a planned hospital group--matching them for many of the relevant factors which would be expected to affect delivery outcome (Mehl, 1977). We found significantly better outcomes in several parameters of maternal and infant outcome among the planned home group. Canonical correlation analysis strongly suggested that these differences were the result of obstetrical intervention in a low-risk population (Mehl et al., 1977). In this study, we approach the question of the outcomes of midwife-attended deliveries in a similar case-control fashion. The question we are interested in is the relative safety of midwife-attended delivery compared to a standard of physician-attended delivery.

Methods

Data Collection

Our institute has been studying delivery alternatives since 1973. Because of the difficulties with birth certificates as a source of subjects, our strategy has been to identify responsible, competent midwives, utilizing them as "index practitioners." To select an index practitioner, we assess the practitioner's knowledge and skills in obstetrics and pediatrics. We determine their practice philosophy by discussing with them their management of several different obstetrical situations. Finally we review their records for completeness and accuracy. If the criteria are met, then we collect data on every woman contacting the midwife between a beginning and an ending time point.

Data for midwives were collected from Nancy Mills, a previously mentioned midwife from Sonoma County, California, who has attended over 650 deliveries, and from midwives from the Santa Cruz Birth Center, a group of midwives whose activities and outcomes have been described elsewhere (Mehl et al., 1975; Ehrlich, 1976; Lang, 1972).[2] The data were collected for the time periods 1972 to 1975 and were obtained by retrospective chart review. For this reason it was essential that our index practitioners were capable of identifying complications and recording them. To test this hypothesis we conpared their outcomes to the outcomes of

physicians attending home deliveries and found no significant differences (Mehl, 1976).

Matching

The initial study design involved matching the data obtained from these midwives to a hospital sample consisting of planned hospital deliveries from one family practice group in western Marin County also attending home deliveries and from two private community hospitals in Madison, Wisconsin, that were also university-affiliated. While not optimal (an optimal sample would have been drawn from San Francisco Bay Area hospitals), it was felt that since the perinatal mortality of these two hospitals was lower than the Bay Area and the median income and education higher, any sampling biases would probably favor the hospital. Since the population was to be matched for socioeconomic status and since we were most concerned with the most basic indicators of perinatal outcome--mortality and morbidity indicators--subtle population effects would be small. We are currently in the process of repeating the study with a California hospital sample.

Matching was done for mother's age, parity, length of gestation, individual major risk factors, total risk factor score, education (our choice for a predictor of socioeconomic status), and presentation. The pertinent characteristics were listed on a face sheet without the

delivery details and, for each home delivery record, a match was searched for in the hospital group. If no match was found the unmatched case from the home group was eliminated and the search was resumed for the next home case. All women planning home deliveries at the time of onset of labor, experiencing the occurrence of a complication necessitating hospitalization and/or delivery, or needing the hospital after birth were included in the planned home group. There was a total of 600 planned home births and 8,000 planned hospital births for matching; 502 of the home births had matches in the hospital sample.

For the second phase of the study, computer capabilities became available, and we received data from 15% of the hospital practitioners who were rated the "least interventionist," that is, the most likely to allow labor to progress without interference and who had the most conservative criteria for intervention. Matching was done by means of a program written in PASCAL on the University of California, Berkeley, CDC6400 computer. Matches were obtained for 421 midwife-physician pairs.

Data Analysis

Statistical analysis on the files obtained were conducted with the SPSS series of statistical programs (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975), Version 6.5, as adapted by the Vogelback Computing Centern, Northwestern

University, for the CDC6000 series. The frequencies and T-test procedures were used.

Results

The initial analysis showed the same proportion of results between midwives and physicians that we found previously between planned home delivery and planned hospital delivery (Mehl, 1977). The midwife sample (which included all births transported to the hospital and cared for by physicians) had significantly less fetal distress, meconium staining, postpartum hemorrhage, birth injuries, and infants requiring resuscitation. The midwife sample also had higher mean Apgar scores. This led us to conclude that the comparison between midwives and hospital-based obstetricians was the same comparison which had been made between planned home and hospital delivery. The reasons for these differences have been indicated in other research to be related to the much greater use and indications for the use of oxytocin, forcepts, analgesia, and obstetrical procedures (Mehl et al., 1977).

For the subsequent analysis we used the midwife sample and the "low-interventionist" physician sample. Table 1 shows that there were no significant differences between the groups besides the higher incidence of planned home births among the midwife group. Table 2 shows that the only significant differences among delivery complications

were more fetal distress among the physician group and more problems with the delivery of the placenta. They also (Table 3) experienced more analgesia, first- and second-stage oxytocin, anesthesia, and obstetrical procedures. Table 4 shows that there were no significant differences in neonatal complications or maternal postpartum complications. Lastly, Table 5 shows that the only significant differences in neonatal outcomes were borderline significantly more Apgar scores at 1 minute less than 7 and 5-minute Apgar scores less than 7.

Insert Tables 1-5 about here

Discussion

From these results and from other studies (Mehl et al., 1977) it seems reasonable to suggest that the improved outcomes reported among a large group of planned home births (attended by competent practitioners) over planned hospital births relate to lesser amounts of obstetrical intervention in the planned home group. Attempted comparisons of midwives with obstetricians were confounded by this relationship.

For the second analysis presented, it would seem reasonable to suggest that the slight differences in outcome favoring the midwife group could be due to even yet

increased interventions (oxytocin, procedures, etc.) among the hospital group.

It can be concluded that, at least among a limited sample size of 421 cases, midwives did as well as physicians for low-risk cases. Larger numbers of cases are required to address questions regarding the performance of midwives in emergency situations requiring immediate intervention or rapid

Also, it must be emphasized that, while the midwives studied here were not licensed or formally trained midwives, they were, nevertheless, very knowledgeable about obstetrics and pediatrics and had acquired considerable skill and competence. Such performance attests to the ability of these women to learn outside of institutional settings. Were formal training made available, it would seem that all would stand to benefit.

From the results of this study it would seem reasonable and prudent to develop and test alternative training programs for such midwives and to establish clinical demonstration/research programs to allow for the further study of the outcomes of such midwives with reference to their possibility for legitimizing their utilization in maternal and child health care delivery. It must also be remembered that this current study is by no means definitive. Current work is underway to develop an entirely California-based hospital sample and to increase the number of midwife deliveries available for study.

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Footnotes

[1]In the remainder of this paper we will include non-certified nurse-midwives and lay midwives under the simplified heading of midwives.

[2]It should be remembered that there are many midwives from the Santa Cruz area who call themselves Santa Cruz midwives but who are not associated with the Santa Cruz Birth Center.

Table 1

Population Characteristics

	Midwife Sample N = 421	Physician Sample N = 421	Significance
Maternal education (mean)	13.4	13.4	NS
Mo. prenatal care began (mean)	3.6	3.5	NS
Primigrairdae	243	243	NS
Para 1	128	128	NS
Para 2	40	40	NS
Para 3	6	6	NS
Para 4-6	3	3	NS
Mean months of follow-up	4.1	5.4	
Vertex presentations	421	421	NS
Length of gestation (mean)	39.9	39.9	NS
Prenatal risk factor score (mean)			
Maternal age	24.4	24.4	NS
Prolonged rupture of membranes	18	18	NS
Number of female infants	223	224	NS
Number of male infants	198	197	NS
Birthweight (grams)	3,412	3,350	NS
Twins	1	1	NS

Table 2

Complications of Labor and Delivery

and Procedures Used

	Midwife Sample $N = 421$	Physician Sample $N = 421$	Significance
Fetal distress	8	25	$p < 0.001$
Placenta problems	6	11	$p < 0.05$
Labor dysfunctions	18	25	NS
Hospital transfers	32	15	$p < 0.01$
Meconium staining	18	16	NS
Posterior deliveries	28	19	NS
Shoulder dystocia	2	2	NS
Partial abruptions	1	3	NS
Procedures			
Caesarean sections	2	3	NS
Mid forceps deliveries	1	5	NS
Analgesia	6	24	$p < 0.01$
Oxytocin, 1st stage	22	40	$p < 0.01$
Oxytocin, 2nd stage	38	53	$p < 0.01$
Oxytocin, 3rd stage	45	298	$p < 0.001$
Low forceps	3	10	$p < 0.01$
Number of anesthetics	4	66	$p < 0.0001$
Obstetrical procedures	16	75	$p < 0.001$

Table 3

Infant Complications

	Midwife Sample N = 421	Physician Sample N = 421	Significance
Neonatal hyperbilirubinemia	8	7	NS
Neonatal cyanosis	1	0	NS
Infection	2	2	NS
Congenital abnormalities	0	3	NS
Newborn metabolic problems	1	0	NS

Table 4

Postpartum Complications

	Midwife Sample N = 421	Physician Sample N = 421	Significance
Breast infections	3	2	NS
Postpartum D & C.	1	0	NS
Maternal infection	0	2	NS
Postpartum depression	1	1	NS
Uterine atony	1	4	NS

Table 5

Neonatal Outcomes

	Midwife Sample $N = 421$	Physician Sample $N = 421$	Significance
Fetal deaths	0	0	NS
Neonatal deaths	0	0	
Perinatal deaths			
Motor cerebral palsy	1	0	NS
1-minute Apgar < 4	4	7	NS
1-minute Apgar < 7	9	21	$p < 0.05$
5-minute Apgar < 4	1	2	NS
5-minute Apgar < 7	1	7	$p < 0.05$
Infant resuscitations	4	7	NS
Respiratory distress > 12 hrs.	3	3	NS
Failure to thrive	0	1	NS
Birth injury	1	0	NS

HOME BIRTH VERSUS HOSPITAL BIRTH: COMPARISONS OF OUTCOMES OF MATCHED POPULATIONS [1]

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Abstract

1046 matched home and hospital deliveries are compared with regard to the frequency of obstetrical procedures utilized, incidence of maternal and neonatal complications, and morbidity and mortality. Each home delivery is matched with a hospital delivery with respect to age, parity, length of gestation, major risk factors, and total risk factor score on the Nova Scotia risk factor screening criteria. Educational and socioeconomic factors are matched so that the hospital population is equally or better educated than the home birth population and of equal or higher socioeconomic class. Home deliveries were collected from six home delivery services in northern California. Hospital deliveries were collected from two community hospitals in Madison, Wisconsin. Results show no significant differences in neonatal and perinatal mortality, number of neurologically abnormal infants, incidence of low birth weight infants, and cases of neonatal infection. There were more neonatal infections and more infants requiring resuscitation in the hospital group. The general equivalence of results are discussed as indicating that pre-selected women may labor and deliver at home in the United States without significant additional risk, and at a lower cost than hospital delivery.

Key Words

Home Birth	Midwife	Obstetric anesthesia
Birth injury	Neonatal infection	Neonatal resuscitation

A continuing trend toward home delivery has been noted recently across many segments of the American population (Hazell, 1975; Ward and Ward, 1976; Arms, 1975). Much of the impetus for home delivery has been derived from consumer rather than professional initiative. Medical reaction to this trend has been largely negative and based on the contention that home deliveries presented unacceptable medical risk to mothers and infants. It has been contended that the technological advances of recent years make hospital delivery mandatory (Cox, 1976). Yet, in the Netherlands, a medically sophisticated technologically advanced country, more than two thirds of all deliveries occur at home with morbidity and mortality statistics that may be favorably compared with those of any nation in the world (Kloosterman, 1968, 1975). In Cardiff, Wales, recent data suggests that a change in the past decade from largely home to largely hospital delivered babies has had essentially no effect on materna or neonatal outcome (Chalmers, 1976a, b). Given the psycho-social advantages proposed by advocates of home delivery (Ward and Ward, 1976) and the data from the Netherlands in home delivery outcome, is it possible that under some conditions home delivery may be a reasonable alternative in the United States? Several recent report have indicated low levels of complications associated with home delivery in the United States (Mehl, et. al., 1975; Brew, 1976). These reports, however, have not included comparison populations who are delivered in hospitals. In order to more appropriately assess the relative safety of home deliveries when compared to hospital deliveries it is necessary to compare the home delivered

population to a hospital delivered population of equivalent age, parity, socioeconomic status, and prenatal medical condition.

In this study, we present a comparison study of 1046 home deliveries with 1046 hospital deliveries, matched for age, risk factors, gestational length, parity, education, and socioeconomic status. This data provides needed information for the assessment of the safety and appropriateness of home delivery for selected patients.

<u>Methods</u>

The methods of data collection for the home birth series have been described elsewhere (Mehl, 1976) and consisted of chart reviews of 6 home delivery services in northern California and one in Madison, Wisconsin. We found all of the medical charts - both home and hospital - to be complete and of a similar quality of observation. Diagnostic criteria used were ours and were based on those defined by Friedman and Greenhill (1974). From reviewing the record and discussing them with all the practitioners concerned, it was our impression that practices in observing, diagnosing and recording clinical findings were not different among all the groups studied. This does not, of course, obviate the problem of retrospective chart review and the disadvantage of this technique, but indicates that the disadvantages were uniformly distributed. Statistics regarding the hospital deliveries were collected by chart review at two hospitals in Madison, Wisconsin, a largely upper middle class community with a median income of $16,000 per annum and from one of the home birth practices in northern California. Both were private

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community hospitals, both University affiliated, both performing approximately 2000 deliveries yearly, one with a regional neonatal intensive care unit and the other with a regional maternal intensive care unit and a developing regional neonatal intesive care unit. Both were staffed by neonatologists and University pediatric and obstetrical faculty and residents as well as private physicians. One hospital's obstetrical services were also staffed by University family practice residents. 90% of the hospital deliveries were from Wisconsin; 10% from northern California.

Risk factors were grouped according to the Nova Scotia Risk Factor Screening Criteria, and for each home delivered patient, a hospital delivered patient was matched for age, length of gestation, parity, risk factor score, education and socioeconomic status, race, presentation, and individual major risk factors (including 1st, 2nd, and 3rd trimester bleeding, rupture of membranes exceeding 24 hours without labor, multiple gestation, hypertension, signs of pre-eclamps pre-existing maternal disease, abnormal glucose tolerance tests, and the like. The risk score for each home and hospital delivered pair were equated for the time of onset of labor.

The home delivery sample included all those women planning to deliver at home immediately prior to the initiation of labor, rupture of membranes, or emergence of a complication necessitating immediate hospitalization and delivery. All cases transferred to the hospital during or after labor or meeting the above criteria are included. For the home birth group, of all the women contacting the home delivery services, 4% were screened out for medical reasons. More

may have been screened out through telephone conversations which would not have appeared in the medical records.

The characteristics, philosophies, and methods of practice of the home delivery attendants are summarized elsewhere (Mehl, 1975, 1976; Eisenstein, 1976; Ettner, 1976; Epstein, et. al., 1976; Mills, 1976; Lang, 1972). Review of these sources will reveal that an inextricable complicating variable in this study is the mode and philosphy of practice of the attendants. The home birth practitioners were predominantly non-interventionist and had a higher threshold for intervention than did the hospital practitioners.

Educational attainment and socio-economic status were matched so that the hospital group had the same educational and/or socio-economic level as the home birth group or higher. Mean maternal age was 25.2 years. 96% of the women were between the ages of 20 and 35. 22% were less than 20 and 1.8% were older than 35. 57.7% were primigravida, 24.3% were para 1, 10.4% were para 2, 2.2% were para 3, 0.9% were para 4, 0.4% were para 5, and 0.1% were para 6. The mean years of education for the home birth group was 13.5 years compared to 14.6 years for the hospital group.[1] All were Caucasian women. Data for each group are presented up to 4 days of age, the time of hospital discharge. Follow-up data on home birth up to a mean of 11.5 months was available on all the home cases but not the hospital births. This is presented in Mehl (1976). 97.7% of the deliveries were vertex with 2.3% breech and other presentations. There were five sets of twins. 74.9% of the hospital deliveries were obstetrician attended; 25.1% were family physician attended.

1 They were matched so that each woman in the hospital group was as educated or more so than her counterpart in the

For the home deliveries, 66.5% were family physician attended; 30.8% lay midwife attended; and 2.7% nurse-midwife attended. The average risk factor score was 1.6% and 9.2% of each group was high risk by the Nova Scotia criteria (We felt this was artificially high.).

Results

Table 1 presents a summary of the procedure utilized during the deliveries of each of the two groups. The hospital practitioners used significantly more oxytocin, both before and after delivery. In home births buccal oxytocin was occasionally administered for uterine inertia, ~~if no results were forthcoming~~, whereas in the hospital, women were given intravenous oxytocin. Many more forceps deliveries were performed by the hospital practitioners, as well as more Cesarean sections. Despite a nine-fold greater incidence of episiotomies, hospital delivered women sustained significantly more third and fourth degree and cervical lacerations. Analgesia and anesthesia were also used much more frequently in hospitals (with the exception of caudal anesthesi (Analgesia, anesthesia, and forceps deliveries were only given or performed after transport to the hospital for the home birth group.) The incidence of manual removal of the placenta was the same in both groups. Indications for procedures were derived from review of charts.*

Table 2 presents the indications for oxytocin for the two groups. The differences were seen to emerge from greater use of oxytocin ~~in~~ the hospital group for rupture of membranes without labor, first stage uterine inertia, and for elective induction. More oxytocin was used in the home group for second stage uterine

* All of the women had had childbirth preparation.

inertia than in the hospital group. Typically, the home birth group waited longer, occasionally longer than 24 hours, before the initiati of oxytocin therapy.

