

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

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

3 (b) The examination shall be in written form.

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

- 6 (1) anatomy of the pelvis and female genital organs;
- 7 (2) physiology of the female genital organs;
- 8 (3) recognition and management of pregnancy;
- 9 (4) understanding fetal presentations and positions;
- 10 (5) mechanisms and management of normal labor;
- 11 (6) management of puerperium;
- 12 (7) injuries to the genital organs following labor;
- 13 (8) sepsis and antisepsis in relation to labor;
- 14 (9) preparation and management of the delivery site and
15 lying-in area;
- 16 (10) hygiene of mother and infant;
- 17 (11) asphyxiation, convulsions, malformation, and infectious
18 diseases of the newborn;
- 19 (12) causes, effects, and prevention of ophthalmia neonatorum;
- 20 (13) emergency occurrences requiring the attention of a
21 physician;
- 22 (14) requirements of vital statistics law relating to report-
23 ing of births and infectious diseases of the newborn;
- 24 (15) the pharmacology of drugs used in emergency maternity
25 care for both mother and infant following childbirth;
- 26 (16) nutrition as it relates to the prenatal, partal and
27 postpartum period;
- 28 (17) management of breast feeding;
- 29 (18) knowledge of the bonding process and family interrela-

1 tionships;

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

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

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

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

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

13 Depts recommends
14 continuing practice and
15 continuing
16 education for
17 license
18 renewal
19 The department shall establish requirements which must be met
20 before a license may be renewed, which must include a requirement that
21 an applicant for renewal has attended 20 births in the previous two
22 years or has completed 20 hours of continuing education. Continuing
23 education may include childbirth-related postsecondary coursework,
24 workshops, or practice in association with another midwife, or any
25 combination of training and experience or a combination of experience
26 and continuing education.
27 suggest deleting

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

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

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

36 (3) the licensed midwife has engaged in unprofessional

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

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

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

- (1) recognition of pregnancy and management of prenatal care;
- (2) preparation and management of the delivery site and lying-in area;
- (3) management of the birth process and delivery of the infant;
- (4) clamping and severing the umbilical cord;
- (5) delivery of the placenta, with anti-hemorrhage techniques;
- (6) recognition of an emergency labor or delivery situation involving the mother or infant;
- (7) emergency procedures for asphyxiation, convulsions, malformation, and infectious diseases of the newborn;
- (8) administration of preventive prophylaxis for ophthalmia neonatorum;
- (9) postnatal care of mother and infant;
- (10) suturing;
- (11) routine laboratory investigation for normal prenatal care.

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

- 1 (1) intramuscular injections for maternal hemorrhage;
- 2 (2) penetration of human tissue for emergency episiotomy,
- 3 repair, and severing the umbilical cord;
- 4 (3) oxygen use.

5 (c) The department shall designate the medications, therapeutic
6 agents, and techniques which a licensed midwife is authorized to admin-
7 ister and the circumstances under which those medications, therapeutic
8 agents, and techniques may be administered.

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

- 13 (1) philosophy of practice;
- 14 (2) education and training;
- 15 (3) experience;
- 16 (4) services and fees;
- 17 (5) procedures for meeting medical emergencies.

18 (b) The licensed midwife shall inform the client that the statis-
19 tical information required by AS 08.69.110 is maintained by the licensed
20 midwife and is available for inspection.

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

- 26 (1) infections;
- 27 (2) hemorrhage;
- 28 (3) hospital transfers;
- 29 (4) malpresentations;

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(5) normal deliveries;

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

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

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

(1) the mother's name and address;

(2) the mother's date of birth;

(3) the mother's gravidity and parity;

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

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

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

(7) APGAR administered to infant;

(8) immediate postpartum progress of mother and infant;

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

(10) other information required by the department.

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

(1) ensure that as reasonably possible before the onset of labor the mother has received a general physical examination by a physician— *recommends adding "or a nurse midwife"*

(2) *(they are qualified - & it would allow more flexibility)* recommend that the mother be transferred to the care of a physician if a medical emergency is indicated.

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

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

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

* (3) that the following requirement be added:

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

1 possess and administer in accordance with a prescription from a consult-
2 ing physician agents used to stop maternal hemorrhage, oxygen, and
3 antibiotic eye drops.

4 Sec. 08.69.150. MIDWIFE APPRENTICESHIP. (a) A person may com-
5 plete a midwifery apprenticeship by observing and assisting in the
6 management and care of the mother and infant in at least 50 births. In
7 the course of 25 of those births, the apprentice must assume primary
8 responsibility, under the supervision and observation of the sponsor,
9 for the prenatal, intrapartal, and postpartal management and care of
10 the mother and child. A person undertaking a midwifery apprenticeship
11 shall register with the department at the beginning of the apprentice-
12 ship.

13 (b) A midwife apprenticeship must be under the immediate super-
14 vision of a sponsor. A sponsor may not supervise more than three
15 apprentice midwives simultaneously. The sponsor shall secure the
16 compliance of the apprentice midwife with this chapter.

17 Sec. 08.69.160. DEFINITIONS. In this chapter

18 (1) "department" means the Department of Commerce and Eco-
19 nomic Development;

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

23 (3) "normal childbirth" means a normal physiological state
24 of health in which the expectant mother is in a stable condition with-
25 out disease or complications;

26 (4) "sponsor" means a physician or ^{nurse} midwife licensed to
27 practice in this state; *(rather than including lay midwives)*

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

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



ALASKA STATE LEGISLATURE
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MEMORANDUM

May 21, 1980

TO: Representative Brian Rogers

FROM: Betty Barton, Issues Analyst

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

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

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

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

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

Background Information

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

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

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

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

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

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

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

DETERMINING THE ROLE OF REGULATION IN LAY MIDWIFERY

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

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

Potential Benefits of Regulation

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

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

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

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

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

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

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

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

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

Potentially Negative Effects of Regulation

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

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

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

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

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

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

Regulatory Control; Is it Necessary?

