HB
382

Charlotte (Shirley) Davis, R.M.
345-1398

14870 Snowshoe Lane
Anchorage 99516

ALASKA PROFESSIONAL
MIDWIFERY SERVICES

Sept. 18, 1991

Representative Niilo Koponen
619 North Cushman Rd. St. 207
Fairbanks, Ak. 99701

Dear Sir,

I am a midwife here in Anchorage, and I have been in practice now for 17 years. I worked for 12 of those years with Dr. Pettyjohn, a naturopathic physician. I have been seeing women at clinic in my home now for three years, and during all these years have attended 629 women primarily in the Anchorage area. We have been working hard on regulating ourselves and adhering to the standards we have set for ourselves.

Licensing would definitely be a benefit to the women we serve for 3rd party reimbursement, medicaid, and clinic.

I've always believed that our statistics speak for themselves and that the need for qualified midwives is growing. I also approve of the National Exam being given by Mana as a standard bearer for all of us.

Reg. midwife
MAA -

Sincerely, Charlotte H. (Shirley) Davis

P.S. I am enclosing a study done by a client of mine, a nursing student - on the problems facing them concerning 3rd party reimbursement.

I believe licensing would benefit all of us by eliminating some of these problems. We also need to work on our own regulations, as opposed to having the medical board over us, for all the reasons shown.

Thank you

Shirley Davis

Personal Attention for the childbearing Family

Kaye Kanne
registered midwife

P.O. Box 22624
Juneau, Alaska 99802
(907) 780-4518

9/23/91

Dear Mr. Koponen,

Thank you for your interest and willingness to help. When we lobbied for the successful passage of midwifery legislation in 1985 we thought the battle was won. We were naive. We thought that if a law was passed that the administration (H+SS) had to take the law seriously and implement it, keeping the intent of the law. After struggling with the dept of H+SS for 6 years, trying to prevent them from regulating us out of practice, it is apparent that the relationship will not work. It is even more apparent to me than ever, that even though

the public opinion is strongly in favor of keep the practice of midwifery alive and well, that the midwives need a licensing board. Without a board we will not survive in any capacity. If legislation is introduced by you this next session I will support it any way I can. I feel it is our only recourse at this time. I am enclosing a copy of legislation written by you in 1985, that is very good, and could possibly be used again.

Thank you,

Kaye Kanne, midwife

Mr. Nilo Koponen
619 N Cushman #207
Fairbanks, AK 99701

September 24, 1991

Dear Mr. Koponen,

This is in regards to the regulations for "lay midwives" in Alaska. First, as a tax paying citizen it appears that our money is being wasted in some areas when a minute project such as these regulations, keep getting shelved until we must start all over again. Surely this could have been an oversight by many, but it certainly makes one wonder why!

As a registered midwife with the Midwives Association of Alaska, I have taken the test to demonstrate my level of competance in this field. MAA's test is equivalent to the certification test given by New Mexico and Washington for licensing midwives. Also, I attended a midwifery school in Texas and took correspondance courses pertaining to midwifery. These are just minute obstacles I, as well as many other midwives, have overcome when compared to the endless frustration the officers of MAA have confronted. I am the mother of five. Three of my children were born at home. The issue of legality for midwives never entered my mind when seeking my attendants. It was only their competancy I was concerened with. If the State of Alaska moves forward and licenses midwives who are committed to this field,it would help weed out the unskilled people attending home births because they think it is "cool".

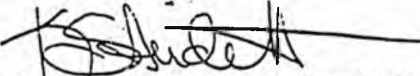
Another benefit of licensing midwives, would be a midwifery regulated board, a board of peers if you will. Therefore when an issue arose,it could be handled in a more efficient and productive manner. Also, third party reimbursement would be, or could be obtained easier. Therefore women requiring state assistance could have a home birth. Alabama began to cover their lay midwives at home births and saved the taxpayers MILLIONS of dollars and they also improved their infant mortality rate. I presently am trying to obtain this information for you to review, but felt the urgency to complete the issue of licensing first. I've enclosed some statistics taken from Sheila Kitzinger's book, "Homebirth" and will be forwarding more information as soon as I obtain it.

Upon receiving the "NEW" regulations from Health and SocialServices, it is unclear why the same issues are once again being reviewed. Last summer the working group, along with DR. Raugh and Ms. Munson, worked out all the problem issues that are being forced upon us once again. Is it the publics safety that is really of concern? The public's opinion messages didn't reflect a need to pursue the ongoing battle of numbers required and doctor visits. It makes one wonder if the person reviewing the regulations knows anything about the education of midwives, or perhaps his opinion of midwives. If we eliminate the lay midwives of Alaska, who will attend the peoples births when the rest of the OB/Gyn's throw in the towel?

Please LOOK AHEAD, to the time when setting forth the test for for licensing midwives. It would be to everyones benefit if the state adopted the Midwives Alliance of North America' test. By utilizing the foot work done by the National organization, we would not only show the competancy of Alaskan Midwives, but also save the Alaskan Taxpayers the unneccesary burden of STARTING ALL OVER AGAIN!

I thank you, Mr. Koponen, for taking the time to push midwifery forward and giving the public the right to make the choice they desire at such a personal time of their life. It is long over due and very much needed.

Sincerely,



Karen "Shine " Audett
#6008-R with MAA
Birthways Professional Midwifery
P. O. Box 287
Girdwood, AK 99587

9-20-91

Rep. Nilo Capman

Hello! My name is Andy Weis. As a student of midwifery, and a voter in the State of Alaska, I'm writing to give my support to the upcoming legislation dealing with the licensing of midwifery in our State. I was happy with the 1985 legis lation which provided for the registration of midwives, but I feel it was only the first step. Registration gave us the recognition & the rules, but none of the rights necessary for us to practice to our full potential. As the laws stand now, we are very limited as to who we can care for as many insurance companies will not pay for our services unless we are licensed in our state. We are also unable to take medicaide clients. I feel that there is a whole segment of our population that is being denied the privilege of having a choice whom their care provider will be. Many of these low income mothers & babies could benefit greatly from the very personal "whole person" approach to care that a midwife can give. Licensing midwifery in Alaska would provide for both of these things, as well as allowing midwives to operate licensed birth centers, & be on equal with midwives in other states.

Alaska is known for her pioneering spirit. Let us be pioneers in this field as well & provide our communities with the best health care system possible.

Thank-you,

Cynthia L. Weis

Cindy Weis
741 Bennett Rd.
Fairbanks, AK. 99712

3605 Arctic Blvd.#531
Anchorage, Ak.99503

January 12, 1990

John A. Buehler, AVP
First American Title Insurance Co.
114 E. Fifth Street
Santa Anna, CA 92701

Re: Health Benefits

On November 14, 1989 I contacted Pacific Coast Administrators regarding the payment of pregnancy related expenses to a midwife. Because the FATCO Group Benefit Plan specifies "charges related to pregnancy" as a benefit I was shocked to hear that no benefits would be paid for midwifery services. According to Pacific Coast Administrators, a midwife does not fall into the classification of "physician" as defined by the plan. The booklet does not specify any limits on care providers. This omission in the standard information to FATCO employees has caused several problems for me this late in my pregnancy. I cannot find an OB to take my case now because I have not used that doctor for my prenatal care. I am writing you now because there are several reasons why I believe a midwife's services should be covered.

I have reviewed the entire health plan and found that it does provide that certain "non-physicians" are covered by the plan. If the professional is "licensed, certificated, or otherwise regulated under state law and acting within their legal authority in performing an act or rendering a service that would otherwise be covered as a benefit under this Plan". The approved list of professionals includes chiropractors and acupuncturists among others. Traditional medical society views midwives in a similar light as chiropractors and acupuncturists. Surely a licensed, certified midwife has as much right to be in the approved category with these other professionals. In Alaska, midwives play an important role in health care because of the geographic isolation of some communities. Midwives became licensable in 1985. They must meet education and training criteria regulated by the Department of Health and Social Services.

I chose to go to a licensed midwife after learning that the obstetrician who delivered my first child is no longer delivering babies because the malpractice insurance premiums are too expensive. According to his nurse, the doctor would

have to deliver fifty babies per month just to pay the insurance premiums. This is not an isolated case. In the last four years, malpractice insurance premiums have doubled. (1) According to the American College of Obstetricians and Gynecologists (ACOG), 12.3% of the nation's obstetricians quit delivering babies in 1985 alone. (2) Each year more and more doctors are leaving the field. You may be interested to know that in California 27% of obstetricians have quit practicing. (3)

The high cost of malpractice has done three things to limit a woman's choices in prenatal care and childbirth. First, there are few caregivers willing to take on pregnant women. Second, according to an ACOG survey in 1985, 23% of doctors surveyed stated they would not accept "high risk" cases (4). Third, the caregivers who do practice use many medical interventions to avoid malpractice suits, such as extensive prenatal tests, C-Section deliveries (now used in over 25% of hospital births), and/or drugs and minor surgery (used in 90% of hospital births). (5) These all cost the health insurance companies millions of dollars each year.

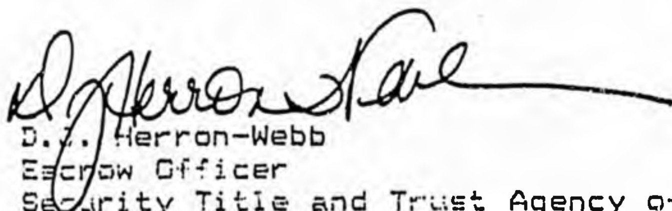
Another reason I chose a midwife is because midwives do not see pregnancy and childbirth as an illness. They avoid using interventions and stress good prenatal care. Ninety-five percent of births occur without complications. A study in 1977 by Dr. Lewis Mehl,MD matched two groups of 1046 women each for race, age, parity, education, socio-economic status, and risk factors. None of the home births were attended by board certified obstetricians and none of the hospital group were attended by midwives. His findings were for the hospital group: 3.7 times more babies required resuscitation, 17 times higher incidence of respiratory distress, 6 times more fetal distress, 4 times higher infection rate, 2.5 times more meconium aspiration pneumonia, 5 times more maternal high blood pressure, 8 times more shoulder dystocia, and 3 times more maternal hemorrhage. In every area, complications were much worse for the hospital group. (6)

Midwives provide essentially the same care as an obstetrician. They provide prenatal care and taking of blood samples. A midwife, however, charges about forty percent of what an obstetrician charges. In my particular case, in 1987 I paid $75 to my OB/GYN for each prenatal visit (ACOG recommends twelve to fifteen visits) and I am currently paying $25 per visit for the exact same care. Well, almost exact; the OB/GYN had his nurse handle the prenatal visits whereas the midwife does them herself. The actual delivery fees are the same ($800) but by using an obstetrician, my insurance company paid over $4,000 in hospital charges. I do not expect to have those additional charges when having a homebirth attended by a midwife. Surely you can see why, as the payer of health benefits, it makes financial sense to give the First American employees a low cost alternative in health care.

The plan specifies that benefits will be paid for what is "medically necessary". It defines medically necessary to include "it is the most appropriate supply or level of service needed to provide safe and adequate care". In the case of a low risk pregnancy (of which I qualify), the services of a midwife is an appropriate level for safe and adequate care. I know that using a midwife is not for every woman, but I do feel that the plan should provide for the option of using an obstetrician or midwife.

I am asking that you consider these points and approve midwifery services for benefit payments. By denying the benefit, you limit the choice in health care options and lock yourself into paying higher than necessary costs. All anyone wants is appropriate health care that matches their interest and health philosophy. I am including a list of my sources, copies of some excellent articles on midwifery, a copy of the Alaska Statue relating to midwifery, and an accounting of the expenses I have incurred in this pregnancy. If you have questions, please feel free to call me at Security Title and Trust (907)276-0909 or at home (907)561-0008 if I am out on maternity leave. I am anxious to hear your response.

Sincerely,



D.J. Herron-Webb
Escrow Officer
Security Title and Trust Agency of Alaska, Inc.

SOURCE LIST

1. Sandroz,Ronni. "When the Obstetrician says "No" ". Health. Nov. 1987

2. Drouin,Michael T.,MD. "I Love Delivering Babies But The Malpractice Crises Forced Me Out." Glamour. July, 1986

3. Sandroz,R.

4. Sandroz,R.

5. Fenwell,Vickie,R.M. "Time-Honored Profession, Midwifery, Must Be Encouraged." Daily News-Minor, Fairbanks, Ak.. April 28, 1985

6. Fenwell,V.

February 5, 1992

To: All Legislators

From: Consumers of Midwifery Services

Dear Legislator;

Please give consideration to HB381 and HB382 regarding licensing of midwives and granting a licensing board. I am in support of the Midwives Association of Alaska in their legislative efforts this session.

HB381 will provide payment by Medicaid to non-nurse midwives for perinatal services. As a consumer of such services, I am in agreement with Medicaid payment.

Please let me know your views on this issue. Thank you.

Sherry Benner 1016 Ronda Palmer, Ak. 99654	Kaylynn Ardell P.O. Bx 874753 Wasilla, AK. 99687
GREG G WEAVER HC 75 BOX 2730 CHUGIAK, AK 99567	Claine Bialka P.C Box 870492 Wasilla, Alaska 99687 Claine Bialka
JENNIFER SVENSON P.O. BOX 203312 ANCHORAGE, AK. 99520	Katie Manckelsdorf HC 33 Box 3180 Wasilla, AK 99654
Steven Ward HC02 Box 7387-C Palmer Ak 99645	Susan Burgess P O Box 1874 Palmer AK 99645

February 5, 1992

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[illegible] Was 99687 [illegible signature]	Paula Harrison P.O. Box 876426 Wasilla, Ak. 99687
[illegible signature] PO Box [illegible] Big Lake Ak 99652	[illegible signature] P.O. Box 876761 Wasilla, AK 99687
[illegible] [illegible] Wasilla, AK. 99654	[illegible signature] P.O. Box 876426 Wasilla AK. 99687
[illegible] Dickey HC02 Box 7323 A Palmer AK. 99645	Pam Weaver PO B671427 Chugiak AK 99567

Midwives Association of Alaska
Vicki Penwell, V. President
600 3rd Street
Fairbanks, Ak 99701
September 25, 1991

Rep Niilo Koponen

Dear Niilo,

I am writing to you on behalf of the Midwives Association of Alaska, to request that you introduce a bill in the 1992 Legislative Session to license the practice of Midwifery.

Midwives are a vital link in the provision of health care in Alaska. Their contribution to the health and safety of the public was well documented during the 1985 Legislative Session, when you introduced a bill to provide for the regulation of midwives in the state. This bill passed unanimously in the Senate, and with only two dissenting votes in the House. At that time we were unable to pass the licensing bill you wrote due to a veto on all new boards by then Governor Bill Sheffield.

Simply regulating midwives through the Department of Health & Social Services has not been satisfactory. We have waited six years and still do not even have regulations or registration for midwives. Midwives have had to fight for the right to have input into the writing of the regulations, even though the 1985 law clearly specified that the Section Six Working Group would draft the regulations.

Native Alaskans, women in the military, military dependants, and low income women are denied the services of a midwife in Alaska, because Medicaid, Champus, and Native Health Service only covers Alaska licensed practitioners. Midwives are still frequently denied third party insurance payments as well, effectively denying another segment of the population access to midwifery care.

Studies have shown conclusively that midwifery care is much more cost effective than traditional American medicine, often one half of the cost of hospitalization for birth. Studies have further proven that midwifery is a safe, practical option for most women, and better serves the long term health and education needs of families.

Thank you for your assistance in this matter

Vicki Penwell

Marilyn Holmes
969 Goldbelt Avenue
Juneau, Alaska 99801
(907) 586-2316

February 19.1992

Submitted to HESS sub-comittee on HB 382 in lieu of oral testimony

In the interest of brevity, I will limit my comments to those things not covered by others in this morning's testimony. I regard this issue from a consumer's vantage point. Both of my daughters were delivered by midwives - the first by a team of nurse midwives and the second by a lay midwife at home.

I consciously chose these options because I sincerely believed they were the best available. I could not have been more satisfied, especially with the lay midwife who was the most skilled and knowledgable of the three.

Midwifery is not medicine or nursing. Normal birth is not a medical emergency. Applying medical technologies which were developed for high risk pregnancies to normal laboring women contributes to our astounding 30% C-section rate in hospital births - in my opinion a full 25% over where it should be. Midwives are specialists in normal birth; they have knowledge and experience not available from most medical practioners.

Alaskan women want to be able to choose between medical and safe alternative birth situations. As soon as you require that alternative births be regulated by the medical profession, they become medical births. Midwives need to regulate midwives. They want licensing which will assure optimum consumer care and preserve the safety and reputation of their profession.

The public member of this board should be a consumer of midwifery, i.e. the board's services - anything else would be beside the point. The medical profession is adequately represented by the board member positions of the nurse midwife and a health care provider. I consider that significant medical involvement.