Table 3 presents the indications for forceps deliveries for the two groups. The majority of the hospital practitioners used the criterion of a second stage of labor longer than one hour as an indication for forceps delivery. The home practitioners typically accepted any length of second stage as long as some progress was evident and there were no signs of fetal distress. This difference in approach is reflected in the greater number of forceps deliveries in the hospital for "prolonged second stage." The hospital practitioners used occiput posterior as an indication for forceps rotation and did not permit any patient to deliver OP, whereas the home birth practitioners did not intervene in the OP labor and deliveries unless signs of labor arrest or fetal distress were present. This i reflected in the higher number of mid forceps rotations in the hospital group. The two groups of practitioners also defined the sa type of forceps delivery by different terms. For the home group, a low forceps delivery was equivalent to a hospital practitioners outl forceps delivery and a mid forceps delivery was equivalent to a low forceps delivery. The home birth practitioners definitions for forceps deliveries were the same as Friedman and Greenhill (1974). There were also significantly more forceps deliveries in the hospita group. for fetal distress.

Table 4 presents the indications given for Cesarean sections for by both groups. The hospital group did many more Cesarean sections

for 1st stage arrest, cephalopelvic disproportion, and/or non-progressive labor than did the home birth practitioners, and did more Cesarean sections for primi-gravida breech presentations and for fetal distress. The home birth practitioners delivered breech infants in the home if the parents continued to request home delivery after risks had been explained and if the Zatuchni-Andros score indicated vaginal delivery. From the table, it is also evident that the indications for Cesarean section were more liberal for the hospital group than for the home group.

Some significant differences in labor length emerged in that for para 0 and 1, length of first and second stages were significantly longer for women delivering at home (See Table 5).

Figure 1 presents significant differences in complications of labor and delivery for the two groups. The hospital group had significantly more intra-uterine fetal distress, elevated blood pressure during labor (from a non-elevated pre-labor baseline), meconium staining, and reported shoulder dystocia. The home group had more bleeding during labor and posterior deliveries. The hospital group had significantly more postpartum hemorrhages. There were no statistically significant differences in the incidence of face deliveries first or second stage dystocia (excluding CPD), occult cord prolapse, placenta previa, abruptio placenta, cord prolapse, posterior labor, retained placental fragments, late Dilation and Curettage after one week, hemorrhage from day 1 to day 3, hemorrhage after day 3, endometritis, vilamentous insertion of the cord, and postpartum thrombophlebitis.

Figure 2 presents statistically significant differences in the incidence of neonatal complications. The hospital group experienced significantly more birth injuries, received significantly more oxyg at 2, 3, 4, and 5 or more minutes, more respiratory distress lasting 12 hours or more among full term infants, and more total non-congenital neonatal complications. There were no significant differences in the incidence of total number of congenital anomalies, congenital heart disease, Down's syndrome, fetal wasting, hypoglycemia, metabolic acidosis, neonatal hypotension, neonatal hypovolemic shock, individual neonatal infections, meconium asperation, pneumonitis, amniotic fluid asperation pneumonitis, pyloric stenosis, polycythemi lung water syndrome, ITP, and cystic fibrosis with meconium ileus. From Table 5, it is evident that the hospital group neonates were g more resuscitation, and had lower one minute and five minute Apgar scores than the home group. There was no significant difference in the incidence of fetal, intrapartum, or neonatal deaths, or in the incidence of neurologically abnoraml infants. Bith injuries includ cephalhematomas resulting in severe anemia requiring transfusion or hyperbilirubinemia requiring exchange transfusion, fractured clavic branchial plexus injuries, facial nerve paralyses, skull fractures, and hemopneumothorax.

Discussion

Given two puerpally matched populations, outcome differences should accrue from the events occurring during labor and delivery. The data presented here indicate that for the home delivery population described, a group selected for low medical risk and attend

by midwife or physician, one may expect an outcome for baby and mother essentially as good as the resulting from a medically matched population delivery in community hospitals delivering high standards of medical care. The significant differences noted in the mangement of the women indicate that those hospital delivered are more likely to encounter oxytocin augmentation of labor, forceps delivery, analygesia, anesthesia, and Cesarean section. Recall that both grou of women were matched for identical medical risk factors prior to labor. In addition, incidence of neonatal infection was higher for hospital deliveries. The incidence of maternal infection was not significantly different for the two groups.

In this group of more than 1000 cases, it is not clear that the additional medical and obstetrical procedures rendered in hospital resulted in improved group outcome over the home delivered group. It therefore seems appropriate to conclude that for low medical risk women, home delivery is an alternative that cannot be dismissed as contraindicated because of unacceptable high risk to maternal and infant health. This data, of course, does not apply to home deliver in a medically unselected population, nor to home deliveries unattended by midwife or physician.

The results are, of course, limited by the limitations of the case-control method and the method of retrospective chart review. More definitive studies are needed, such as prospective studies by non-clinically involved individuals including practitioners doing both home and hospital deliveries and with controls for obstetrical practice philosophy, nutrition, and others, with all of the deliver

occurring in the same geographical area. Such a study should also include uniform examination and evaluation of the neonate by an independent examiner blind to the place of delivery.

From these results, it would seem reasonable and prudent to plan pilot projects in out-of-hospital deliveries or in changing hospital policy to create a more home-like environment and in evluating them as discussed above. It would also seem of importance to identify the specific aspects of the hospital environment which increase risk to mothers and infats and eliminate these aspects of hospital deliveries.

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TABLE 1

Procedures Utilized

	Home		Hospital		
	Number	Percent	Number	Percent	Stat. S
1st stage oxytocin	69	6.6	159	15.2	<0.000
2nd stage oxytocin	38	3.6	159	15.2	<0.000
Total prepartum cases	76	7.3	173	16.5	<0.000
3rd stage oxytocin	251	24.0	993	95.0	<0.000
Mid (low) forceps	10	0.9	205	19.6	<0.000
Low (outlet) forceps	3	0.3	115	11.0	<0.000
Mid forceps rotations	3	0.3	40	3.8	<0.001
Manual rotations	0	0.0	5	0.5	NS
Cesarean Sections	28	2.7	86	8.2	<0.05
Episiotomy	103	9.8	914	87.4	<0.000
1st degree lacerations	18	1.7	18	1.7	NS
2nd degree lacerations	136	13.0	56	5.4	<0.000
3rd degree lacerations	8	0.7	44	4.3	<0.001
4th degree lacerations	5	0.5	73	7.0	<0.000
Cervical lacerations	3	0.3	32	3.2	<0.000
Pudendal anesthesia	0	0.0	655	62.6	<0.000
General anesthesia	2	0.2	96	9.2	<0.000
Paracervical block	1	0.1	52	5.0	<0.000
Manual remoyal of plancenta	15	1.4	15	1.4	NS
Analgesia	14	1.3	555	53.1	<0.000
Caudal anesthesia	32	3.0	0	0.0	<0.000

TABLE 2

Indications for Oxytocin

Indication	Home Number	Hospital Number	Stat. Sig.
Rupture of membranes without labor	6	56	$p < 0.0001$
1st stage uterine inertia	44	79	$p < 0.025$
Protracted descent, OP pres.	0	4	NS
Elective induction	0	22	$p < 0.005$
2nd stage uterine inertia	19	8	$p < 0.05$
Partial abruption	0	1	NS
Elevation blood pressure	0	1	NS
Baby died in early labor	0	1	NS

TABLE 3

Indications for Forceps

Indication	Home Number	Hospital Number	Stat. Sig.
Low Forceps			
Arrest of descent	2	0	NS
Elective		42	$p < 0.0001$
Prolonged 2nd stage and/or protracted descent	1	54	$p < 0.0001$
Fetal distress	0	18	$p < 0.005$
Piper forceps to ACH	0	1	NS
Mid Forceps			
Elective	0	63	$p < 0.0001$
Prolonged 2nd stage and/or protracted descent	4	86	$p < 0.0001$
Fetal distress	4	53	$p < 0.0001$
2nd stage arrest	2	0	NS
Bleeding	0	1	NS
Meconium staining	0	1	NS
Perineal dystocia	0	1	NS
Mid Forceps Rotation			
Elective, OP	0	30	$p < 0.0001$
Elective, OT	0	3	NS
2nd stage arrest	0	1	NS
Prolonged 2nd stage and/or protracted descent	2	2	NS
Fetal distress	1	4	NS
Manual Rotation			
Elective	0	1	NS
Fetal distress	1	2	NS

TABLE 4

Indications for Cesarean Sections

Indication	Home Number	Hospital Number	Stat. Si
Hypertonic labor (after oxytocin)	0	3	NS
Hypotonic labor, no response to oxytocin	0	1	NS
Vaginal obstruction by paraovarian cyst	0	1	NS
History of previous difficult forceps	0	1	NS
2nd stage arrest, CPD	6	4	NS
Rupture of membranes, no response to oxytocin	1	1	NS
Labor longer than 24 hours total	0	1	NS
Placenta previa	0	1	NS
Fetal distress	5	8	NS
Repeat Cesarean	0	1	NS
1st stage arrest, CPD	12	45	$p < 0.005$
Multigravida breech (with or w/o CPD)	1	2	NS
Primigravida breech (as above)	0	7	$p < 0.05$
Severe toxemia	1	0	NS
Meconium at 42 weeks	0	1	NS
Face presentation	0	2	NS
Transverse lie	0	2	NS
Suspected postmaturity	0	1	NS
Positive stress test	0	1	NS
Prolapsed cord	1	0	NS
Fetal arrhythmia on monitor	0	1	NS
Amnionitis, no labor, no rupture of membranes	1	0	NS

TABLE 5

	Home	Hospital	Stat. Sig.
Birthweight, mean	3518	3439	NS
Labor length			
para 0, 1st stage	14.5 hrs	10.4 hrs	<0.01
para 0, 2nd stage	94.7 min	63.9 min	<0.05
para 1, 1st stage	8.5 hrs	5.9 hrs	<0.01
para 1, 2nd stage	48.7 min	19.0 min	<0.005
para 2, 1st stage	7.7 hrs	6.6 hrs	NS
para 2, 2nd stage	21.7 min	15.9 min	NS
3rd stage	21.0 min	4.6 min	<0.005

TABLE 6

Neonatal Outcomes

	Home	Hospital	Stat. Sig
Intrapartum death	1	1	NS
Fetal death	2	0	NS
Neonatal death	0	1	NS
Perinatal mortality/1000	2.9	1.9	NS
Neonatal mortality/1000	0	0.9	NS
Neonatal asphyxia	3	7	NS
Neonatal resuscitations required	14	52	$p < 0.0001$
Birth injuries	0	30	$p < 0.0001$
Neurological abnormal infants	1	6	NS
1 min Apgar score 4	20	36	$p < 0.05$
1 min Apgar score 7	56	116	$p < 0.0005$
5 min Apgar score 4	3	8	NS
5 min Apgar score 7	11	23	$p < 0.05$

Figure I
STATISTICALLY SIGNIFICANT DIFFERENCES IN COMPLICATIONS OF LABOR AND DELIVERY

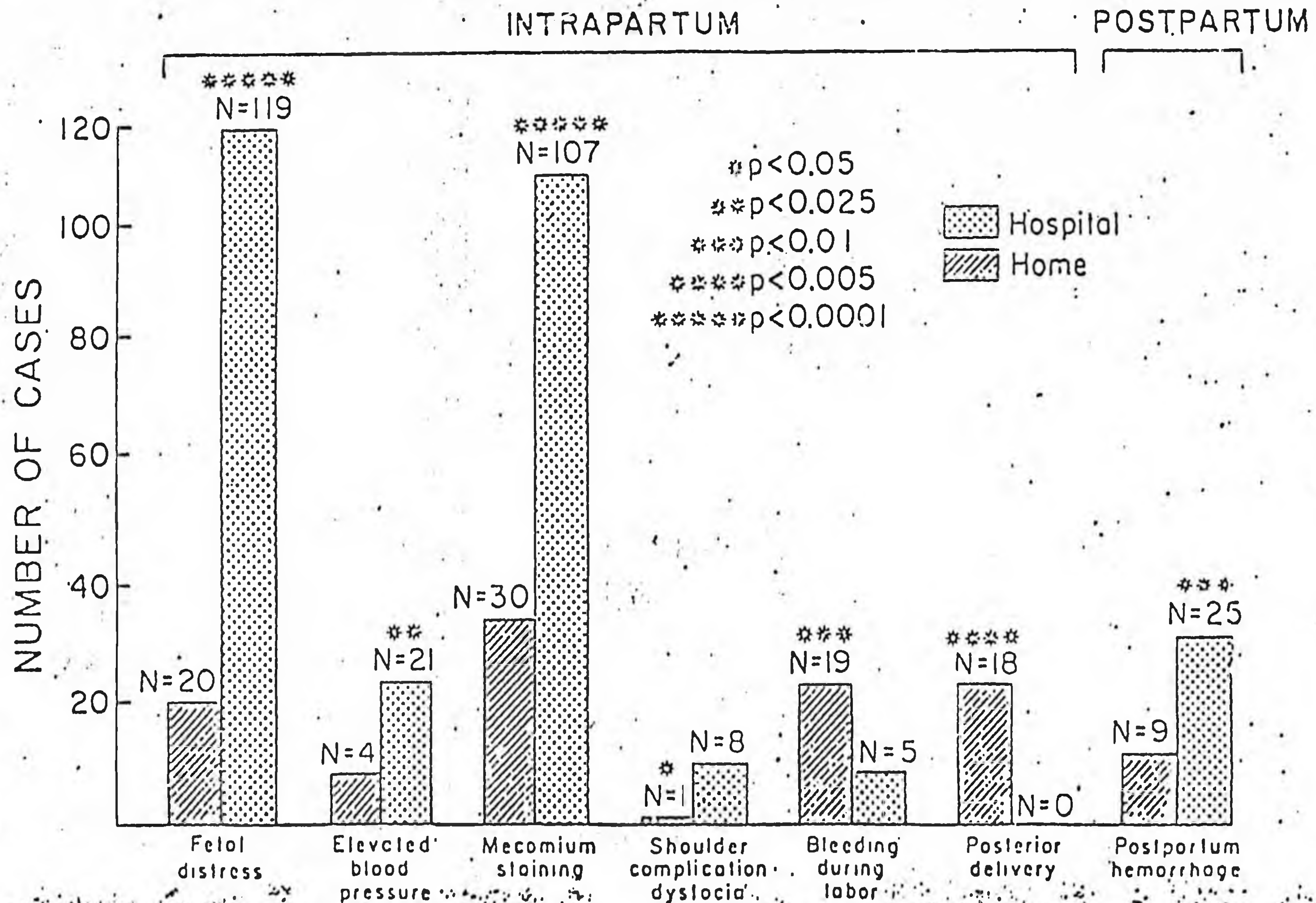
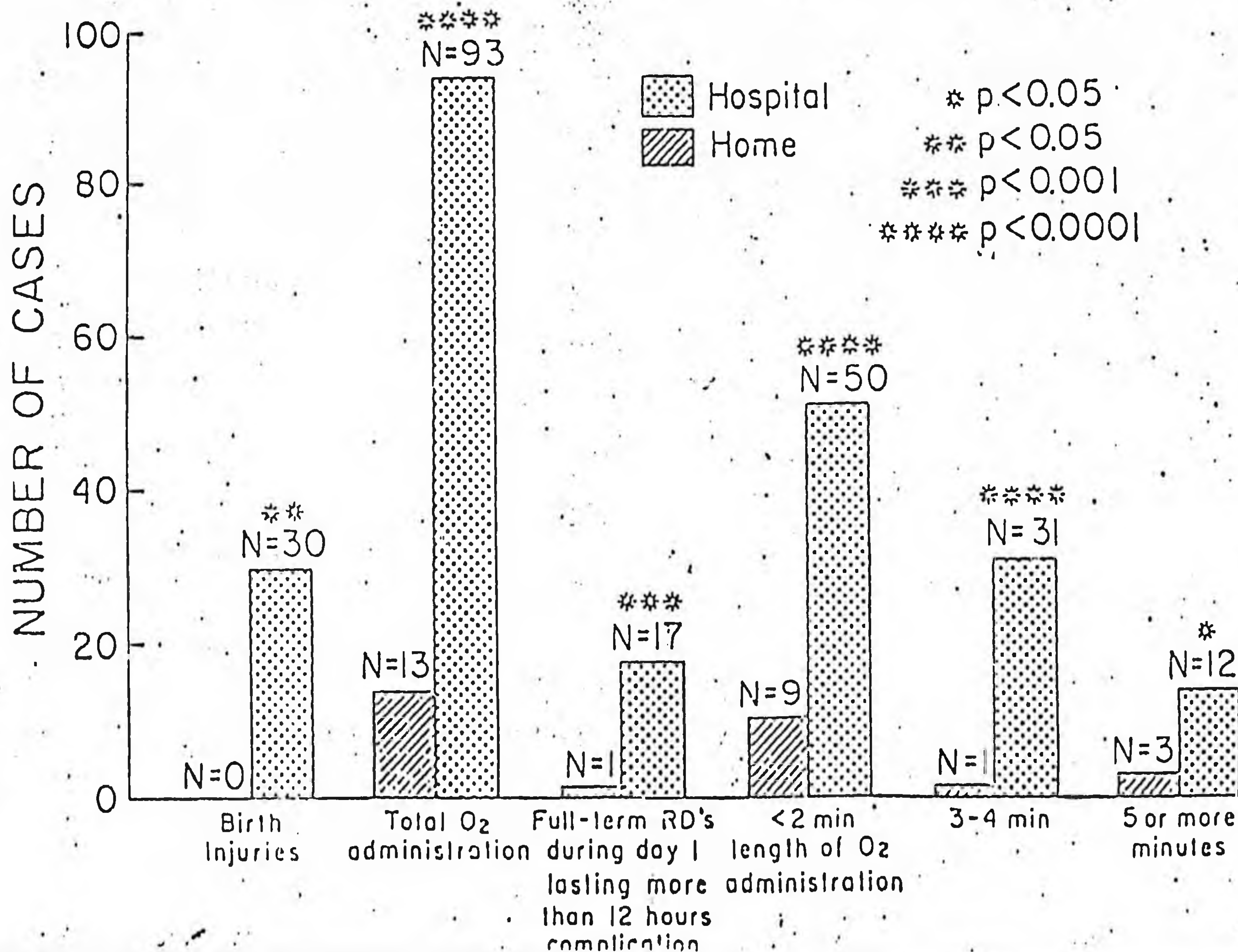


Figure 2

STATISTICALLY SIGNIFICANT DIFFERENCES IN COMPLICATIONS OF THE NEWBORN



Statistical Outcomes of Home Delivery
I. Comparison to similarly selected
Hospital Deliveries [1,2]

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2 Presented at the first annual meeting of the National Association of Parents and Professionals for Safe Alternatives in Childbirth, Washington, D.C., May 15, 1976.