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

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

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

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

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

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

MODEL REGULATORY PROVISIONS REGARDING LAY MIDWIFERY

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

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

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

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

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

3 months prenatal care in a hospital

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

3 months neo-natal intensive care and postpartal care

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50 births minimum with practicing lay midwife

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

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

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

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

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

BB/bf

Attachment

INTERVIEW LIST

Dr. David Stuart:	Executive Director NAPSAC Post Office Box 267 Marble Hill, Missouri 63764 Telephone: (314)238-2010		
Ms. Shari Daniels:	<table border="0"> <tr> <td data-bbox="723 491 1239 666"> Director El Paso Maternity Center 1119 E. San Antonio El Paso, Texas 79901 Telephone: (915)533-8142 </td> <td data-bbox="1247 491 1647 742"> President National Midwives Asso P. O. Box 163 Princeton, N.J. (915)565-9623 (Home number)* *After 6:00 p.m. El Paso time </td> </tr> </table>	Director El Paso Maternity Center 1119 E. San Antonio El Paso, Texas 79901 Telephone: (915)533-8142	President National Midwives Asso P. O. Box 163 Princeton, N.J. (915)565-9623 (Home number)* *After 6:00 p.m. El Paso time
Director El Paso Maternity Center 1119 E. San Antonio El Paso, Texas 79901 Telephone: (915)533-8142	President National Midwives Asso P. O. Box 163 Princeton, N.J. (915)565-9623 (Home number)* *After 6:00 p.m. El Paso time		
Ms. Ruth Zeeman: (Nurse-midwife)	Coordinator Lay Midwifery Program Department of Health Services State of Arizona Tucson, Arizona Telephone: (602)255-1024		
Ms. Margaret Crawford: (nurse-midwife)	Greater Juneau Borough Health Clinic Juneau, Alaska Telephone: 586-3736		
Ms. Peggy Newman:	Director BABE Prince of Peace Drive Anchorage, Alaska Telephone: 694-9050		
Dr. Charles Muller:	Medical Director Blue Cross of Washington & Alaska P. O. Box 327 Seattle, Washington 98111 Telephone: (206)361-3417		
Dr. Patrick O'Donoghue:*	President Policy Center, Inc. Denver, Colorado		

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

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

Dear Representative Bierne:

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

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

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

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

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

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

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

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

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

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

Sincerely,

Zelda Collett-Paula

Charlene "Zelda" Collett-Paula

January 30, 1982

P.O. Box 1327

Eagle River, Alaska
99577

Dear Representative,

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

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

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

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

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

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

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

Sincerely,

Jane Orsood

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

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

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

SB 747

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

March 3, 1982

To: Representative Pat Carney, Chair
House Finance Subcommittee

From: Representatives Brian Rogers
and Tony Vaska

Prepared
By: Ginger Baim, Aide to
Senator Vic Fischer

Re: CS SS House Bill 11 and Senate Bill 747

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

1. Approximately 5% of all births in Alaska occur at home.
2. Most home-birth parents are covered by health care insurance but chose to pay a midwife "out-of-pocket" rather than use the services of a physician or a certified nurse midwife in a hospital setting covered by insurance.
3. Physicians and Certified Nurse Midwives (CNM) face suspension of licensure if they participate in a home-birth even though such practice is not in violation of the law in Alaska.
4. Most homebirth parents state they would chose an out-of-hospital birth with a midwife even if such a practice were in violation of the law.
5. The average cost of a "natural " and uncomplicated hospital birth attended by a physician or CNM, is \$2,000 and up. This fee covers both birth attendents and facility charge.
6. Some Alaskan hospitals and physicians average 20% C-sections. Consumer cost for this surgery is nearly double the average for a "natural" birth.
7. The average cost of ch ldbirth at Alaska's only birthing center is \$1,500. Because the facility is not licensed, only the services of the CNM are covered by health care insurance, requiring out-of-pocket payment of nearly a \$1,000.
8. Average costs for the services of a "lay" midwife for a homebirth is less than \$500. This fee includes all pre and post natal care, laboratory costs, services of the midwife and, usually, an assistant or apprentice, during the acutal birth.
9. Statistically the incidence of complications, mortality, morbidity and risks to both infant and mother in a home birth attended by a midwife compare favorably with hospital births attended by a physician.
10. Current practice prevents licensed health care providers from attending home births and limits consumers in free choice of health care. Consumers currently have no mechanism for determining the competency

levels of midwives attending homebirths.

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

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

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

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

TO: Representative Joe McKinnon January 14, 1980

FROM: Christine Johnson, Research Analyst *CJ*
House Research Agency

THROUGH: Duncan L. Read, Director
House Research Agency

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

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

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

CJ/bf
Encl.s

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

ALABAMA

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

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CALIFORNIA

(Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CONNECTICUT

(377.20-75)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

FLORIDA

(30.485.011 - 30.485.091)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

INDIANA

(25-22-1-5, 22-22-1-6; Admin. Code (25-22.5-5-5)-1, (25-22.5-5-5)-2)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MARYLAND
(Art.43.82-94)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MINNESOTA

(148.30 - 148.32)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MONTANA
(66-1246)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

NEW JERSEY

[45,10]

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

OHIO
(4731.30-4731.34)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

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

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

WASHINGTON

(18.50.090 - 18.50.110)

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

WEST VIRGINIA

(30-15-1 -30-15-8)

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

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

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

II. FISCAL DETAIL

Agency Affected Department of Commerce & Economic Development
 Program Category Affected Public Protection

BRU, Program, Or Subprogram(s) Affected Regulation & licensing of professions; admin
 (Note: If more than one budget component is affected, separate line-item boards, an
 amounts and funding for each component in the analysis section.) investigati

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		24.2	26.4	28.9	31.6	34.6
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

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

TRAVEL - 10% inflation factor projected.