HB 382 is pro-life, pro-choice, pro- ily and provides affordable health care. Please preserve and protect irth care options in Alaska.

Sincerely,

Marilyn Holmes

Dear Legislator, 2/7/92

I recently received a letter from my midwife's requesting my support. After reading their letter and asking a few additional questions I find myself in complete agreement with them. I am letting you know of my complete support of passage of HB381 & HB382. I am also requesting that these bills be passed as quickly as possible. I believe passage of these bills is in the best interest of practicing and future midwife's and all women seeking their assistance in the state of Alaska.

I'm greatful that Alaska allows midwifery. Midwifery has been a tried and true approach to childbirth throughout time. It's been my experience that midwife's are caring people who truely love their work. Their knowledge and assistance are invaluable to those of us who choose natural childbirth in the comfort of our homes, and I support any effort which might make their practices easier.

I would like to thank you in advance for you prompt support of HB381 & HB382.

Dawn Nelson

Dawn Nelson
P.O. Box 670123
Chugiak, AK
99567-0123

Letters of Support

FEBRUARY 4, 1992

DEAR LEGISLATOR

I SUPPORT HOUSE BILL 382 CREATING A MIDWIFERY BOARD. IT HAS BECOME EVIDENT THAT THE MIDWIFERY LAW PASSED IN 1985 IS BASICALLY INEFFECTUAL. THE RESPONSIBILITY OF REGULATING AND LISCENCING MIDWIVES SHOULD NOT BE IN THE HANDS OF HEALTH & SOCIAL SERVICES WHO DO NOT HAVE THE EXPERTISE/BACKROUND TO CARRY OUT THIS FUNCTION. A BOARD, AS OUTLINED IN HOUSE BILL 382 IS ESSENTIAL TO KEEPING MIDWIFERY ALIVE IN THE STATE.

AS A MOTHER OF TWO CHILDREN WHOSE BIRTHS WERE ASSISTED BY A MIDWIFE, I FEEL STRONGLY THAT MIDWIFERY IN ALASKA NOT ONLY STAY ALIVE BUT CONTINUE WITH HIGH STANDARDS. BOTH BIRTHS WERE TREMENDOUS EXPERIENCES FOR MY HUSBAND AND I AND WERE SO, MUCH BECAUSE OF THE ROLE OUR MIDWIFE PLAYED. PRENATAL AND POSTNATAL CARE COULD NOT HAVE BEEN BETTER.

A MIDWIFERY BOARD AS STATED IN HOUSE BILL 382 WOULD HELP TO ENSURE THAT POSITIVE BIRTH EXPERIENCES, AS TRULY AN ASPECT OF A HIGH STANDARD OF LIVING, BE A RIGHT FOR ALL ALASKANS.

THANKYOU FOR YOUR TIME,

SINCERELY,

ELIZABETH MARANTZ
BOX 6083
SITKA, AK.
99835

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE
WELTGESUNDHEITSORGANISATION
ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ

REGIONAL OFFICE FOR EUROPE
BUREAU REGIONAL DE L'EUROPE
REGIONALBÜRO FÜR EUROPA
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

PLEASE NOTE!
FROM 13 AUGUST 1991
NEW ☎ NUMBER
+45 39 17 17 17

telefax 10871

Date

28 October 1991

Governor Hickel
c/o Susanne Rich
1243 McCarty Avenue
Fairbanks
Alaska 99701

Fax No 907 - 452 3805

Our reference
Notre référence
Unser Zeichen
См. наш номер

MCH/NR

Your reference
Votre référence
Ihr Zeichen
На Ваш номер

Dear Governor Hickel,

We have been informed that the State of Alaska is considering new legislation with regard to midwifery. The purpose of this letter is to inform you that there is strong evidence worldwide, most especially in the highly industrialized countries, that midwifery is an essential profession in the care of the woman during pregnancy and at birth. Therefore, this profession needs to be strengthened and supported in every way possible. This profession would be particularly important in a state such as yours where there are long geographical distances and small isolated groups of people. Indeed, Dr Marsden Wagner, the former WHO Regional Officer for Maternal and Child Health from this office, visited Alaska last year and met with doctors and midwives both in Anchorage and in Fairbanks and it was clear then that there is an urgent need to expand and strengthen midwifery in Alaska.

Unfortunately, the proposed regulations contain certain aspects which would not support and expand midwifery in your state, but rather do the opposite. Every birthing woman in Alaska should have the freedom of choice with regard to birth attendants. This means that your legislation should do nothing to inhibit this free choice. Insisting on requiring 25 births a year for midwives is unheard of in any of the health professions in any of the industrialized countries and is certainly totally inappropriate for a state such as Alaska. Furthermore, all of the countries in the world have the regulating board for midwifery with a majority of midwives and a minority of physicians or nurses.

For all of the above reasons we would strongly urge that the proposed regulations not be approved but that new legislation be drafted that would truly provide the women of Alaska with freedom of choice in their own birthing.

Yours sincerely,

B. C.

Beverley Chalmers, Ph.D.
Consultant, Maternal and Child Health

cc: Assistant Secretary for Health, Dept of Health and Human Services, Washington DC 20201
Regional Director, World Health Organization, Regional Office for the Americas, Washington DC

Jan 31, 1992

Deborah H Sogge
Box 9245
Reno, NV 89507

Dear Legislator,

I am writing in support of House Bill 382. The creation of a Midwifery Board is a necessary step to allow for continued practice of midwifery in Alaska.

I gave birth joyfully to three healthy babies at home in Alaska and was very happy with the care I received from local midwives. I am currently attending medical school in Nevada but am still an Alaska resident. Competent midwives can lower health care costs while providing low-risk mothers with a wonderful alternative to hospital delivery. Please support HB 382, Alaska's midwives and mothers who want to deliver at home with professional care.

Thankyou.

Deborah H Sogge

Alaska Family Health & Birth Clinic

600 3rd Street, Fairbanks, Alaska 99701 • (907) 456-3719

600 3rd St.-Graehl
Fairbanks, Ak. 99701
September 24, 1991

Rep. Niilo Koponen
119 Cushman St. #27
Fairbanks, Ak. 99701

Dear Rep. Koponen,

Thank you for being interested in the licensure of midwives. I have practiced here for seven years and am currently licensed from the state of New Mexico. Licensure of midwives in Alaska would contribute to a high standard of care and add more credibility to this profession. It would also add to consumer protection.

We are viewing a national trend in the maternal health care system which includes direct entry (non-nurse) midwives Licensure would enable midwives to qualify for Medicaid funds and insurance coverage. This would enable women with these coverages to choose midwife care.

For Alaska, this would assure families that they are getting the finest in health care, when choosing a midwife. I desire to see Alaska be a fine example of this level of care, as is New Mexico.

I suggest that the state use the Midwives Alliance of North America's (MANA) National Certifying Test as a basis of licensure. I look forward to holding an Alaskan license in midwifery and thank you once again for your support.

Sincerely,

Dana Everson

Dana Everson, L.M.

January 31, 1992

Dear Legislator,

Please support HB 382. We need to have a Midwifery Board. Right now the department of Health and Social Services is attempting to limit the practice of midwifery to just a few midwives in the state. Midwives need to have a say in their own regulations.

Our two children were born with a very warm, capable midwife in attendance. She helped make those births highlights of our lives. Please don't deny us the right to choose a midwife for our future childbearing. Please don't deny other women and their families the joy of having safe homebirths with another woman caring for them. (Midwifery means "with woman")

We need more midwives in our state, not less. Please support HB 382 and support women, babies, and families at the same time. Thank you.

Sincerely,

Mark and Lori Ortega

Mark and Lori Ortega
P.O. Box 218
Gustavus, AK 99826

Sept 23, 91

Dear Mr. Koponen,

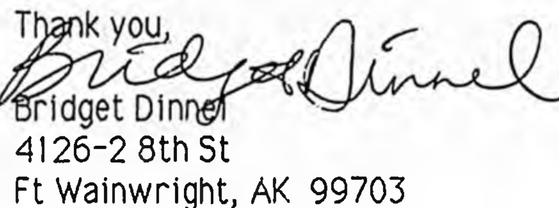
I am writing to express my support of a licensing board for direct-entry midwives in Alaska. I am presently a student of midwifery in Fairbanks, and feel that a license from the state of Alaska would be advantageous in many ways. Midwifery is recognized as a viable profession in Alaska, but a license would serve to insure our full rights as health care workers.

A license would provide for the coverage of clients whose insurance companies will only pay for health care workers who are licensed in their state of practice. It would also allow people on medicaid a choice as to the type of prenatal care and delivery they have. Many of these people are being denied the care they desire because of their financial situation. This is also important for me as a military dependent in that CHAMPUS does not yet pay for midwife care.

I also believe that a licensing board would serve to set up a consistent level of training and qualification standards for midwives.

The inception of licensing for midwives would help to provide our communities with the best health care possible, as well as choices in health care.

Thank you,



Bridget Dinnel
4126-2 8th St
Ft Wainwright, AK 99703

P.O. Box 71715
Fairbanks, Ak. 99707
Sept. 24, 1991

Rep. Niilo Koponen
119 Cushman St. #27
Fairbanks, Ak. 99701

Dear Rep. Koponen,

I am writing to express my appreciation to you for supporting midwifery in Alaska. I would ask you again to advocate for us again by introducing legislation to fulfill the intent of the legislation passed in 1985. As a midwifery student in Alaska I feel licensing would make give credibility to the profession. This far we have responsibility, yet no rights.

I would like to see this legislation cover several points. These are:
1. Licensure
2. Eligibility for Medicaid payments
3. Birth Center Licensing

The licensing of Midwives would enable us to continue as a viable profession in Alaska and to continue to provide quality care to the families of Alaska.

Thank you for you time and for listening to the voice of the midwives of this state.

Sincerely,

Cindy Nafpliotis
457-2529

Dear Mr. Coponen,

I am writing to you as you requested. First of all I want to thank you for your time and interest.

My reasons for desiring a licensing rather than a registration are these:

1. A license would be a credential acceptable in another country should I go out into the field as I desire to do.
2. I would very much like to be covered by medicaid and be able to offer my services to people covered by medicaid.
3. Having a license in this state would also enable me to own and operate a birthing center.
4. A license would also be acceptable to Champus and therefore military families so choosing a homebirth would have the benefit of coverage.

Thank you again for your time Mr. Coponen.

Sincerely,

Scherrill D. Malone

4002 Barbara Dr.
Anchorage, AK 99517

ph: 258-9433

September 21, 1991

Rep. Niilo Koponen
119 N. Cushman, #207
Fairbanks, AK. 99701

Dear Sir:

I have been practicing midwifery in Alaska for several years. The purpose of this letter is to request that legislators consider the "licensing" of midwives in this state, rather than regulation of them by Health and Social Services. This would benefit the public and midwives in several ways:

1. The public could be assured that the midwives licensed in this state are educated and qualified to practice midwifery. Just as doctors and nurses have to answer to their particular professional boards, the same would be for midwives. This would help to protect the public from unskilled practitioners. It would also benefit midwives, in that those on the board would be intimately familiar with midwifery, not just nursing or medicine.

2. Many families on Medicaid would like to have a birth at home, but cannot at this time because unlicensed midwives do not qualify for Medicaid payment. Low income families could have the option of a home birth.

3. Licensed midwives can receive third-party reimbursement from insurance companies.

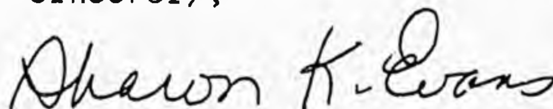
The licensing of midwives in this state can provide another benefit to the public - midwives for the future. With licensing in place, the door can be opened for those desiring to enter the profession. Of course, I realize, provision must be made in the law for midwives to be able to have apprentices or students. Perhaps the state will someday approve a midwifery school.

Many of us have taken the time and funds to go to another state to receive our licenses, after having provided all the educational requirements necessary to take the licensing exam. In this way, we have been able to prove that we are educated and qualified to care for the childbearing public in a safe manner.

I have been keenly aware of the process of regulating midwives in this state, and, frankly, I am dismayed at the pace at which the issue is being solved.

If public safety is truly the bottom line, then the licensing of midwives should be a priority. I believe that you are really aware of our dilemma as a profession. I also believe that you can present this to legislation in a logical, articulate and convincing manner.

Sincerely,



Sharon K. Evans
Midwife
P.O. Box 3224
Kenai, AK 99611

PUBLIC OPINION MESSAGES RECEIVED BY REP. KOPONEN AS OF 2/12/92

D.J. Herron-Webb
3605 Arctic Blvd. #531
Anchorage AK 99503

Scherill Malone
4002 Barbara Drive
Anchorage AK 99517

Shirley Davis
AK Professional Midwifery Services
Anchorage AK

Jeanne Pepper
Box 211043
Auke Bay AK 99821

Dawn Nelson
P.O. Box 670123
Chugiak AK 99567

Dana Everson
600 Third Street
Fairbanks AK 99701

Jim Eichner
1030 2nd Ave.
Fairbanks AK 99701

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Fairbanks AK 99707

Cindy Weis
741 Bennett Rd
Fairbanks AK 99712

Cristina Schneider
163 Syracuse #4
Fairbanks AK 99709

Dalena Englund
2550 Cushman
Fairbanks AK 99701

Elizabeth Demar
2022 Turner
Fairbanks AK 99701

Kaija Anderson
1725 University Ave.
Fairbanks AK 99709

Marie Lovo
351 Cloudberry
Fairbanks AK 99709

Melanie Wells
329 Baranof
Fairbanks AK 99701

Sana Everson
Fairbanks AK 99701

Suzanne Rich
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Ft. Wainwright AK 99703

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North Pole AK 99705

Darcie Sjoblom
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North Pole AK 99705

Liz Martinez
Box 6083
Sitka AK 99835

Shannon Kohler
Box 1746
Soldotna AK 99669

Larae Pepper
P.O. Box 874521
Wasilla AK 99687

2-12-92

Dear Alaska Legislators,

I wish to voice strong support for H.B. 382. I am married to a midwife, and can therefore testify more accurately than most about this issue.

I have great respect for my wife's training, credentials, professionalism, concern for her clients, and integrity. I know the hours she devotes to mother and child during long labors and also follow up care, far in excess of the time normally given women by routine hospital scenarios. I am convinced her clients receive superlative care, and I believe they are quite lucky she is available to them.

I knew nothing of midwives before I met my wife. I imagined them a backwoods lot, prone to superstition and feminist zeal. I have learned the truth since then, and am proud to be among their most ardent supporters, because I know their cause is honest, beneficial, and needed. You've no doubt heard some statistics by now, showing many countries using midwives, all with better maternal and infant outcomes (much lower caesarian rates, much less

infection) than the U.S. These facts need to be heeded, for the health of Alaskans as well as a real answer to concerns about rising health care costs.

A midwife trained in recognizing potential risk factors is better equipped to deal with normal, healthy pregnancies than a doctor in typical practice, because she can devote far more time and attention to mother & child, and in many cases effect an easier birth through calming fears the mother may have incurred through unfortunate conditioning. A birth in one's home especially can be a wonderful, calm, memorable event, and is virtually an impossibility without trained midwives.

I favor the use of midwives whenever possible, but I am not asking you to concur, only that you allow Alaskan women that choice. I am convinced this is the direction health care is headed, and I applaud this. I urge you to pass H.B. 582, and propel Alaska forward toward better birthing statistics. Additionally, a board comprised of midwives governing themselves is critically needed, to prevent hostile interests from crushing this fledgling movement. I am sure you can understand the wisdom

LuAnn and Bruce Weyhrauch
Box 32193
Juneau Alaska 99811

February 18, 1992

The Honorable Bill Hudson
Representative
Room 114, Capitol
Box V
Juneau Alaska 998811

Re: House Bill 382

Dear Representative Hudson:

I write in support of House Bill 382. This bill, in part, creates a five member Midwifery Board consisting of a certified nurse midwife licensed by the State Board of Nursing, a public member who has received or paid for the services of a licensed midwife, a health care professional, and two state-licensed midwives.

The Midwifery Board created by HB 382 would regulate the practice of midwifery in the state. Through the mechanism established by HB 382, you ensure:

- responsible regulation over the licensing of midwives working in Alaska;

- the licensing of those midwives who practice in Alaska to ensure public oversight;

- that regulation of midwives reposes in a Midwifery Board and not in the State Department of Health and Social Services;

- that midwives who practice in Alaska have a voice in the process that regulates their practice;

- that birthing mothers in Alaska have access to a safe, healthy, and regulated midwife practice;

We appreciate the opportunity to offer testimony on HB 382. If you have any questions, or would like additional information, please call.

Very truly yours,

LuAnn Weyhrauch
Bruce Weyhrauch

LuAnn and Bruce Weyhrauch

Alaska State Legislature
Representative Niilo Koponen
House District 21

Pouch V
Juneau, Alaska 99811
(907) 465-4992

119 N. Cushman, Suite 207
Fairbanks, Alaska 99701
(907) 456-8172

POSITION PAPER

HB 382 "An Act relating to regulating the practice of midwifery."