ABSTRACT

Medical records of 1,146 elective home births from 5 home delivery services in northern California were compared with medical records of 180 planned hospital deliveries conducted by one of the same services, and consisting of women who met their criteria for home delivery. Three of the services consisted of family physicians and nurse-midwives, while two consisted of lay midwives without immediate physician supervision. Rates of medical complications in both groups were low. Significantly more analgesia and anesthesia (although low) was used in the planned hospital group; the incidence of low Apgar scores in this group was higher than for the planned home group. Results of both groups were better than those of the general population. Possible reasons for this are discussed. Most other measures of perinatal outcome and complications were not significantly different between the two groups or between physicians and midwives. The neonatal mortality rate was 5.0/1000; the perinatal mortality rate was 9.5/1000. There were no maternal deaths. These figures support the conclusion that in a self-selected, medically screened population, home delivery can be a safe alternative. Possible reasons for this are cited.

Key Words

Home Birth Midwife Perinatal

Neonatal Mortality Infant Morbidity

Acknowledgments

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Introduction

We began our studies on the statistical outcomes of home deliveries because of the tremendous rise in the number of home deliveries across the country and the lack of available data on their outcomes. We had hoped to provide data which parents and professionals could use on their individual scales of relative value along with the already available experiential data on emotional outcomes as they weighed risks and benefits to determine what kind of delivery they would choose to have or to attend. The purpose of this study was to compare the outcomes of 1146 elective home deliveries with 180 similarly selected hospital deliveries performed by one of the same groups of physicians involved in the home deliveries.

Methods

Our sources of data for the 1146 elective home deliveries and our methods of analysis have been described elsewhere (Mehl, et al., 1976). In summary these deliveries were collected from the medical charts of five San Francisco Bay Area services consisting of three physician-midwife groups: a rural-based family practice in Western Marin County, an urban-based family practice in Mill Valley, and an urban-based group consisting of one physician (trained in pediatrics/neonatology) and two midwives; and two midwife groups consisting of 10 lay midwives in Santa Cruz County and 1 lay midwife in Sonoma County. 59.2% of the deliveries were performed by physicians and 40.8% by lay midwives. The methods of operation of these services, their screening procedures, obstetrical philosophies and practices, and the sociodemographic characteristics of their population have all been described elsewhere (Mehl, et al., 1976).

The planned hospital comparison group was drawn from the records of the Point Reyes family practice and consisted of 180 deliveries. These women came from the same population pool as those women planning home deliveries and had many of the same attitudinal sets. They would have been attended at home had they chosen to deliver there. Women with complications of prenatal care obviating a home delivery were excluded from this sample. For the hospital comparison group 81.2% were followed at least six months. 110 of the infants and mothers were discharged at the end of two hours post-delivery. The hospital comparison group tended to be less from the counter-culture and were characterized by a more uniform middle-class socioeconomic background with usually one or both parents a college graduate.

DISCUSSION

Each group was a self-selected health group of women screened for complicating medical problems. Comparisons between the home birth group and the planned hospital group suggests that for women delivering in the home with the particular philosophies and practices of this particular group of practitioners, there was no significant increase in risk with a home delivery versus a hospital delivery.

Several points may be made -- that the perineal massage technique

(next page)

There was no association among either group between length of labor and length of second stage with the incidence of low Apgar scores at birth or with other complications. The mean length of first stage labor among the planned hospital group was 12.5 hours for primigravidae and 5.4 hours for multigravidae. For the home group it was 10.2 hours and 4.6 hours, respectively. This difference was significant at $p < 0.05$. The mean length of second stage labor for the planned hospital primigravidae was 106.8 min ± 31.0 min and for multigravidae was 50.1 min ± 28.3 min. For the home series the mean length of second stage was 118.2 min ± 40.5 min. for primigravidae and 44.6 min ± 23.7 min for multigravidae. The primigravidae differences were significant at $p < 0.05$.

There were 14 cases of prolonged rupture of membranes in the home birth series and 11 in the planned hospital series ($p < 0.01$). There were no infections in the infants except for one low birth weight infant whose mother developed signs of amnionitis prior to delivery and had had multiple vaginal exams. She was in the planned hospital series. Table 9 presents some additional data on the reasons for which home deliveries were transported to the hospital for the home birth series.

utilized by the midwives in preventing vaginal lacerations during delivery did indeed function and that as the physicians adopted this technique, their laceration rate decreased. The higher utilization of oxytocin after delivery by the physicians may have reflected its availability to them and their training to use it frequently. The equivalence of hemorrhage and blood loss results between the physician and midwife group suggests that it was not needed as frequently as used. The lay midwives took women to the hospital more frequently than the physicians, presumably reflecting their decreased capabilities to handle specific complications at home and their lower threshold level for going to the hospital possibly related to a lower level of knowledge. The reasons for transport which were most significantly different between the groups were for prolonged rupture of membranes, uterine inertia, decreasing fetal heart rate, manual removal of a retained placenta, and treatment of postpartum hemorrhage. The physicians were able to treat some of their cases of uterine inertia with buccal oxytocin at home, and removed several retained placenta at home, as well as carrying oxytocin and methergine to treat third stage bleeding at home. The greater number of FHT problems brought to the hospital by the midwives may reflect their greater level of anxiety in dealing with and desire for transporting abnormal situations to the hospital early.

The planned hospital population, while having equivalent training for childbirth, used more analgesia during labor than the home birth series, and this may have contributed to their higher incidence of low one minute Apgar scores, second stage dystocia, and greater incidence of fetal heart rate drops, The much lower incidence of "excessive bleeding" in the planned hospital group may be indicative of the attendents lesser anxiety for equivalent blood loss in the hospital than in the home. The

incidence of postpartum hemorrhage was greater in the planned hospital group and may represent the greater tendency to pull on the umbilical cord to aid in the delivery of the placenta. At home, the umbilical cord was rarely pulled to aid placental delivery, but rather, the natural expulsive forces of the uterus were relied on. This is substantiated by the longer third stages seen in the home group.

The failure of prolonged second stage to be associated with infant problems in this series may relate to the slower descent with less intense pushing placing less of a stress on the infant, or may relate to other factors. This has been found to hold, as well, in the British Perinatal Study (1973) and by Friedman (1974). Clearly many of these findings may need to be substantiated by further study in such populations as these. It may be that much current obstetrical thinking is influenced by many of the studies having been completed on welfare populations, while different results may hold in different populations. More work needs to be done in this area.

The 0.3% incidence of neurologically abnormal infants at one year follow-up contrasts favorably with the 1.7% incidence of neurologically abnormal infants at 1 year of age found by the National Institute of Neurological Diseases and Stroke (1972). The Apgar scores in this series were scored by an attendent not involved in the actual delivery, and may be inflated here, as in the hospital, where often the physician delivering the infant assesses the Apgar score. They are useful however in assessing the accoucheur's perception of the infant's immediate difficulties, which in this series, seem minimal. The total percent of 1 minute Apgar scores less than 7 was 4.1% compared to a 21% incidence of such scores in a non-welfare population in the hospital found by Drage and Berendes (1966). The contribution of other factors such as lower stress in the home en-

in a study such as this. Incidences of meconium staining in this group was less than that of the general population (Klaus and Farnaroff, 1973). This was true as well for labor dystocia (Friedman, 1974) and (Eastman and Hellman, 1968), as well as for other complications (Eastman and Hellman, 1968).

Neonatal mortality rate for the home delivery population was 5.2 per 1000, and perinatal mortality was 9.5 per 1000. Intrapartum asphyxia deaths occurred at a rate of 0.95 per 1000. Unfortunately few studies are available for comparison. Behrman, et al[9] report a neonatal mortality rate of 5.0 per 1000 in 39,896 non-premature, white middle-class pregnancies receiving private prenatal care. The non-premature perinatal rate for this group was 7.6 per 1000, and the overall neonatal and perinatal mortality rates were 13.8 and 17.6 per 1000, respectively. Chan, et al[10] report an intrapartum stillbirth rate due to asphyxia of 1.7 per 1000 in 1162 patients receiving random assignment fetal monitoring at Loma Linda University Hospital, and Shenker, et al[11] report a 0.5 per 1000 intrapartum asphyxial death rate in fetal monitored patients. The prematurity rate of the Behrman, et al study was 4.8%; in the home delivery series it was 3.0%. The planned hospital population had a neonatal mortality rate of 5.5 per 1000 and a perinatal mortality rate 11.0 per 1000.

T

This compares favorably to the work of Halverkamp (1976) showing superior results of nurse monitorring labors compared to fetal monitor machines. Table 10 is included to show the equivalence of physician midwife observations for the home delivery series. Since these same physicians were making observations in the hospital, this suggests that the quality of observations between the two populations was equivalent.

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portion and had more low forceps deliveries, significantly more because of a drop in fetal heart rate.

Table 4 presents the comparison complication figures for the home delivery population (4A) and the planned hospital group (4B). The planned hospital group showed significantly more second stage labor dystocia ($p < 0.025$), more drops of the fetal heart rate ($p < 0.005$), more postpartum hemorrhage ($p < 0.001$), more forceps deliveries ($p < 0.001$), episiotomies ($p < 0.001$), Cesarean sections ($p < 0.025$), analgesia ($p < 0.001$), and significantly less total unmedicated deliveries ($p < 0.001$).

Table 5 compares the perinatal outcome data. The neonatal and perinatal mortality results were not significantly different between the planned hospital group and the home delivery group, nor was the rate of low birthweight infants, or the mean length of infant follow-up. The hospital neonatal death rate was 5.5 per 1000 live births with 11.1 perinatal deaths per 1000 total births. Table 6 compares infant morbidity obtained and outcome, and Table 7 compares neonatal complications. The planned hospital group had significantly more fetal hypoxia ($p < 0.025$) and significantly more 1 minute Apgar scores less than 4 ($p < 0.025$). Among the home birth series, the midwives had more infants who received phototherapy for jaundice than did the physicians ($p < 0.025$). Causes of fetal deaths are compared in Table 8.

The prematurity rate for the population initially seeking assistance from one of the services studied was 3.0%. For the planned hospital group it was 2.8%. There was no significant difference between one minute Apgar scores ranging from 4-6 between the home birth group and the planned hospital group with 40 and 7 such ratings, respectively. Average Apgar scores for the planned hospital group were 8.6 at one minute and 9.7 at five minutes, and were not statistically significantly different from the home birth group.

Results

Table I compares the statistics on the selection of the planned hospital group with the elected home delivery group. There were more primigravidae in the hospital group and fewer secundipara. The other differences were not significant. The maternal age was not statistically different between groups. Virtually all the women in the planned hospital group were trained in childbi[rth] classes (as were the home group) such as Bradley or LaMaze. A high incidence of breast feeding also characterized the planned hospital group. All women in the planned hospital group attempted breast feeding except one, and, for a variety of reasons, two of these were not successful.

Statistics on the presentations and deliveries are compared in Table 2. The planned hospital group contained more breech infants, had more Cesarean sections, had more analgesia, received more oxytocin during first stage, second stage, and after third stage labor, had more low and mid forceps deliveries, and more episiotomies. The breech infants did not contribute to these differences with the exception of one Cesarean section. It is important to note that the labor attendents for these planned hospital deliveries had the same philosophies as the home birth attendents so that these differences presumably come as a result of the effect of being in the hospital and may relate to a lower motivation for the women to carry through with an unmedicated delivery or to more readily available analgesia or an atmosphere more encouraging of analgesia, or to a feeling of pressure transmitted to the birth attendents to intervene sooner or more aggressively in the hospital than at home. These may be related to the subtle effects of atmosphere which are as yet difficult to measure. The indications given for forceps and Cesarean deliveries are compared in Table 3. The planned hospita[l] group had more Cesarean sections, primarily related to cephalopelvic dispro-

	Home Number	Home Percent	Hospital Number	Hospital Percent	California 1973	Stat. Sign.
Mother's Age	1146	100.0	180	100.0	100.0	
<20	60	5.2	12	6.7	17.3	NS
20-34	1068	93.2	160	89.9	77.6	NS
≥ 35	18	1.6	6	3.4	5.1	NS
Mean Age	24.9					
Range	16-44					
Variance	16.8					
S.D.	4.1					
Parity	1146	100.0	180	100.0	100.0	
para 0	729	63.6	133	73.9	43.3	$p<.005$
para 1	237	20.7	33	18.3	31.0	NS
para 2	128	11.2	9	5.0	13.3	$p<.025$
para 3	34	3.0	2	1.1	6.0	NS
para 4	18	1.6	1	0.6	6.3	NS
Prenatal Care Began	1146	100.0	180	100.0	100.0	
1st Trimester	707	61.7	114	64.0	72.8	NS
2nd Trimester	362	31.6	63	35.4	20.2	NS
3rd Trimester	74	6.5	1	0.6	4.5	**
None	3	0.3	0	–	2.4	NS

*includes prenatal care unknown

Indications for C-Sections and Forceps Deliveries in Women Beginning Labor at Home

	Home Number	Hospital Number
Low Forceps Delivery		
Protracted descent	6	0
Arrest of descent	2	3
Dysfunctional labor	1	0
Brow presentation with arrest of descent	1	0
Fetal heart drop	1	3
Bleeding during 2nd stage	0	1
	11	7
Mid Forceps Delivery		
Protracted descent	3	0
Arrest of descent	1	1
Dysfunctional labor	1	0
Fetal heart drop, occiput posterior presentation	1	0
Fetal heart rate drop, amnionitis, maternal hypertension	0	1
	6	2
C-Sections		
Cephalopelvic disproportion	16	7
Failure to descend, occiput posterior presentation, relative CPD	6	
Arrest of active phase dilation, fetal heart drop, cord 4x neck	1	
Prolapsed cord	1	(1)
Breech with amnionitis	1	
Psychotic reaction to labor	1	
Acutely dropping fetal heart tones	1	
Toxemia	1	
Breech with low breech score, poor labor progression	0	1
Transverse lie with one prolapsed cord	(1)	2
	28	10

Perinatal Outcome

	Home Number	Home Rate	California St. 1973	Sign.	Hospital Number	Hospital Rate
Total Births	1152*				180**	
Live Births	1147*				180**	
Fetal Deaths	5	4.3[1]	8.2[1,3]	NS	1	5.5[1]
Neonatal Deaths	6	5.2[2]	10.3[2]	NS	1	5.5[2]
Total Perinatal Deaths	11	9.5[1]	20.3[1]	NS	2	11.1[1]
Low Birthweight (2501g)	15	1.3[2]	5.3[2,3]	NS	3	1.7[2]
Mean Length of Infant Follow-Up	11.5 mos.			NS	11.6 mos.	
S.D. Length of Follow-Up	+10.3 mos.			NS	+10.4 mos.	
% Infants Followed to 6 mos.	83.4%			NS	81.2%	

*includes 6 sets of twins
** includes 2 sets of twins

1 per 1000 total births
2 per 1000 live births
3 for white, non-Spanish surname, age 20-29

Complications	Primigravidae N=729 M.D.'s N=464 Home	To Hosp	Midwives N=265 Home	To Hosp	SS[1]	Multigravidae N=417 M.D.'s N=221 Home	To Hosp	Midwives N=196 Home	To Hosp	SS[1]	Total M.D.'s N=685 Home	To Hosp
Jaundice reg. Rx	1	5	2	9	$p<0.025$	2	1	0	1	NS	3	6
Fecal hypoxia	2	0	0	0	NS	0	1	0	0	NS	2	1
Neurological Abnormalities[2,4]	2	1	0	1	NS	0	0	0	1	NS	2	1
Cerebral palsy	1	0	0	1	NS	0	0	0	0	NS	1	0
Neonatal FTT	1	1	0	1	NS	0	0	0	0	NS	1	1
Apgar (1 min.) score												
score less than 4	3	0	1	1	NS	0	1	0	1	NS	3	1
score 4 - 6	12	7	5	3	NS	2	4	2	5	NS	14	11