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

\$ 6,000.00

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

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

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

\$ 9,400.00

IV. DATE March 2, 1982

PREPARED BY Margorie Odland

(continued.)

AGENCY Division of Occupational Licensing

Original: Legislative Finance

PHONE 465-2535

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

CONTRACTUAL - 9% inflation factor projected.

Printing of new statute booklets, applications and licenses for midwives desiring to become licensed.	\$ 2,000.00
Meeting notices, regulation publications, mailing costs of application packets and statute booklets	800.00
General operating costs including phones, computer time (prorated by board), and similar daily costs.	1,000.00

Development of examination, professional services contract basis, including updates, pool of questions for use by state board, storage in in-house computer system	5,000.00
--	----------

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

Average 6 hour days:

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

Room Rental for examinations:
2 exams per year., 1 day each.

200.00

Proctors for examinations:

Head Proctor - \$50/day

100.00

Monitor - \$35/day

70.00

TOTAL CONTRACTUAL - \$ 14,831.00

HTB #1

Page
Board

Robson - No.

Europe - diff. stds. - ore nurses.

Cert. N. Midwife

Phy. Asst.

collaborative relationship

congen. dia. test

1. PKU

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Treager - D.O. Lic.
fiscal note

Pat Duffin

STATE OF ARIZONA
DEPARTMENT OF HEALTH SERVICES

ARTICLE 2. LICENSING OF MIDWIFERY

R9-16-200. Reserved

R9-16-201. Minimum qualifications

An application for a license to practice midwifery shall submit:

1. An application on a form prescribed by the Department;
2. Evidence satisfactory to the Director of the Department of Health Services showing successful completion of a course of instruction meeting the requirements of R9-16-203;
3. The initial license fee prescribed by A.R.S. 536-754;
4. A request to undertake the next available qualifying examination to be administered by the Department.

Historical Note

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

2/28/78 Supp. 78-1

R9-16-202. Renewal application

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

Historical Note

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

R9-16-203. Course of instruction

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

1. Information regarding the laws and Regulations concerning midwifery in Arizona;
2. Basic course in aseptic techniques, basic observational skills, recognition and management of emergency situations, and special requirements of home delivery;
3. Clinical courses covering the knowledge and skills necessary for:
 - a. Provision of care during the antepartum, intrapartum, postpartum and newborn periods, and
 - b. Management of birth and the immediate care of the mother and newborn infant;
4. Observation of a minimum of ten (10) births;
5. Delivery of a minimum of fifteen (15) women, under direct supervision by a licensed physician, licensed midwife or certified nurse-midwife, and verified by a written statement from the supervisor that competence has been demonstrated.

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

Historical Note

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

R9-16-204. Qualifying examination

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

1. A written examination designed to test knowledge of the subjects required in the course of instruction;
2. An oral examination designed to test clinical judgment in midwifery case management;
3. A practical examination designed to demonstrate the mastery of skills necessary for practice in midwifery, meeting the requirements of R9-16-203.

Historical Note

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

R9-16-205. Responsibilities of the midwife

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

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

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

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

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

R9-16-206

HEALTH SERVICES

Title 9

R9-16-206. Reports

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

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

Historical Note

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

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

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

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

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

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

2/26/78 Supp. 78-1

- t. Excessive pain or discomfort during or after labor;
- u. Shortness of breath;
- v. Seizures;
- w. Wishes of the client.
2. Conditions of the infant:
 - a. Weight less than 2,500 g or 5½ pounds;
 - b. Congenital anomalies;
 - c. Apgar score less than 7 at 5 minutes;
 - d. Respiratory distress;
 - e. Irregular heartbeat;
 - f. Signs of immaturity, prematurity, or postmaturity on physical assessment;
 - g. Jaundice;
 - h. Abnormal cry;
 - i. Pale, cyanotic or gray color;
 - j. Excessive edema.
3. Any other abnormal condition not listed above that might endanger the woman or infant.
 - D. At the time of delivery the midwife shall:
 1. Place two drops of 1 percent silver nitrate solution into each of the infant's eyes (or in lieu of silver nitrate, any other preparation specifically approved by the Director) in accordance with R9-6-115;
 2. Inspect the umbilical cord for the appropriate number of vessels and record on the birth record;
 3. Inspect the placenta and membranes to note their completeness;
 4. Inspect the perineum for laceration.
 - E. The midwife shall observe both mother and infant for a minimum of two (2) hours following birth.
 - F. The midwife shall file a birth certificate with the local Registrar within ten (10) days after birth.
 - G. The midwife shall reevaluate the condition of the mother and infant between 36 and 72 hours of delivery to determine whether physician consultation is required.
 - H. All equipment used in the practice of midwifery shall be maintained in an aseptically-clean manner and in working order.
 1. The midwife shall maintain records of each patient attended and make them available for audit and review as requested by the Director or his staff.