In 1985 SLA 1985 Chapter 33 provided for the registration of midwives in Alaska. The new law directed the Department of Health and Social Services to adopt regulations by establishing a Midwives Working Group. This Group was to propose regulations to the Commissioner regarding registration, training, educational requirements and disciplinary measures for lay midwives. The Department was to report on these proposed regulations by the tenth day of the second session of the Fourteenth Alaska Legislature. It did not do so. Alaska's licensed midwives continued to practice without the benefit of regulations. Now, over six years later, the Department has proposed regulations which would effectively exclude the majority of presently-practicing midwives from their chosen profession.

HB 382 solves this problem by creating a Board of Licensed Midwives, consisting of one health care professional, one certified nurse midwife licensed by the Board of Nursing, two state-licensed midwives, and one public member who has received or paid for the services of a midwife. The Board would license Alaska's midwives using existing national standards. The Board would also develope strict regulations and monitor professional practice by peer review and education. Certified, licensed, high quality care would be available to Alaskans who either prefer home births or are denied financial or geographic access to physicians' care.

Sponsor Statement

Alaska State Legislature
Representative Niilo Koponen

Pouch V
Juneau, Alaska 99811
(907) 465-4992

House District 21

119 N. Cushman, Suite 207
Fairbanks, Alaska 99701
(907) 456-8172

Explanation of changes from HB 382 for the new CSHB382

1. Page 1 Section 2 (in the CS) was added for the purpose of allowing only licensed midwives to use identification appropriate letters or a title after the personals name that represents that person's specific field of practice. This will allow no other person to be able to falsify themselves as a registered licensed midwife.

2. Page 4 Line 13 - deleted from HB 382 , the board at a minimum, shall utilize the examination provided by the Midwives Alliance of North America. This was changed in page 4 line 15 to read, The board may utilize the examination provided by a nationally certified midwives organization recognized by the board.

3. Page 8 Line 15, in the CS - Added Section to Read LICENSED REQUIRED IF DESIGNATION USED for the same reasons as stated in number one listed above.

4. Page 8 Line 12 in HB 382 - deleted "caring for" and expanded the definition of the "Practice of Midwifery in new page 9 Line 8.

Changes in CS HB 382( )

#5

ALASKA NURSES ASSOCIATION

R E S O L U T I O N

Regarding

LAY-MIDWIFERY REGULATIONS

Whereas, the State of Alaska has proposed regulations (7AAC16.010) for defining and outlining the registration, training and scope of practice of the lay-midwife, and

Whereas, the Department of Health and Social Services has been placed as the regulating body for the State of Alaska in overseeing the implementation of these regulations without providing funds for the process, and

Whereas, a number of allowed skills are included which we feel are not appropriate for lay-midwifery such as tracheal intubation, intramuscular medication administration, intravenous administration of Lactated Ringers solution, metabolic screening of the newborn, and

Whereas, the method of education is a strictly apprenticeship training with no method of assuring good clinical competency by either instructor or student, and

Whereas, the health care of the pregnant and delivering woman and her newborn are of social and community concern and

In As Much As nurses are a part of the community and directly involved in all health care outcomes involving maternal/child health

Therefore, Be It Resolved That The Alaska Nurses Association stands opposed to 7ACC16.010 as written and requests reconsideration of the regulations.

To be copied to: Office of the Governor
Mr. John Pugh, Commissioner, DHSS
Mr. David Bruce, DHSS
All Representatives and senators

No. #4 1979

ALASKA NURSES ASSOCIATION

R E S O L U T I O N
Regarding

CERTIFIED NURSE MIDWIVES

Whereas, the supply of physicians able and willing to take obstetrical cases is limited, and

Whereas, there is an increase in the number of births in the State, and

Whereas, nurse midwives in the State of Alaska are legally certified to care for women during pregnancy and capable of deliverying babies, thus relieving physicians for more serious cases, and

Whereas, high quality care dictates that pregnant women receive service beginning as soon as pregnancy is determined and continuing throughout the cycle, and

Whereas, women are entitled to choices in their health care,

Therefore, the Alaska Nurses Association recommends that certified nurse midwives be accepted in the health system as independent providers of normal maternity care, and

The Alaska Nurses Association also recommends that certified nurse midwives be granted hospital privileges to deliver babies and maternity care to clients in hospitals.

cc: All HSAs
Alaska State Medical Society
Alaska Board of Nursing
Alaska Health Coalition
All Hospitals
Anchorage Medical Society

ALASKA NURSES ASSOCIATION

RESOLUTION

Regarding

SCOPE OF NURSING SERVICES IN RURAL COMMUNITIES

WHEREAS, Vast distances between Alaskan communities and poor communication with population centers cause unique health care needs in our state, and

WHEREAS, Many small Alaskan communities cannot support the services of a physician or a mid-level practitioner, and placement of a mid-level practitioner would be inappropriate use of health manpower according to the guidelines established in the Alaska State Health Plan "Levels of Care", and

WHEREAS, All levels of nursing have a role in providing health care needs in Alaska and many small communities rely primarily on nurses for their care, and

THEREFORE, BE IT RESOLVED THAT the Alaska Nurses Association believes that the scope of practice of the professional nurse allows for health promotion, prevention of illness, and the provision of primary care services including functioning under standing orders within the context of a health care system, and

BE IT FURTHER RESOLVED THAT we support the provision of these services by all professional nurses, especially the itinerant public health nurse.

Tabled by House of Delegates
Alaska Nurses Association
18 March 1983

Copies to:

Board of Nursing
DHSS Commissioner
Director of Public Health
Chief of Public Health Nursing

No. 24 -1983

ALASKA NURSES ASSOCIATION

RESOLUTION

Regarding

NURSE MIDWIVES

WHEREAS, The membership of the Alaska Nurses Association supports freedom of choice for families in the selection of competent health care professional and in the location of birth, and

WHEREAS, The membership is aware that Alaskan families are currently seeking assistance from untrained "midwives" as providers of intrapartum care in the home, and

THEREFORE BE IT RESOLVED THAT the Alaska Nurses Association does not support the delivery of intrapartum care in the home by non-nurse midwives.

Adopted by House of Delegates
Alaska Nurses Association
18 March 1983

Copies to:
Alaska State Legislature

No. 11 - 1985

ALASKA NURSES ASSOCIATION

R E S O L U T I O N

Regarding

NURSE MIDWIVES

WHEREAS, the membership of the Alaska Nurses Association supports freedom of choice for families in the selection of competent health care professionals and in the location of birth, and

WHEREAS, the membership is aware that Alaskan families are currently seeking assistance from "lay midwives" as providers of intrapartum care in the home, and

WHEREAS, we recommend physicians be willing to provide emergency support for certified nurse midwives who are asked to provide home birthing services by the consumer, and

THEREFORE BE IT RESOLVED THAT the Alaska Nurses Association opposes "lay midwives" and supports certified nurse midwives practicing in alternative birthing sites with physician back-ups

BE IT FURTHER RESOLVED THAT the Alaska Nurses Association voting body affirmation be sent to the Alaska State Legislature.

Adopted by the House of Delegates
Alaska Nurses Association
12 April 1985

Midwifery Education

Denise Hodges

I am a midwife and also an educator. I have been teaching in public school and/or privately for 19 years. During those years, I've pursued a special interest in how people actually learn. There is a great deal of new, and old, research and information on this topic. How people learn *best* is the subject I will address in this article.

Public schooling and classroom style learning have been in existence for only a very short period of time in terms of human history. Public schooling/classroom style learning was originally established to incorporate the masses into the work force for the industrial revolution. It was (and is) useful to encourage certain standards of conformity, behavior, and minimal basic skills in literacy. It has never been shown to be an effective method to teach people of any age to think creatively, make important decisions, or to adopt to constantly changing circumstances; all of which are vital to midwifery care.

Throughout history, the recognized superior method of learning has been one-to-one teaching, primarily experiential; some form of apprenticeship or tutoring. The wealthy peoples of the world have always taken advantage of this fact and hired private tutors for their children. Before the advent of public schooling, when a young person wished to learn a trade, they were apprenticed out to a local craftsperson. This system served for hundreds of years successfully and is still used today in some trades. Many historians believe the lack of quality in many of our goods and services today, compared to days of yore, stems from the fact that there is no longer apprenticeship for most trades.

Apprenticeship works where classroom education fails. It has many distinct advantages. Even if you are a straight A student, when you finish a class in any subject, if tested just a few months later on that subject, you will probably fail the test. This has been shown in educational research many times. We rarely retain information presented in a classroom setting for very long periods of time. Apprenticeship has the advantage of ensuring that most information will enter long-term memory. The reason for this is that one of the best ways to *really* learn something is to *experience* that information on a very personal level.

Here is a simple example. A student listens to a lecture on shoulder dystocia, reads about it, and even writes a research paper on it. After a certain period of time has passed, usually only a few months, only a small percentage of that information will be retained and available when needed. Another student is apprenticing and witnesses and *experiences* a serious shoulder dystocia. Her senior midwife says "Apply supra-pubic pressure! Get her feet up by her head!" There is a very real emotional thrust to this very real lesson. Immediately after that experience, if she discusses shoulder dystocia with her senior midwife and other midwives and reads all she can find on the subject, she will *never* forget this lesson which is now on a visceral level.

Apprenticeship is the par excellence of learning, simply because there is no way you can fail to learn a lesson if your senior midwife is at all diligent. She will be able to tell immediately when the apprentice doesn't know something, because she doesn't have a classroom full of other students to attend to. Then, the apprentice is taught the fact/skill/concept she was lacking. Most of us who have gone through high school and college know how easy it can be to just get by in a class—even get decent grades—just by knowing what a particular teacher will test on. It is entirely possible for students to get good grades without understanding concepts on a deeper level. You can't get away with that when you are an apprentice and you actively engage in activities and discussion. Therefore, apprenticeship can weed out those who are not really cut out for midwifery in a way classroom and group learning cannot.

Of course, there are drawbacks even to apprenticeship. The most obvious is the dependency on the senior midwife's level of skill, knowledge, and teaching competency. She must take her job seriously, to the point of feeling responsible if her apprentice doesn't know what she needs to know. She must be willing to judge tenaciously her apprentice's knowledge and skill before she gives her the go ahead to attend births on her own.

Apprenticeship is also a major benefit to the senior midwife. Having an apprentice constantly keeps you on your toes and helps keep your factual knowledge current. It has been said, "To learn, you must teach." I am always learning, or re-learning things from my apprentices. One asks me, "what is the percent false positives in the AFP test?" We look up the answer together. Next time, I remember that piece of information because I had to look it up to answer her question and because we discussed it. The learning goes both ways and never stops, as is essential to maintain high standards.

In a classroom or group setting, real learning *can* stop. There are always some teachers who will rely on one textbook and simply go through it year after year. There may be little discussion and no update of information. The teacher gets into an easy rut and barely needs to think to get through the day and neither do the students. This scenario can't happen in an apprenticeship. There are too many variables to allow it; such as a new complication at a birth, a new client with a unique history, or a newborn with an unusual anomalie.

I purposely chose apprenticeship as my route to becoming a midwife. I

continued on page 13

Midwifery Education

continued from page 12

had a friend who was going through a CNM program at the same time, and it was interesting to note the differences in our training. I didn't envy her hours of classroom work, but I did envy her access to much clinical experience in a relatively short period of time. Apprenticeships could be improved nationwide if CNM and medical schools worked cooperatively with direct-entry midwives in providing this kind of experience.

I hope the MANA Board, the ACNM Board, and the Carnegie Foundation will carefully research how people actually learn best before they establish any standards for midwifery education. It is ludicrous to assume that two or three years of classroom instruction, even with (group) clinical experience, can improve the one-to-one learning that takes place in apprenticeship. It is my opinion that this type of learning will not standardize midwifery education or improve it but will only weaken it as a whole. Apprenticeship must be used as the basis of training to ensure high standards.

Report to MANA Regarding ACNM's Efforts to Accredit Direct-Entry Programs

Therese Stallings

The following report is based on conversations with Joyce Roberts, Chair of the American College of Nurse-Midwives' (ACNM's) Division of Accreditation (DOA) June and July 1991.

The ACNM has taken some preliminary steps to accredit direct-entry programs, prompted by requests in recent years from Washington State, Arizona and New York. Their intention is to follow closely their current criteria, articulating the "nursing" content they assume a student gets in nursing school so they can verify that direct-entry programs provide this, thereby being able to say that the programs train students equivalently to nurse-midwifery programs. This way, they aren't really creating another category of midwives as much as they are just expanding the routes of training. In the same way, they envision going to legislators to lobby that graduates of these programs aren't really any different than current nurse-midwives in that all have mastered the same core competencies, therefore, they should be legally recognized as the same as CNMs.

The first challenge in this process is articulating the "nursing component" which Joyce has begun to do. Her first draft of a list of "competencies," essential to midwifery which are taught in nursing school, was circulated to Interorganizational Work Group members in early June for feedback. After she receives feedback from this preliminary list, she will further develop it and incorporate this into a "Delphi study" she is conducting. This questionnaire will be sent to direct-entry midwifery educators and others and will help develop a foundation of information from which the ACNM will proceed.

At this point, Joyce is beginning to gather a "task force" who will work with her in evaluating the results from the preliminary questionnaire, developing the Delphi study, and identifying appropriate people to be included in the study. This task force is comprised of CNMs with experience in innovative models of midwifery education as well as a few direct-entry midwives. There are a few unanswered questions about this part of the process such as: what is the ideal sample size for the study, and how will it be determined who is or is not included? The task force and an already existing "advisory board" will work with her in making these decisions.

The current ACNM Board has recommended that direct-entry programs be post-baccaleaureate. Ultimately, it is the Division of Accreditation (DOA) who will determine this level. Joyce personally thinks the post- baccaleaureate requirement will not fly, because, within the constituents of the DOA (i.e., all the programs they currently accredit), there is a firm commitment to "certificate" as well as "degree" programs. Requiring a bachelors degree for admission to direct-entry programs would undermine their current certificate-level programs that only require an Associate Degree in Nursing.

The process for the ACNM developing criteria for the accreditation of direct-entry programs is a many-year process. After the DOA has collected all the information it needs, gotten feedback from its constituents, and compiled a report and a recommended plan of action, it will submit this to the ACNM Board who ultimately will need to approve it.

At this point, the ACNM has no intention of *starting* direct-entry programs, it is only interested in having a mechanism in place in order to respond to those programs that might request accreditation by the ACNM. Joyce and I had long discussions about the difficulties of university-affiliation, and I do believe she now has a good grasp of how much of a barrier that criteria alone would be for direct- entry programs. I shared with her MEAC's first draft of accreditation criteria.

Joyce is retiring as chair of the DOA this fall to be replaced by Helen Varney Burst. It seems most important that communication channels between the Midwifery Education Accreditation Council and the ACNM-DOA are open and clear so efforts can be cooperative when possible.

Therese is co-chair of the MANA Education Committee and involved with the Seattle Midwifery School.

19 Feb 92
Juneau, AK

We oppose the House Bill # 382
"An act relating to regulating the practice of midwifery" and to form a Board of Licensed Midwives.

I We Oppose:
1) The formation of a Board for midwives.
- members qualification are unclear and are without medical regulation
2) licensure by apprenticeship -
(Not enough education/experience for Safety)

II We are Concerned:
1) licensure did not discuss CEU's
2.) Creates further confusion regarding the difference of Cert. Nurse-midwives and lay midwives.
3) liability insurance; Can they get it?
4) Can their Board be self sustaining as decreed by State Law?

The bill is not comprehensive enough in the scope of practice, education, and clinical experience to protect Alaskan consumers seeking care given by lay midwives.

Our recommendation is to reject HB No 382.
And to Review:
HESS Draft 12/21/91
Title 7 HESS amended Chapter 16. Lay midwives

Thank-you,
Yolanda A. Meza CNM work # 552-2264

submitted by: Cheryl Chesnut, CNM, Chairperson Alaska Chapter of Cert. Nurse-Midwives

STATE OF ALASKA
1992 LEGISLATIVE SESSION

FISCAL NOTE

BILL NO. HB 382

Revision Date. ______

Department Affected: Commerce & Economic Development

Title: An Act relating to regulating the practice of midwifery; and providing for an effective date.

