HB

382

(7) HOUSE COMMITTEE REPORT

Date Referred: February 26, 1992 FURTHER REFERRALS: Finance

Date of Committee Action: 4/1/92

The JUDICIARY 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: [X] the same title
be replaced with C.S HB382 (JUDICIARY) [ ] a new title
[ ] have attached amendments(s)
[X] 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 _____
[X] zero fiscal note H&SS - State Health Svcs. 3/31/92

APPROVES PREVIOUS: (Dept/Date)
[X] fiscal note(s) Commerce/Occup. Licensing 2/26/92
[ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Ellis	X				
Virgin Pat Parnell	✓				
Terry Martin	✓				
Rob Hanley	X				
M. Thomas	—				

M. Thomas
CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. House Bill No. CSHB382

Revision Date:
Title: An Act relating to regulating the practice of midwifery; and providing for an effective date
Sponsor: Kookonen, B. Davis
Requestor: HESS

Dept. Affected: Health and Social Services
BRU: State Health Serivces
Component: Maternal Child & Family Health

COMPONENT SERIAL NO. 0290

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Peter M. Nakamura, MD, MPH, Director
Division: Public Health
Phone: 465-3090
Date: March 31, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date:

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

(Rev 12/91)

1992 LEGISLATIVE SESSION

(H) Publish Date: 2-26-92

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. 0356

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)

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:

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 Phone: 465-2144

Division: Occupational Licensing Date: 01/21/92

Approved by Commissioner: Glenn A. Olds /s/ Cont. 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 **COMMITTEE COPY** FN 14.8 Operating 29.6 Receipts DCED

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.

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. House Bill No. CSHB382

Revision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to regulating the practice of midwifery; and providing for an effective date
BRU: State Health Serivces
Component: Maternal Child & Family Health
Sponsor: Koponen, B. Davis
Requestor: HESS
COMPONENT SERIAL NO. 0290

Expenditures/Revenues (Thousands of Dollars)

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FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Peter M. Nakamura, MD, MPH, Director
Phone: 465-3090
Division: Public Health
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Legislative Sponsor
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OMB
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(Rev 12/91)

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

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ANALYSIS: (Attach a separate page if necessary)
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Prepared By: Jennifer Strickler Phone: 465-2144

Division: Occupational Licensing Date: 01/21/92

Approved by Commissioner: Glenn A. Olds for Cont. 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

FN 14.8 Operating 29.6 Revenue DCED

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:

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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

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

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: [✓] the same title
be replaced with CS HB 382 (HES) [ ] 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
not Carne	—				
	✓	Cheri Davis		✓	
		Betty Davis		✓	
		Mark E. Hanley		X	
J. E. Gonzales	✓				

CO-CHAIRMAN'S SIGNATURE

Personal Attention for the childbearing Family

Kaye Kanne
registered midwife

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

#2

Subject: Testimony for HB 382 For House HESS Committee

My name is Kaye Kanne. I practice midwifery here in Juneau and have been for almost 8 years. I received my training in Las Cruces New Mexico where midwives are licensed by the state. When we ask for regulation and licensing in Alaska in 1985 we tried to pattern Alaska's law after New Mexico. New Mexico has been licensing midwives for many years with very good statistics.

In 1985 legislation was passed with the intent of making midwifery a legal regulated profession in Alaska. We were told at the time that it would be impossible to create a midwifery board so we opted to be put under the administration of Health and Social Services. A Midwife Working Group was created by the legislature to insure that regulations developed were consistent with the practice of midwifery. This Midwife Working Group has not been fully acknowledged by H & SS and it has been determined by legal opinion that according to administrative law they do not have to consult the working group in the writing of midwifery regulations. Regulations have never been put in place and the 1985 legislation has never been administered. We are no closer today to having a regulated and licensed profession than we were 8 years ago.

I have been working on this issue for 8 years and would really like to see a this work completed. I would like to see midwifery become a licensed, regulated profession with quality standards of care and fair regulation. I see the only way to bring this about is with a midwifery board. Midwives need to have a say in their own regulatory process. Without representation from our own profession we are at risk of being regulated out of practice. It is obvious that the people of Alaska want the option of midwife attended home birth.