Historical Note

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

5. History of birth injury to either mother or previous child;
6. History of difficult delivery and/or depressed baby at birth.
- C. The midwife will not perform any operative procedures other than that of clamping and severing the umbilical cord.
- D. The midwife will not use any artificial, forcible or mechanical means to assist birth, nor may the midwife attempt to correct fetal presentations by external or internal version.
- E. Except as provided in R9-6-205.D.1. the midwife will not administer any drugs, medications or herbs.

Historical Note

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

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

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

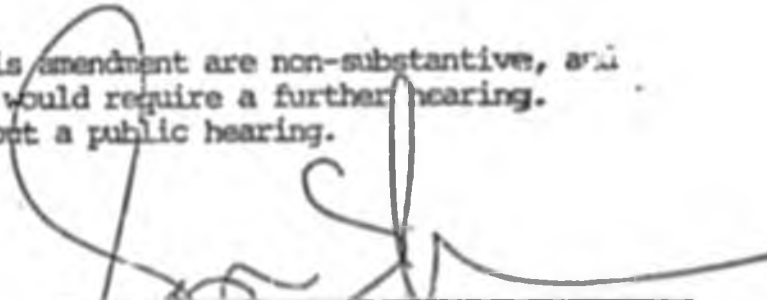
FILE CATEGORY:
REGULATION NO.: HED-80-3A (HSD)
ORIGINATOR: Health Services Division

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

REASONS FOR ADOPTION:

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

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



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

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

HED-80-3A(HSD)

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

General Provisions

- 100. LEGAL BASIS: The regulations set forth herein are promulgated by the Secretary of Health and Environment by authority of 9-7-6(F) NMSA 1978 and 24-1-3(R) NMSA 1978. Administration and enforcement of these regulations is the responsibility of the Health Services Division of the Health and Environment Department. Enforcement is provided by 24-1-21 NMSA 1978.
- 101. PURPOSE: These regulations establish policies, standards and criteria relating to registration, practice and continuing education of persons who practice lay midwifery. These regulations do not apply to any licensed medical or osteopathic physician or certified nurse midwife.
- 102. GUIDELINES: In the absence of specific direction in these regulations as to standards of practice or ethics, the Standards of Care of the American College of Obstetricians and Gynecologists and procedures and policies of the Health and Environment Department and Health Services Division are established as guidelines.
- 103. OTHER LAW AND REGULATIONS: These regulations are subject to the provisions of the Health and Environment Department's Regulations Governing Promulgation of Regulations and Regulations Governing Public Access to Department Records. In addition, department regulations on related subjects include: registration of nurse midwives; prevention of infant blindness; newborn screening for phenylketonuria and other congenital malfunctions; registration of births, deaths and fetal deaths, and control of diseases and conditions of public health significance. Copies of regulations may be obtained by writing to the Health Services Division, Post Office Box 968, Santa Fe, New Mexico 87503. Appeal of an adverse decision of the Division shall be in accordance with the Uniform Licensing Act, 61-1-1 thru 61-1-28 NMSA 1978.

104. DEFINITIONS: As used in these regulations, the following terms shall have the meaning given to them, except where the context clearly requires otherwise:
- 104.0... "Apprentice permit" means a permit issued by the Division to authorize a person desiring to become a lay midwife and pursuing the required course of study to obtain clinical experience under supervision of a physician, certified nurse midwife or registered lay midwife.
- 104.02. "Certified nurse midwife" means a graduate nurse licensed to practice in this state who has been certified by the American College of Nurse-Midwives and registered with the Division pursuant to the provisions of the Department's Nurse-Midwife Regulations.
- 104.03. "Contact hour" means a unit of measurement to describe 50-60 minutes of an approved, organized learning experience or two hours of planned and supervised clinical practice which is designed to meet professional educational objectives.
- 104.04. "Continuing education" means participation in an organized learning experience under responsible sponsorship, capable direction and qualified instruction and approved by the Division for the purpose of meeting requirements for renewal of registration under these regulations.
- 104.05. "Division" means the Health Services Division of the Health and Environment Department.
- 104.06. "Lay Midwifery" means the provision of health care services in pregnancy and childbirth by a person not a licensed physician or a certified nurse-midwife.
- 104.07. "Physician" means a person licensed to practice medicine or osteopathy in this state.
- 104.08. "Registered lay midwife" means a person who is currently registered and in good standing on the registry of lay midwives maintained by the Division.
- 104.09. "Registration" means a document issued by the Division identifying a legal privilege and authorization to practice within the scope of these regulations. Registration under these regulations is not transferable.

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STATE OF NEW MEXICO
DEPARTMENT OF HEALTH

- 104.10. "Registration year" means the period from December 31 of any year through December 30 of the following year; initial registration may be issued at any time but shall expire on the following December 30; apprentice permits may expire at any time but no later than the following December 30.
- 104.11. "Supervision" means the coordination, direction and continued evaluation at first hand of the person in training or engaged in obtaining clinical experience or engaged in direct delivery of lay midwifery services within the scope of these regulations.

APPLICABILITY

- 200. LIMITATION: Lay midwifery in New Mexico is limited in scope to practice as outlined in these regulations.
- 201. SCOPE: The lay midwife may provide care to low risk patients determined by physician evaluation and examination to be prospectively normal for pregnancy and childbirth. Such care includes:
 - 201.01. prenatal supervision and counseling;
 - 201.02. preparation for childbirth;
 - 201.03. supervision and care during labor and delivery and care of the mother and the newborn in the immediate postpartum period, so long as progress meets criteria generally accepted as normal.
- 202. REQUIREMENT OF REGISTRATION: From and after July 1, 1980 no person shall hold him/herself out as a lay midwife or offer, for compensation or otherwise, any services which constitute lay midwifery unless currently registered as a lay midwife under these regulations, or holding a provisional or apprentice permit issued by the Division. Violation of this provision is subject to prosecution or civil action as may be provided by law.