BRU: Occupational Licensing

Component: Administration

Sponsor: Rep. Koponen

Requestor: House HESS

COMPONENT SERIAL NO. 0 3 5 6

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	4.1	4.1	4.1	4.1	4.1	4.1
TRAVEL	6.5	6.5	6.5	6.5	6.5	6.5
CONTRACTUAL	3.1	3.1	3.1	3.1	3.1	3.1
SUPPLIES	1.1	1.1	1.1	1.1	1.1	1.1
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	14.8	14.8	14.8	14.8	14.8	14.8
CAPITAL						
REVENUE	29.6		29.6		29.6	

FUNDING: (Thousands of Dollars)

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
GENERAL FUND						
FEDERAL FUNDS						
OTHER - GF/PR	14.8	14.8	14.8	14.8	14.8	14.8
TOTAL	14.8	14.8	14.8	14.8	14.8	14.8

POSITIONS:

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary)

HB 382 establishes a five member Board of Licensed Midwives to regulate the practice of midwifery in Alaska. Information provided by supporters of the bill have indicated there are approximately 50 individuals currently in Alaska who may seek and qualify for licensure.

Prepared By: Jennifer Strickler [signature] Phone: 465-2144

Division: Occupational Licensing [signature] Date: 01/21/92

Approved by Commissioner: Glenn A. Olds [signature] Act. Comm.

Agency: Department of Commerce & Economic Development Date: 1.21.92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

14.8 Operating DCED
FN 29.6 Revenue

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. HB 382

The following is an explanation of anticipated costs to be associated with the new licensing program:

Personal Services - $ 4.1

All licensing programs share the costs of support resources in the division, often referred to as "overhead expenses". Based on 50 practitioners, the midwives licensing program will be responsible to cover less that one percent (0.17) of the overhead costs. This is determined by dividing the number of practitioners (50) by the total number of current licensees in occupational licensing programs (28,631).

Travel - $ 6.5

This funding provides transporation and per diem for board and staff to meet twice each year; based on one meeting in Anchorage and one in Juneau. Special meetings are anticipated to be held by teleconference.

Contractual Services - $ 3.1

This funding will provide for printing and advertising of public notices for meetings and examinations, facility rentals for meeting and exams, proctor fees, postage and other communication costs.

Supplies - $ 1.1

This funding will provide standard operating supplies for the program.

REVENUE:

The division anticipates this program will cover its costs through licensing fees. Since licenses are biennial, fees collected at the onset of the bill and every other year thereafter are doubled to cover program costs over the biennial cycle. Although funding collected in one fiscal year cannot be used in the next fiscal year, renewal dates of the many licensing programs within the division are staggered so that licensing fees cover program expenses from year to year. The revenues are based on licensees paying a fee of approximately $300 each year to cover the costs of the licensing program regulated by a five member board.

3

HOUSE COMMITTEE REPORT

2-26-92

(7)
Date Referred: January 13, 1992

FURTHER REFERRALS: Judiciary ~~Finance~~

Date of Committee Action: 2/25/92

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 382

HOUSE BILL NO. 382 — LICENSING OF MIDWIVES

"An Act relating to regulating the practice of midwifery; and providing for an effective date."

RECOMMENDATIONS:
be replaced with CS HB 382 (HES)

[✓] the same title
[ ] a new title

[ ] have attached amendments(s)
[ ] do pass
[ ] do not pass
[ ] no recommendations
[✓] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: ______ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[✓] fiscal impact DCED

[ ] zero fiscal note ______

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) ______

[ ] zero fiscal note(s) ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
(Mol) [signature]	✓				
(Carney) [signature]	✓	Cheri Davis		✓	
[illegible]		Betty Davis		✓	
		Mark Hanley		X	
[signature] Gonzales	✓	[illegible]		✓	

CO-CHAIRMAN'S SIGNATURE

7-LS1631\G
Luckhaupt
2/13/92

CS FOR HOUSE BILL NO. 382 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES KOPONEN, B.Davis, Ulmer, Brown

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulating the practice of midwifery; and providing for an effective**
2 **date."**

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

4 * **Section 1.** AS 08.01.010 is amended by adding a new paragraph to read:
5 (33) Board of Licensed Midwives (AS 08.65.010).
6 * **Sec. 2.** AS 08.02.010(a) is amended to read:
7 (a) An acupuncturist licensed under AS 08.06, an audiologist licensed under AS 08.11,
8 a person licensed in the state as a chiropractor under AS 08.20, a dentist under AS 08.36, a
9 medical practitioner or osteopath under AS 08.64, **a midwife licensed under AS 08.65,** a
10 registered nurse under AS 08.68, an optometrist under AS 08.72, a registered pharmacist under
11 AS 08.80, a physical therapist or occupational therapist licensed under AS 08.84, a psychologist
12 under AS 08.86, or a clinical social worker licensed under AS 08.95 [,] shall use as professional
13 identification appropriate letters or a title after that person's name **that** [WHICH] represents that
14 person's specific field of practice. The letters or title shall appear on all signs, stationery, or

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1 other advertising in which the person offers or displays personal professional services to the
2 public. In addition, a person engaged in the practice of medicine or osteopathy as defined in
3 AS 08.64.380, or a person engaged in any manner in the healing arts who diagnoses, treats, tests,
4 or counsels other persons in relation to human health or disease and uses the letters "M.D." or
5 the title "doctor" or "physician" or another title that tends to show that the person is willing or
6 qualified to diagnose, treat, test, or counsel another person, shall clarify the letters or title by
7 adding the appropriate specialist designation, if any, such as "dermatologist," "radiologist,"
8 "audiologist," "naturopath," or the like.
9 * Sec. 3. AS 08.03.010(c) is amended by adding a new paragraph to read:
10 (23) Board of Licensed Midwives (AS 08.65.010) -- June 30, 1996.
11 * Sec. 4. AS 08.64.370 is amended to read:
12 Sec. 08.64.370. EXCEPTIONS TO APPLICATION OF CHAPTER. This chapter does
13 not apply to
14 (1) officers in the regular medical service of the armed services of the United
15 States or the United States Public Health Service while in the discharge of their official duties;
16 (2) a physician or osteopath, who is not a resident of this state, who is asked by
17 a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case;
18
19 (3) the practice of the religious tenets of a church;
20 (4) [REPEALED
21 (5)] a physician in the regular medical service of the United States Public Health
22 Service or the armed services of the United States volunteering services without pay or other
23 remuneration to a hospital, clinic, medical office, or other medical facility in the state;
24 <u>(5)</u> [(6)] a person who is <u>licensed</u> [REGISTERED] as a [LAY] midwife by the
25 <u>department</u> [DEPARTMENT OF HEALTH AND SOCIAL SERVICES] under <u>AS 08.65</u>
26 [AS 18.05.040] or who is excluded from registration under <u>AS 08.65.160(3) and (4)</u>
27 [AS 18.05.057] while engaged in the practice of [LAY] midwifery whether or not the person
28 accepts compensation for those services.
29 * Sec. 5. AS 08 is amended by adding a new chapter to read:
30 CHAPTER 65. MIDWIVES.
31 Sec. 08.65.010. BOARD ESTABLISHED. (a) There is established the Board of

1 Licensed Midwives.

2 (b) The board consists of five members appointed by the governor subject to
3 confirmation by the legislature in joint session. Members serve for staggered terms of four years
4 and until a successor is appointed and qualified. The board consists of two members who are
5 licensed in this state as licensed midwives, one health care professional, one certified nurse
6 midwife licensed by the Board of Nursing in this state, and one public member who has received
7 or paid for the services of a midwife licensed under this chapter.

8 (c) The board shall elect a chairperson and a secretary from among its members to terms
9 of one year.

10 (d) A member may serve no more than two complete consecutive terms on the board.

11 Sec. 08.65.020. MEETINGS. The board shall meet twice annually and may hold special
12 meetings at the call of the chairperson or on the written notice of two board members.

13 Sec. 08.65.030. DUTIES AND POWERS OF BOARD. (a) The board shall

14 (1) examine applicants and issue licenses to those applicants it finds qualified;

15 (2) adopt regulations establishing licensing and license renewal requirements;

16 (3) issue permits to apprentice midwives;

17 (4) hold hearings and order the disciplinary sanction of a person who violates this
18 chapter or a regulation of the board;

19 (5) supply forms for applications, licenses, permits, certificates, and other papers
20 and records;

21 (6) report annually to the governor and the department on the board's proceedings
22 during the year;

23 (7) enforce the provisions of this chapter and adopt regulations necessary to make
24 the provisions of this chapter effective.

25 (b) The board may by regulation require that a licensee undergo a uniform or random
26 period of peer review to ensure the quality of care provided by the licensee.

27 Sec. 08.65.040. PROCEDURES. The Administrative Procedure Act (AS 44.62) applies
28 to regulations and proceedings under this chapter.

29 Sec. 08.65.050. QUALIFICATIONS FOR LICENSE. (a) The board shall issue a license
30 to practice midwifery to a person who

31 (1) applies on a form provided by the board;

1 (2) pays the fees required under AS 08.65.100;
2 (3) furnishes evidence satisfactory to the board that the person has not engaged
3 in conduct that is a ground for imposing disciplinary sanctions under AS 08.65.110;
4 (4) furnishes evidence satisfactory to the board that the person has completed a
5 course of study and supervised clinical experience; the study and experience must be of at least
6 one year's duration;
7 (5) successfully completes the examination required by the board.
8 (b) The board may issue a license to a person who meets the requirements of (a)(1) - (3)
9 and (5) of this section if the board determines that the person substantially satisfies the
10 requirements of (a)(4) of this section. The board may defer consideration of an application under
11 this subsection and require completion of additional study or supervised clinical experience before
12 making its decision.
13 Sec. 08.65.060. EXAMINATIONS. The board shall conduct examinations at least twice
14 each year. Examinations may be written, oral, or practical or a combination of these. The board
15 may utilize the examination provided by a nationally certified midwives organization recognized
16 by the board. An applicant who has failed the examination may not retake the examination for
17 a period of six months.
18 Sec. 08.65.070. LICENSURE BY CREDENTIALS. The board may by regulation
19 provide for the licensing without examination of a person who meets the requirements of
20 AS 08.65.050(1) - (4) and who is currently licensed in another state with licensing and
21 examination requirements at least equivalent in scope, quality, and difficulty to those of this state
22 at the time of licensure. At a minimum, an applicant for licensing by credentials
23 (1) may not be the subject of an unresolved complaint or disciplinary action
24 before a regulatory authority in this state or another jurisdiction;
25 (2) may not have failed the examination for a license to practice midwifery in this
26 state;
27 (3) may not have had a license to practice midwifery revoked in this state or
28 another jurisdiction;
29 (4) shall submit proof of continued competency satisfactory to the board; and
30 (5) shall pay the required fees.
31 Sec. 08.65.080. RENEWAL. A license issued under AS 08.65.050 or 08.65.070 expires

1 on a date determined by the board and may be renewed every two years upon payment of the
2 required fee and the submission of evidence satisfactory to the board that the licensed midwife
3 has met the continuing education requirements of the board and has not committed an act that
4 is a ground for discipline under AS 08.65.110.
5 Sec. 08.65.090. APPRENTICE MIDWIVES. (a) The board shall issue a permit to
6 practice as an apprentice midwife to a person who satisfies the requirements of AS 08.65.050(1) -
7 (3). The permit application must include information about the supervisor's licensing and
8 experience and be signed by the supervisor. The permit is valid for a term of two years and may
9 be renewed in accordance with regulations adopted by the board.
10 (b) An apprentice midwife may perform all the activities of a licensed midwife if
11 supervised by
12 (1) a licensed midwife who has been licensed and practicing in this state for at
13 least two years;
14 (2) a licensed midwife who has been licensed for at least two years in a state with
15 licensing requirements at least equivalent in scope, quality, and difficulty to those of this state
16 at the time of licensing, who is licensed in this state, and who has practiced midwifery for the
17 last two years;
18 (3) a physician licensed in this state; or
19 (4) a certified nurse midwife licensed by the Board of Nursing in this state.
20 Sec. 08.65.100. FEES. The department shall set fees under AS 08.01.065 to implement
21 this chapter.
22 Sec. 08.65.110. GROUNDS FOR DISCIPLINE, SUSPENSION, OR REVOCATION OF
23 LICENSE. After a hearing, the board may impose a disciplinary sanction on a person licensed
24 under this chapter if the board finds that the licensee
25 (1) secured a license through deceit, fraud, or intentional misrepresentation;
26 (2) engaged in deceit, fraud, or intentional misrepresentation in the course of
27 providing professional services or engaging in professional activities;
28 (3) advertised professional services in a false or misleading manner;
29 (4) has been convicted of a felony or other crime that affects the licensee's ability
30 to continue to practice competently and safely;
31 (5) intentionally or negligently engaged in or permitted the performance of client

1 care by persons under the licensee's supervision that does not conform to minimum professional
2 standards regardless of whether actual injury to the client occurred;
3 (6) failed to comply with this chapter, with a regulation adopted under this
4 chapter, or with an order of the board;
5 (7) continued to practice after becoming unfit due to
6 (A) professional incompetence;
7 (B) failure to keep informed of current professional practices;
8 (C) addiction or severe dependency on alcohol or other drugs that impairs
9 the ability to practice safely;
10 (D) physical or mental disability;
11 (8) engaged in lewd or immoral conduct in connection with the delivery of
12 professional service to clients.
13 Sec. 08.65.120. DISCIPLINARY SANCTIONS. (a) When it finds that a licensee is
14 guilty of an offense under AS 08.65.110, the board, in addition to the powers provided in
15 AS 08.01.075, may impose the following sanctions singly or in combination:
16 (1) permanently revoke a license to practice;
17 (2) suspend a license for a determinate period of time;
18 (3) censure a licensee;
19 (4) issue a letter of reprimand;
20 (5) place a licensee on probationary status and require the licensee to
21 (A) report regularly to the board upon matters involving the basis of
22 probation;
23 (B) limit practice to those areas prescribed;
24 (C) continue professional education until a satisfactory degree of skill has
25 been attained in those areas determined by the board to need improvement;
26 (6) impose limitations or conditions on the practice of a licensee.
27 (b) The board may withdraw probationary status if it finds that the deficiencies that
28 required the sanction have been remedied.
29 (c) The board may summarily suspend a license before final hearing or during the
30 appeals process if the board finds that the licensee poses a clear and immediate danger to the
31 public health and safety if the licensee continues to practice. A person whose license is

1 suspended under this section shall be entitled to a hearing by the board no later than seven days
2 after the effective date of the order. The person may appeal the suspension after a hearing to the
3 superior court.
4 (d) The board may reinstate a license that has been suspended or revoked if the board
5 finds after a hearing that the applicant is able to practice with reasonable skill and safety.
6 (e) The board shall seek consistency in the application of disciplinary sanctions, and
7 significant departure from prior decisions involving similar situations shall be explained in
8 findings of fact or orders.
9 Sec. 08.65.130. CRIMINAL PENALTY. A person who violates this chapter is guilty
10 of a class B misdemeanor.
11 Sec. 08.65.140. REQUIRED PRACTICES. (a) Except as provided in (d) of this section,
12 a licensed midwife may not assume the care or delivery of a client unless the licensed midwife
13 has recommended that the client undergo a physical examination performed by a physician,
14 public health nurse, or nurse midwife, who is licensed in this state, and the client is in normal
15 physical condition and is expected to have a low risk pregnancy.
16 (b) A licensed midwife shall inform a woman seeking home birth of the possible risks
17 of home birth and shall obtain a signed informed consent from the woman before the onset of
18 labor. A licensed midwife shall accept full legal responsibility for the midwife's acts or
19 omissions.
20 (c) A licensed midwife shall comply with the requirements of AS 18.15.150 concerning
21 taking of blood samples, AS 18.15.200 concerning screening of phenylketonuria (PKU),
22 AS 18.15.160 concerning birth registration, AS 18.50.230 concerning registration of deaths,
23 AS 18.50.240 concerning fetal death registration, and regulations adopted by the Department of
24 Health and Social Services concerning prophylactic treatment of the eyes of newborn infants.
25 (d) Unless a physician is not available to attend a delivery, a licensed midwife may not
26 knowingly deliver a woman who
27 (1) has a history of thrombophlebitis or pulmonary embolism;
28 (2) has diabetes, hypertension, Rh disease with positive titer, active tuberculosis,
29 active syphilis, active gonorrhea, epilepsy, heart disease, or kidney disease;
30 (3) contracts genital herpes simplex in the first trimester of pregnancy;
31 (4) has severe psychiatric illness;

1 (5) is addicted to narcotics or other drugs;
2 (6) has multiple gestation;
3 (7) has a fetus of less than 37 weeks gestation at the onset of labor;
4 (8) has a gestation of more than 42-1/2 weeks by dates and examination;
5 (9) has a fetus in any presentation other than vertex at the onset of labor;
6 (10) is a primigravida with an unengaged fetal head in active labor, or any woman
7 who has rupture of membranes with unengaged fetal head, with or without labor;
8 (11) has a fetus with suspected or diagnosed congenital anomalies that may
9 require immediate medical intervention;
10 (12) has pre-eclampsia or eclampsia;
11 (13) has bleeding with evidence of placenta previa.
12 Sec. 08.65.150. PROHIBITED PRACTICES. Except as provided in AS 08.65.160(3) and
13 (4), a person who is not licensed under this chapter as a licensed midwife may not practice
14 midwifery for compensation.
15 Sec. 08.65.160. LICENSE REQUIRED IF DESIGNATION USED. A person who is not
16 licensed under this chapter or whose license is suspended or revoked, or whose license has
17 lapsed, who knowingly uses in connection with the person's name the words or letters "L.M.,"
18 "Licensed Midwife," or other letters, words, or insignia indicating or implying that the person is
19 licensed as a midwife by this state or who in any way, orally or in writing, directly or by
20 implication, knowingly holds out as being licensed by the state as a midwife in this state is guilty
21 of a class B misdemeanor.
22 Sec. 08.65.170. EXCLUSIONS. This chapter does not apply to a person
23 (1) who is licensed as a physician in this state;
24 (2) who is licensed as a certified nurse midwife by the Board of Nursing in this
25 state;
26 (3) who is practicing midwifery on the effective date of this Act and who receives
27 compensation for services if the person's cultural traditions have included, for at least two
28 generations, the attendance of lay midwives at births, and if the person has attended at least 10
29 births;
30 (4) whose cultural traditions have included, for at least two generations, the
31 attendance of midwives at births, who accepts compensation for the practice of midwifery if the

1 person has assisted another in at least 10 births and the person assisted is excluded from
2 registration under this section or is a licensed midwife, physician, nurse midwife, or public health
3 nurse.