I'm asking you to support HB 382 because I think it is important to make these changes in the 1985 statute to make this a workable law.

Thank You.

Alaska
Nurses
Association

237 East Third Avenue
Anchorage, Alaska 99501
(907) 274-0827
. . . a constituent of American Nurses' Association

March 5, 1992

Representative Dave Donley
Chair, Judiciary Committee
State Capital
Juneau AK 99811

CSHB 382 (HES)

Dear Representative Donley:

The following recommendations related to CSHB 382 (HES) are proposed by the Alaska Nurses Association, the Alaska Chapter of the College of Nurse Midwives, and the Alaska Nurse Practitioner Association. These comments refer to substantive issues not addressed in the previous committee.

General background: Alaska is one of only TEN of the United States in which non-nurse midwifery is legal according to the *Wall Street Journal* (9-25-90). Alaska is not following a "Uniform" act which has been tried and proven in other states. Indeed, the practice of midwifery is so diversely practiced that, "Some states, such as Washington, require midwives to take a three-year state-accredited midwifery course and pass a licensing exam. But in Texas, midwives need only plunk down $5 to become registered" (*Wall Street Journal*). Given these diverse conditions, it is imperative that legislation providing some form of accreditation to non-professional midwives provide the best of assurances for public safety and understanding.

1. The titles in this bill refer to "Licensed Midwife." The public may become easily confused with this term. The Alaska Board of Nursing provides for the licensure and additional certification of Advanced Nurse Practitioners based on a Bachelor of Science in Nursing followed by some 13-24 months of advanced training and education in the specialty of obstetrics. The title bestowed on these practitioners is "Certified Nurse Midwife." The World Health Organization, with a great deal of experience with the practice of midwifery, particularly lay or non-professional midwifery, recognizes and recommends the use of the title, "Direct-entry midwife" to avoid the public confusion surrounding the term "licensed midwife."

RECOMMENDATION: The term, "DIRECT-ENTRY MIDWIFE," should be used throughout the legislation.

2. The National Council of Boards of Nursing provides guidelines for the use and definition of the terms licensed, certified, and registered (see attached definitions). Licensed implies, "Skill/Training: Highly specialized, Post-baccalaureate education. Clinical proficiency is certified by an accrediting body." Certified implies, "Skill/Training: Specialized; can be differentiated from ordinary work. Education and/or experience must be certified by recognized accrediting body."

RECOMMENDATION: Direct-entry midwives should be "Certified Direct-entry Midwives" throughout the legislation.

3. The licensure and practice of obstetrics (which includes midwifery) generally requires the licensed practitioner as well as the licensors (Boards, Colleges, Academies) to maintain a current practice and up-to-date working knowledge of the field. To be the most effective, as well as to provide the highest degree of public safety and confidence, the medical members of the Board of Certified Direct-entry Midwives should have a current obstetrical practice or be specialized in obstetrics. Thus medical professionals with no current knowledge of obstetrics would be eliminated from participation on the board.

RECOMMENDATION: *Sec. 5. Sec. 08.65.010 (b) line 5 add:
The medical professional and the certified nurse midwife must have a current obstetrical practice or be specialized in obstetrics.

4. Other licensing boards possess the authority to approve training, education, apprenticeships, and other forms of entry into the regulated practice. The charge is made to provide direct supervision and approval of all educational programs as well as for continued competence. Other Alaskan boards providing for licensure or certification also possess this authority, example: AS 08.60.100. DUTIES AND POWERS OF THE BOARD (OF NURSING).

RECOMMENDATION: *Sec. 5. 08.65.030 add:

(8) approve curricula and adopt standards for basic education, training, and apprentice programs that prepare people for licensing under AS 08.65.060.

(9) provide for surveys of the basic direct-entry midwife education programs in the state at the times it considers necessary.

(10) approve education, training and apprentice programs that meet the requirements of this chapter and of the board, and deny, revoke,or suspend approval of such programs for failure to meet the requirements.