*Referred
by MD*

REGISTRATION OF LAY MIDWIVES

300. TYPES OF PERMITS AND FEES: Upon application, meeting requirements and payment of fees, a person subject to these regulations may be issued an apprentice permit, a provisional registration permit, or a regular registration permit, as applicable, in accordance with these regulations. Permits shall be issued without fee through December 31, 1980; thereafter fees, new or renewal, shall be submitted in accordance with the fee schedule prescribed in Section 400. hereof.
301. APPRENTICE PERMIT: An apprentice permit may be issued to any person for a period not to exceed one year and may be renewed once only for an additional one-year period. Education and clinical experience required for regular registration may be obtained during the apprentice period.
302. PROVISIONAL REGISTRATION PERMIT: Upon application a provisional registration permit may be issued to:
- 302.01. Any person who under former regulations of the Division is currently permitted to engage in lay midwife practice under the supervision of the District Health Officer, or,
 - 302.02. Any person who presents satisfactory evidence of education, training and experience; such person shall submit:
 - 302.02.01. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;
 - 302.02.02. Evidence of satisfactory completion of required clinical experience cited in Section 600.
 - 302.02.03. Evidence of satisfactory completion of a Health Services Division approved course in prenatal nutrition (may be completed during provisional registration period);
 - 302.02.04. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting (may be completed during provisional registration period);

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- 302.02.05. Current physician's statement certifying absence of communicable disease;
- 302.02.06. Satisfactory reference from a physician, certified nurse midwife or midwifery instructor;
- 302.02.07. Fee as prescribed by the Division.
- 302.03. A provisional permit may be issued for a period not to exceed one year and may be renewed once only for an additional one-year period.
- 302.04. The requirements of section 600 hereof may be met during the provisional registration period.
303. REGISTRATION UNDER REGULAR PERMIT: Upon meeting the requirements of Section 600, a person holding an apprentice or provisional permit may apply for regular registration as a lay midwife and shall submit:
- 303.01. An application to sit the next qualifying examination;
- 303.02. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;
- 303.03. Evidence of satisfactory completion of a course in theory of pregnancy and childbirth;
- 303.04. Evidence of satisfactory completion of required clinical experience;
- 303.05. Evidence of satisfactory completion of an HSD approved course in prenatal nutrition;
- 303.06. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting;
- 303.07. Evidence of satisfactory completion of a certified course in cardiopulmonary resuscitation of the adult and newborn;
- 303.08. Current physician's statement certifying absence of communicable disease;

- 303.09. Four recommendations (one each from a physician or certified nurse midwife, a midwifery instructor, a consumer and a member of the community); and
- 303.10. Fee as prescribed by the Division.
304. FOREIGN EXPERIENCE: Applicants for registration as a lay midwife who lack the required clinical experience in New Mexico, but who have equivalent experience from another jurisdiction, may apply to sit the qualifying examination after submitting evidence of experience and of all other requirements. Action of the Division on the request may be appealed under the provisions of the Uniform Licensing Act.
305. LIMITATION: Registration as a lay midwife in New Mexico is not to be construed as valid in any other jurisdiction.
306. EXAMINATION REQUIRED: Registration as a lay midwife in New Mexico is by examination only; there is no reciprocity with other jurisdictions.
307. RENEWAL OF REGISTRATION: Every lay midwife registration must be renewed annually. An applicant for renewal of registration shall submit to the Department:
- 307.01. A renewal application on the form prescribed by the Department;
 - 307.02. Evidence of completion of eight contact hours of continuing education as required by Section 604; and
 - 307.03. Renewal fee as prescribed by the Division.
308. GRACE PERIOD: Delinquency in renewal of registration of 6 months or greater shall result in termination of registration.
309. INACTIVE LIST: Any person registered as a lay midwife in New Mexico who moves from the state may retain registration by fulfilling the requirements previously described. Absence from the State of New Mexico for longer than 10 years shall result in termination of registration.
310. RE-CERTIFICATION: Any person previously registered as a lay midwife in the State of New Mexico whose registration has been terminated may be recertified as a registered lay midwife by:

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- 310.01. Submitting evidence of eight contact hours of continuing education annually;
- 310.02. Submitting evidence of being current in practice in another jurisdiction;
- 310.03. Applying for a lay midwife apprentice permit in order to obtain clinical experience to become current in practice as determined by the Department;
- 310.04. Sitting any or all portion(s) of the qualifying examination as required by the Department; and
- 310.05. Submitting renewal fee as prescribed by the Division.

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

- 400.01. Fee for annual renewal of provisional and regular registration shall be \$25.00 a year.
- 400.02. Examination fee shall be \$25.00 and is not included in registration fee.