4 Sec. 08.65.180. DEFINITIONS. In this chapter,

5 (1) "board" means the Board of Licensed Midwives;

6 (2) "department" means the Department of Commerce and Economic
7 Development;

8 (3) "practice of midwifery" means providing reproductive health care to women
9 and newborns in a community; providing necessary supervision, health care, and education to
10 women during pregnancy, labor, and the postpartum period, conducting deliveries on the
11 midwife's own responsibility, and providing immediate postpartum care of the newborn and
12 primary reproductive health care to the woman during the interconceptual period; "practice of
13 midwifery" includes preventative measures, the identification of physical, social, and emotional
14 needs of the newborn and the woman, and arranging for consultation, referral, and continued
15 involvement when the care required extends beyond the abilities of the midwife, and the
16 execution of emergency measures in the absence of medical assistance. as specified in regulations
17 adopted by the board.

18 * Sec. 6. AS 18.05.040(a) is amended to read:

19 (a) The commissioner shall adopt regulations consistent with existing law for

20 (1) the definition, reporting, and control of diseases of public health significance;

21 (2) cooperation with local boards of health and health officers;

22 (3) protection and promotion of the public health and prevention of disability and
23 mortality;

24 (4) the transportation of dead bodies;

25 (5) carrying out the purposes of this chapter;

26 (6) the conduct of its business and for carrying out the provisions of laws of the
27 United States and the state relating to public health;

28 (7) establishing the divisions and local offices and advisory groups necessary or
29 considered expedient to carry out or assist in carrying out a duty or power assigned to it;

30 (8) the voluntary certification of laboratories to perform diagnostic, quality
31 control, or enforcement analyses or examinations based on recognized or tentative standards of

1 performance relating to analysis and examination of food to include seafood, milk, water, and
2 specimens from human beings submitted by licensed physicians and nurses for analysis;
3 (9) the regulation of quality and purity of commercially compressed oxygen sold
4 for human respiration;
5 (10) the registration of **birth centers, except that the commissioner may not**
6 **require the presence of a physician or nurse midwife at a birth resulting from a low risk**
7 **pregnancy attended by a midwife licensed in this state** [LAY MIDWIVES WHO MEET THE
8 REQUIREMENTS ADOPTED BY THE DEPARTMENT FOR EDUCATION, TRAINING, AND
9 DISCIPLINE OF PERSONS ENGAGED IN THE PRACTICE OF LAY MIDWIFERY].
10 * **Sec. 7.** AS 18.05.056, 18.05.057, 18.05.060, 18.05.070(3) are repealed.
11 * **Sec. 8.** Notwithstanding AS 08.65.050, enacted by sec. 5 of this Act, the board may issue a license
12 to a person who is practicing midwifery in this state on the effective date of this Act or who has
13 practiced midwifery in this state within the two years immediately before the effective date of this Act
14 if the person fulfills the requirements of AS 08.65.050(1) - (3), substantially fulfills the requirements of
15 AS 08.65.050(4), and passes the examination provided by AS 08.65.060.
16 * **Sec. 9.** Notwithstanding AS 08.65.150, enacted by sec. 5 of this Act, a person who is practicing
17 midwifery on the effective date of this Act or who has practiced midwifery within the two years
18 immediately before the effective date of this Act may accept fees for practicing midwifery until the date
19 180 days after the effective date of this Act even if the person is not licensed under AS 08.65.
20 * **Sec. 10.** TEMPORARY SUPERVISORS. A midwife who has been licensed in this state for less
21 than two years may supervise an apprentice until two and one-half years after the effective date of this
22 Act if the licensed midwife has practiced midwifery in this state for at least two years immediately
23 before the effective date of this Act.
24 * **Sec. 11.** INITIAL APPOINTMENTS TO THE BOARD. (a) Notwithstanding AS 08.65.010, one
25 initial member of the Board of Licensed Midwives shall be appointed for a term of one year, one initial
26 member shall be appointed for a term of two years, one initial member shall be appointed for a term of
27 three years, and two initial members shall be appointed for terms of four years. The members appointed
28 to initial terms less than four years under this section may be reappointed to one full four-year term.
29 (b) In making initial appointments of midwives and a person who has received or paid for the
30 services of a midwife to the Board of Licensed Midwives, the governor shall consider a midwife licensed
31 for the purpose of AS 08.65.010 if the midwife has practiced midwifery in this state for a period of two

1 years.

2 * Sec. 12. This Act takes effect immediately under AS 01.10.070(c).

MIDWIVES ASSOCIATION OF ALASKA

EXECUTIVE SUMMARY OF RESOLUTION

#1: Birthing is normal. It is not a medical event.

#2: In most industrialized nations, midwifery and modern medical technology are integrated into a fulfilling maternal-infant health care system

#3: The United States ranks 23d - 24th in infant mortality rates. Caesarean rates approach 30% when 20 years ago it was 5%.

#4: The World Health Organization supports care of normal pregnancies through use of trained midwives.

#5. The 1991 Governor's Conference was advised that "certified midwifery" would be an integral part of any well planned U.S. health care system paralleling all industrialized Europe.

#6: Midwives of Alaska share basic worldwide midwife philosophies

#7: Midwifery care reduces stress on pregnant woman associated with hospital delivery systems.

#8: Midwifery is an issue of choice for a woman.

#9: Midwifery enjoys a supportive statewide constituency.

#10: Midwifery reduces health care costs with potential to reduce health care insurance premiums.

#11: Midwifery is clearly legal in several states.

#12: Alaska statutes regarding midwifery passed in 1985 (AS 18.05) has never been administered. Extensive popular support in 1985.

#13: Several attempts to develop implementing regulations with Dept. of Health and Social Services failed, along with passage of time through three separate administrations.

#14: Original legislation flawed due to compromises which may have been expedient in 1985, but which are no longer applicable due to evolution of professional stature of midwifery in the past 7 years. MAA recommends deletion of old law and implementation of new law containing establishment of a regulatory board with authority to promulgate regulation which addresses continuing evolution of midwifery.

#15: Midwives Association of Alaska initiated move to become licensed and regulated in 1985. It was not imposed upon from outside. Current initiative on this issue is one of professionalism and as a preventative of any possible future abuse reflecting negatively on the profession in Alaska. MAA feels sense of responsibility and ownership to bring issue to rightful closure.

#16: Start up costs of licensing board reduced due to existence of recognized standard tests and draft regulations needing only revision, allowing board to transition into minimum operating budget levels more quickly.

Sponsor provided back-up

MIDWIVES ASSOCIATION OF ALASKA

RESOLUTION

1.WHEREAS..... Birthing is normal. It is not a medical event. In most of the world, normal birth is attended by midwives. Woman have attended women in childbirth since time immemorial. The medicalization of childbirth is less than 100 years old. The tradition of women attending women at birth dates back into prehistory, to include the practices of indigenous Alaska native populations even into the present, and

2.WHEREAS.... We live in a modern, technological society in which medicine and interventions can and do save lives. Yet, in most industrialized nations, midwifery care forms a cornerstone of maternal-infant health with midwives attending uncomplicated births at home and in the hospital, and obstetricians attending complicated births in the hospital. In no European country do obstetricians provide primary health care for most women with uncomplicated pregnancies and births. In every single country in the European region with prenatal and infant mortality rates lower than the United States, a midwife is the principle and only birth attendant at uncomplicated births, i.e. there is no physician in the room at time of birth Appendix B), and

3.WHEREAS.... The United States ranks 23d to 24th in infant mortality worldwide. A baby born in Hong Kong has a better chance of survival than a baby born in Washington D.C. Our caesarean rate approaches 30 percent, while only 20 years ago it was less than 5% (Appendix B). While some would advocate more technology, others postulate that medicalization of childbirth has accelerated these statistics, and

4.WHEREAS....the World Health Organization considering the issue of appropriate technology for birth issued 16 recommendations, one of which was: "the training of professional midwives or birth attendants should be encouraged. Care during normal pregnancy, birth and afterwards should be the duty of this profession" (please refer to appendix B for documents evidencing the wide range of support for midwifery in various governmental and health organizations worldwide), and

5.WHEREAS....the nation's governors in their annual 1991 meeting were addressed by Mr. Willis Goldberg, consultant to the World Health Organization, who noted that state government officials are the most cognizant of the true human costs of insufficient health care planning at the federal level. He advised the governors, in part, that restrictions on alternative health care services in America are stifling creativity and change. He mentioned, in particular, that "certified midwives" would be an essential part of any well planned U.S. health care system paralleling those of all industrialized Europe (Appendix B), and

6.WHEREAS.... Midwives of the Midwives Association of Alaska share with trained midwives all over the world these basic philosophies:

They recognize the right of all women to safe, satisfying health care. Childbirth is

one of the most creative and powerful processes life has to offer. The outcome of childbirth is determined primarily by the care women give themselves and the training of their birth attendants rather than by place of birth. Midwives educate pregnant women regarding diet, exercise, avoidance of harmful substances, etc.

Midwives encourage family-centered child bearing, meaning family members are an intrinsic part of the birth experience, not mere observers given permission to be present. Family participation and bonding are encouraged throughout the entire birth.

Midwives are committed to making possible the woman's desires regarding their childbirth experience. In addition to physical care, midwives address the emotional, spiritual, social and educational needs of the client. They foster the woman's self-determination to participate in their own care and consider them responsible partners in the health care system.

Within the limits of safety, midwives are committed to a philosophy of nonintervention during the birth. Midwives are guardians of normal birth but are also concerned with preventing complications and handling unexpected problems. If complications require a physician, the midwife will arrange for this referral while maintaining support to the client, and

7.WHEREAS.... In contrast to the time and space stresses surrounding hospital health care delivery systems, midwifery provides the pregnant woman with extensive personal attention and support. Midwives routinely have long, involved prenatal visits with their clients, see them every week toward the end of their pregnancy and make home visits up to six weeks postpartum. They offer family and personal counseling as well, and

8.WHEREAS.... From a woman's viewpoint, midwifery is an issue of choice. It is an option that should be freely available to any woman who investigates the benefits of homebirth, while at the same time, assuring the greatest degree of medical safety through licensing and regulation of the profession as proposed by the Midwives Association of Alaska, and

9.WHEREAS.... Midwifery has the popular support of constituents statewide as discovered by several solicitations for public comment by DHSS (chronological overview attached as Appendix A), and

10.WHEREAS.... Midwifery care consistently costs less than that of hospital obstetrical care. Legislative bodies are being hard pressed to find solutions to astronomically rising health care costs. It is a difficult issue not yielding to immediate and simplified proposals. About four million woman give birth annually in the United States. Prenatal care is the second most frequent ambulatory care visit to hospitals; second only to general medical examinations (US Dept. of Health & Human Services 1988/ Appendix B). Surely, at this level of statistical frequency, reducing the costs of prenatal and birth care of pregnant

women by sanctioning safe midwifery care through responsible legislation will have a significant impact on lowering health care costs. Lowering health care costs will help lower health insurance premiums, an associated social issue having to be addressed by legislative bodies nationwide, and

11.WHEREAS.... In 1990, midwifery is clearly legal in 9 states; in 6 additional states it is legal through statutory inference or judicial interpretation; in another 13 states, it is neither legally defined nor prohibited, while being openly practiced in many of those states. Therefore, in over half of the states in the union, direct entry midwifery is an option of choice for pregnant women. In 1989, New Mexico licensed midwives became the first direct entry midwives in the country to qualify for direct Medicaid payments. Midwives now qualify as eligible for insurance payments by the several large carriers of employee health insurance (Aetna, for instance), and

12.WHEREAS.... Midwifery legislation was passed into law by the Alaska legislature in 1985 (SCHB 335) amending portions of AS 08.64.370; AS 08.64.380; AS 18.05.040(a);AS 18.05.056-057. The intent of this legislation was that midwives would practice in Alaska with regulations and a certification process. Significant and overwhelming public support evidenced to support the licensing and regulatory intents of this legislation. Despite specific instructions for implementation by the 1985 legislature to the Department of Health and Social Services, this law has never been administered (Appendix A), and

13.WHEREAS.... Several attempts to develop implementing regulations through the two separate working groups formed as defined by the 1985 legislature in SCHB 335 were nonproductive due to several reasons to include (1) impasse on some key issues among the participant interests, (2) delays caused by procurement of public testimony, and (3) the passage of time which has transcended three separate administrations each with differing political philosophies and each having appointed new department commissioners needing familiarization with the issues, and

14.WHEREAS.... The past seven years has proven the difficulty of adjusting the existing, compromising 1985 Alaska law, to the factual and changing circumstances surrounding the issue of midwifery to include its subsequent development into a recognized and sanctioned profession in several states and many nations of the world. Rather than trying to fix an old law with its several glaring deficiencies in the light of 1991 evolutions, the Midwives Association of Alaska recommends the implementation of new law incorporating several core structural changes along with complete deletion of law created in 1985, and

15.WHEREAS.... The Midwives Association of Alaska sponsored the 1985 initiative to license and regulate midwifery in Alaska with an intent to see midwifery develop as a safe option of choice for childbearing woman, in parallel and conjunct with the expanding professional regard to midwifery in other states nationwide and in nations worldwide, and secondly, as a preventative to any possible breaches of safety by untrained and unskilled practitioners which would reflect poorly upon the profession of midwifery in Alaska. Because of this initiative by the association (as opposed to regulatory disciplines imposed

from outside) the association acts with a sense of responsibility and proprietorship towards the development of sensible laws and regulations that will not only work in the present but allow for future dynamics in the evolution of midwifery in Alaska and its several distinct regions, and

16.WHEREAS....in seeking the creation of a new occupational licensing board, the Midwives Association of Alaska is cognizant of the related costs to the State and is pleased to note that major start up costs will be reduced significantly by the existence of a nationally recognized qualifications test (North American Registry of Midwives Exam) and substantial draft regulations needing only revision action. Both the test and draft regulations, after revision, can be adopted by the licensing board saving the State significant start up costs. It means the board can move into an operations budget model faster than normal,

NOW THEREFORE BE IT RESOLVED THAT.... The Midwives Association of Alaska on behalf of all midwives practicing in Alaska and on behalf of all woman in Alaska who desire the option of reasonable alternatives in their method of birth, unanimously recommend to the Seventeenth Alaska State Legislature the passage of HB #382, and its companion HB #381 which provides authority for Medicaid payments to midwives granted licensed status under the conditions outlined in HB #382. Both these bills (Appendix C) are cosponsored by Representative Nilo Koponen and several others during the 1992 legislative session.

Meeting of the National Governors' Association

C-Span, February 7, 1991

Willis Goldbeck, founder of the Washington Business Group on Health and consultant to the World Health Organization and to corporations in the United States, spoke to the annual gathering of the fifty governors in Washington, D. C. on the subject of health policy in the United States. Knowing that the governors are more likely to be aware of the true human costs of the massive budget deficits than the U. S. national government, which continues to cut programs designed to improve public health, Mr. Goldbeck wasted no time in stating that the health care system in the United States is the most expensive, most redundant and least able to cover the health care needs of the public of all of the western industrialized countries. Contesting the current estimate of thirty- eight million Americans without health care insurance, Goldbeck provided his best estimate of those who have little or no health care insurance: seventy million people! This figure amounts to more than a quarter of the entire population of our country. "This nation is heading toward some sort of national health insurance reform," he said.

Goldbeck's description of the health care systems of the other industrialized nations made a sharp contrast to the piecemeal, profit- driven American health care industry. Five key features are shared by the health care systems of all industrialized European countries (including Canada), features that Mr. Goldbeck urged the governors to consider as the United States moves closer to some sort of national health plan, features which do not underlie the current U. S. health care system.