1 calculated on the basis of home & hospital
2 include cerebral palsied infants
4 development at 1 year follow-up

Condition	Number	Rate per 1000 LB	Delivery	Complications	Outcome
Congenital Defects	6	5.2			
PDA			Home	None	repaired surgically at 1 year
Coarctation of aorta			Home	None	repaired surgically at 2 years
Omphalocele			Home	None	repaired surgically at 15 hours
Myelomeningocele, thoracic			Home	None	mental & motor retardation at 18 month:
Multiple minor anomolies			Hosp	FHT↓, C-S	no mental or motor retardation at 1 ye:
Down's syndrome			Home	Meconium	mental retardation
Cerebral palsy	2	1.7	Home	FHT↓, precip. del.	motor retardation
			Home	None	mild spastic with slow verbal developm:
Surgical Conditions	2	1.7	Home	None	pyloric stenosis repaired at 5 and 8 da
Low Birthweight	15	13.1	Hosp	2nd Tri Bleed	1332 grams, in hospital 1 month, severe
			Home	None	1729 grams, in hospital 2 weeks, mild [illegible]
			Home	Breech	2154 grams, in hospital 12 days, mild [illegible]
		Others:	Home	None	No problems
Low Birthweight	3	16.6	Hosp	FHT prior to del.	neonatal sepsis and amnionitis
			Hosp		2 cases mild RDS
Hyperviscosity syndrome	1	5.5	Hosp	None	resolved

Age at Death	Number	Delivery	Complications	Cause of Death
5 months est. gest. age	1	Home	None	Rh incompatability, insisted on home delivery
35 weeks est. gest. age	2	Home	None	Intrauterine death, unknown cause
During labor	1	Hosp	Amnionitis IUD in place	Overwhelming intrauterine sepsis
During labor	1	Home	None	Unknown cause
2 days	1	Home	None	Macrosomia, single umbilical artery, bilateral adr[illegible] hemorrhage, numerous congenital anomalies
7 days	1	Home	None	Cystic fibrosis, meconium ilius, postoperative per[illegible] tinitis and sepsis
7 days	1	Home	None	Coarctation of aorta
10 days	1	Home	None	Cor biloculare
2 weeks	1	Home	None	Sudden infant death syndrome
3 weeks	1	Home	None	Post surgery for tetralogy of Fallot
During labor	1	Hosp	Rapidly ↓ FHT	Meningoencephalitis, etiology unknown
8 days	1	Hosp	None	Aplastic left ventricle

Neonatal Outcomes

...igravidas N=729 M.D.'s N=·64	Midwives N=265			Multigravidas N=417 M.D.'s N=221		Midwives N=196			Total N=1146 M.D.'s N=685		Midwives N=461			Planne... N=17...
...e To Hosp	Home	To Hosp	SS[1]	Home	To Hosp	Home	To Hosp	SS[1]	Home	To Hosp	Home	To Hosp	SS[1]	
5	2	9	$p<0.025$	2	1	0	1	NS	3	6	2	10	$p<0.025$	3
0	0	0	NS	0	1	0	0	NS	2	1	0	0	NS	3
1	0	1	NS	0	0	0	1	NS	2	1	0	2	NS	0
0	0	1	NS	0	0	0	0	NS	1	0	0	1	NS	0
1	0	1	NS	0	0	0	0	NS	1	1	0	1	NS	1
0	1	1	NS	0	1	0	1	NS	3	1	1	2	NS	6
7	5	3	NS	2	4	2	5	NS	14	11	7	8	NS	7

...home & hospital
...fants
...w-up

Primigravidae (N=52/133=39.1%)			
Complication	Hospital	Percent	Stat. Sign.**[1]
Intrapartum			
Dystocia 1st Stage[2]	15	11.3	NS
Dystocia 2nd Stage	10	7.5	p 0.025
CPD	7	5.3	NS
Meconium stain only	4	3.0	NS
FHT↓ (c̄, s̄ meconium)	10	7.5	p 0.005
Hypertension	2	1.5	NS
Precipitous labor	2	1.5	NS
Other*	6	4.5	
TOTAL	56		
Postpartum			
Hemorrhage[3]	5	3.8	p 0.001
Excessive PP bleed[3]	2	1.5	p 0.001
Retained placenta	2	1.5	NS
Endometritis	3	2.3	NS
PP Depression	1	0.8	NS
TOTAL	13		

Multigravidae (N=10/45=22.2%)			
Complication	Hospital	Percent	Stat. Sign.**[1]
Intrapartum			
Dystocia 1st Stage	2	4.4	NS
Dystocia 2nd Stage	1	2.2	NS
CPD with breech	1	2.2	--
Precipitous labor	2	4.4	NS
FHT↓	1	2.2	NS
Hypertension	1	2.2	--
Transverse lie	1	2.2	--
TOTAL	9		
Postpartum			
Hemorrhage	0	--	NS
Excessive PP bleed	1	2.2	NS
Retained placenta	1	2.2	NS
Endometritis	1	2.2	NS
TOTAL	3		

*single cases of amnionitis, shoulder presentation, cord prolapse, cord knot, recurrent pyelonephritis, transverse lie.

**compared with Table 5A

[1] Percent complications per 133 primigravidae, 45 multigravidae.

[2] Dystocia as used in this table is defined as: prolonged or arrested first stage, failure to dilate; prolonged or arrested 2nd stage, failure to descend, according to Friedman and Greenbill (1974).

[3] Hemorrhage is defined as more than 650 ml; excessive bleeding as "more than normal", and includes late bleeding after the third postpartum day.

Neonatal Outcomes

[illegible]gravidae N=729	Midwives N=265			Multigravidae N=417 M.D.'s N=221		Midwives N=196			Total N=1146 M.D.'s N=685		Midwives N=461			Planned N=17[illegible]
To Hosp	Home	To Hosp	SS[1]	Home	To Hosp	Home	To Hosp	SS[1]	Home	To Hosp	Home	To Hosp	SS[1]	
5	2	9	$p<0.025$	2	1	0	1	NS	3	6	2	10	$p<0.025$	3
0	0	0	NS	0	1	0	0	NS	2	1	0	0	NS	3
1	0	1	NS	0	0	0	1	NS	2	1	0	2	NS	0
0	0	1	NS	0	0	0	0	NS	1	0	0	1	NS	0
1	0	1	NS	0	0	0	0	NS	1	1	0	1	NS	1
0	1	1	NS	0	1	0	1	NS	3	1	1	2	NS	6
7	5	3	NS	2	4	2	5	NS	14	11	7	8	NS	7

home & hospital
fants
w-up

Reasons for Transportation to the Hospital and Therapy Applied

Complication	M.D.'s N=58	Midwives N=78	Stat. Sign.
1st Stage Complications			
No prenatal care			
Dehydration→IV Hydration	1	0	NS
severe toxemia→Cesarean	0	1	NS
Prolonged rupture of membranes→induction	0	4	p 0.01
Dystocia 1st stage (excluding CPD)			
Uterine Inertia→Oxytocin	7	19	p 0.001
Labor Prolongation with ↓ FHT→ internal monitor & oxytocin	1	0	NS
Arrest of Dilation			
Involving ↓ FHT and uterine inertia→int. monitor & oxytocin	1	0	NS
Brow presentation→oxytocin & low forceps	1	0	NS
Arrest & Uterine Inertia→oxytocin, low forceps	0	2	NS
Arrest→CPD, Cesarean	10	7	NS
Arrest→FHT nuchal cord x4 Cesarean	1	0	NS
Hypertension, Rx'ed with mag. sulfate	1	0	NS
untreated	5	0	NS
Bleeding during labor→no treatment	1	0	NS
Amnionitis→antibiotics	1	0	NS
Fear, desire for hospital	2	6	p 0.05
Desire for anesthesia			
Anesthesia given	3	0	NS
Analgesia only	1	0	NS
Hyperemesis→IV's and compazine	1	0	NS
Dropping FHT's			
No therapy, monitor applied	0	4	p 0.001
Cesarean section	0	1	NS
Cord prolapse→Cesarean	0	1	NS
with meconium→intubation	0	3	p 0.025
Psychotic Reaction to Labor Cesarean	0	1	NS

Midwife Services Functioning Independently of Physicians

Complication	Primigravidae N=729				Multigravidae N=417				Totals N=1146			
	MD's N=464		Midwives N=265		MD's N=221		Midwives N=196		MD's N=685		Midwives N=461	
	Home[2]	Hosp[3]	Home	Hosp	Home	Hosp	Home	Hosp	Home	Hosp	Home	Hosp
Intrapartum												
Hypertension	1	6	2	0	0	0	0	0	1	6	2	0
Dystocia 1st stage	25	16	2	18	2	4	0	8	27	20	2	26
Dystocia 2nd stage[7]	9	8	1	6	4	3	0	6	13	11	1	12
3rd stage oxytocin	115	43a	1	7a[x]	38	35a	2	4a[x]	153	78a	3	11a[x]
Meconium staining totals	19	2	4	2a	7	0	4	1a	26	1	8	3a
Meconium c̄↑ BP	0	2a	0	0	0	0	0	0	0	2	0	0
Meconium stain with FHT irreg. or↓	2a	3a	0	0	2	0	0	1	5	3	0	1
Precipitous labor	1	0	0	0	7	0	0	0[y]	8	0	0	0[y]
CPD	0	4	0	9	0	1	0	0	0	14	0	9
Poly/oligohydramnios	0	2	0	1	0	1	0	0	0	3	0	1
Brow presentation	1	1	0	1	0	0	0	0	1	1	0	1
Placenta previa	0	1	0	0	0	0	0	0	0	1	0	0
Partial abruption	0	1	0	0	0	0	0	0	0	1	0	0
Shoulder dystocia	1	0	0	1	0	0	1	0	1	0	1	1
FHT irreg/↓ s̄ mec.	2	5	1	6	1	1	0	2	3	5	1	3
Postpartum -												
Excessive PP bleed[4]	[illegible]	1a	2	1a	10	2a	4	2a	16	3a	6	3a
PP Hemorrhage[4]	1	0	0	3	3	0	0	2	3	1	0	1
Retained Placenta	8	2	2	2	4	2	0	2	12	2	2	2
PP Depression	0	2a	0	2a	0	1	0	0	0	0	0	2a
Endometritis	6	1a	3	1	2	1a	1	0	8	2a	4	1
Thrombophlebitis	0	0	0	1	0	0	0	0	0	0	0	1

[1] calculated on home + to hospital totals 2 complication managed at home 3 complication managed at hospital
[4] see Table 5A for definition 5 24-48 hours after delivery 6 after third postpartum day 7 excluding abnormal presentation a already at hospital for another reason

STATISTICAL SIGNIFICANCE[1]: x=$p < 0.001$ y=$p < 0.025$ all others = not significant

	M.D.'s N=58	Midwives N=78	Stat. Sign.[b]
2nd Stage Complications			
Protracted descent			
Rx'ed with low forceps (1 FHT↓)	4	2	NS
Rx'ed with mid forceps with FHT↓	2	1	NS
Rx'ed with oxytocin	5	9	NS
Arrest			
CPD, Cesarean Section	4	2	NS
Abnormal Presentation, mid forceps	1	1	NS
Brow presentation, low forceps	0	1	NS
Dropping FHT's			
Low forceps	1	0	NS
With meconium→oxytocin, intubation	0	2	NS
mid forceps	1	0	NS
Bleeding→oxytocin	0	1	NS
3rd Stage Complications			
Retained placenta→manual removal	2	5	$p<0.05$
Hemorrhage→oxytocin, meth., blood	1	4	$p<0.025$
Cervical laceration→suturing	0	1	NS

a sums of complications
b based on total N's (685 and 461, respectively)

Senator Charlie Parr
HESS Committee
Pouch V
Juneau, Alaska
99811

March 22, 1982

Senator Charlie Parr and all other Legislators

Sir:

I am in support of SB 747 "An Act Related to Midwifery". I feel that pregnancy and childbirth is a natural physiological process and, in as much, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

Leo & Carolyn Evans

Note:

Gentlemen:

I, Carolyn Evans, am a Childbirth Educator in Sitka & feel very strongly that HB 747 must & should be passed legalizing midwives in Alaska. We are a rural & isolated area, & we need choices & alternatives for our

(over)

mothers + couples when it comes to their childbirth!

Please vote in favor of this bill!!

Thank you,

CEvans

Box 902
Sitka, AK
99835

March 16, 1982

747

Charles Parr
H ESS
And All State Legislators
Juneau, Alaska.

Dear Sir,

I am writing you concerning Senate Bill 747, concerning Home Birth. I have had a home birth myself and support Sen Fischers Bill. Homebirth needs controll but also it needs to be a viable alternative for those parents that wish it. We need to make Home birth safer not stop it. In reality, Parents will choose home birth whether this bill is passed or not, but this bill does attempt

to make this alternative safer for everyone.

Thank you for your time, and hopefully your support.

Sincerely,

Marylenne C. Maryamaa
SRA Box 2396D
Anchorage, Alaska 99507.

747

Dear Senator Parr.

Please support senate Bill 747 an act relating to midwifery.

it should be within the parents constitutional rights to be able to have birthing with whome and where they want.

USA is a Free-country.

We are going to have a baby this fall and will not have it in the hospital with sick people.

Professionals are not interested to come and birth at our home,

and we are comfortable with an certain Lay midwife and are going to have birthing with her.

Do not make us criminals because of that. it is our right as a parents to have our children with whome we are comfortable and we wish you would vote yes on Bill 747 for our sake and for the sake of so many others.

Thank you for your support.

Mrs J. [illegible]. 976. Homer Ak 99603

Dear Senator Charlie Parr, Legislator Brian Rogers and all other Legislators,

I am writing this letter in support of Senate Bill 747. Having the choice of where I have my children is very important to me, actually two of the most important decisions of my life came down to the fact I didn't want to give birth in a hospital. Both of my babies were born at home. My first was born at the midwives home, and my second was born in my own bed. Both times I felt very secure and safe. It is also very important who women give birth with and deserve the choice. Women needs lots of love, encourgment and understanding during birth. lay midwives have the time to be continuously with the woman doing her job.

Please don't misunderstand me I am not against doctors and hospitals we all know we have to have them but birth is not a sickness and need not be done in the hospital every time. Statics show that there is less mortality and morbitity with home births than with hospital births

Please support this Bill as it is a very good one and I would like to see the day when midwives will be accepted as true and gifted people dedicated to their work.

Thank You very much,

Nanette Woodman

S.R. BOX 50537

FBX AK 99701

STATISTICAL OUTCOMES OF HOMEBIRTHS IN THE U.S.: CURRENT STATUS

Lewis E. Mehl, MD*

We began our studies on the statistical outcomes of home deliveries because of the tremendous rise in the number of home deliveris occurring across the country and the lack of any available data on their outcomes. We had hoped to provide data which parents and professionals could use on their individual scales of relative value along with the experiential data on emotional outcomes as they weighed the risks and benefits to determine what kind of delivery they would choose.

First, I will report the statistical outcomes of 1146 planned homebirths in the San Francisco Bay Area and then I will compare this to 180 similarly selected hospital deliveries performed by one of the same groups of physicians. This is part of some ongoing work in which we are attempting to accumulate a matched hospital series with which to compare the home delivery statistics.

Our sources of data (Mehl, et al.,1976)[11] were the medical charts from five home delivery services in northern California. The five services included 3 physician groups and 2 lay midwife groups as follows:

(1) A rural-based family practice in Western Marin County (Point Reyes) composed of 3 family physicians and 3 registered nurses, performing both home and hospital deliveries since 1970 as part of a comprehensive family practice.
(2) An urban-based family practice in Mill Valley composed of 2 physicians and 2 registered nurses--one a maternity nurse practitioner--in practice since 1973.
(3) An urban-based group in Berkeley consisting of 1 physician (whose training had been in pediatrics/neonatology) and 2 registered nurses, affiliated with a women's health cooperative in Berkeley. This group did not have hospital privileges and performed only home deliveries, referring women requiring hospital care to local obstetricians. They had been functioning since early 1974.
(4) 10 lay midwives from Santa Cruz County, functioning in both urban and rural settings without immediate medical supervision, and with limited medical backup, performing births since 1971.
(5) A rural lay midwife (Nancy Mills) from Sonoma County with good physician backup, performing births since 1970.