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

- 500.01. Dereliction of any duty imposed by law;
- 500.02. Incompetence;
- 500.03. Conviction of a felony;
- * 500.04. Practicing while suffering from a contagious or infectious disease;
- * 500.05. Practicing under a false name or alias;
- 500.06. Violation of any of the standards of practice set forth in Sections 800 and 905;
- 500.07. Obtaining any fee by fraud or misrepresentation;

- 500.08. Knowingly employing directly or indirectly any suspended unregistered person or persons not holding an apprenticeship permit to perform any work covered by these regulations;
- 500.09. Using or causing or promoting the use of any advertising matter, promotional literature, testimonial, or any other representation however disseminated or published, which is misleading or untruthful.
- 500.10. Representing that the service or advice of a person licensed to practice medicine will be used or made available when that is not true, or using the words "doctor," "clinic" or similar words, abbreviations or symbols so as to connote the medical profession when such is not the case;
- 500.11. Permitting another to use his registration;
- 500.12. Directly or indirectly giving or offer to give, or permitting, or causing to be given money or anything of value to any person who advises another in a professional capacity as an inducement to influence him or have him influence others to use the services of the registration or permit holder, or to influence persons to refrain from seeking services elsewhere; or
- 500.13. Violating any of the provisions of these regulations.

EDUCATION

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

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

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STATE OF TEXAS
DEPARTMENT OF HEALTH

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

	<u>Provisional Requirements</u>	<u>Regular Requirements</u>
600.09. Special Requirements of home delivery	May be done during provisional registration period	Required at application
600.10. Information regarding the laws and regulations relating to the practice of midwifery in New Mexico	Required by both the registration levels	
601. <u>LIMITATION:</u> The course of study must not include the independent, medically unsupervised use of any <u>drugs</u> in the antepartum, intrapartum, postpartum or newborn periods except for prophylactic treatment of the eyes; and the course must not contain any training in any surgical procedures other than the procedure for repair of a first or second degree laceration.		
602. <u>CLINICAL EXPERIENCE:</u> Clinical experience in lay midwifery may be obtained in any setting (i.e., office, clinic, hospital, maternity center, home). Clinical experience must include at least the following types and numbers of experiences:		

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

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STATE COMMISSION OF NURSING

	<u>Provisional Requirements</u>	<u>Regular Requirements</u>
602.05. Postpartum home visits (within 36 hours of delivery)	10	30
602.06. BCYC Department of Pediatrics NICU and Nursery (8 hours minimum). Other acceptable observations entities will be considered	May be done during registration period	Required at application
602.07. BCYC Department of Obstetrics and Gynecology High Risk perinatal Unit observation entities will be considered	May be done during registration period	Required at application
602.08. Observation of one complete series of prepared childbirth classes	May be done during registration period	1-6 hour class series preferred
602.09. Observation of one complete La Leche League series	May be done during registration period	1 series of 4 meetings
602.10	Five experiences in each of categories 602.01, 02, 03 and 04 must be with an approved physician or certified midwife trainer. Required at application.	

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

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

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

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

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

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

7 FIELDS TESTED: The examination shall consist of three parts:

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

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

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

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

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

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

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702.01.02. Normal growth and development of fetus and placenta; ARCHIVES

702.01.03. Normal progress of pregnancy, labor and delivery;

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

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

702.01.06. Prenatal nutrition.

702.02. Patient teaching;

702.03. Special requirements of home delivery;

702.04. Risk factors in pregnancy;

702.05. Terminology used in the practice of lay midwifery;

702.06. Normal newborn characteristics and possible problems including anomalies;

702.07. Care of the newborn; and

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

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

703.01. Evaluation of judgment to cover areas of:

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

703.01.02. Recognition and treatment of emergency situations

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

704. SCOPE OF PRACTICAL EXAMINATION: The practical examination shall cover basic observational skills:
- 704.01. Temperature, pulse, and respiration
 - 704.02. Blood pressure
 - 704.03. Fetal heart tones
 - 704.04. Abdominal palpation
 - 704.05. Cervical dilatation
 - 704.06. Fetal position
 - 704.07. Measurement of fundal height
 - 704.08. Exam for edema

DUTIES AND RESPONSIBILITIES

800. COVERAGE: The registered lay midwife must assure that all women she plans to deliver receive required tests.
801. MEDICAL EVALUATION: The lay midwife must require the patient to have a risk evaluation and physical examination by a physician before a registered lay midwife assumes her care.
802. REQUIRED TESTS: Initial physician examination shall include clinical pelvimetry and the following laboratory tests -- VDRL, GC screen, blood type and group, hematocrit and hemoglobin, rubella titer and urinalysis: Hematocrit must be rechecked at 28 and 36 weeks gestation.
803. PRENATAL VISITS: Prenatal visits should be every 4 weeks until 28 weeks gestation, every 2 weeks from 28 until 35 weeks gestation and weekly from 36 weeks until delivery.
804. PHYSICIAN VISITS: Each woman must also have one prenatal visit with a physician at 36 to 40 weeks.
805. RECORDS: The lay midwife shall maintain records of physician's visit with evidence of his/her exam for the Division.

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806. ADVANCE PREPARATION FOR NEED: The registered lay midwife, prior to the onset of labor, must have:
- 806.01. Arrangements made for transport of mother and/or infant to a hospital; and
 - 806.02. Agreement for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.
807. INFORMED CONSENT: The registered lay midwife must inform any woman seeking home birth of possible risks of home birth and must obtain informed consent of the woman for home birth prior to the onset of labor on a form provided by the Department.
808. COMMUNITY RESOURCES: The registered lay midwife must be familiar with community resources for pregnant women such as prenatal classes, WIC program, La Leche League and HSD clinics.
809. LATE PREGNANCY PERIOD: The registered lay midwife will make a home visit no more than 4 weeks prior to the EDC to assess the physical environment, to ascertain that the woman has all necessary supplies to prepare the family for the birth and to instruct the family to correct problems or deficiencies.
810. NORMAL DELIVERY: The registered lay midwife must remain with the mother and infant for at least two hours postpartum, or until the mother's fundus is firm and lochia normal, the mother has voided and the infant has a normal temperature and is nursing well, whichever is longer.
811. HOSPITALIZATION: The registered lay midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and a verbal report to the physician assuming care. If possible, she should remain with the mother and/or infant to ascertain outcome.
812. PHYSICIAN EVALUATION OF NEWBORN: The registered lay midwife must recommend that any infant delivered at home be evaluated by a physician within 3 days of age, or sooner when it becomes apparent that the newborn needs medical attention.
813. POSTPARTUM VISITS: The registered lay midwife shall make postpartum home visits to evaluate the condition of mother and infant at least twice - once within 16 hours of birth and once on the fourth or fifth postpartum day. Additional visits shall be made as indicated.