Feature One: the idea of a common, well- known public health policy.

Feature Two: each country has a health care budget.

Feature Three: the health care system of each country has some way of negotiating with health care providers; there are no free- for- alls in countries with national health care plans.

Feature Four: insurance as a commercial product is never the basis for attaining access to health care.

Feature Five: the role of employers as health insurance providers is defined by the government.

One of the first big pay- offs provided by these five features is that health care management costs are greatly reduced in the countries with national health plans. Goldbeck also remarked that European countries are following the advice of the World Health Organization in viewing the promotion of health as a nationwide responsibility. Several European countries or cities have begun plans for healthy cities, healthy schools and legislation that provides for health in the workplace. Cities and countries that have introduced effective programs are sharing information with each other, and there is a sense of progress in the field of disease prevention. Remarking that health promotion barely exists in public policy in the United States, except for weight loss programs and legislation and city ordinances regarding smoking in the workplace and in public buildings and transportation, Goldbeck stressed that the governors would do well to follow the European lead in this area.

Anticipating that the medical lobby may well resist any moves toward a national health plan on the grounds that any such plan will inevitably cause rationing of health care, Goldbeck stressed that the United States system already involves considerable rationing, that, in fact, the seventy million people who have no insurance coverage get far less care than they actually need. Since we already have rationing, he said, why fear it? With national health insurance reform, such rationing could be planned, and essential services could then be considered the birthright of every citizen.

Another point made by Mr. Goldbeck dealt with the restrictions on alternative health care systems in the United States; he made it clear that such restrictions are stifling creativity and change within our system. He mentioned, in particular, that "certified midwives" would be an essential part of any well- planned health care system and that, currently, obstetricians are effectively blocking moves towards well- spread use of midwives as maternity care providers in this country.

Write to: C-Span
400 N. Capitol Street, Suite 650
Washington, D. C. 20001

Mothering, Fall 1989

Hospital Birth Deemed "Too Risky"

At an international medical conference on the psychology of medicine and birth, held in Jerusalem this past spring, Dr. Marsden Wagner warned doctors that hospital births endanger mothers and babies—primarily because of the impersonal procedures and overuse of technology and drugs. Wagner, the European director of the World Health Organization, criticized hospitals for routinely using medical procedures once reserved for extreme situations only. "Ten out of every 1,000 babies in developed countries die," he noted. "In an effort to save those 10 babies, we put 990 babies through procedures that profoundly disrupt the experience of birth."

One such procedure is the routine use of the hospital nursery, which Wagner referred to as "a cradle of germs, separating babies from their mothers at the most sensitive point of their relationship." Citing studies that link separation at birth to later child abuse, he commented, "I am convinced the procedure of placing all newborn babies in one room was the biggest mistake of modern medicine."

Wagner's remarks drew applause and further commentary from the attending physicians. Although some defended the routine use of technology during birth, others did not. Dr. Luke Zander, of London, England, pointed out that "obstetricians see childbirth as a potentially fatal condition. They assume the body has failed and they ask themselves what they can do." Zander said he began attending homebirths after studies revealed they were at least as safe as hospital births. His experience has shown that when mothers are first evaluated for a homebirth, the results are even better. (*Chicago Sun-Times*, 2 April 1989, p. 19)

Midwives Impact on Normalization of Birth

Both cesarean and vaginal extraction rates are declining significantly as a New South Wales hospital replaces obstetric nurses with midwives. The combined rate of cesareans and forceps-vacuum extractions, which was 24.6 percent in 1977, dropped to 15.[illegible] percent in 1986 as midwives began taking on the related nursing attendance. The [illegible] attributes the decline to the [illegible] that midwives "initiate support and encourage [illegible] and respond [illegible] to the needs of the woman and her [illegible]." (*Australian Journal of Advanced Nursing* [illegible])

In an independent announcement released at a national news conference in Brisbane, Australia, the Doctors Reform Society is calling for freedom of choice for birthing women and increased availability of medical backup. The group states, "Women should have the right to choose homebirth where there are no serious overriding contraindications, and health departments should make available doctors and midwives to assist homebirths and provide ambulance backup." (*New Doctor*, no. 49; reprinted in *The Compleat Mother*, Spring 1989, p. 9)

M·A·N·A

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Standards and Qualifications for the Art and Practice of Midwifery

Adopted and printed in *MANA News*, March 1985;
Revised June 9, 1991

The midwife recognizes that childbearing is a woman's experience and encourages the active involvement of family members in care.

1. **Skills**
   Necessary skills of a practicing midwife include the ability to:
   - provide continuity of care to the woman and her family during the maternity cycle, continuing interconceptually throughout the childbearing years;
   - assess and provide care for normal antepartal, intrapartal, postpartal and neonatal periods;
   - identify and assess deviations from normal;
   - maintain proficiency in life saving measures by regular review and practice; and
   - deal with emergency situations appropriately.

   It is affirmed that judgment and intuition play a role in competent assessment and response.

2. **Appropriate equipment**
   Midwives are equipped to assess maternal, fetal, and newborn well-being; to maintain a clean and/or aseptic technique; to treat maternal hemorrhage; and to resuscitate mother or infant.

3. **Records**
   Midwives keep accurate records of care provided for each woman such as are acceptable in current midwifery practice. Records shall be held confidential and provided to the woman on request.

4. **Compliance**
   Midwives will comply with Public Health requirements of the jurisdiction in which the midwifery practice will occur.

5. **Medical Consultation and Referral**
   All midwives recognize that there are certain conditions when medical consultations are advisable. The midwife shall make a reasonable attempt to assure that her client has access to consultation and/or referral to a medical care system when indicated.

6. **Screening**
   Midwives respect the woman's right to self-determination within the boundaries of safe care. Midwives assess each woman for initial and continuing eligibility for midwifery services. Women will be informed of the assessment. It is the right and responsibility of the midwife to refuse or discontinue services, and to make appropriate referrals when indicated, for the protection of the mother, baby, or midwife.

7. **Informed Choice**
   Each midwife will present accurate information about herself and her services, including but not limited to:
   - her education in midwifery
   - her experience level in midwifery
   - her protocols and standards
   - her financial charges for services
   - the services she provides
   - the responsibilities of the pregnant woman and her family

8. **Continuing Education**
   Midwives will update their knowledge and skills.

9. **Peer Review**
   Midwifery practice includes an on-going process of review with peers.

10. **Protocols**
    Each midwife will develop protocols for her services that are in agreement with the basic philosophy of MANA and in keeping with her level of understanding

The following sources were utilized for reference:

American College of Nurse-Midwives documents

Nurse Midwifery by Helen Varney

New Mexico Regulations for the Practice of Lay Midwifery, Rev. 1982

ICM Membership and Joint Study on Maternity Care, FIGO, WHO, etc., Rev. 1972

Northwest Coalition of Midwives Standards for Safety and Competency in Midwifery

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MANA Core Competencies for Basic Midwifery Practice

Draft as of 6-8-91 to be Voted on by the Board and/or Membership Fall 1991

I. The entry level midwife provides midwifery care with an understanding of the following guiding principles:

A. Midwives respect the dignity and rights of their clients;
B. Midwives respect that pregnancy, childbirth and the postpartum are normal physiologic processes;
C. Midwives recognize women's empowerment inherent in childbearing, and strive to protect and promote this opportunity;
D. Midwifery is an autonomous profession, working interdependently with other health and social service professions;
E. Midwives strive to avoid the unnecessary use of interventions;
F. Midwives understand the importance emotional and psycho- social factors which may affect the childbearing cycle and reproductive health; and,
G. Midwives synthesize clinical observations, theoretical knowledge and intuitive judgment as components of a competent decision making process.

II. Certain concepts, skills and knowledge from health and social sciences and health and social services permeate all components of midwifery practice. The following have been identified:

A. Communication, counseling and teaching techniques, including the areas of client education and inter-professional collaboration;
B. Human anatomy and physiology relevant to human reproduction;
C. Community standards of care, including midwifery and medical standards for women during the childbearing cycle;
D. Inter-professional communication and collaboration with community health and social resources for women and children;
E. Significance of and methods for thorough documentation of client care through the childbearing cycle;
F. Informed decision making;
G. Health education, health promotion, and self care;
H. The principles of clean and aseptic techniques, and universal precautions;
I. Psychosocial, emotional and physical components of human sexuality, including indicators of common problems and methods of counseling;
J. Ethical considerations relevant to reproductive health;
K. Epidemiologic concepts and terms relevant to perinatal and women's health;
L. The principles of how to access and evaluate current research relevant to midwifery practice;
M. Family centered care, including maternal, infant and family bonding;
N. Identification of an appropriate referral of disease in women and their families;
O. The importance of accessible, quality health care for all women that includes continuity of care;

III. Components of Midwifery Care. Implicit in midwifery knowledge base is the ability to perform skill and/or have a working knowledge of the following areas:

A. Antepartum Care

1. The entry level midwife provides health care, support and information to women throughout pregnancy, determining when it is necessary to consult and refer;
2. The midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Preconceptional factors likely to influence pregnancy outcome;
   b. Basic genetics, embryology and fetal development;
   c. Anatomy and assessment of the soft and bony structure of the pelvis;
   d. Identification and assessment of the normal changes of pregnancy, fetal growth, and position;
   e. Nutritional requirements for pregnant women and methods of nutritional assessment and counseling;
   f. Environmental and occupational hazards for pregnant women;
   g. Education and counseling to promote health throughout the childbearing cycle;
   h. Methods of diagnosing pregnancy;

i. The etiology, treatment and referral, when indicated, of the common discomforts of pregnancy;
j. Assessment of physical and emotional status, including relevant historical and psycho-social data;
k. Counseling for individual birth experiences, parenthood, and changes in the family;
l. Indications for, risks and benefits of screening/diagnostic tests used during pregnancy;
m. Etiology, assessment of, treatment for, and appropriate referral for abnormalities of pregnancy;
n. Identification of, implications of and appropriate treatment for various STD/vaginal infections during pregnancy;
o. Special needs of the Rh negative woman; and,
p. Identification and care of women who are HIV positive, have hepatitis or other communicable and non-communicable diseases.

B. Intrapartum Care

1. The entry level midwife provides the appropriate health care, support and information to women throughout labor, birth and early postpartum, attending deliveries on her own responsibility, and assessing the need for consultation and referral.
2. The midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Normal labor and birth processes;
   b. Anatomy of the fetal skull and its critical landmarks;
   c. Parameters and methods for assessing maternal and fetal status including relevant historical data;
   d. Emotional changes and support during labor and delivery;
   e. Comfort and support measures during labor, birth, and immediately postpartum;
   f. Techniques to facilitate the spontaneous vaginal delivery of the baby and placenta;
   g. Etiology, assessment of, appropriate referral or transport of and/or emergency measures (when indicated) for the mother or newborn for abnormalities of the 4 stages of labor;
   h. Anatomy, physiology, and supporting normal adaptation of the newborn to extrauterine life;
   i. Familiarity with medical interventions and technologies used during labor and birth; and,
   j. Assessment and care of the perineum and surrounding tissues.

C. Postpartum Care

1. The entry-level midwife provides the appropriate health care, support, and information to women during the postpartum period determining the need for consultation and referral.
2. The entry-level midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Anatomy and physiology of the postpartum period;
   b. Anatomy and physiology and support of lactation, and appropriate breast care and assessment;
   c. Parameters and methods for assessing and promoting postpartum recovery;
   d. Etiology and methods for managing the discomforts of the postpartum period;
   e. Emotional, psycho-social and sexual changes which may occur postpartum;
   f. Nutritional requirements for women during the postpartum period;
   g. Etiology, assessment of, treatment for and appropriate referral for abnormalities of the postpartum period, and
   h. Methods to assess the success of the breastfeeding relationship and identify lactation problems, and mechanisms for making appropriate referrals.

D. Neonatal Care

1. The entry-level midwife provides health care to the normal newborn during the first 6 weeks of life, assessing the need for consultation and referral. In addition, the entry-level midwife provides support and information to parents regarding newborn care.
2. The midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Anatomy and physiology of the newborn's adaptation and stabilization in the first hours and days of life;
   b. Parameters and methods for assessing newborn status, including relevant historical date and gestational age;
   c. Nutritional needs of the newborn;
   d. Community standards and state laws for and administration of prophylactic treatments commonly used during the neonatal period;
   e. Community standards for, indications, risks and benefits of, and methods of performing common screening tests for the newborn; and,
   f. Etiology, assessment of (including screening and diagnostic tests), emergency measures and appropriate transport/referral or treatments for neonatal abnormalities.

E. Family Planning/Well Woman Care

1. The entry level midwife provides healthcare, sup-

port and information to women in matters of reproductive health and family planning, determining the need for consultation and referral.

2. The midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Information relating to steroidal, mechanical, chemical, physiological, and surgical conception control methods;
   b. Issues involved in decision making regarding unplanned pregnancies, and resources for counseling and referral;
   c. Etiology, assessment of, and treatments for and appropriate referral for abnormalities of the reproductive system and breast;
   d. Methods of pregnancy testing on urine and blood; and
   e. Assessment of physical and emotional status, including relevant historical data.

F. Professional, Legal and Other Aspects

1. The entry-level midwife assumes the role and responsibilities of the professional midwife.
2. The midwife uses a foundation of knowledge and/or skills which includes the following:
   a. MANA's Standards, Functions, and Qualifications for the Practice of Midwifery;
   b. The purpose and goals of MANA and local (state or provincial) midwifery associations;
   c. Familiarity with the principles and process of peer review, chart review, case presentation, and developing midwifery protocols;
   d. The principles of data collection and analysis as relevant to midwifery practice;
   e. Laws governing the practice of midwifery in her local jurisdiction;
   f. The history of midwifery, medicine and health care in the United States;
   g. The organization of and factors affecting maternal and infant care in the United States;
   h. Various sites, styles an modes of practice within midwifery;
   i. Awareness of the responsibility of the midwife to participate in the education of midwives, and to support legislative contributions to high quality maternal and child health services.

American College of Nurse-Midwives documents were referenced during the drafting of the MANA Core Competencies.

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Midwives' Alliance of North America Statement of Values and Ethics

As you read through this working draft of the MANA Statement of Values and Ethics, please understand this isn't the final copy. New sections are in italics and have not been approved by the MANA Board or published in the *MANA News* . When you vote to accept, reject or be undecided about this document, please vote according to the general content and structure. Also, please forward any comments, complaints, suggestions or compliments to Anne Frye, Ethics Committee Chair, 189 Pine Street, New Haven, CT 06513 (203) 624-2438.

We, as women and as midwives, have a responsibility to educate ourselves and others regarding our values and ethics. Our exploration of ethical midwifery is a critical reflection of moral issues as they pertain to maternal/child health on every level. This statement is intended to provide guidance for professional conduct in the practice of midwifery, as well as for MANA's policy making, thereby promoting quality care for childbearing families.

First, we recognize that values often go unstated, and yet our ethics (how we act) proceed directly from a foundation of values. Since what we hold precious infuses and informs our ethical decisions and actions, the Midwives' Alliance of North America wishes to explicitly affirm our values as follows:

I. *Woman as an Individual with Unique Value and Worth*

A. *We value women and their creative, life-affirming and life-giving powers which find expression in a diversity of ways.*

B. *We value a woman's right to make choices regarding all aspects of her life.*

II. Mother and Baby as Whole

A. We value the oneness of the pregnant mother and her unborn child; an inseparable and interdependent whole.

B. We value the birth experience as a rite of passage; the sentient and sensitive nature of the newborn; and the right of each baby to be born in a caring and loving manner, without separation from mother and family.

C. We value the integrity of a woman's body and the right of each woman and baby to *be totally supported in their efforts to achieve* a natural, spontaneous vaginal birth.

D. We value the breastfeeding relationship as the ideal way of nourishing and nurturing the newborn.

III. The Nature of Birth

A. We value the essential mystery of birth.[1]

B. We value pregnancy and birth as natural processes that science will never supplant.[2]

C. We value the integrity of life's experiences; the physical, emotional, mental, psychological and spiritual components of a process are inseparable.

D. We value pregnancy and birth as intimate, internal, sexual and private events to be shared in the environment and with the attendants a woman chooses.[3]

E. We value the learning experiences of life and birth.

F. We value pregnancy and birth as processes which have lifelong impact on a woman's self esteem, ability to nurture, health, and personal growth.

IV. The Art of Midwifery

A. We value our right to practice the art of midwifery. We value our work as an ancient vocation of women which has existed as long as humans have lived on earth.

B. We value expertise which incorporates academic knowledge, clinical skill, intuitive judgment and spiritual awareness.[4]

C. We value all forms of midwifery education and acknowledge the ongoing wisdom of apprenticeship as the original model for training midwives.

D. We value the art of nurturing the intrinsic normalcy of birth and recognize that each woman and baby have parameters of well-being unique unto themselves.