** LEWIS E. MEHL is on the faculty of the University of Wisconsin, Center for Health Sciences, Department of Family Practice and Psychiatry, and is Coauthor of "The Homebirth Trend," "Management of Complications of Home Delivery," and other works.*

In the latter service, records had been kept only for the last 171 of her estimated 500 deliveries during a five year time span. All records until April 1975 were reviewed by one of us (LEM). They were adequately detailed regarding prenatal care, intrapartum and post partum events, and infant and maternal follow-up. The groups represented the following percentages of the total sample:

Group	Percentage
(1) The Point Reyes physician group:	40.4%
(2) The Mill Valley physician group:	11.2%
(3) The Berkeley physician group:	7.6%
(4) The Santa Cruz County midwives group:	30.8%
(5) The Sonoma County midwife:	10.0%

The lay midwife from Sonoma County (Nancy Mills) began her midwifery activities accidentally, visiting a friend in labor. Others learned she had attended a birth and asked her to their deliveries, until she eventually developed a reputation as a midwife (See the Chapter by Nancy Mills later in this book for more details on her midwifery experience). Her training was self-acquired through reading and experience. The Santa Cruz midwives began functioning in much the same fashion, becoming midwives to meet an experienced need in the community, and educating themselves through discussion groups, experience, and reading. Their average fee per birth was $35.00, so that their motivation was clearly not monetary. Typically, they were women who had had an unattended homebirth and had decided to help other women avoid their predicament. The Sonoma County midwife had good medical backup through physicians (mainly family practice residents) at the Community Hospital of Santa Rosa, who, while unwilling to attend home deliveries, were willing to discuss problems over the telephone and handle complicated deliveries in the hospital. The Santa Cruz group had poor medical backup, and were not able to obtain telephone consultation. They were often heavily criticized and condemned when bringing women to the hospital who needed hospital care, and had few supportive physicians to whom they could refer women with complications. Labors in the Sonoma area were occasionally as far as one hour from a hospital, although the usual distance was approximately 15 minutes. Labors in the Santa Cruz area were occasionally as far as 45 minutes from a hospital, but usually ranged from 5 to 15 minutes. Transport facilities for both lay midwife groups consisted of the midwife's car without any specialized support equipment. Equipment present at deliveries with the lay midwives was also minimal and typically consisted of a bulb syringe, sterile gauze, sterile gloves, a fetoscope, blood pressure cuff, urine dipsticks for testing acetones, glucose, and protein, a portable scale, and little else. Their mode of operation has been described by Lang.[10]

The physician services brought a home delivery kit with them to births. Typically the nurse would attend the labor from its inception and the physician would arrive during the second stage for primigravidae and late first stage for multigravidae. The physician kit included IV equipment, oxytocin and methergine for use after delivery, other emergency drugs, forceps to use if necessary, as well as suture supplies. (However, there was no intravenous oxytocin or forceps used at home in this series.) The only equipment or drugs not present in their kit and usually present in the hospital was whole blood. A

complete list of supplies is available on request (see addresses of authors tabulated at end of book). The transport vehicle for the physician groups was also the car belonging to the birth attendant. For the Point Reyes group, the closest hospital was 20 miles. For the Berkeley and Mill Valley groups the distance from a hospital was usually 5-10 minutes.

Prenatal care was essentially the same for all groups and did not deviate from the standards recommended by the American College of Obstetrics and Gynecology with regard to visit frequency, laboratory tests, and clinical assessment. The lay midwife groups required a minimum of two visits to a physician at which time clinical pelvimetry, Rh status, blood type, rubella titre, hemoglobin, hematocrit, VDRL and gonorrhea culture were determined. Nutrition, the avoidance of prenatal medication, and the psycho-social aspects of pregnancy were stressed more than is typically done in prenatal care, and visits usually lasted 20-30 minutes for the physician groups involving discussions with the nurse and then the doctor. For the lay midwife group, the visits were typically 30-60 minutes. Three women had no prenatal care, and first presented themselves in labor.

There was no limiting of weight gain. It was felt that every woman should gain at least 20-30 lbs. during pregnancy and the average weight gain was in the 30-35 lb range. Women with chronic medical disease were encouraged to seek a hospital, as were women who remained anemic. The threat of a hospital birth usually increased patient compliance with iron-containing preparations and, as a result, the number of women delivering at home with hemoglobins of less than 11.0 gm% was minimal (less than 1%).

Intrapartum care was essentially similar among the groups as well. The lay midwife groups did not perform breech or twin deliveries at home. The physician groups did, on occasion, although only after explaining the problems inherent in such deliveries. After 1973 the usual policy was to recommend Cesarean section to women with low breech scores (Zatuchni-Andros breech score) and to attend women with breech scores indicating safe vaginal delivery at home if the women so desired and requested. (Since the completion of this study, the lay midwives have begun attending some breech deliveries at home because of parents' dissatisfaction with the rising incidence of Cesarean section in the breech presentation.)

Labor prolongation, of itself, was not treated as a complication requiring hospitalization. Uterine inertia was initially often treated with buccal oxytocin by the physician group at home, and if results were not forthcoming, the woman was transported to the hospital for IV oxytocin. Prolongation of the second stage of labor was also not treated as a complication; indeed, most of the practitioners felt that a slower second stage with little pushing by the mother (often 2-3 hours) was *preferable* to a shorter second stage (less than 2 hours) characterized by an intense pushing effort by the mother. Cases of second stage arrest, however, if not responsive to buccal oxytocin over a 1-2 hour period, were transported to the hospital for forceps delivery. The midwives were unable to administer oxytocin and, consequently, sent more of their patients to the hospital for dystocia.

LAY MIDWIVES HAVE BEGUN ATTENDING SOME BREECH DELIVERIES AT HOME BECAUSE OF PARENTS' DISSATISFACTION WITH THE RISING INCIDENCE OF CESAREAN SECTION IN THE BREECH PRESENTATION.

Both groups monitored the fetal heart rate closely throughout the first and second stage, using a fetal stethoscope or Doppler ultrasound fetoscope, and felt that any significant drop in heart rate requiring intervention would be noticed. Blood pressures were checked approximately every 1-2 hours during labor. Fetal heart tones were checked as often as after every contraction during second stage if some variability had been noted or if the mother were pushing particularly hard, but usually were taken every 15 minutes during second stage and every 25-40 minutes during first stage, depending on the character of the labor and the fetal heart rate pattern. The fetal heart was occasionally listened to through a contraction and for some time afterwards to determine the presence of any abnormal pattern.

Meconium staining without fetal heart rate irregularities was not treated. (Meconium staining with fetal heart rate irregularities was cause for hospitalization, and the infants, with one exception, were treated with intubation and lavage.) Prolonged rupture of membranes in a term sized infant was followed, but not treated unless necessary. It was felt that if the mother did not show signs of amnionitis and had a good socioeconomic/nutrition background, that intervention was not necessary within 24 hours. If labor had not begun by 24 hours, induction in the hospital was usually undertaken.

The midwives practiced perineal massage to prevent tearing, while the physicians typically did not. This was optimally done by the mother and father for the month prior to delivery and was done by the midwife during the last half of the second stage. This was not done consistently by all parents or all midwives, but it was felt by the midwives that it helped prevent lacerations during delivery.

Forceps deliveries were not conducted at home, and no analgesia or anesthesia was administered at home. If the latter was desired, hospital transport was necessary for the woman to receive it.

The room in which the delivery occurred was kept warm and the baby was given to the mother immediately after delivery to hold and nurse, with blankets being placed around the infant to prevent heat loss. The umbilical cord was not clamped until it ceased pulsating except in Rh negative mothers, in whom it was clamped immediately after delivery. RhoGam was given to the Rh negative mothers within 48 hours. Silver nitrate was not applied routinely to the infants' eyes unless there had been a past history of gonorrhea, or one or both parents were unsure of the other. Most of the infants were fed only by breast without glucose or formula supplementation, and were fed ad lib.

Home visits were usually made each day for the first three postpartum days, and telephone contact was maintained with the couple. The infants were seen by the physicians at one week in their offices and again at four weeks. After that point, the recommendations for well child care of the American Academy of Pediatrics were observed. Midwives referred infants for newborn care after the first week to pediatricians or family physicians, and continued to follow the infants themselves for varying periods of time. All mothers had a postpartum examination from 4-6 weeks by a physician, and for the lay midwives, results of this examination were recorded in their records.

STUDY POPULATION

Hazell[8] has described the demographic characteristics of the homebirth population in the San Francisco Bay Area in a study of 300 home deliveries from the socioanthropological standpoint. Her subjects overlapped to some extent with our sample and were derived from the same subject pool--San Francisco Bay Area couples planning homebirth.

TABLE 1
HOME DELIVERY STUDY POPULATION

Contacted Home Delivery Service:	1,348	100.0%
Screened Out, Medical Dx	55	4.1%
Decided Against	147	10.9%
Attempted Home Delivery:	1,146	85.0%
Physicians	685	59.6%
Midwives	461	40.2%
Taken to Hospital:	136	11.9%
Physicians	58*	5.1%
Midwives	78*	6.8%
Completed Home Delivery	1,010	74.9%

* Patients hospitalized represented 8.5% of physicians' cases, 16.9% of midwives' cases.

In Hazell's study, 90% lived in typical American fashion, with the father gainfully employed, in a single family dwelling with one or two cars, were not members of an ethnic minority, not on welfare, and without household servants. A general characteristic of the group was described as a self awareness shown in a concern for nutrition, health foods, ecology, humanistic psychology, and a strong feeling for a natural birth process. Typically, the mother and father had both attended college, but neither had graduated. The fathers' occupations were noted to vary through the range of occupations present in the Bay Area, from auto mechanic to physician to homesteader. Only one tenth were classified as "hip," in rebellion to "normal American Values," living in a variety of alternative styles.

In our study, patients of the lay midwives tended to belong more to the counter-culture than Hazell's population. In the physician groups, more professional couples were included. A detailed socioeconomic study on one of the lay midwife groups (the Sonoma County sample) is currently being coordinated by one of us (VCH), and a psychological/developmental outcome study on a subsample of the Santa Cruz group is being analyzed by two of us (LEM and GHP).

Table 1 (p. 77) presents statistics on the selection of the study population. Only 4% of those women who requested a home delivery were screened out for medical reasons (including premature labor, toxemia, and underlying systemic disease). This low percentage would seem to indicate that women seeking home deliveries are a self-selected healthy group, probably knowledgeable about childbirth, and the importance of nutrition in pregnancy. Nine women with previous fetal deaths were included in the homebirth sample. Previous obstetrical complications (with the exception of Ceasarean section) were not used as screening criteria, since it was felt that these were, to some extent, iatrogenic.

11% of the women who considered home delivery decided against it for non-medical reasons. This was highest in the lay midwife groups and may have been related to a hesitation to deliver without physician backup. In the physician-directed services, a common reason cited for switching to a hospital birth was that Medicaid would cover only hospital deliveries.

TABLE 2
CHARACTERISTICS OF MOTHERS

	Number	Percent	Calif 1973
Mother's Age:	1,146	100.0%	100.0%
< 20	60	5.2	17.3
20-34	1,068	93.2	77.6
≥ 35	18	1.6	5.1
Parity:	1,146	100.0%	100.0%
para 0	729	63.6	43.3
para 1	237	20.7	31.0
para 2	128	11.2	13.3
para 3	34	3.0	6.0
para ≥ 4	18	1.6	6.3
Prenatal Care Begun:	1,146	100.0%	100.0%
1st trimester	707	61.7	72.8
2nd trimester	362	31.6	20.2
3rd trimester	74	6.5	4.5
none	3	0.3	2.4*

*Includes prenatal care unknown

Of the 1,146 women beginning labor at home with the intention of delivering there, 136 (11.9%) were sent to the hospital to complete their delivery for treatment of intrapartum (11%) or postpartum (0.9%) problems. 88% of the deliveries begun at home were completed there. Thus, of the initial set of women contacting the home delivery services, 75% successfully delivered at home.

Four surviving infants required hospitalization for other than phototherapy within 3 days of delivery; a fifth was born very prematurely in the hospital, and remained there for one month.

Table 2 (p. 78) presents characteristics of the mothers and compares them to California statistics for 1973.[14] Over 90% were in the optimal childbearing age of 20-34 years, the average being 24.9 years. There was a high number (64%) of primigravidae in this series, and an incidence of grand multiparity of less than 1%. Virtually all of the women were trained in childbirth classes such as Bradley or Lamaze. 1145 women attempted breastfeeding (i.e., all but 1 of the series of 1146 total) and at 6 months of age 1138 were successful (i.e., 99.4% ... These women tended to begin prenatal care later than the California 1973 sample, perhaps because they felt more knowledgeable and therefore, less of a need.

TABLE 3
CHARACTERISTICS OF PRESENTATION & DELIVERY

Presentations	1,146	100.0%
Vertex	1,125	98.2%
Brow	(3)	(0.3%)
Shoulder	(3)	(0.3%)
Breech	21	1.8%
Delivery:	1,146	100.0%
Cesarean	28	2.4%
Vaginal	1,118	97.6%
Analgesia only	(14)	(1.2%)
Anesthesia only	(3)	(0.3%)
Both	(6)	(0.5%)
None	(1,095)	(95.5%)
Oxytocin:		
1st & 2nd Stage Labor	85	7.4%
3rd Stage Labor	235	20.5%
Forceps:		
Low Forceps	11	1.0%
Mid Forceps	6	0.5%
Perineal lesions:		
Lacerations Requiring Repair	148	12.9%
Episiotomies	89	7.8%

Table 3 (above) presents statistics on the presentations and deliveries. Most of the deliveries were vertex presentations (98. ... Of the 21 breech presentations (1.8%) 10 delivered successfully, by choice, at home, while 11 were taken to the hospital. The latter were all unexpected and with lay midwives.

1% of the women studied had low forceps deliveries, 0.5% had mid forceps deliveries, and 2.4% were delivered by primary Cesarean section. The California Cesarean section rate was 9.9% in 1973. ... as the Mayo Clinic[1] found, half of the Cesarean sections are repe... then California's primary section rate would approximate 50% (or d... ble) the rate of this study.

OF THE 1,146 HOMEBIRTHS OF THIS STUDY, ONLY 8% HAD EPISIOTOMIES AND ONLY ANOTHER 13% HAD TEARS IN NEED OF REPAIR; THE LOWEST INCIDENCE OF TEARING WAS AMONG LAY MIDWIVES, ONLY 5%, WHILE IT WAS 40% AMONG THE HOMEBIRTHS ATTENDED BY PHYSICIANS.

Lacerations requiring repair were lowest (4.4% and 5.7%) in the lay midwife groups and highest (40.2%) in the physician group with the shortest experience in performing home deliveries without episiotomies. Similarly, episiotomies were much lower for the lay midwife groups than for the physician groups.

TABLE 4
INDICATIONS FOR THE 45 C-SECTIONS & FORCEPS DELIVERIES IN THE 1,146 WOMEN BEGINNING LABOR AT HOME

Indication	Number
LOW FORCEPS DELIVERY	
Protracted descent	6
Arrest of descent	2
Dysfunctional labor	1
Brow presentation with arrest of descent	1
Fetal heart drop	1
	11
MID FORCEPS DELIVERY	
Protracted descent	3
Arrest of descent	1
Dysfunctional labor	1
Fetal heart drop, occiput posterior (OP) presentation	1
	6
C-SECTIONS	
Cephalopelvic disproportion (CPD)	16
Failure to descend, OP presentation, relative CPD	6
Arrest of active dilation, fetal heart drop, cord 4x neck	1
Prolapsed cord	1
Breech with amnionitis	1
Psychotic reaction to labor	1
Acutely dropping fetal heart tones	1
Toxemia	1
	28

Analgesia and/or anesthesia were used in only 2% of the vaginal deliveries. During the first and second stage of labor, 38 women (or 3.3%) received buccal oxytocin at home, while 47 women (or 4.1%) received IV oxytocin in the hospital. Following completion of the third stage of labor, 146 mothers received oxytocics at home (given entirely by the physician group), 89 in the hospital. The mean length of first stage was 10.2 hours for primigravidae and 4.6 hours for multigravidae; second stage means were 118 and 45 minutes respectively. Table 4 (above) presents the indications for forceps deliveries and Cesarean sections in the women beginning labor at home. There were 23 C-sections for cephalopelvic disproportion, 1 for fetal distress, 1 for toxemia, 1 for amnionitis, and 1 for psychotic reaction to labor.

TABLE 5
COMPLICATIONS OF LABOR & DELIVERY
(INDIVIDUAL WOMEN MAY BE LISTED UNDER MORE THAN 1 COMPLICATION)

PRIMIGRAVIDAE (N-136/729-18.6%)

Complication	Home	Hosp	Total	Percent[1]
Intrapartum				
Dystocia[2] 1st stage	27	34	61	8.4%
Dystocia 2nd stage	10	14	[illegible]4	3.3
CPD	0	23	23	3.2
Meconium stain, only	24	3	27	3.7
FHT↓(c̄,s̄ meconium)	6	13	19	2.6
Hypertension	3	6	9	1.2
Brow presentation	1	2	3	0.4
Shoulder dystocia	1	1	2	0.3
Polyhydramnios	0	2	2	0.3
Other*	1	10	11	1.5
TOTALS	73	108	181	
Postpartum				
Hemorrhage[3]	1	3	4	0.5%
Excessive PP Bleeding[3]	11	7	18	2.5
Retained Placenta	10	4	14	1.9
Endometritis	9	2	11	1.5
PP Depression	0	4	4	0.5
TOTALS	31	20	51	

* single cases of oligohydramnios, amnionitis, toxemia, prolapsed cord, thrombophlebitis, placenta previa, placenta abruptio, dehydration, urinary tract infection, 2nd trimester bleeding, and precipitous labor.

MULTIGRAVIDAE (N-78/417-18.7%)

Complication	Home	Hosp	Total	Percent[1]
Intrapartum				
Dystocia[2] 1st stage	2	12	14	3.4%
Dystocia 2nd stage	4	9	13	3.1
Meconium stain, only	11	1	12	2.9
FHT↓(c̄,s̄ meconium)	3	4	7	1.7
Precipitous labor	7	0	7	1.7
Other†	1	2	3	0.7
TOTALS	28	28	56	
Postpartum				
Hemorrhage[3]	4	1	5	1.2%
Excessive PP Bleeding[3]	9	4	13	3.1
Retained placenta	4	4	8	1.9
Endometritis	3	1	4	1.0
PP Depression	0	1	1	0.2
TOTALS	20	11	31	

† single cases of cephalopelvic disproportion (CPD), shoulder dystocia, oligohydramnios.