814. RH BLOOD FACTOR: In the case of an unsensitized Rh negative mother, the registered lay midwife shall:
- 814.01. Obtain a sample of cord blood from the placenta and deliver it to a laboratory within 24 hours of the birth.
 - 814.02. Be certain that the mother consults a physician within 24 hours.
815. PREVENTION OF INFANT BLINDNESS: Within one hour of birth, the registered lay midwife shall administer two drops of 1% solution of silver nitrate or other antiseptic of equal potency and harmlessness into the eyes of the infant in accordance with the Health and Environment Department's Regulations Governing the Prevention of Infant Blindness.
816. BIRTH REGISTRATION: The registered lay midwife must complete a birth certificate and file it with the local registrar within ten days of the birth.
817. SANITATION: The registered lay midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.
818. RECORDS: The registered lay midwife shall maintain records of each patient on forms approved by the Department. Inactive records shall be maintained no less than ten years.
819. ANTEPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the antepartum period:
- 819.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.
 - 819.02. Develops edema of the face and hands.
 - 819.03. Develops severe, persistent headaches, epigastric pain or visual disturbances.
 - 819.04. Does not gain 14 pounds by 30 weeks gestation or at least 4 pounds a month in the last trimester or gains more than 6 pounds in two weeks in any trimester.
 - 819.05. Develops glucosuria or proteinuria.

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STATE DEPARTMENT OF
HEALTH SERVICES

- 819.06. Has symptoms of vaginitis.
- 819.07. Has symptoms of urinary tract infection.
- 819.08. Has vaginal bleeding before onset of labor.
- 819.09. Has premature rupture of membranes.
- 819.10. Noted decrease in or cessation of fetal movement.
- 819.11. Has inappropriate gestational size.
- 819.12. Has demonstrated anemia by blood test (hematocrit less than 30%).
- 819.13. Has a fever of 100.4 degrees F. or 38 degrees C for 24 hours.
- 819.14. Has effacement and/or dilatation of the cervix prior to 36 weeks gestation.
- 819.15. Has polyhydramnios or oligohydramnios.
- 819.16. Has excessive vomiting or continued vomiting after 24 weeks gestation.
- 819.17. Is found to be Rh negative.
- 819.18. Has severe, protruding varicose veins of extremities or vulva.
- 819.19. Is 36 years of age or older.

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

- 820.01. Develops a blood pressure of 160/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.
- 820.02. Develops severe headache, epigastric pain or visual disturbance.
- 820.03. Develops proteinuria.
- 820.04. Develops a fever over 100.4 degrees F or 38 degrees C.
- 820.05. Develops respiratory distress.

- 820.06. Has fetal heart tones below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular.
- 820.07. Has ruptured membranes without onset of labor after 12 hours.
- 820.08. Has bleeding prior to delivery.
- 820.09. Has meconium stained amniotic fluid.
- 820.10. Has a presenting part other than a vertex.
- 820.11. Does not progress in effacement, dilatation or station after 2 hours in active labor (or 1 hour if distance to hospital is greater than 60 miles).
- 820.12. Does not show continued progress to delivery after 2 hours of second stage labor (or 1 hour if distance to hospital is greater than 60 miles).
- 820.13. Does not deliver the placenta within 2 hours if there is no bleeding and the fundus is firm (or 1 hour if distance to hospital is greater than 60 miles).
- 820.14. Has a partially separated placenta with bleeding or has a blood pressure below 100 systolic or a pulse rate over 100 beats per minute or is weak or dizzy.
- 820.15. Bleeds more than 500 cc (2 cups) with or after the delivery of the placenta.
- 820.16. Has retained placental fragments or membranes.
- 820.17. Desires medical consultation or transfer.
- 821. POSTPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the postpartum period:
 - 821.01. Has a second, third or fourth degree laceration.
 - 821.02. Has uterine atony.
 - 821.03. Bleeds in an amount greater than normal lochial flow.

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- 821.04. Does not void within 6 hours of birth.
- 821.05. Develops a fever greater than 100⁴F. 38⁰C on any 2 of the first 10 days postpartum excluding the first 24 hours.
- 821.06. Develops foul smelling lochia.
- 822. NEONATAL PROBLEMS: The registered lay midwife will refer for medical evaluation and/or care any infant who:
 - 822.01. Has an Apgar score of 7 or less at 5 minutes.
 - 822.02. Has any obvious anomaly.
 - 822.03. Develops grunting respirations, retractions or cyanosis.
 - 822.04. Has cardiac irregularities
 - 822.05. Has a pale, cyanotic or grey color.
 - 822.06. Has an abnormal cry.
 - 822.07. Weighs less than 5 1/2 pounds or 2500 grams or weighs more than 9 pounds or 4100 grams.
 - 822.08. Shows signs of prematurity, dysmaturity or postmaturity.
 - 822.09. Has meconium staining.
 - 822.10. Does not urinate or pass meconium in the first 12 hours after birth.
 - 822.11. Is lethargic or does not nurse well.
 - 822.12. Has edema.
 - 822.13. Appears weak or flaccid, has abnormal froth or appears not to be normal in any other respect.