(11) prescribe requirements for competence before a former certified direct-entry midwife may resume the practice of midwifery under this chapter.

5. There may be as few as 47 direct-entry midwives statewide who will be participating in this certification program. With so few, it makes economic sense to require the exam be offered only once each year. The Board of Nursing, responsible for 5,000 licensees, is required to offer the nursing exam only twice per year.

RECOMMENDATION: *Sec. 5. Sec. 08.65.080. EXAMINATIONS. Should be changed to read:

The board shall conduct examinations at least once [TWICE] each year.

6. A refresher course or additional continuing education should be required of an applicant direct-entry midwife who has failed to pass the examination more than one time. Without such a provision, the test-taking ability of the applicant is what is being tested, rather than the knowledge and abilities of the applicant. Such a requirement would be consistent with similar licensing boards.

RECOMMENDATION: *Sec. 5. Sec. 08.65.060. Add at the end of the paragraph:

An applicant who has failed the examination more than one time must participate in further education or training programs as prescribed by the board.

7. Licensing and testing requirements vary greatly from state to state. The board could spend excessive amounts of time trying to compare other state exams with the national exam required of Alaska's certified direct-entry midwives. The national exam provided for in Sec. 08.65.060 should be required of all applicants for certification.

RECOMMENDATION: *Sec. 5. Sec. 08.65.070. LICENSURE BY CREDENTIALS. Should be changed to read:

The board may by regulation provide for the licensing without examination of a person who meets the requirements of AS 08.65.050 (1) -(4) and who

is currently licensed in another state with licensing [AND EXAMINATION] requirements at least equivalent in scope, quality, and difficulty to those of this state [AT THE TIME OF LICENSURE] and who has passed the national examination required of certified direct-entry midwives in this state.

8. The proposed legislation provides for "Apprentice Midwives" without providing for a clearly defined framework within which the apprentice would practice. Language proposed above (08.65.030) would empower the Board to oversee the content and nature of such a program for entry into the practice. Sec. 08.65.090 should contain specific reference to that Board authority. Further, this section should clearly indicate that apprentice practice must be under the direct supervision of a board approved trainer utilizing a board approved training and education protocol. Sec. 08.65.090 (b) would allow, "An apprentice midwife may perform all the activities of a licensed midwife.." without requiring any direct supervision or any previous training or education. Further, all supervision of apprentice direct-entry midwives should be by individuals with current obstetrical practices.

RECOMMENDATION: Sec. 08.65.090 APPRENTICE MIDWIVES. Change to read:

(a) The board shall issue a permit to practice as an apprentice direct-entry midwife to a person who satisfies the requirements of AS 08.65.050(1)-(3) and who has been accepted into a program of education, training, and apprenticeship approved by the board under AS 08.65.030. The permit application must include information [ABOUT THE SUPERVISOR'S LICENSING AND EXPERIENCE AND BE SIGNED BY THE SUPERVISOR] sufficient to satisfy the requirements of the board regarding the educational, training and apprenticeship program.

(b) An apprentice direct-entry midwife may perform all the activities of a [LICENSED] certified direct-entry midwife if directly supervised in a manner prescribed by the board by

(3) a physician with a current obstetrical practice licensed in this state; or

(4) a certified nurse midwife with a current obstetrical practice licensed by the Board of Nursing in this state.

9. Violations of this chapter and the regulations promulgated under it are for the protection of public health and safety. Violations require immediate action to protect the public. The legislation requires the Administrative Procedures Act AS 44.62. To protect the public the board must have the authority to sanction an individual immediately to prevent continued practice until such time as a hearing may be held.

RECOMMENDATION: *Sec. 5. Sec. 08.65.110 GROUND FOR DISCIPLINE, SUSPENSION, OR REVOCATION OF [LICENSE] CERTIFICATION. Should be changed to:

[AFTER A HEARING,] The board may impose a disciplinary sanction on a person licensed under this chapter if the board finds that the licensee

10. In the interest of public protection, the certified direct-entry midwife is required to recommend a physical examination (Sec. 08.65.140) and to obtain a signed informed consent from the woman. Such recommendation and consent should become a part of the woman's permanent client record.