1 Percent complications per 729 primigravidae, 417 multigravidae.
2 Dystocia is defined here as: prolonged or arrested 1st stage, failure to dilate, prolonged or arrested 2nd stage, failure to descend. (as per Greenhill & Fri[illegible])
3 [illegible]

TABLE 7
REASONS FOR TRANSPORTATION TO THE HOSPITAL & THERAPY APPLIED

COMPLICATION & THERAPY	M.D.'s N=58*	Midwives N=78*	Stat. Sign.†
1st Stage Complications			
No prenatal care			
Dehydration→IV Hydration	1	0	NS
Severe Toxemia→Cesarean	0	1	NS
Prolonged rupture of membranes→Induction	0	4	p 0.01
Dystocia 1st stage (excluding CPD)			
Uterine Inertia Oxytocin	7	19	p 0.001
Labor prolongation with↓FHT→ Internal monitor & Oxytocin	1	0	NS
Arrest of Dilation			
Involving↓FHT & uterine inertia→ internal monitor & oxytocin	1	0	NS
Brow presentation→Oxytocin & low forceps	1	0	NS
Arrest & Uterine Inertia→Oxytocin & low forceps	0	2	NS
Arrest→CPD, Cesarean	10	7	NS
Arrest→FHT, nuchal cord x4, C-sec	1	0	NS
Hypertension→			
Rx'ed with magnesium sulfate	1	0	NS
Untreated	5	0	NS
Bleeding during labor→No treatment	1	0	NS
Amnionitis→Antibiotics	1	0	NS
Fear, Desire for hospital	2	6	p 0.05
Desire for anesthesia→			
Anesthesia given	3	0	NS
Analgesia only	1	0	NS
Hyperemesis→IV's and compazine	1	0	NS
Dropping FHT's			
No therapy, monitor applied	0	4	p 0.001
Cesarean section	0	1	NS
Cord prolapse→Cesarean	0	1	NS
With meconium→Intubation	0	3	p 0.025
Psychotic reaction to labor→Cesarean	0	1	NS

* sums of complications
† based on total N's (685 & 461 respectively)

TABLE 7 CONT'D
REASONS FOR TRANSPORTATION TO THE HOSPITAL & THERAPY APPLIED

COMPLICATION & THERAPY	M.D.'s N=58*	Midwives N=78*	Stat. Sign.†
2nd State Complications			
Protracted descent→			
Rx'ed with low forceps (1 FHT↓)	4	2	NS
Rx'ed with mid forceps with FHT↓	2	1	NS
Rx'ed with oxytocin	5	9	NS
Arrest			
CPD→Cesarean section	4	2	NS
Abnormal presentation→Mid forceps	1	1	NS
Brow presentation→Low forceps	0	1	NS
Dropping FHT's			
Low forceps	1	0	NS
With meconium→Oxytocin, Intubation	0	2	NS
Mid forceps	1	0	NS
Bleeding→Oxytocin	0	1	NS
3rd Stage Complications			
Retained placenta→Manual removal	2	5	p<0.05
Hemorrhage→Oxytocin, methergine, blood	1	4	p<0.025
Cervical laceration→Suturing	0	1	NS

* sums of complications
† based on total N's (685 & 461 respectively)

PERINATAL OUTCOME

Six sets of twins were successfully delivered at home, bringing the total number of births to 1,152. There was no maternal mortality or residual morbidity. Infant morbidity is summarized in Table 8 (p. 86).

Fifteen infants, including two sets of twins, weighed less than 2501 grams at birth. Eleven of these were over 2250 grams. Fourteen of the low birthweight infants were born at home.

One 1332 gram infant was born in the hospital following second trimester bleeding and remained there for a month. Two of the smaller babies weighing 1700 and 2200 grams were admited to the hospital with mild respiratory distress syndrome. All the low birth weight babies survived without other postnatal complications than those mentioned above.

TABLE 11
CHARACTERISTICS OF MOTHERS

	Home		Hosp		Calif. 1973	Stat. Sign.
	Number	Percent	Number	Percent		
Mother's Age	1145*	100.0%	180	100.0%	100.0%	NS
<20	60	5.2	12	6.7	17.3	NS
20-34	1062	93.2	160	89.9	77.6	NS
≥35	18	1.6	6	3.4	5.1	NS
Parity	1145	100.0%	180	100.0%	100.0%	
para 0	729	63.6	133	73.9	43.3	p<.005
para 1	237	20.7	33	18.3	31.0	NS
para 2	128	11.2	9	5.0	13.3	p<.025
para 3	34	3.0	2	1.1	6.0	NS
para 4	18	1.6	1	0.6	6.3	NS
Prentl Care Began	1146	100.0%	180	100.0%	100.0%	
1st Trimester	707	61.7	114	64.0	72.8	NS
2nd Trimester	362	31.6	63	35.4	20.2	NS
3rd Trimester	74	6.5	1	0.6	4.5	**
None	3	0.3	0	0.0	2.4†	NS

* For home group: Mean age=2[illegible], Range=16-44, Varience=16.8, SD=4.1
† Includes prenatal care unknown.

Virtually all of the women in the planned hospital group were trained in childbirth classes (as were the home group) such as Bradley or Lamaze. A high incidence of breastfeeding also characterized the planned hospital group. All women in the planned hospital group attempted breastfeeding except for one. For a variety of reasons, two of these women were not successful.

RESULTS

Statistics on the presentations and deliveries are compared in Table 12 (p. 91). The planned hospital group contained more breech infants, had more Cesarean deliveries, had more analgesia, received more oxytocin during first, second, and after third stage labor, and had more low and mid forceps deliveries and episiotomies. It is important to note that their attendants had the same philosopies as the home delivery attendants, so that these differences come as a result of being in the hospital and may relate to a lower motivation for the women to have natural childbirth or to a more readily available analgesia or to a feeling of pressure transmitted to the birth attendents to intervene sooner and more aggressively in the hospital than in the home. These may all be related to the subtle effects of "atmosphere" which are, as yet, difficult to measure. The indications given for forceps and Cesarean deliveries are compared in Table 13 (p. 92). The planned hospital group had more Cesarean sections, primarily related to CPD and have more low forceps deliveries, significantly more because of a falling fetal heart rate.

TABLE 12
CHARACTERISTICS OF PRESENTATION & DELIVERY

	Home		Hosp		Statis. Signif.
	Number	Percent	Number	Percent	
Presentation	1145	100.0%	178	100.0%	
Vertex	1125	98.2	167	93.8	p<0.005
Brow	3	(0.3)	0	0.0	**
Shoulder	3	(0.3)	1	0.6	**
Breech	21	1.8	9	5.1	p<0.010
Delivery	1146	100.0%	178	100.0%	
Cesarean	28	2.4	10	5.6	p<0.025
Vaginal	1118	97.6	168	94.4	p<0.025
Analgesia only	14	(1.2)	9	(5.0)	p<0.025
Anesthesia only	3	(0.3)	3	(1.7)	**
Both	6	(0.5)	1	(0.6)	**
None	1095	(95.5)	154	(86.5)	p<0.001
Oxytocin					
1st & 2nd stage	85	7.4	29	15.3	p<0.001
3rd stage labor	235	20.5	54	30.3	p<0.005
Forceps					
Low forceps	11	1.0	7	3.9	p<0.001
Mid forceps	6	0.5	2	1.1	p<0.001
Perineal Lesions					
Laceratns req. repair	148	12.9	26	15.6	NS
Episiotomies	89	7.8	42	25.1	p<0.001

Table 14 (p. 93) presents the comparison complication figures for the planned hospital population, and compares these results with those obtained by the population delivering at home. The planned hospital group showed significantly more second stage labor dystocia ($p<0.025$), more drops of the fetal heart rate ($p<0.005$), more postpartum hemorrhage ($p<0.001$) and less "excessive bleeding" (defined as less than 650 cc's but more than the attendant is comfortable with) postpartum ($p<0.001$). The planned hospital population had significantly more forceps deliveries ($p<0.001$), episiotomies ($p<0.001$), Cesarean sections ($p<0.025$), and analgesia ($p<0.001$), and significantly less total unmedicated deliveries ($p<0.001$)

RELATIVE PERINATAL OUTCOME

Table 15 (p. 94) compares the perinatal outcome data. The neonatal mortality and perinatal mortality results were not significantly different between the planned hospital group and the home delivery group, nor was the rate of low birthweight infants, or the mean length of infant follow-up. The hospital neonatal death rate was 5.5 per 1000 with 11.1 perinatal deaths per 1000.

TABLE 13
INDICATIONS FOR C-SECTIONS AND FORCEPS DELIVERIES
IN WOMEN BEGINNING LABOR AT HOME

	Home Number	Hosp Number
Low Forceps Delivery		
Protracted descent	6	0
Arrest of descent	2	3
Dysfunctional labor	1	0
Brow presentation with arrest of descent	1	0
Fetal heart drop	1	3
Bleeding during 2nd stage	0	1
	11	7
Mid Forceps Delivery		
Protracted descent	3	0
Arrest of descent	1	1
Dysfunctional labor	1	0
Fetal heart drop, occiput posterior (OP) pres.	1	0
FHT↓, amnionitis, maternal hypertension	0	1
	6	2
C-Sections		
Cephalopelvic disproportion (CPD)	16	7
Failure to descent, OP presentation, rel. CPD	6	0
Arrest of active dilation, FHT↓, cord 4x neck	1	0
Prolapsed cord	1	(1)
Breech with amnionitis	1	0
Psychotic reaction to labor	1	0
Acutely dropping fetal heart tones	1	0
Toxemia	1	0
Breech with low breech score, poor labor progress	0	1
Transverse lie with one prolapsed cord	(1)	2
	28	10

TABLE 14
COMPLICATIONS OF LABOR C DELIVERY (HOSPITAL GROUP)
(INDIVIDUAL WOMEN MAY BE LISTED UNDER MORE THAN 1 COMPLICATION)

PRIMIGRAVIDAE (N=52/133=39.1%)

Complication	Hosp	Percent	Statis. Sign.[1]†
Intrapartum			
Dystocia[2] 1st stage	15	11.3	NS
Dystocia 2nd stage	10	7.5	$p<0.025$
CPD	7	5.3	NS
Meconium stain only	4	3.0	NS
FHT↓(c̄, s̄ meconium)	10	7.5	$p<0.005$
Hypertension	2	1.5	NS
Precipitous labor	2	1.5	NS
Other*	6	4.5	--
TOTAL	56		
Postpartum			
Hemorrhage[3]	5	3.8	$p<0.001$
Excessive PP bleeding[3]	2	1.5	$p<0.001$
Retained placenta	2	1.5	NS
Endometritus	3	2.3	NS
PP Depression	1	0.8	NS
TOTAL	13		

MULTIGRAVIDAE (N=10/45=22.2%)

Complication	Hosp	Percent	Statis. Sign.[1]†
Intrapartum			
Dystocia[2] 1st stage	2	4.4	NS
Dystocia 2nd stage	1	2.2	NS
CPD with breech	1	2.2	--
Precipitous labor	2	4.4	NS
FHT↓	1	2.2	NS
Hypertension	1	2.2	--
Transverse lie	1	2.2	--
TOTAL	9		
Postpartum			
Hemorrhage[3]	0	[illegible]	NS
Excessive PP bleeding[3]	1	2.2	NS
Retained placenta	1	2.2	NS
Endometritis	1	2.2	NS
TOTAL	3		

* single cases of amnionitis, shoulder presentation, cord prolapse, cord knot, recurrent pyelonephritis, transverse lie.
† compared with Table 5 on page 81.

1 Percent of complications per 133 primigravidae, 45 multigravidae.
2 Dystocia as used in this table is defined as prolonged or arrested 1st stage, failure to [illegible] or arrested 2nd stage [illegible]

TABLE 15
COMPARATIVE PERINATAL OUTCOME

	Home Number	Home Rate	Hosp Number	Hosp Rate	Calif. 1973	Stat. Sign.
Total Births	1152*		180†			
Live Births	1147*		180†			
Fetal Deaths	5	4.3α	1	5.5α	8.2α,γ	NS
Neonatal Deaths	6	5.2β	1	5.5β	12.3β	NS
Total Perinatal Deaths	11	9.5γ	2	11.1α	20.3α	NS
Low Birthweight (<2501 g)	15	1.3β	3	1.7β	5.3β,γ	NS
Mean Length of Infant Follow-up	11.5 mos.		11.6 mos.			NS
S.D. Length of Follow-up	10.3 mos.		10.4 mos			NS
% Infants Followed to 6 mos.	83.4%		81.2%			NS

* Includes 6 sets of twins.
† Includes 2 sets of twins.

α 1 per 1000 total births
β 1 per 1000 live births
γ for white, non-Spanish surname, age 20-29

Table 16 (p. 95) presents infant morbidity for the hospital group. Table 17 (pp. 96-97) compares neonatal complications. The planned hospital group had significantly more fetal hypoxia ($p<0.025$) and significantly more 1 minute Apgar scores less than 4 ($p<0.025$). Among the homebirth series, the midwives had more infants who received phototherapy for jaundice than did the physicians ($p<0.025$). Causes of fetal deaths are compared in Table 18 (p. 98).

The prematurity rate for the population initially seeking assistance from one of the services studied was 3.0%. For the planned hospital population it was 2.8%. There was no significant differences between 1 minute Apgar scores ranging from 4-6 between the homebirth group and the planned hospital group with 40 & 7 such ratings, respectively. Average Apgar scores for the planned hospital group were 8.6 a at 1 minute and 9.7 which were not significantly different from the homebirth group.

There was no association among the hospital group either between length of labor and length of second stage of incidence of low Apgar scores at birth or other complications.

TABLE 16
INFANT MORBIDITY OF PLANNED HOSPITAL GROUP*

Complication	Number	Rate per 1,000 LB	Delivery	Complications	Outcome
Low Birthweight	3	16.6	Hosp		
Case one	1		Hosp	FHT↓ prior to del.	neonatal sepsis and amnionitis
Case two	1		Hosp	None	mild RDS
Case three	1		Hosp	None	mild RDS
Hyperviscosity syndrome	1	5.5	Hosp	None	resolved

* To compare these data with the homebirth group, see Table 8, p. 86.

The mean length of 1st stage labor among the group planning hospital birth was 12.5 hrs for primigravidae and 5.4 hrs for multigravidae. For the home group it was 10.2 hrs and 4.6 hrs respectively. The standard deviations were 2.6 and 1.3 hrs, respectively, for planned hospital group and 1.9 and 1.2 hrs, respectively, for planned home group. This difference was significant at $p<0.05$.

The mean length of 2nd stage labor for the planned hospital primigravidae was 106.8 min ± 31.0 min and for multigravidae was 50.1 min ± 28.3 min. For the home series, the mean length of 2nd stage was 118.2 min ± 40.5 min for primigravidae and 44.6 min ± 23.7 min for multigravidae. The primigravidae differences were significant at $p<0.05$. Multigravidae were not comparable for parity and could not be compared.

There were 14 cases of prolonged rupture of membranes in the homebirth series and 11 in the planned hospital series ($p<0.01$). There were no infections of the infants except for one low birthweight infant whose mother developed amnionitis. She was in the planned hospital series.

TABLE 17
COMPARATIVE NEONATAL OUTCOMES

COMPLICATIONS	HOME PRIMIGRAVIDAE N=729				STATIS. SIGNIF.[1]
	M.D.'s N=464		Midwives N=265		
	Home	To Hosp	Home	To Hosp	
Jaundice Req. Rx	1	5	2	9	p<0.[illegible]
Fetal Hypoxia	2	0	0	0	NS
Neurological Abnormalities[2,3]	2	1	0	1	NS
Cerebral Palsy	1	0	0	1	NS
Neonatal FTT	1	1	0	1	NS
Apgar (1 min.)					
Score < 4	3	0	1	1	NS
Score = 4-6	12	7	5	3	NS

COMPLICATIONS	HOME MULTIGRAVIDAE N=417				STATIS. SIGNIF.[1]
	M.D.'s N=221		Midwives N=195		
	Home	To Hosp	Home	To Hosp	
Jaundice Req. Rx	2	1	0	1	NS
Fetal Hypoxia	0	1	0	0	NS
Neurological Abnormalities[2,3]	0	0	0	1	NS
Cerebral Palsey	0	0	0	0	NS
Neonatal FTT	0	0	0	0	NS
Apgar (1 min.)					
Score < 4	0	1	0	1	NS
Score = 4-6	2	4	2	5	NS

COMPLICATIONS	HOME TOTAL N=1146				STATIS. SIGNIF.[1]
	M.D.'s N=685		Midwives N=461		
	Home	To Hosp	Home	To Hosp	
Jaundice Req. Rx	3	6	2	10	p<0.025
Fetal Hypoxia	2	1	0	0	NS
Neurological Abnormalities[2,3]	2	1	0	2	NS
Cerebral Palsey	1	0	0	1	NS
Neonatal FTT	1	1	0	1	NS
Apgar (1 min.)					
Score < 4	3	1	1	2	NS
Score = 4-6	14	11	7	8	NS

Cont'd on next page

TABLE 17 CONT'D
COMPARATIVE NEONATAL OUTCOMES

COMPLICATIONS	PLANNED	STATIS. SIGNIF.[1]
Jaundice Req. Rx	3	NS
Fetal Hypoxia	3	p<0.025
Neurological Abnormalities[2,3]	0	NS
Cerebral Palsy	0	NS
Neonatal FTT	1	NS
Apgar (1 min.)		
Score < 4	6	p<0.025
Score = 4-6	7	NS

1 Calculated on the basis of home & hospital
2 Includes cerebral palsied infants
3 Development at 1 year follow-up

CONCLUSION

In conclusion, the home delivery group of women were a self-selected group screened for obvious problems and complications occurring during pregnancy, while the hospital group is a similarly selected group who would have been eligible for a home delivery had they decided to have one. While the home delivery outcomes are not directly comparable to State statistics, their outcomes are better than average and lower than might have been expected. Behrman et al.[2] have studied 39,000 white middle-class women in Oregon receiving prenatal care from private physicians and found a neonatal mortality rate of 12 per 1000 live births and a perinatal mortality rate of 17 per 1000 total births. Interestingly enough, if one eliminates premature infants from Behrman's series, the neonatal death rate was 3.5 per 1000 and the perinatal death rate was 7.5 per 1000 which is not statistically significantly different from the home delivery series of this report (cf. Table 15, p. 94).