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

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

- 900.01. Has had a previous Cesarean section or other known uterine surgery such as hysterotomy or myomectomy.
- 900.02. Has a history of difficult to control hemorrhage with previous deliveries.
- 900.03. Has a history of low birth weight infants (2500 grams or less), stillbirths or neonatal deaths.
- 900.04. Has a history of birth injury to mother or infant in any previous delivery.
- 900.05. Has a history of third trimester bleeding.
- 900.06. Has history of thrombophlebitis or pulmonary embolism.
- 900.07. Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, hepatitis, heart disease or kidney disease.
- 900.08. Has genital herpes simplex in the first trimester or in the last four weeks of pregnancy.
- 900.09. Has a contracted pelvis.
- 900.10. Has severe psychiatric illness or a history of psychiatric illness in the 6 month period prior to pregnancy.
- 900.11. Is addicted to narcotics or other drugs.
- 900.12. Ingests more than 2 ounces of alcohol or 2 beers a day on a regular basis or participates in binge drinking.
- 900.13. Has a multiple gestation.
- 900.14. Has a fetus of less than 37 weeks gestation at the onset of labor.
- 900.15. Has a gestation beyond 42 weeks by dates.
- 900.16. Has a fetus in any presentation other than vertex at the onset of labor.

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- 900.17. Is a primigravida with an unengaged fetal head at the onset of labor, or any woman who has rupture of membranes with unengaged fetal head, with or without labor.
- 900.18. Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention.
- 900.19. Has pre-eclampsia.
- 900.20. Has a parity greater than 5.
- 900.21. Is 17 years of age or younger.
- 900.22. Smokes 20 cigarettes or more, per day, and is not likely to cease in pregnancy.
901. EXAMINATION IN LABOR: The registered lay midwife will not perform any vaginal examinations on a woman with ruptured membranes and no labor, other than an initial examination to be certain there is no prolapsed cord. Once active labor is assuredly in progress, exams may be made as necessary.
902. OPERATIVE PROCEDURES: The registered lay midwife will not perform any operative procedure other than: clamping and cutting the umbilical cord; repair of a first or second degree laceration.
903. MEDICATIONS: The registered lay midwife will not administer any drugs, medications or herbs except when specifically ordered to do so by a physician and when administering medication in accordance with Regulations Governing the Prevention of Infant Blindness.
904. ARTIFICIAL MEANS: The registered lay midwife will not use any artificial, forcible or mechanical means to assist the birth.
905. CORRECTION OF PRESENTATION: The registered lay midwife will not attempt to correct fetal presentations by external or internal version.

SUPERVISION BY DIVISION

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

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

1000.02. One certified nurse midwife;

1000.03. Two regularly registered lay midwives;

1000.04. One member at large.

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

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

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

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

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

1005. PREVENTION OF INFANT BLINDNESS: The Department will provide necessary supplies for prophylactic treatment of infant eyes as required by these regulations.
1006. These regulations supersede the Regulations governing the Practice of Midwifery adopted by the State Board of Public Health, May 4, 1944, and the previous version of the same Regulations, No. HED-80-3 (HSD) filed on February 5, 1980.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

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

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

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

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

POSITIONS

FULL TIME	0	0	0	0	0
PART TIME					
TEMPORARY					

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

TRAVEL - 12% inflation factor projected.
 Dept. staff to administer examination, 2 times/yr. \$ 700.00
 Dept. staff to attend regulation hrgs., Anch/Fbks/Jnu 1,600.00
 Additional travel and field work by investigators, located in Anchorage & Juneau, to investigate midwife complaints:
 2 Investigators { 1 day per diem/mo, @ \$67 per day 1,900.00
 { 1 trip every 4 mos, @ \$160 per trip
 \$ 4,200.00

CONTRACTUAL - 7% inflation factor projected.
 Legal notices, publications, duplicating and printing costs of applications, consent forms etc.; printing/mailing/distribution costs of statute and regulation booklets; development of exam. \$ 3,000.00
 (continued next page.)

IV. DATE 5-1-81 PREPARED BY Narjorie Odland
 AGENCY DIVISION OF OCCUPATIONAL LICENSING
 PHONE 465-7535

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

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

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

STATE OF ALASKA

Holli
JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

POUCH K - STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3100

May 5, 1981
465-3600 x 56

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

Re: SSB 11 -- Services of Nurse Midwives

Dear Representative Clocksin:

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

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

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

Sincerely,

WILSON L. CONDON
ATTORNEY GENERAL

By: 
Sarah T. Kavasharov
Assistant Attorney General

STX/jb

5-1-81

J. Rogers

ATS 11
SB 4

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Bert Walker, A.R.N.
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Diane ~~Do~~ - DPA



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

BEIRWE
5-1-81

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

MEMORANDUM

May 21, 1980

TO: Representative Brian Rogers

FROM: Betty Barton, Issues Analyst

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

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

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

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

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

Background Information

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

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

Representative Brian Rogers

May 21, 1980

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

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

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

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

Representative Brian Roge. 3

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

DETERMINING THE ROLE OF REGULATION IN LAY MIDWIFERY

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

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

Potential Benefits of Regulation

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

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

Representative Brian Roger.

May 21, 1980

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

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

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

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

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

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

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

Potentially Negative Effects of Regulation

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