RECOMMENDATION: *Sec. 5. Sec. 08.65.140 REQUIRED PRACTICES. Should be changed to read:

(b) A certified [LICENSED] direct-entry midwife shall inform a woman seeking home birth of the possible risks of home birth and shall obtain a signed informed consent, including the recommendation for a physical examination as per AS 08.65.140(a), from the woman before the onset of labor. Such consent shall become part of the woman's record. A certified [LICENSED] direct-entry midwife shall accept full legal responsibility for the midwife's acts or omissions.

11. The delivery of a woman who has a condition under 08.65.140. (d) which contraindicates home delivery by a certified direct-entry midwife should simply not be allowed. Physician availability is no reason to allow dangerous practices. Women with such conditions should be delivered in a setting prepared to deal with the problem.

RECOMMENDATION: *Sec. 5. Sec. 08.65.140 (d) should be changed to read:

(d) [UNLESS A PHYSICIAN IS NOT AVAILABLE TO ATTEND A DELIVERY,] A [LICENSED] certified direct-entry midwife may not [KNOWINGLY] deliver a woman who

12. The list of conditions which a woman might posses which would contraindicate a home birth should be expanded to be more inclusive of other potentially life-threatening conditions. The list should include all conditions that are accepted by the American College of Obstetrics and Gynecology, the Academy of Family Physicians, and the American College of Nurse Midwives as high risk conditions of the pregnant woman which can lead to a poor birth outcome.

RECOMMENDATION: *Sec. 5. Sec. 08.65.140 (d) should have the following added:

(2) has gestational diabetes, diabetes, hypertension,

(3) contracts genital herpes simplex in the first trimester of pregnancy or has active genital herpes in the last two weeks of pregnancy;

(5) inappropriately uses controlled or legend drugs [IS ADDICTED TO NARCOTICS OR OTHER DRUGS];

(8) has a gestation of more than 41 [42] - 1/2 weeks by dates and examination;

(15) has had a previous caesarean delivery or other uterine surgery;

(16) experienced the rupture of membranes 24 hours before;

(17) is less than or equal to 17 years old at the time of delivery.

(e) Except in a verifiable emergency, and when neither a physician or certified nurse midwife is available in the geographic vicinity, a certified direct-entry midwife may not attempt to correct fetal presentations by external or internal version.

13. The term "direct-entry midwives" is the standard which has been set by the World Health Organization. We support its use so as to not confuse the consuming public who have difficulty understanding the difference between a "Certified Nurse Midwife" possessing a baccalaureate degree, 13-24 month of advance training, and successful completion of a rigorous examination; from a midwife with one year of "supervision" and passage of an examination. The public should not be confused with inappropriate abbreviation or terminology.

RECOMMENDATION: *Sec. 5. Sec. 08.65.160. LICENSE REQUIRED IF DESIGNATION USED. Should be changed to read:

A person who is not licensed under this chapter or whose license is suspended or revoked, or whose license has lapsed, who knowingly in connection with the person's name the words or letters "C.D.E.M." ["L.N.M."], Certified Direct-entry Midwife [LICENSED MIDWIFE], or other letters, words, or insignia indicating or implying that the person is certified [LICENSED] as a direct-entry midwife by this state or who in any way, orally or in writing, directly or by implication, knowingly holds out as being certified [LICENSED] by the state as a direct-entry midwife in this state is guilty of a class B misdemeanor.

14. The scope of practice of the certified direct-entry midwife should be confined to the prenatal, antepartum, intrapartum, and post-partum periods. Certified direct-entry midwives are trained in the obstetrical care of women and newborns, not in evaluating the gynecological conditions or performing gynecological examinations of the non-pregnant woman. Reproductive health care is beyond the scope of practice of the certified direct-entry midwife and its practice could prove detrimental to the reproductive health of women. Equally, certified direct-entry midwives are not trained in pediatric care beyond the neonatal period.