Another often asked question is that of the need for routine fetal monitoring. Chan et al.[4] have studied the role of fetal monitoring in reducing intrapartum deaths and in a study in which patients were randomly assigned to fetal monitoring, there was no statistically significant difference between the monitored group and the non-monitored group. Also important is that Chan's study revealed an intrapartum death rate of 1.7 per 1000 in his 1162 monitored patients. This is not statistically significantly different from the intrapartum death rate of 0.95 per 1000 in our series of 1146 home deliveries. In another study, Shenker et al.[13] reported a 0.5 per 1000 intrapartum death rate in monitored patients. This is not statistically significantly different from our series either.

TABLE 13

CAUSES OF PERINATAL DEATH IN PLANNED HOSPITAL GROUP*

Age At Death	Number	Delivery	Complications	Cause of Death
During labor	1	Hosp	Rapidly + FHT	Meningoencephalitis, etiology unknown
8 days	1	Hosp	None	Aplastic left ventricle

* To compare these data with the homebirth group, see Table 10, p. 89.

Shenker et al.[13] did, however, show a significant decrease in intrapartum deaths in the monitored series versus the unmonitored series in Bellevue Hospital in New York City. Clearly, the nursing care in Bellevue Hospital is not adequate, which brings us to recent studies from the West Coast showing an equivalent success rate of nurses versus fetal monitor, but with less infections reported with the nurses. It is not hard to imagine which was the more supportive personal care.

Other important points can be made. The perineal massage technique used by the midwives to aid in preventing vaginal lacerations during delivery was effective, and, as the physicians adopted this technique, their laceration rate decreased. The higher utilization of oxytocin after delivery by the physicians may have reflected its availability to them and their training to use it frequently. The equivalence of hemorrhage and blood loss results between the physician and midwife group suggests that it was not needed as frequently as used. The lay midwives took women to the hospital more frequently than the physicians, presumably reflecting their decreased capabilities to handle specific complications at home and their lower threshold level for going to the hospital possibly related to a lower level of knowledge. The physicians were able to treat some of their cases of uterine inertia with buccal oxytocin at home, and removed several retained placenta at home, as well as carrying oxytocin and methergine to treat third stage bleeding at home. The greater number of FHT problems brought to the hospital by the midwives may reflect their greater level of anxiety in dealing with and desire for transporting abnormal situations to the hospital early.

Comparisons with the planned hospital group suggests that for women delivering at home with the philosophies and practices of this particular group of practitioners, there was no significant increase in risk with a home delivery versus a hospital delivery. In fact, by avoidance of obstetrical medication, such as was used more frequently in the hospital by equivalently prepared women (presumably because of the effect of the hospital atmosphere on the encouragement for obstetrical medication), the incidence of low Apgar scores was less at home as was the incidence of fetal hypoxia.

The greater use of analgesia in labor by the planned hospital group may have also contributed to their greater incidence of second stage dystocia and greater incidence of fetal heart-rate drops. The breech infants did not contribute to these problems. The incidence of postpartum hemorrhage was greater in the planned hospital group and may represent the greater tendency to pull on the umbilical cord to aid in the delivery of the placenta. At home, the umbilical cord was rarely pulled to aid placental delivery, but rather, the natural expulsive forces of the uterus were relied upon. This is substantiated by the longer third stages seen in the home group. The contribution of other factors such as lower stress in the home environment, alternative delivery positions, and the like cannot be assessed in a study such as this, but may be significant.

Of note, as well, are the close similarity of these findings to the home delivery statistics in the Netherlands (personal communication, Jan Kloosterman, MD, University of Amsterdam) and to home delivery statistics compiled by Gregory White, MD,[15] in Chicago, and by Victor Berman, MD,[3] in Los Angeles.

Generally, the response of physicians to home delivery has been negative. Many view homebirth as an irresponsible risk to mother and child. They do not encourage or attend home deliveries, and many have refused to give prenatal care, advice, or instruction to couples planning homebirth. A dichotomy exists in obstetrics today between the technological trend represented by high risk obstetric units with fetal monitoring and readily available medical and surgical intervention, and the family-centered, natural childbirth trend represented in its extreme by couples planning home delivery *without medical support*. We feel that reducing the antagonism between these divergent poles would enhance care for women choosing hospital as well as home deliveries.

More studies of this kind are needed before any conclusions can be drawn. We are currently engaged in a study in which we are attempting to match a comparison hospital group. However, evidence from this study population already strongly suggests that home delivery is a safe alternative for medically screened healthy women; they deserve adequate care for the delivery of their choice. This would include prenatal care by a physician, childbirth education, and only necessary intervention by attendants. Hospitals should be encouraged to adopt those techniques of homebirth that improve pregnancy outcome, which might include perineal massage and gentle head delivery to avoid episiotomies and lacerations, choice of the use of analgesia and anesthesia, and generally provide a supportive, friendly, and comfortable environment for labor and delivery.

Finally, what these statistics have missed is the importance of the spiritual and the emotional aspects of birth. Someday, perhaps, we will be able to empirically validate what our feelings tell us is true.

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child care of the American Academy of Pediatrics were observed. Midwives referred infants for newborn care after the first week to pediatricians or family physicians, and continued to follow the infants themselves for varying periods of time. All mothers had a postpartum examination from 4-6 weeks by a physician, and for the lay midwives, results of this examination were recorded in their records.

STUDY POPULATION

Hazell[8] has described the demographic characteristics of the homebirth population in the San Francisco Bay Area in a study of 300 home deliveries from the socioanthropological standpoint. Her subjects overlapped to some extent with our sample and were derived from the same subject pool--San Francisco Bay Area couples planning homebirth.

TABLE 1

HOME DELIVERY STUDY POPULATION

Contacted Home Delivery Service:	1,345	100.0%
Screened Out, Medical Dx	55	4.1%
Decided Against	147	10.9%
Attempted Home Delivery:	1,145	85.0%
Physicians	635	[illegible]
Midwives	451	40.2%
Taken to Hospital:	135	11.9%
Physicians	59*	5.1%
Midwives	75*	6.3%
Completed Home Delivery	1,010	74.9%

* Patients hospitalized represented 8.5% of physicians' cases, 16.9% of midwives' cases.

In Hazell's study, 50% lived in typical American fashion, with the father gainfully employed, in a single family dwelling with one or two cars, were not members of an ethnic minority, not on welfare, and without household servants. A general characteristic of the group was described as a self awareness shown in a concern for nutrition, health foods, ecology, humanistic psychology, and a strong feeling for a natural birth process. Typically, the mother and father had both attended college, but neither had graduated. The fathers' occupations were noted to vary through the range of occupations present in the Bay Area, from auto mechanic to physician to homesteader. Only one tenth were classified as "hip," in rebellion to "normal American Values," living in a variety of alternative styles.

In our study, patients of the lay midwives tended to belong more to the counter-culture than Hazell's population. In the physician groups, more professional couples were included. A detailed socioeconomic study on one of the lay midwife groups (the Sonoma County sample) is currently being coordinated by one of us (WEH), and a psychological/developmental outcome study on a subsample of the Santa Cruz group is being analyzed by two of us (LEM and GHP).

3:15 UP FROM BLACK

Senator PARR'S INTRO: (2-5 min)

Fairbanks (35 min)

MSG 82-00016633 PRTY 1 03/25/82 10:46:02 ORIG: LF01 IN= 0003 OUT= 0026
FROM: DEBBIE/FBX TO: LINDA/JUNEAU
TARGET: LJH2 SUBJ: VIDEO PARTICIPANT LIST FINAL PAGE 0001

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1. VICKI PENWELL PRO —
2. LIZ GOLLOGLY CON — lay mid,
3. ENID GEIST PRO
4. DR. JEAN WILBUR CON
5. LOIS DE RAADT PRO
6. JENNIFER GLEASON CON
7. CATHY REIMHERR PRO — able to help in emergency
8. ELAINE MC KENZIE CON
9. DIANE FULLER PRO — no kids, has attended home births
10. EILEEN MONTANO CON
11. PAT FRITSCH PRO — dr may refuse pre-natal care
12. JANICE CONGER PRO —
13. WENDY HOGAN PRO —
14. KATHIE GETTINGER PRO — 2 kids, next one due, will be at home
15. TODD FARIS PRO
16. DOROTHY WOOL PRO
17. COLLEEN MORKAL PRO

SITKA TESTIMONY (35 min)

MSG 82-00016565 PRTY 1 03/25/82 08:47:27 ORIG: LS00 IN= 0001 OUT= 0006
FROM: ELAINE TO: LINDA
TARGET: LJH2 SUBJ: MIDWIFE T.C. SITKA LIST-CORRECTED PAGE 0001

LINDA, HERE IS MY "FINAL" LIST NOW, AS I UNDERSTAND IT. I HAVE CHANGED TWO NAMES AND CORRECTED ONE WHICH YOUR LIST YESTERDAY REFLECTED AS "CON". THE CHANGES ARE **:

1. DR. SUSAN CARLSON, CON — pediatrician -
2. CAROLYN EVANS, PRO —
3. **DR. EDWARD SPENCER, CON
4. BETH COX, PRO
5. JEAN FRANK, CON — RN — fiscally irresponsible. Bd not qual. Need good med
6. KATHY HENDERSON, PRO
7. **DR. RODNEY VAUGHT, CON — advocate of unborn child,
8. **MARY CLAYTON PEARCE, PRO (ADDING MIDDLE NAME PER REQUEST) RN, experienced
9. **TED PALMER, PRO (YOU HAD HIM LISTED "CON) —
10. CARLENE STOKES, PRO —
11. KATHY GODDARD, PRO
12. ANN LOWE, PRO — need more work on bill NOTE, TWO PEOPLE DROPPED YESTERDAY ARE DELETED

Pat Kehoe - RN - pro. but need for more training

Ø ANCHORAGE (45 min)

MSG 82-00016630 PRTY 1 03/25/82 10:39:05 ORIG: LA08 IN= 0001 OUT= 0023
FROM: MICKI IN ANCHORAGE TO: LINDA IN JUNEAU
TARGET: LJH2 SUBJ: NEW PARTICIPANTS FOR VIDEO PAGE 0001

IN ANCHORAGE WE WILL HAVE

1. SUSAN PECK, PRO — child w/ midwife. consumer protection. midwife more than baby-catcher
2. DR. DOUG SMITH, CON — AMA legch, council against
3. CHRIS RUSHING, PRO — Drs & RN's not able to meet needs, not treated as in other illnesses
4. DR. JACK JACOB CON — dir AK new born project. legitimizes obstetrics who are untrained — OK if trained. Europe experience
5. TIGER OR MARY KEOUGH PRO — family centred experience
6. DR. MARIAN WITT CON — 45 pediatrician.
7. DR. PATTON PETTYJOHN PRO — screen beforehand, prepare, trained birth attendant. Center Disease Control, Atlanta — mortality rate. Need more tng in bill
8. KAY LAHDENPERA CON — AK Nurses Assn — against — need distinguish nurse midwives from lay midwives — no backup. 7 nurse midwives — 3 in govt practice

MSG 82-00016630 PRTY 1 . 03/25/82 10:39:05 ORIG: LA08 IN= 0001 OUT= 0023
FROM: MICKI IN ANCHORAGE TO: LINDA IN JUNEAU
TARGET: LJH2 SUBJ: NEW PARTICIPANTS FOR VIDEO PAGE 0002

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9. SHERRI HOLLEY PRO — only 1 of 12 labs will do pre-natal work. Drs charge 2-3 as much for pre-natal care for home birth couples
10. PAULA KORN NURSE-MIDWIFECON
11. CLAY NEWMAN PRO 3 children (1 hosp, 2 home)
12. AL RUSHING PRO
13. JULIE GORHAM PRO sought lay midwife, couldn't find list. Drs arrogant. Home birth safe if properly handled.

ALTERNATE

14. LESLIE BRECHE PRO — home birth. No obstetrician on call at Providence
15. ZELDA COLLETTE-PAULE PRO lay midwife. some drs refuse see woman planning home birth, lab work

WE ARE HOPING TO HAVE ALL 15 SPEAK

Karen Malone — 1 child (hosp), 1 on way (midwife)
Michael ~~Callahan~~ O'Callaghan — 3 children at home, Carter first pres born in hosp religious + personal experience
Karen Redstone — pro one child hosp, unsatisfactory, 2d child hosp, third will be at home.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

March 9, 1981

MEMORANDUM

TO: Representative Mike Beirne

FROM: Betty Barton
Research Staff

RE: Alaskan Abortion Data Trends
Research Request No. 81-54

This memorandum responds to your request for data on abortions performed in Alaska within the past 3 to 5 years. To respond to this request, we have contacted staff from the State Department of Health and Social Services, the Commission on the Status of Women, and Planned Parenthood. In addition, we have contacted representatives of Bartlett Memorial Hospital, which is one of the hospitals in the state where abortions are currently performed. In the course of our research, we have learned that the data you are seeking appear to be unavailable on a statewide basis.

The Department of Health and Social Services (DHSS) compiles data regarding the incidence and nature of abortions conducted in Alaska. However, the data are submitted solely on a voluntary basis. The Department receives its information from hospital providers who submit abortion reports on a form devised by DHSS; private practitioners do not usually provide the Department with data. Because of this, the data are not regarded by DHSS staff as an accurate measure of abortion trends in Alaska. Consequently, the data have been omitted from the Department's report, Alaska Vital Statistics since 1978, and according to Department staff, some thought is being given to discontinuing the abortion reports altogether.

In the event that you have not seen them, we are enclosing a copy of the Abortion Profile 1970-1977 and excerpted materials from the 1977 issue of Alaska Vital Statistics, the most recent report that included the abortion data.

If you would like us to attempt to obtain more up-to-date information for selected regions of the state, we could undertake some additional research. The additional research could include:

- contacting Anchorage-based private physicians, who are known to perform abortions, to determine the size and nature of their caseloads. As I am sure you are aware, the majority of the abortions taking place in Alaska are performed in Anchorage, and, consequently, this data could provide a fairly significant sample of statewide patterns. However, there is some indication that these practitioners may hesitate to provide us with the information due to the sensitive nature of this topic.

- contacting all hospitals within the state where abortions are performed. It is unclear whether abortion data of hospital agencies would be accessible. In my conversation with records personnel from Bartlett Memorial Hospital, I learned that no separate records regarding abortions are maintained, which means that data retrieval would entail sorting through annual records. The Bartlett spokesperson added that they would be hesitant to provide any data beyond the total number of abortions performed due to potential privacy act infractions. The staff person added that this policy might be modified if the hospital could receive justification for the release of more detailed information.

- contacting Planned Parenthood to determine the number of abortion referrals made in the Anchorage area. Staff at Planned Parenthood, which has recently opened a medical referral clinic, informed me that they would be able to compile data regarding the nature and number of abortion referrals that have been made by staff at the clinic within the past year. This data, of course, would not reflect the number of women who actually pursued this course of action nor would it include the number of individuals who have obtained referrals from other agencies. Nonetheless, Planned Parenthood does capture a significant proportion of the population seeking information regarding abortions, which perhaps would be useful information for you.

It is unlikely that any of the above options or combination of options would provide you with comprehensive statewide information. However, if you would like us to explore any of these options, please contact us. In the meantime, we hope that you find the enclosed materials helpful.

BB/bf

Encls.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

December 28, 1981

MEMORANDUM

TO: Representative Fred Zharoff

FROM: Jonathan Sherwood
Research Staff

RE: Cost-of-Living Differences in Alaskan Communities
Research Request No. 81-145

Richard Osterman of your office requested that we provide information regarding the differences in the cost-of-living among Alaskan communities. He indicated that the focus should be on a minimun standard of living, e.g. food and rent. Although no current estimates of comprehensive cost-of-living differences are available, we have provided recent estimates of costs of food and housing for Alaskan communities.

FOOD COSTS

A price index for food costs in Alaskan communities is published on a quarterly basis by the University of Alaska Cooperative Extension Service (CES). This index compares the cost of one week's food for a family of four with two children in elementary school. The food items and their quantities are based on the U.S. Department of Agriculture's Low Cost Food Plan, which estimates consumption levels for a diet that fulfills minimum nutritional requirements.