E. We value the empowerment of women in all aspects of life and particularly as that strength is realized during

[1] Mystery is defined as something that has not or cannot be explained or understood; the quality or state of being incomprehensible or inexplicable; a tenet which cannot be understood in terms of human reason.

[2] Supplant means to supersede by force or cunning; to take the place of.

[3] In this context, internal refers to the fact that birth happens within the body and psyche of the woman: ultimately she, and only she, can give birth.

[4] An expert is one whose knowledge and skill is specialized and profound, especially as the result of practical experience.

pregnancy, birth and thereafter. We value the art of allowing that strength to manifest openly so that women can birth unhindered and secure.

F. We value skills which support a complicated pregnancy or birth to move toward a state of greater well-being or to be brought to the most healing conclusion possible when that hope is lost. We value the art of letting go.[5]

G. We value the acceptance of death as an appropriate outcome. We value our focus as supporting life rather than avoiding death.[6]

H. We value standing for what we believe in the face of social and political oppression.

V. Woman as Mother

A. We value a mother's intuitive knowledge of herself and her baby before and after birth.[7]

B. We value a woman's innate ability to nurture her pregnancy and birth her baby; the power and beauty of her body as it grows and the awesome strength summoned in labor.

C. We value the mother as the only direct care provider for her unborn child.[8]

D. We value supporting women in a non-judgmental way, whatever her state of physical, emotional, social or spiritual health. We value the broadening of her available resources whenever possible so that the desired goals of health, happiness and *personal growth are realized according to her needs and perceptions.*

E. We value the right of each woman to choose a care giver appropriate to her needs and compatible with her belief systems.

F. We value pregnancy and birth as rites of passage integral to a woman's evolution into mothering.

G. We value the potential of *partners*, family and community to support women in all aspects of birth and mothering.[9]

VI. The Nature of Relationship

A. We value relationship. The quality integrity, equality and uniqueness of our interactions inform and critique our choices and decisions.

B. We value caring for women to the best of our ability without prejudice against their age, race, religion, culture, sexual orientation, physical abilities, or socioeconomic background.

C. We value honesty in relationship.

D. We value direct access to information readily understood by all.

E. We value our relationship to a process larger than ourselves, recognizing that birth is something we can seek to learn from and know, but never control.[10]

F. We value humility in our work.[11]

G. We value the concept of self responsibility and the right of individuals to make choices regarding what they deem best for themselves. We value the right to true informed choice, not merely informed consent to what we think is best. We support people to make decisions based on their own values and respect those values as precious.

H. *We value sharing information and our understanding about birth experiences, skills and knowledge.*

I. We value midwifery community as a support system and an essential place of learning and sisterhood.

J. We value diversity among midwives; recognizing that it broadens our collective resources and challenges us to work for greater understanding of birth and each other.

K. We value the recognition of our own limits and limitations.

L. We value mutual trust and respect, which grows from a realization of all of the above.

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[5] This addresses our desire for normal birth whenever possible and a recognizes that there are times when it is impossible. That is to say, a woman may be *least traumatized* to have a Cesarean and a live baby, but the hope of a normal spontaneous vaginal birth, in this case, is lost. We let go of that goal to achieve the possibility of a healthy baby. Likewise, the situation where parents choose to allow a very ill or deformed infant to die in their arms rather than being subjected to multiple surgeries, separations and ICU stays. This too, is a letting go of the normal for the most healing choice possible within the framework of the parent's ethics given the circumstances. What is most healing will, of course, vary from individual to individual.

[6] We place the emphasis of our care on supporting life (preventive measures, good nutrition, emotional health, etc.) and not pathology, diagnosis, treatment of problems, and heroic solutions in a attempt to preserve life at any cost of quality.

[7] This addresses the medical model's tendency to ignore a woman's sense of well being or danger in many aspects of health care, but particularly in regard to her pregnancy.

[8] This acknowledges that the thrust of our care centers on the mother, her health, her well-being, her nutrition, her habits, her emotional balance and, in turn, the baby benefits. This view is diametrically opposed to the medical model which often attempts to care for the fetus/baby while dismissing or even excluding the mother.

[9] While partners, other family members and a woman's larger community can and often do provide her with vital support, we wish to acknowledge that many women find themselves pregnant in abusive and unsafe environments.

[10] Seek is the key word, we recognize that we can never fully know birth.

[11] We acknowledge that in birth and life there are no guarantees, and that our best decisions in the moment may lead to unforeseen outcomes. These recognitions necessitate and maintain humility.

Making Decisions and Acting Ethically

These values reflect our feelings regarding how we frame midwifery in our hearts and minds. However, due to the broad range of geographic, religious, cultural, political, educational and personal backgrounds among our membership, how we act based on these values will be very individual. Acting ethically is a complex merging of our values and these background influences combined with the relationship we have to others who may be involved in the process taking place. We call upon all these resources when deciding how to respond in the moment to each situation.

MANA has chosen not to delineate a specific ethical code. We acknowledge the limitations of ethical codes which present a list of rules which must be followed, recognizing that such a code may interfere with, rather than enhance, our ability to make judgments, and we must have adequate information; with all of these, an appeal to a code becomes superfluous. Furthermore, when we set up rigid ethical codes, we may begin to cease considering the transformations we go through as a result of our choices as well as negate our wish to foster truly diversified practice. Rules are not something we can appeal to when all else fails. However, this is the illusion that traditional ethical codes foster. MANA's support of the individual's moral integrity grows out of an understanding that there cannot possibly be one right answer for all situations.

We acknowledge the following basic concepts and believe with these thoughts in mind ethical judgments can be made:

- *Moral agency and integrity are born within the heart of each individual.*
- *Judgments are fundamentally based on awareness and understanding of ourselves and others and are primarily derived from one's own sense of moral integrity with reference to clearly articulated values. Becoming aware and increasing our understanding are on-going processes facilitated by our efforts at personal growth on every level. The wisdom gained by this process cannot be taught or dictated, but one can learn to realize, experience and evaluate it.*
- *The choices one can or will actually make may be limited by the oppressive nature of the medical, legal or cultural framework in which we live. The more our values conflict with those of the dominant culture, the more risky it becomes to take action truly in accord with our values.*
- *Client and midwife are both individual moral agents unique unto themselves having independent value and worth.*
- *We support both midwives and clients to follow and make known the dictates of their own conscious as their relationship begins, evolves and especially when decisions must be made which impact them or the care being provided. It is up to those individuals to work out a mutually satisfactory relationship when and if that is possible.*

It is useful to understand the two basic theories upon which moral judgments and decision making processes are based. These processes become particularly important when one considers that, in our profession, a given clients' rights may not be absolute in all cases, or that in certain situations, the client may not be considered autonomous or competent to make her own decisions.

One of the main theories of ethics states that one should look to the consequences of the act (i.e. the outcome) and not the act itself to determine if it is appropriate care. This point of view looks for the greatest good for the greatest number. The other primary ethical theory states that one should look to the act itself (i.e. type of care provided) and if it is right, then this could override the net outcome. This is a more process oriented, feminist perspective. Midwives weave these two perspectives in the process of making decisions in their practice. Since the outcome of pregnancy is ultimately an unknown and is always unknowable, it is inevitable that, in certain circumstances, such decisions will lead to consequences we could not foresee.

In summary, acting ethically is facilitated by:

- *carefully defining our values;*
- *weighing the values in consideration with those of the community of midwives, families and the culture in which we find ourselves;*
- *acting in accord with our values to the best of our ability as the situation demands; and*
- *engaging in on-going self-examination and evaluation.*

There are both individual and social implications to any decision making process. The actual rules and oppressive aspects of a society are never exact. Therefore conflicts may arise, and we must weigh which choices or obligations take precedence over others. There are inevitably times when resolution does not occur and the midwife cannot make peace with any course of action or may feel conflicted about a choice already made. The community of women, both midwives and clients, will serve as a fruitful resource for continued moral support and guidance.

MANA recognizes this document as an open, ongoing articulation of our evolution regarding values and ethics.

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TESTIMONY BEFORE THE US COMMISSION TO PREVENT INFANT MORTALITY

by
Marsden Wagner
Regional Office for Europe, World Health Organization

EXECUTIVE SUMMARY

Infant mortality is not a health problem. Infant mortality is a social problem with health consequences. The first priority for lowering infant mortality in the United States is not more obstetricians or paediatricians or hospitals, nor even more prenatal clinics or well-baby clinics, but rather to provide more social and educational support to families with pregnant women and infants. This is the number one lesson to be gleaned from the experience of those industrialized countries in the world with the best record for lowering infant mortality. 70% of infant mortality occurs in the first month of life and is closely related to what happens during pregnancy and birth. Here the European experience does not support expanding medically-oriented prenatal care as a high priority in the US. On the other hand every European country, including the more developing ones, has an extensive system of social and financial benefits for families with pregnant women and infants and this should be given urgent priority in the United States. Caesarean section rates in the United States are double to triple those found in all European countries with infant mortality rates lower than the United States. At least one billion dollars are spent every year in the United States on these excessive surgical births with no benefit and with increased risk to both woman and baby. Every country in Europe with perinatal mortality and infant mortality rates lower than the United States uses midwives as the principal and only birth attendant for at least 70% of all births. The European experience shows that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions. The United States should spend far less money on interventionist obstetric care and put more resources into building up a large strong midwifery profession. For the 30% of infant mortality between one month and 12 months of age, the excess deaths in the United States are related to poor social and economic conditions for these families. The principal solution for this type of infant mortality is not more medical care but, as exists in every European country, a system of social and financial benefits for families with infants. The United States is the only developed country in the world which is not putting an adequate basic minimum of resources into social and financial programmes for families with pregnant women and infants. As a WHO staff member and as an American, I hope this Commission will have the vision and courage to start the process of rectifying this situation.

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TESTIMONY BEFORE THE US COMMISSION TO PREVENT INFANT MORTALITY

by
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Regional Office for Europe, World Health Organization

As an American paediatrician and epidemiologist who worked for 15 years in the United States in paediatrics and maternal and child health and then worked for 15 additional years in Europe in the same fields, I have had the opportunity both to understand the European perspective on infant mortality and also the US dilemma in infant mortality. The World Health Organization is most pleased to be able to assist one of its Member States, the United States of America, by bringing its data and its expertise to bear on the urgent issue of infant mortality.

Infant mortality is not a health problem. Infant mortality is a social problem with health consequences. It is analagous to traffic accident mortality in children: the first priority for improving traffic accident mortality in children is not to build more and better medical facilities, but rather to change traffic laws and better educate drivers and children. In other words, the solution is not primarily medical but environmental, social and educational. The same is true for infant mortality: the first priority is not more obstetricians or paediatricians or hospitals, nor even more pre-natal clinics or well-baby clinics, but rather to provide more social, financial and educational support to families with pregnant women and infants. This is the number one lesson to be gleaned from the experience of those industrialized countries in the world with the best record for lowering infant mortality. Most of the countries with infant mortality lower than the United States are in my Region, the European Region, and this report will outline the major findings from the successful effort of these countries to lower infant mortality and suggest the implications of these findings for the United States.

Infant mortality is normally divided into two parts - the first month (28 days) of life, and the next 11 months. This division is made because the causes of death are quite different in these two time intervals. In the United States approximately 70% of all infant mortality occurs in the first 28 days, called the neonatal or newborn period. Most of the deaths in the first 28 days are closely related to what happened at birth and, in turn, what happened during pregnancy. This means we need to turn our attention to pregnancy, birth and services provided at that time. The World Health Organization Regional Office for Europe has for eight years now carefully studied the services provided during pregnancy and birth. I have selected four aspects of this care for which it appears that the lengthy and varied experience of the European countries has direct implications for the improvement of infant mortality in the United States.

SEE PAGE 6-7
ATTACHED

The rationale for operative delivery is to minimise the risk of injury, disease or death for mother and child. The only practical yardstick for international comparison is the perinatal mortality rate. When these operative delivery rates are compared with national perinatal mortality rates in the European countries in question, only very weak correlations are found. This means that the frequency of operative deliveries does not contribute much, if anything, to the variation in perinatal mortality rates among the countries.

Obstetrical interventions have been increasing in a number of countries in Europe and this, combined with the great variation, has been causing concern among the European countries. But the obstetrical intervention rates in the United States far exceed those of any country in Europe. Indeed, the caesarean section rate in the United States ranges from nearly double to over triple that of European countries. The cost (both financial and human) in the United States for so many caesarean section births is staggering. Let me illustrate briefly.

In 1986 in the United States, the caesarean section rate was 24.1% - of the 3,731,000 live births, 899,171 were born by caesarean section. Everyone, including a National Institute of Health Consensus Conference on Caesarean Section and the American College of Obstetrics and Gynaecology (the organization of obstetricians in the US), agrees that this number of caesarean births far exceeds that really necessary for the health of mother and baby. What could we save if we had fewer caesarean sections? A meeting organized by WHO with experts from many countries in North and South America and Europe (including US experts) stated that "countries with some of the lowest perinatal mortality rates in the world have caesarean section rates of less than 10%. There is no justification for any region to have a rate higher than 10-15%.". The Scandinavian countries with some of the very lowest perinatal and infant mortality rates in the world now have caesarean section rates around 15%. What if then, for example, 15% of all births in the United States were caesarean sections instead of 24%? Then in 1986, instead of 899,171 caesarean sections, there would have been 559,650 caesarean sections: that is, by this criterion, there were 339,521 caesarean sections too many in the United States that year. If we say that each caesarean section cost $3000 more than a vaginal birth (a conservative estimate), then these excess caesarean sections cost $1 018 563 000 - over one billion dollars for that year alone. If the US caesarean section rate in 1986 had been the same as the Netherlands (6.5%) instead of 24%, there would have been 242,515 caesarean sections, leaving an excess of 656,656 caesarean sections that year in the United States at a cost of $1 969 968 000 or just under two billion dollars. It is not reasonable to assume that this two billion dollars is saving lives, since both the perinatal mortality and the infant mortality are lower in the Netherlands than in the US. Finally, since caesarean section birth carries a greater risk of illness and death, both for woman and baby, the US is also paying a considerable human price for this excess obstetrical intervention.

The fourth aspect of pregnancy and birth care in Europe with important implications for the US is midwifery. In every European country there is a large group of practising midwives - they far outnumber obstetricians. In no European country do obstetricians provide the primary health care for most women with normal pregnancy and birth. This pattern of having the midwives provide the majority of pre- and postnatal care as well as being the principal birth attendant at uncomplicated births is fundamental to the entire perinatal

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care system in the European Region. This division of labour is important since in general midwives and doctors have quite different styles of care during pregnancy and birth. The midwife stays with the woman during all stages of labour and birth and sees her role as encouraging and assisting the woman without taking over, while also serving as the woman's advocate when needed. This is a more social, non-interventionist clinical approach. The physician does not stay with the woman but rather comes when called by the midwife to diagnose and treat any undesirable deviation. The physician's role is more interventionist and medical in nature. These two styles nicely complement each other. In several countries, the midwife's presence even at complicated births (including caesarean section) is an essential reminder to all those present that most of what is going on is still normal.

The implications of midwifery practice in Europe for the situation in the United States are profound. Every single country in the European Region with perinatal and infant mortality rates lower than the United States uses midwives as the principal and only birth attendant for at least 70% of all births, i.e. there is no physician in the room at the birth. This fact alone should dispel any notions that obstetricians are safer than midwives as birth attendants at uncomplicated births. As mentioned earlier, there is also evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process. Consequently, it is perhaps not surprising that in the US one finds the highest obstetrical intervention rates as well as a serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread, independent midwifery practice in the United States as a most important counterbalance to the present situation.

With regard, then, to the approximately 70% of infant mortality which occurs in the first month of life, clearly what is needed is not more resources thrown at the problem but rather a major shift in priorities and in where the present resources are spent. Every country in Europe with a lower infant mortality than the United States spends less of their gross national product on health than the US. What is needed is less money spent on medically-oriented prenatal care, more resources shifted to social and financial support and maternity benefits for families, far less money spent on interventionist obstetrical care and more resources put into building up a large, strong, independent midwifery profession.

What is the situation with the approximately 30% of infants who die between one month and one year of age (post neonatal mortality)? The United States and the European countries have approximately the same number of babies dying from sudden infant death and from accidental death during this time interval. But beyond these common problems, the United States has an excess numbers of babies dying from infections like pneumonia and gastroenteritis. This is surprising and at first glance might suggest that what is needed is more medical care for the families with such infants, so they could receive more antibiotics earlier, etc. However, a more careful analysis makes it very clear that these deaths are related to poor housing, poor nutrition, inadequate child supervision and, generally speaking, poor social and economic conditions. It is these poor conditions which, in turn, lead to the weakened condition of the infant who is more susceptible to contracting such infections and because of inadequate resistance, dies. So once more it is clear that the solution to the problem of post neonatal

Time-honored profession, midwifery, must be encouraged

Daily News-Miner, Fairbanks, Alaska, Sunday, April 28, 1985

By VICKI PENWELL, R.M.