RECOMMENDATION: *Sec. 5. Sec. 08.65.190. (3) should be changed to read:

(3) "practice of midwifery" means [PROVIDING REPRODUCTIVE HEALTH CARE TO WOMEN AND NEWBORNS IN A COMMUNITY;] providing necessary supervision, health care, and education to women during pregnancy, labor, and the postpartum period, conducting deliveries on the midwife's own responsibility,and providing immediate postpartum care of the newborn [AND PRIMARY HEALTH CARE TO THE WOMAN DURING THE INTERCONCEPTUAL PERIOD]; "practice of midwifery" includes preventive measures, the identification of physical, social, and emotional needs of the newborn and the woman, and arranging for the consultation, referral, and continued involvement when the care required extends beyond the abilities of the midwife, and the execution of emergency measures int he absence of medical assistance, as specified in regulations adopted by the board.

Thank you for the time to read these comments and concerns.

Sincerely,

Patti Hong, RN, MA
President
Alaska Nurses Association

Lila McEwen, RN
President
Alaska Nurse Practitioner Association

Cheryl Chesnut, RN
President
Alaska Chapter American College of Nurse Midwives

cc: Judiciary Committee Members
Representative N. Kopenen
Representative B. Davis
Representative F. Ulmer
Representative K. Brown

attachment: Guidelines for Determining Level or Degree of Regulation from National Council on Boards of Nursing

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 noninterven-tion 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.

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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 15.1 percent in 1986 as midwives began taking on the role of nursing attendants. The [illegible] attributes the decline to the fact that midwives "[illegible] support and encouragement, advice, and [illegible] spend adequate time to the needs of the woman and her baby." (*Australian Journal of Advanced Nursing*, vol. 6, no. 3)

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 home birth where there are no serious [illegible] 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)

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

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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 interprofessional 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.

Bibliography

Cross, Star, MANA Ethics Chair, 1989, unpublished draft of Ethics Code

Daly, Mary, Gynecology: The Mataethics of Radical Feminism, *Beacon Press, Boston, MA 1978*

Hoagland, Sarah Lucia, Lesbian Ethics: Toward New Value, *Institute of Lesbian Studies, Palo Alto, CA 1988*

Johnson, Sonia, Going Out of Our Minds: The Metaphysics of Liberation, *Crossing Press, Freedom, CA 1987*

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
Marsden Wagner
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.

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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.

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 complied 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....

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.

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
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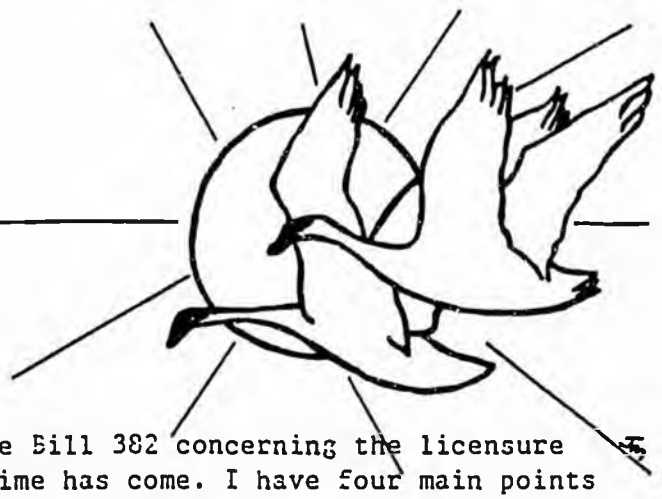
(907) 456-BABY

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

1. Amer. Jour. Obstetrics & Gynecology, 1969. Vol. 105, No. 1, p. 3. Montgomery, T., *A Case for Nurse-Midwives*. Gives data showing superiority of certified nurse-midwives in hospital setting as measured by lower mortalities and rates of permaturity compared to doctors in same hospital setting with same population demographics.