The CES receives no funding for this program; the information is gathered by volunteers in each community. Unfortunately, the volunteers receive no training to assure data is gathered in a consistent manner. Therefore, the data may be somewhat distorted.

The U.S.D.A. plan is not intended to reflect the consumption habits of the Alaskan consumer but is used to allow comparisons with national averages, which are based on the same list of items. Variation between communities in Alaska is probably very great, given the limited selection of goods and the significance of fish and games taken to meet subsistence needs in some communities.

According to Marguerite Stetson, who compiles the information for CES, the U.S.D.A. Low Cost Food Plan is about twenty years old and may not reflect the current buying habits of any contemporary consumer very

well. For instance, soft drinks are not included on the list of items priced.

Table I shows the cost of one week's food and the percent of Anchorage cost for selected Alaskan communities for September 1981. Sitka has the lowest food costs, and Barrow the highest, with a range of 122%.

TABLE I
Cost Of Food At Home For a Week For a
Family of 4 with Elementary School Children

	September 1981	% of Anchorage
Anchorage	$ 86.69	100
Barrow	160.05	220
Cordova	135.39	185
Delta	111.62	129
Fairbanks	98.47	114
Juneau	93.95	108
Kotzebue	152.54	176
Nome	150.27	173
Petersburg	95.17	110
Sitka	84.63	98
Tok	114.80	132
Unalakleet	174.42	201
Valdez	106.68	123

Source: Cooperative Extension Service, University of Alaska and U.S. Department of Agriculture cooperating.

HOUSING

The U.S. Department of Housing and Urban Development provides estimates for the construction costs of low income housing for thirteen locations in Alaska. These estimates do not include property costs or site preparations; however, they do serve to show the relative construction cost differences in comparable locations. The HUD data in Table II show that construction costs are almost twice as high in remote locations as they are in Southeastern and along the Railbelt.

Al Robinson, an economist with the Anchorage HUD office, felt that the estimates, made by the Washington D.C. offices, were very low. According to Mr. Robinson, the maximun funding limit of $92,200 per unit is required for almost all HUD projects in Alaska. Most projects are for units comparable to those assumed for the table. Mr. Robinson mentioned that the Alaska office is just beginning a survey of construction costs throughout Alaska to use as evidence to obtain approval from Washington to raise the funding limit.

TABLE II
HUD Prototype Cost For Low Income Public Housing
June 1981

Location	Cost for Two Bedroom Detached House	% of Anchorage
Anchorage	$44,000	100%
Fairbanks	46,700	106
Juneau	42,400	96
Ketchikan	42,300	96
Sitka	42,450	96
Kenai	48,200	110
Yakutat	48,200	110
Ft. Yukon	67,500	153
Galena	72,500	165
Coastal (N. of Aleutians)	81,750	186
Tok	62,650	142
North Coast	84,100	191
Mainland (N. of Aleutians)	93,500	213

Source: Federal Register, June 29, 1981. Percentages computed by House Research Agency.

HUD also provides estimates of rents for newly built homes in six Alaska locations, as shown in Table III. Lee Huskey, an economist with the Institute of Social and Economic Research expressed some skepticism of the actual costs given, but felt that the relative differences were probably fairly accurate.

TABLE III
Fair Market Rents For New Construction
1980

Location	Cost For Two Bedroom Detached Housing	% of Anchorage
Anchorage	$643	100%
Fairbanks	633	98
Juneau	670	104
Ketchikan	584	91
Western Coast	947	147

Source: Federal Register, August 29, 1980. Percentages computed by House Research Agency.

The most recent information on comprehensive cost-of-living differences among Alaskan communities is Alaska Interregional Cost Differentials, a study by the University of Alaska Center for Northern Educational Research published in 1977. The study compares the cost of food, housing, transportation, and personal care in 31 communities and 21 Regional Education Attendance Areas for 1976.

The study was made during the height of pipeline construction activity; some communities had inflated prices resulting from heightened demand. Cost-of-living differences for this period may reflect a situation untypical of more recent years. In addition, the study based its housing cost estimates on a State survey which had canvassed a disproportionate number of State employees, as the survey was to be used to adjust State salaries.

The Division of Personnel conducted surveys of food and housing expenditures in 1972 and 1976. The former study served as the basis for regional differential in the State salary schedule. The Director of the Division of Personnel of the State of Alaska is empowered by AS 39.27.030-.040 and AS 44.31.020 to require the Department of Labor to gather data reflecting cost-of-living differences among election districts for use in their annual salary survey, but he has not done so in the ten years the law has been in effect.

We regret we are unable to provide more complete, up-to-date cost-of-living information, but to our knowledge, no State agency has compiled such information. If you have any questions, or if we can be of further assistance, please do not hesitate to contact us.

JS/dp

Al Rushing
PO Box 4-381
Anch 99509

Dear Al

Today we received a letter from Ken Fanning with a copy of your letter of March 26, 1983.

I have to say that I am very distressed at your implications that the Senate HESS Committee has excluded you from testifying on SB 747. Ginger Brin and myself have worked for months on this project, have spoken to you at length on several occasions, have provided your written information and research to our legislators, have searched for legal opinions on midwifery, have lobbied the medical community and state departments on behalf of the midwives and have carefully rewritten this bill again and again to insure it's passage.

I'm sure you must remember the video teleconference we had in March in which you were a participant. You must also be aware that committee meeting schedules are developed a minimum of 5 days in advance, are published in the newspapers, and are available at all Legislative Information offices. In addition, I know you have had weekly contact with Ginger and I feel you have little reason to

suggest to other legislators that we have undermined your rights as a citizen to have input in the legislative process

Sincerely,

Childbirth experiment goes well

by Peter Eisner
Associated Press

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

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

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

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

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

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

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

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

Araujo cited U.N. statistics which show that, if present trends continue, there will be three billion births worldwide between now and the year 2000. The statistics also indicate that one billion of those infants will die, an additional 400 million will not reach a year of age and 100 million women will die in the birth cycle.

Araujo, medical director of the Maternity Hospital in Fortaleza — an Atlantic coast city of 1.3 million 1,800 miles north of Rio de Janeiro — says the data he is gathering show at least 85 percent of pregnant women can give birth without hospital care.

"Modern medicine is using more and more sophisticated apparatus, making birth more a matter of surgery than a physiological act," said Araujo, who has sponsored international forums on health care and has lectured in the United States and elsewhere.

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

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

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

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

Ceara, with a population of more than five million, is in Brazil's drought-stricken northeast poverty belt. The birth rate here is higher than the national rate of 36 per 1,000 and the infant mortality rate higher than the national rate of 109 per 1,000.

The statistics at the satellite center at Aquiras, 25 miles from Fortaleza, are markedly better. Since the clinic opened on May 1, 1977, there have been 2,359 admissions and 1,806 births. An additional 329 cases were referred to the Fortaleza center and other women received pre-and postnatal care. There were 26 infant deaths among the 1,806 births, a death rate of 12 per 1,000 — one-eighth of the national average and lower than the U.S. infant mortality rate of 15 per 1,000. The overall statistics in the Ceara project are similar, Araujo said.

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

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

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

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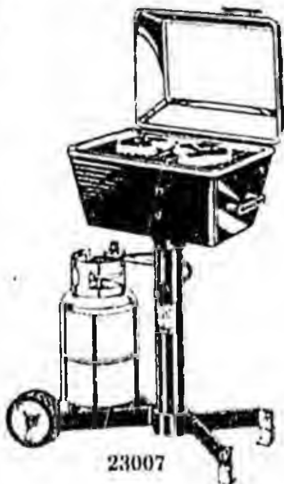

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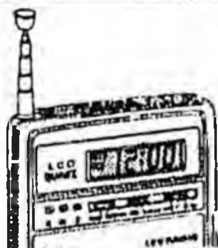

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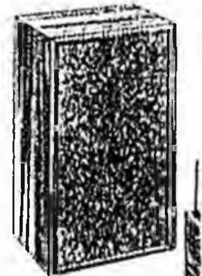

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SB 747 March 25
Telleconference

Fairbanks

Vicki Penwell - childbirth educator, birth attendant - Pro
need for medical backup.
freedom of choice
pro voluntary licensure

Liz Colleby - (husband an M.D.) lay midwives from Britain (training in Louisiana)
reasonable & appropriate regulation
low risk only - adequate physician evaluation
obj.
pg 1 - for all midwives - if one fails exam, could continue to practice
physician, PHN, nurse midwife on Board

inadequate requirements - only 20 observations

scope of practice - should limit to low risk
should insist on M.D.

Enid Deist - childbirth educator, teaches home birth classes.
free choice - pro education
spiritual & emotional aspects of birth

Dr. Jan Wilbur - fam. prac. Tanana Clinic
doesn't favor home del. by anyone

MMI

MMM

pg 1 line 28 - mandatory
pg 2 line 8 - physician or nurse on Board
line 22 - "Examination" too lose. MD should write exam - need practical
pg 3 line 12 - 20 births inadequate
line 28 - 10 births not enough
list definite course requirement
pg 5 line 22 - resusitation requires extensive training —
- define degree of suturing
pg 7 line 10 - medical history, previous preg and congenital anomalies in family
routine care defined

pg 7 line 20 - Friedman curve

Lois ~~[illegible]~~ De Ruadt - have birth parent.
good bill, support midwife concept.

Jennifer Gleason - Ch. State Board of Nursing
minimum requirements.
- more education for scope of practice
- req. ongoing backup.
pg 3 line 29 - "sponsor" should be req. to have much more training
- should be mandatory

Board of Nursing does not support.

Cathy Reimker - mother - pro.
essential in Alaska because of rural area -
seasonally employed cannot afford hospital
care.

Elaine McKenzie
- need to gather data about homebirths
and true situation
New Mexico regulations would be a good
model - scope of practice - what are limits?
better definitions needed.

Diane Fuller - pro
support freedom of choice + safeguards on practitioners

Eileen Montana RN - con
member of nursing board. Licensure says
state endorses practice.

Pat ~~[illegible]~~ Fritsch - pro
- rewarding, economic.
- difficult to find midwife - scarcity, secrecy.
- medical profession turn down for pre-natal
care, do not support home births. no emergency
back ups for midwives

Janice Conger - mother - pro
M.D. & midwife delivery in hospital.
personal attention of midwife excellent, supportive

Wendy Hogan - pro
freedom of choice

Kathy Oettinger pro
2 hospital births
has attended home births, plans on delivering
next at home (any day)

Toro Paris pro

Sitka

Carolyn Evans - Childbirth Educator.
Parents Assoc. of free Choice

free choices available in S.E.

Kathy Henderson - home birth parent.
2,500 - 3,000 lay midwives in US

Dr. Rodney Vogt - family practice - obst.
advocate of unborn child.

homebirth for parents at expense of child's safety
747 unacceptable - sanction midwives who
have unacceptable training

Mary Pierce - RN - Childbirth Ed - Pro
attended many home births - trend not
a fad. Need to open communication w/
medical community.
home birth parent.
earlier mentioned amendments are good.

Ted Palmer - home birth parent. - Pro
Bill needs more work, supports Dr
Wilbur's amendments. (FBKS)

Carline Stokes - mother, childbirth Ed - Pro
attending 20 births in a small community
would be hard.

Ann Lowe - home birth parent < 1 M.D. / 1 RN
made choice of birth attendant through self-ed.
more work on Bill. get physicians involved
in home birth.

Pat Keho - RN - Pro midwives
need better standards & education

Anch

Susan Pick - pro - consumer - home birth parent
pre/post natal care w/ midwife
freedom of choice
good for rural Ak.
good public support.

Dr. Douglas Smith - Leg. Ch. of AMA
AMA adopted resolution -
Birth centers available close to hospital
few M.D.s will collaborate w/ midwife
license will increase public confidence in midwives
against bill, will disseminate info to parents planning home birth.

medical model has decreased mortality and morbidity.

Chris Rushing - midwife
1940-1950 50% home births
medical community doesn't have time/skill or inclination to do home births.
hospital harrasses & discriminates against women birthing w/ midwives.

Dr. Jack Jacobs - Newborn ICU Providence - CON.

747 legitimizes obstetrics by poorly trained.
Not opposed to home birth
Works when
1. highly developed med. services for screening high risk.
2. Emerg. med. evacuation backup

MD don't deliver at home - no guarantee of safety.
PHS had excessive newborn mortality decreased recently related to decrease in home births.

Mary Keogh - Pro
survey of Anch homebirths 92% home / 3.5% hosp - good exper.

Dr. Marian Witt - rep. 45 Pediatricians - CON

Change Board Structure
Not opposed to home birth. - no medical backups available in Ak.

Dr. Pettijohn - Naturopath -
homebirth criteria - screening, adequate

training & prep., qualified attendant.
Center for Disease Control, Atlanta - study of licensed midwives - homebirths, screened - mortality rate better than hospital (N.C.)
climate of medical profession - anti - home birth.
need additional training.

<u>Kay Lahdenpera</u> Ak Nurses Assoc. Ch. Leg. Comm.
opposes.
quality standards are inadequate

Cert. Nurse-Midwife can practice in collaboration w/ M.D.
- not a professional board
- no relationship w/ medical profess.
- no training required.
-

<u>Al Rushing</u> Pres. of Better Ak. Birthing Experience
R.N.
no obj. scientific data against home birth.
Anch. has emerg. trans. system.
refered to Brazil study.
30% C-section rate in Anch. hospital.

<u>Julie Gorham</u> - Home birth parent. Ed. admin. in M.R.
pro

Leslie Breche - home birth parent. - pro

good prenatal care can screen many complications. Anch. Comm. Hosp. does not have OB on call for Emergencies.

Zelda Collette-Paule - lay midwife in Anch. - pro

feels capable of handling normal pre-natal and birthing care. M.D's refuse pre-natal care to those planning home birth. More difficult to get lab work done in Anch.

prefers to be licensed for her own protection.

has informed consent form.

liability -

labs have been pressured by M.D's not to do lab work

Karen Malone - parent - planning home birth - pro

bad experience in hospital. Midwife has time to know family, give personal care.

Michael O'Callaghan - home birth parent. - pro

Karen Redstone - pro

SITKA

Dr. Susan Carlson - Con.

Audio

Soldotna

Debbie Willington - Lay Midwife / Childbirth Ed. - Pro

— active in political battle in Calif. against AMA. Member of Ak. Midwife Assoc. Have high quality standards of care.
— supports recognition of midwives.

Judy Harvey - mother 3 home births - midwife. Pro
over opposition from medical community.
10 midwives in Anch, profession is growing as is homebirth.
no M.D.'s will attend home births.
people came to Ak. for independence & free choice
5% home births in Kenai.

Diane Thorne - Stewart Study

Merilee Wilson - home birth parent.
chose H.B. because of bad hospital experience.

Dillingham

Camila Martinez - Medical Anthropologist / midwife (appreciation)

involved in home birth

denial of lab work, back-up through Medical.

Parents & Midwives are encountering

unprofess. medical treatment in hospital

E.R's - harassment.

midwives she has studied w/ have extensive

hands on training & Book learning.

Don't make us outlaws.

Robert Clark - Health Corp.

need option with cut back in Fed dollars

expect increase in home births.

(IHS)

FBKS

Kay Kent - parent

Better description of philosophy practice - too technical

drugs are practicing medicine.

should be mandatory.

Homer -

Marilyn Kelsey - Midwife Nurse/Pract. - oppose

Am. College of Nurse Midwives have

carefully set standards of care.

lay & nurse midwife should adhere to

the same requirements

Kathleen Stier - Mother / HB parent / Birth Ed.
— member of N.W. Coalition of Midwives, BABE and MA.
— testimony is that adequate Ed / testing is necessary. More important that the knowledge is there.
Midwifery includes emotional & spiritual.

Claudia Child - Parent pro
freedom of choice

Ray Bill - oppose Certified Fam. Prac. training in Obstet.
— Bill would foster false confidence
— need proficiency to recognize warning signs of problems
— Board - not suff. expertise for exams: Stats:
1 neonatal death
3 membrane mismanagement
2 aspirations

Paul Eneboe - Dr
doing home births in Ak. for 18 yrs. carefully screens
long history in favor of lay midwives.
Homer 1970-75 — 77 home births
11 infant deaths
problems in H.B. - emotional decision, midwives

not adequately trained, cannot recognize fetal distress.
commitment to deliver at home often delays evac.
to hospital.

John Child - 9 children, 2 at home - Pro
in hosp. situation, he ended up delivering his
own baby. Both doctors on vacation.

Mat-Su

Brigitte Preston - 2 home births w/ midwives pro

— Midwives in gray area legally, would help
situation of lab work & prenatal screening.

Thomas Preston - pro - home birth parent.
Newsweek Cesarean 300% increase in past years.
freedom of choice.

Karen Saelinger - exp. mother planning H.B. pro
— licensing should insure adequate knowledge / exper.
should have access to lab tests, backup emerg. proced.
— midwives do screen applicants.

Yvonne Hall - 4 home births R.N. / midwife in
Arkansas, had physician in team.
400 births - no problems. Medical establishment

in Ak. no faith in midwives.
Midwife spends more time with mother than M.D.
are there enough trained midwives to educate others? Need more medical ed.
infection in hosp. are problematic

Jannie Schrager – R.N. Oppose
scope of prac. like nurse/midwife
nothing prohibits practice w/o license –
gray area of legality would remain.