Currently in the state of Alaska, there is a strong push by the medical profession to outlaw and annihilate the time-honored profession of midwifery. A recent Medical Review Board opinion stated that "assisting healthy women in the natural delivery of their infants at home" constituted the practice of medicine. The Medical Review Board decision did not come about because of any charge or complaint against a midwife.

Pending in the Legislature is HB 335 that would define and regulate the practice, making midwifery clearly legal and setting high standards of training and practice. While public opinion in favor has been overwhelming (legislators are saying they have never seen such positive input on any subject) a small but vocal percentage of Alaskan doctors are adamantly and venomously opposed.

There were many factors that contributed to the drop in infant and maternal mortality around the turn of this century. Understanding aseptic technique was a major factor. (Deaths were never higher than when women first began going to hospitals in the early 1900s and doctors would examine them with blood on their hands from another patient or corpse). Other factors were better nutrition, better living conditions, and fewer children in a family.

About this time, the medical profession, only recently interested in obstetrics, waged a high smear campaign to discredit midwives as "ignorant, dirty, superstitious grannies." Many of the midwives during this period were European immigrants, who had gone through much the same training as a doctor in their native countries, and were highly respected professionals back home. However, because of laguage and cultural barriers, midwives in America were not able to unite and successfully fight off this unprovoked attack. In areas of the deep South and in poor rural areas, midwives continued to practice, and it is significant, if not sad, to note that as long as midwives only assisted poor women who had no money to pay a doctor, they went unopposed.

In the past 20 years, the demand for midwives in this country has been steadily increasing, this time cutting across all social and economic lines and now the opposition is heard.

Not all physicians agree with opposition to midwifery, however. Current studies have shown outcomes as good and better than physician-attended hospital births. Dr. Robert Mendleson, M.D., says that "Modern Medicine invents a crisis out of a normal situation. By treating childbirth as a disease, the obstetrician makes his intervention indispensable." He goes on to say that 95 percent of births proceed entirely without complication and should occur in a home setting.

In 1977, Dr. Lewis Mehl, M.D., did the only truly matched study to date comparing home with hospital births. He matched two groups of 1,046 women each, for race, age, parity, education, socio-economic status, and risk factors. None of the home birth group were attended by board- certified obstetricians and none of the hospital group were attended by midwives. His findings were:

For the hospital group: 3.7 times more babies required resuscitation, respiratory distress was 17 times higher, six times more fetal distress, four times higher infection rate, 2.5 times more meconium aspiration pneumonia, five times more maternal high blood pressure, eight times more shoulder dystocia, three times more maternal hemorrhage. In every area, complications were much worse for the hospital group.

Guest opinion

The Daily News-Miner welcomes guest opinions on a variety of topics from readers who have some expertise in a particular subject matter. Contact editorial page editor Sue Mattson at 456-6661 to discuss a specific idea.

Dr. David Stewart, president of the National Association of Parents and Professionals for Safe Alternatives in Childbirth, states that "other studies have yielded similar results. The conclusion that we draw is that hospitals pose hazards to mothers and babies that are unique to the hospital."

All of the findings used to argue the danger involved in out-of-hospital births are no more than raw statistics and data collected by Public Health departments; they are not carefully modeled studies such as those done by Dr. Mehl. When doctors quote a study that claims hospital births are five times safer, they are using a study done by the Health Department in 11 states that clumped all out-of-hospital births together: Premature births before viable age, accidental births while in transit to the hospital, unplanned home deliveries, and planned home deliveries with no attendant and no prenatal care at all.

The Farm, a community of families in Tennessee, has carefully compiled statistics of over 1,000 births attended at home by midwives. The perinatal outcomes are excellent, more than three times less than that of the state of Tennessee, and as much as four times less than several other medical centers

Cont....

around the country.

Midwives do not use drugs or surgery in the course of normal pregnancy, labor, and delivery. (The definition of the practice of medicine has commonly been "drugs and surgery"). If it seems likely that a mother or her baby would benefit from either of these, she is taken to a hospital. Use of drugs or surgery place a mother and baby in a high-risk category and she should be under a doctor's care. Midwives who assist at home deliveries in Alaska follow a standard of care which recognizes potential problems. Transfers to a medical facility are rarely emergencies. For example, the standard of care requires consult or transfer for a women who does not show appropriate weight gain or uterine growth, or when the baby is presenting other than head first. A transfer rate of 10 to 12 percent is realistic, in view of the fact that midwives' first concern is for safety, and not for "homebirth at any cost." A significant factor here is that 88 to 90 percent of women who seek midwifery care deliver with no drugs and no surgical intervention at all. Compare this with the local hospital statistics of drug use in 90 percent of all birth, and surgical procedures in almost 100 percent of vaginal deliveries (amniotomy—artifically breaking the bag of water, and episiotomy—cutting the vagina) and 20 percent cesarean deliveries (major abdominal surgery) to extract the baby.

From these local statistics it is easy to see that childbirth is, in the majority of cases, able to occur safely outside of a hospital, and without medical intervention. The fact that most doctors use surgery and drugs on practically every woman in their care does not mean that it is necessary, or in fact desirable.

VICKI PENWELL
Registered Midwife

It has been stated that regardless of setting, delivery is risky to the baby. How much more so for an infant whose small system is already compromised by drugs and interventions used on his mother during labor? The American Academy of Pediatrics has stated that no drug has been proven safe for the unborn baby. Dr. Caldreyo-Barcia, president of the International Federation of Obstetritions and Gynecologists, published a study that proved artificially breaking the bag of water produced a significant adverse effect on the unborn baby.

In June 1984, Dr. Philipson, et al., in an article published in the American Journal of Obstetrics and Gynecology, found that even a simple seemingly harmless local anesthetic right before birth has dangerous effects on the baby (commonly used lidocaine, given prior to episiotomy, goes into the baby's bloodstream in less than 1 minute).

Yet all of these are common practices during childbirth in a hospital.

I find it interesting to note that when a doctor is faced with the issue of lay midwifery, he often cites the "medical model" training of certified nurse-midwives as ideal. However, there have been certified nurse-midwives in this community as well as other places in Alaska who have been restricted in their practice or not allowed to work at all because no doctor would back them, even for hospital births. CNMs rarely attend home deliveries because, not being an independant practice, they need physician approval for their very existence. It is obvious to me that many if not most physicians in Alaska are merely giving lip service to the desire to work with midwives, and really wish we could all be wiped off the face of the earth.

With the exception of two doctors in Homer, I know of no physicians in this state willing to attend out-of-hospital births. In fact the trend throughout Alaska is for doctors to deny care of any kind to pregnant women expressing a desire not to be hospitalized for childbirth. For a Fairbanks doctor to say that a woman who wants a homebirth has the option of seeking care from a CNM or physician is misleading and completely false. That option does not exist.

The Midwives Association of Alaska is a professional, self-regulating organization, which offers a two-year training program that incorporates coursework (teaching modules that use obstetrical textbooks as the base) with a clinical apprenticeship or preceptorship. This apprenticeship or preceptorship may be with a physician, certified nurse-midwife or registered midwife. If physicians are concerned about what midwives may or may not know, it is their option to help train them, as is the case in New Mexico, where Taos Holy Cross Hospital and individual OBs and pediatricians supervise midwives doing prenatals, labor managements and deliveries, and newborn exams.

Midwives are also taught emergency measures, and carry emergency equipment with them to out of hospital deliveries.

The midwifery standard of care espouses the following principles: individualized prenatal care; special attention to nutrition; family centered, natural childbirth; home or birth center delivery; immediate family-infant bonding; and early and extended breast feeding.

Nobody wants to go backwards to the days in which many babies and sometimes mothers died in childbirth.

Midwifery of today is moving forward, looking to work as equal members of the health care team to lower our astonishingly high infant death rate in this country. There is room for both doctor and midwife, especially in Alaska, where medical help is not readily available or financially feasible to all citizens. Midwives have proven themselves to be a safe alternative for healthy women. Now it is a freedom of choice issue. It would be discrimination of the worst kind to deny Alaskan women the right of attendance in childbirth if they will not or cannot be hospitalized.

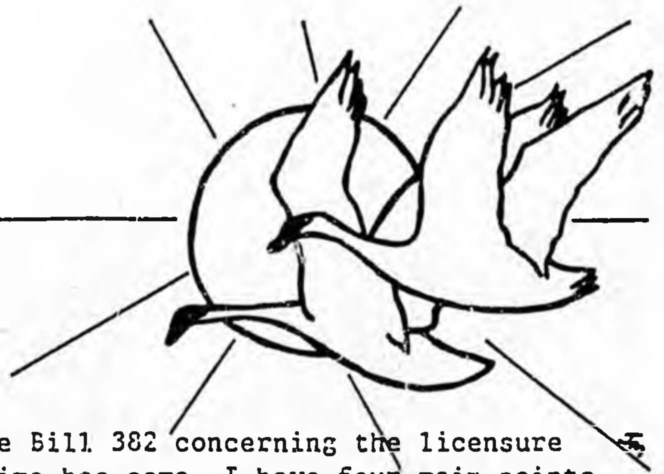
Public Opinion Messages on this matter can be sent to members of the House and Senate free of charge, through the Legislative Information Office. I urge all who believe people should have freedom to choose safe alternatives in childbirth to voice their opinons now.

Vicki Penwell, R.M., is director of the Midwives Association of Alaska. Licensed by the state of New Mexico and a member of the International Confederation of Midwives, she currently practices in Fairbanks.

A Birth Place

1243 McCarty Avenue
Fairbanks, Alaska 99701
(907) 456-BABY

Suzanne Rich, Licensed Midwife



February 10, 1992

Dear Legislator,

I wish to urge you to vote in favor of House Bill 382 concerning the licensure of midwives. This is a long awaited bill whose time has come. I have four main points I would like to make: 1. Midwives are safe. 2. Midwives are a desired resource 3.Midwives are cost effective. 4. Midwives need a midwife board.

1. Midwives are safe. Scientific research in medical journals (list enclosed) have shown midwives to be as safe or safer than doctor attended births of normal healthy women. Also the World Health Organization endorses the widespread use of midwives in the United States and Alaska in particular. Industrial countries that employ midwives exclusively for healthy women have lower infant and maternal death than the U.S.

2. Midwives are a desired resource. Throughout my 12 years service as a midwife I have been asked by poor women on medicaide to serve them in childbirth. I have lowered my fees for some of them but for a majority neither I or they could afford the accomodation. Also women who have insurance are often not allowed to choose a midwife as the insurance company does not make payments to Alaska unlicensed midwives. I have a license from the state of New Mexico which satisfies some insurance companies but not all. Therefore my services are denied many families. There are some clients who because of their strong desire to have a midwife attend them have paid out of their own pocket even though they have insurance or qualify for medicaide. There is no reason why they should be penalized. Other midwives have the same story of clients desiring their services.

3. Midwives are cost effective. I probably do not need to point out that midwife attended births cost much less than hospital births. One reason is that overhead costs are much less and secondly midwives regularly promote preventative measures (teach good health practices). When World Health Organization official Dr, Marsden Wagner visited Alaska in 1988, he pointed out that the State of Alaska was spending millions of dollars on unnecessary cesarean births. Midwife attended births result in a dramatic lowering of cesarean rates with no higher risk outcome. Native Alaskan women could stay at home in their small communities if attended by a licensed midwife saving the state millions of dollars in expensive air flights, housing, drugs and needless technology and at the same time improve infant and maternal outcome.

4. Midwives need a midwife board. In order to govern and protect midwife issues, midwives need a board who actively desires to see midwifery promoted. That means only midwives and those supportive of midwives should be on the board.

Midwives have much more to offer than current law allows. Let Alaska join the progressive states such as New Mexico and New Hampshire that have already licensed midwives and granted us medicaide payments. Vote YES for HB 382,

Please feel free to contact me for any further discussion you may desire.

Very Sincerely,

Suzanne Rich

Suzanne Rich BA LM

THE SCIENTIFIC SUPPORT FOR MIDWIFERY AND/OR HOME BIRTH
AN ANNOTATED BIBLIOGRAPHY

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IMPORTANT NOTE: The studies listed here are but a sample of the published reports supporting home birth and midwifery. For an exhaustive survey, discussion, and bibliography, citing hundreds of references, see the book, **THE FIVE STANDARDS FOR SAFE CHILDBEARING**, by Dr. David Stewart, available from NAPSAC International, Box 646, Marble Hill, MO 63764. Price $9.95 ppd. This 484 page publication is the most comprehensive review of the statistics of midwifery and home birth ever compiled. It is used as the difinitive publication by courts of law and government agencies in the U.S., Canada and other countries. It is used by the World Health Organization.

MIDWIFERY PRACTICE:

AN URGENT NEED

Marsden Wagner

In every European country, there is a large group of practicing midwives. They far outnumber obstetricians. *In no European country do obstetricians provide the primary health care for most women with normal pregnancy and birth.* This pattern of having the midwives provide the majority of pre- and postnatal care, as well as being the principal birth attendants at uncomplicated births, is fundamental to the entire perinatal care system in the European region.

The implications of midwifery practice in Europe for the situation in the United States are profound. Every single country in the European region with perinatal and infant mortality rates lower than the United States uses midwives as the principal and only birth attendants for at least 70 percent of all births; that is, there is no physician in the room at the birth. This fact alone should dispel any notions that obstetricians are safer than midwives as birth attendants at uncomplicated births. There is also evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process.

Consequently, it is perhaps not surprising that in the United States one finds the highest obstetrical intervention rates as well as a serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread independent midwifery practice in the United States as a most important counterbalance to the present situation.

[Reprinted with permission from Marsden Wagner's testimony before the US Commission to Prevent Infant Mortality, delivered February 2, 1988, at the United Nations in New York City.]

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Marsden Wagner, MD, (59) is a pediatrician, neonatologist, perinatal epidemiologist, and father of four. A native Californian, he has been living in Copenhagen, Denmark, and working for 12 years with the Maternal and Child Health Division of the World Health Organization as regional officer for 32 European countries. His current work focuses on the demedicalization of human reproduction, pregnancy, childbirth, and childhood.

Birth Is Not An Illness!

17 Recommendations From The World Health Organization

The recommendations are based on the principle that each woman has a fundamental right to receive proper prenatal care; that the woman has a central role in all aspects of this care, including participation in the planning, carrying out and evaluation of the care; and that social, emotional and psychological factors are decisive in the understanding and implementation of proper prenatal care.

• The whole community should be informed about the various procedures in birth care, to enable each woman to choose the type of birth care she prefers.

• The training of professional midwives or birth attendants should be encouraged. Care during normal pregnancy, birth, and afterwards should be the duty of this profession.

• Information about birth practices in hospitals (rates of cesarean section, etc.) should be available to the public.

• There is no indication for pubic shaving or a predelivery enema.

• Birth should not be induced (artificially started) for convenience. No geographic region should have rates of induced labor over 10%.

• Artificial early rupture of membranes, as a routine process, is not justifiable.

• There is no evidence that routine electronic fetal monitoring during labor has a positive effect on the outcome of pregnancy. Electronic fetal monitoring should be carried out only in carefully selected medical cases (related to high perinatal mortality rates) and in induced labor.

• Pregnant women should not be put in a lithotomy (lying down flat) position during labor or delivery. They should be encouraged to walk about during labor and each woman must freely decide which position to adopt during delivery.

• During delivery, the routine administration of analgesic or anesthetic drugs, that are not specifically required to correct or prevent a complication in delivery, should be avoided.

• The systematic use of episiotomy is not justified.

• There is no justification in any specific geographic region to have more than 10- 15% cesarean section births. ← In fairbanks, Ak. it is 20%

• There is no evidence that a cesarean section is required after a previous transverse low segment cesarean section birth. Vaginal deliveries after a cesarean should normally be encouraged wherever emergency surgical capacity is available.

• The immediate beginning of breastfeeding should be promoted, even before the mother leaves the delivery room.

• The healthy newborn must remain with the mother whenever possible. Observation of the healthy newborn does not justify separation from the mother.

• Governments should consider developing regulations to permit the use of new birth technology only after adequate evaluation.

• Technology assessment should involve all those using the technology, epidemiologists, social scientists, health authorities, and the women on whom the technology is used.

• Obstetric care that criticizes technological birth care and respects the emotional, psychological, and social aspects of birth should be encouraged.

These recommendations are taken from a report on Appropriate Technology for Birth published by the World Health Organization in April, 1985. The full set of 27 recommendations is published and available from the WHO Regional Office for Europe, 8Scherfigsvej 8, DK-2100 Copenhagen ø Denmark.

Copies of this leaflet can be obtained from:

FAMILY MIDWIFERY
1243 McCARTY
FAIRBANKS, AK 99701

Similar leaflets are published in Italy by MINA, in France by Nouvelles Dimensions Familiales, in the US by Childbirth Alternatives Quarterly.