2. Amer. Jour. Obstetrics & Gynecology, 1971. Vol. 109, No. 1, pp. 50-58. Levy, B., Wilkinson, F., & Marine, W., *Reducing Neonatal Mortality Rates With Nurse-Midwives*. Gives data showing superiority of certified nurse-midwives in hospital setting compared to doctors in same hospital setting.

3. Jour. Reproductive Medicine, 1977. Vol. 19, pp. 281-290. Mehl, L., Peterson, G., Whitt, M., et al., *Outcomes of Elective Home Births: A Series of 1146 Cases*. Gives data showing safety of home births attended by Direct-Entry ("Lay") Midwifes.

4. Birth & Family Jour., 1977. Vol. 4, No. 1, pp. 47-58. Devitt, N., *The Transition from Home to Hospital Birth, U.S.* A Historical Review of available scientific & statistical data showing that hospitals have never been proven to be the safest place for most mothers to give birth.

5. NAPSAC International Publications, 21st Century Obstetrics, 1978. Vol. 1, pp. 171-207. Mehl, L., *Scientific Research on Childbirth Alternatives & What It Tells Us About Hospital Practice*. This is the only "Matched Population study ever done on the relative safety of home vs. hospital. 2092 patched pairs. Very detailed. Many tables. Shows attended home birth safer than hospital when assisted by midwife or family physician.

6. Jour. Amer. Medical Assoc., May 2, 1980. Vol. 243, No. 17, pp. 1732-1736. Adamson, G. & Gare, D. *Home or Hospital Births?* A partial review of home birth data by two physicians, neither of which believe in nor practice home birth, but who nevertheless conclude that no valid data exist that prove hospitals to be safer than home.

7. Jour. Amer. Medical Assoc., May 2, 1980. Vol. 243, No. 17, p. 1747. McQuarrie, H., *Home Delivery Controversy*. An editorial urging medical doctors to be more objective & less emotional in their consideration of home birth.

8. Jour. Amer. Medical Assoc., Dec 19, 1980. Vol. 244, No. 24, pp. 2741-2745. Burnett, C., Jones, J., Rooks, J., Tyler, C., Miller, A., *Home Delivery & Neonatal Mortality in North Carolina*. An excellent study showing safety of planned, attended home births with direct-entry (Lay) midwives or family physicians. Researchers include MD's, Gov't statisticians, a nurse-midwife, and past President, Am. Pub. Health Assoc., A. Miller, MD.

9. Jour. Amer. Public Health Assoc., June 1983. Vol. 73, No. 6, pp. 641-645. Sullivan, D., & Beeman, R., *Four Years Experience With Home Birth by Licensed Midwives in Arizona*. Gives data showing safety of successful new licensing program for direct-entry (Lay) midwives in Arizona.

10. World Health Organization, 1983. Suppliment 117, Acta Obstet. Gynecol. Scand., 39 pages. *Scientific Basis for Selected Perinatal Procedures & Their Psychosocial Effects*. Points out fact that hospitals have never been proven to be safest place for most mothers to give birth and that home is at least as safe for low risk mothers.

11. Jour of Nurse-Midwifery, Jan-Feb 1984. Vol. 29, No. 1, pp. 21-28. Weitz, R. & Sullivan, D., *Licensed Lay Midwives in Arizona*. Reports successful program of licensed direct-entry (lay) midwives engaged in home birth, regulated by recently enacted (January 1978) Arizona statute.

12. U.S. Gov't Center for Health Statistics, 1984. Publication (PHS) 84-1918, Series 21, No. 40, 43 pages, Taffel, S., *Midwife & Out-Of-Hospital Deliveries in the United States*. Gives data showing that, both in the hospital and at home, midwives get better outcomes as measured by lower rates of prematurity and low-birth-weight babies.

13. Survey of British Births, Modern Obstetrics in General Practice, 1985. pp. 203-223. Oxford University Press. Tew, M. *Safety in Intranatal Care: The Statistics*. Presents irrefutable data showing that at least 80% of women could more safely give birth at home with midwife or general practitioner than by the usual practices of obstetric specialists in hospitals. Thoroughly documented.

14. Jour. Amer. Medical Assoc., Mar 15, 1985. Vol. 253, No. 11, pp. 1578-1582. Hinds, M., Bergeisen, G. & Allen, D. *Neonatal Outcome of Planned vs. Unplanned Out-Of-Hospital Births in Kentucky*. Gives data showing safety of home birth attended by direct-entry (lay) midwives. Corroborates North Carolina study, Ref. 8 cited above.

• • • Bibliography Continued. The Most Recent Studies are Listed on Back Side of This Page.

(15) **Practicing Midwife, The, Spring 1985.** Vol. 2, No. 2, pp. 5-10, Kloosterman, G.J., *Why Midwifery?* An excellent review of midwifery outcomes from 16th century to present showing consistently better results by midwives vs. doctors. Gives Dutch data for 1982 (when Holland had 40% home births) showing significantly better outcomes for home over hospital with care of direct-entry (not nurse) midwives.

16. **Australian Jour. Family Physician, March 1985.** Vol. 14, No. 3, pp. 206-209, Carpenter, H., *Domiciliary Obstetrics* Author, Hugh Carpenter, MD, is State Director of Family Medicine Program in Australia. Cites data showing that Australia, as a country, could responsibly adopt program of up to 30% home birth without compromising safety with a nationwide savings in medical costs of $83,000,000 per year.

(17) **Jour. Royal College General Practitioners, Aug 1985.** Vol. 35, pp. 390-394. Tew M., *The Place of Birth & Perinatal Mortality.* Professor Tew is Research Statistician in Nottingham Medical School, England. Analysis of statistics for Britian shows that mortality rates in hospitals with board certified obstetricians is unjustifiably and significantly higher than for general practitioners or for home births. The data bring question as to whether even high risk mothers actually benefit (or, perhaps made worse) by hospitals and certified obstetricians?

(18) **World Health Organization, The Lancet, 1985.** August 24, pp. 436-437. *Appropriate Technology for Birth,* Recommends training and use of direct-entry midwives (not necessarily nurses) as best way to help improve pregnancy outcomes worldwide, including in the industrialized, developed countries.

(19) **Jour. Midwifery [Br.], Nov 1985.** Vol. 1, pp. 1-8, Tew, M., *The Practices of Birth Attendants & the Safety of Birth.* An excellent statistical study showing that overutilization of hospital for birth increases over-all death rates & natural approach of midwifery results in better outcomes for women and babies than sophisticated obstetrics.

(20) **Nursing Times [Br.], Nov 20, 1985.** Vol. 81, No. 47, pp. 22-24. Tew, M., *We Have the Technology.* Presents statistical data showing non-interventive midwifery safer than OB technology. Same issue of *Nursing Times* has good editorial addressing women's rights to choose place of birth.

21. **Hastings Center Report, Institute of Society Ethics & Life Science, Dec. 1985.** pp. 19-27. Hoff, G. & Schneiderman L., *Having Babies at Home: Is It Safe? Is It Ethical?* A scholarly review of the home vs. hospital safety question by two physicians who conclude that regardless of a doctor's opinion for or against home birth, to refuse back-up is "ethically and medically indefensible" and that physicians "should move to make both hospital and home delivery as safe as possible."

(22) **Brit. Jour. of Obstetrics & Gynecology, July 1986.** Vol. 93, pp. 659-674. Tew, M. *Do Obstetric Intranatal Interventions Make Birth Safer?* A detailed scientific study showing that "obstetric intranatal (during labor) interventions make birth less safe, not more safe, for the vast majority of cases." Conclusively proves case for non-interventive midwifery approach to childbirth.

(23) **British Medical Journal, Sept 6, 1986.** Vol. 293, pp. 606-608. Loudon, I. *Obstetric Care, Social Class and Maternal Mortality.* A scholarly review of published data, since 1785 to present, showing that improvements in pregnancy outcome since 1900 cannot be due to increased obstetric intervention, nor hospitals, that these technologic factors are more closely correlated with bad outcomes than good.

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
1268 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.