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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 imbued 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 intrapartum 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

David Stuart:	Executive Director NAPSAC Post Office Box 267 Marble Hill, Missouri 63764 Telephone: (314)238-2010	
Ms. Shari Daniels:	Director El Paso Maternity Center 1119 E. San Antonio El Paso, Texas 79901 Telephone: (915)533-8142 (Maternity Center) (915)565-9623 (Home number)* *After 6:00 p.m. El Paso time	President National Midwives Assoc. P. O. Box 163 Princeton, N.J.
Ms. Ruth Beeman: (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.

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ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

March 27, 1981

MEMORANDUM

TO: Representative Tony Vaska
FROM: Leslie Longenbaugh LL
Research Staff
RE: Lay Midwifery in Oregon
Research Request Number 81-89

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

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

We spoke with Marianne Remy, of the Oregon Department of Health¹, who was able to answer your questions as follows.

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

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

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

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

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

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

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

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

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

4. Does Oregon keep a register of lay midwives?

There is no list of midwives compiled by the state.

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

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

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

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

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

LL/dp



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

March 31, 1981

MEMORANDUM

TO: Representative Tony Vaska

X 2994 FROM: Leslie Longenbaugh L
Research Staff

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

In our memorandum to you of March 27, we mentioned that we would be contacting the author of the Oregon Attorney General's opinion on lay midwifery. We spoke this morning with Arnie Silver¹ of the Oregon Attorney General's office, who offered a somewhat different perspective on lay midwifery in that state.

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

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

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

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

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

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

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

TO: Tim

FROM: Ed

RE: SB 4 Insurance Coverage of Nurse-Midwife Services

This bill would extend health insurance coverage to maternity services provided by licensed nurse-midwives. It would allow nurse-midwives to bill insurance companies directly instead of billing through physicians. This would affect only policies issued or amended after January 1, 1982.

Nurse-midwives are a long established (50 years), highly trained group of professionals. They are recognized and licensed in 47 states, including Alaska. Nurse-midwives are all registered nurses (R.N.) who have completed a graduate course in the specialty of midwifery. Thus, most nurse-midwives have 6 years of professional education. They also must pass a national certification examination.

Nurse-midwives are employed by hospitals, public health agencies, private physicians, the military, prepaid health plans and birthing centers. Nurse-midwives are limited to handling the 90 per cent of mothers who have normal, low-risk pregnancies and deliveries. They are trained to recognize any abnormalities which might arise and to refer such problems to an obstetrician.

Nurse-midwives are required by Alaska law to be associated with and "collaborate" with a licensed physician (obstetrician). The nurse-midwife profession is regulated jointly by the State Medical Board and by the State Nursing Board.

Nurse-midwives are preferred over physicians for normal delivery and maternity care by a large and growing number of women and men nationally. Women say they prefer the nurse-midwives because they spend more time with them throughout the entire pregnancy and labor, as well as follow-up treatment; they answer questions more readily and thoroughly; and since most nurse-midwives are women, many of whom have had babies themselves, they are more empathetic with the expectant mothers.

There is also strong evidence that nurse-midwives have a positive effect in reducing the rate of infant mortality. As seen in the tables below, the United States is not among the top developed countries with low mortality rates. Several other countries consistently have lower mortality rates. Most of those countries, especially Netherlands, Sweden, Norway, Finland, Denmark, Australia and Japan, employ midwives extensively.

INFANT MORTALITY RATES FOR SELECTED COUNTRIES

Country	Rate per 1,000		Country	Rate per 1,000	
	1971	1972*		1971	1972*
Sweden	11.1*	10.8	New Zealand	16.6	
Netherlands	11.1	11.4	Australia	17.3	16.7
Finland	11.8*	11.3	Canada	17.6	17.1
Japan	12.4*	11.7	United Kingdom	17.9*	
Norway	12.8*	11.3	East Germany	18.0	17.7
Denmark	13.5*		Ireland	18.0	17.7
France	14.4*	13.3	Hong-Kong	18.4	17.5
Switzerland	14.4	13.0	United States	19.2*	18.5

Information from the Statistical Office of the United Nations provided by Doris Haire.
*Provisional.

INFANT MORTALITY RATES FOR SELECTED COUNTRIES
(Rate per 1,000)

Country	1964	Country	1964
Sweden	14.2	England and Wales	19.9
Netherlands	14.8	Japan	20.4
Norway	16.4	Czechoslovakia (provisional)	21.2
Finland	17.0	Ukrainian SSR	22.0
Iceland	17.7	France	23.3
Denmark	18.7	China (Taiwan) -	23.9
Switzerland	19.0	Scotland	24.0
New Zealand	19.1	Canada	24.7
Australia	19.1	United States of America	24.8

Information from the Statistical Office of the United Nations, provided by U.S. Public Health Service

The New Homebirth

THE HOMEBIRTH REVOLUTION

Despite the fact that almost all of the people now alive in the world were born at home,¹ the homebirth movement in the United States, which I call the new homebirth, is completely revolutionary, something which has never before happened in human history. We now find that women, together with their partners, are giving birth at home as safely and with fewer complications than in the average hospital birth,² and are finding it a joyous process, indeed a peak experience in their lives.

This joyful experience of birth is the keynote of the new homebirth. Indeed the current return to home deliveries is not a return at all, because it involves a new *consciousness* of birth. When your great-grandmother gave birth at home, she probably did so shouting, moaning and praying that it would soon be over. She believed that the pains of childbirth were women's lot and was embarrassed before her husband, who either paced nervously downstairs, or went out to get drunk. After participating in just such births in rural Mexico, I am strengthened in the conviction that there is no such thing as "natural childbirth"—a woman either follows her cultural conditioning or makes the leap to a new realization which, although still only recognized by a minority of women, is now available to us all.

The new homebirth is a completely new response to birth, a recognition that what we need to vitalize our

lives, save our humanity, and renew our sensitivity, is to choose actively to *feel* and to know ourselves, our lives, our births, our deaths. Through this realization, women are not only actively giving birth with dignity and joy, but are also reclaiming their birthright—the right to be self-determined and recognized, especially in the uniquely feminine act of giving birth.

The second key to the new homebirth is women's desire to assume active responsibility for their bodies, their lives and their birth experiences. Instead of showing a blind dependency on experts, passively allowing doctors to impose their authority on them, couples are informing themselves as much as possible and selecting birth attendants who will help *them* in their actions—attendants who are not only medically skilled, but also sensitive and aware of the emotional and psychological qualities of birth. For people are coming to know in their hearts that the *way* in which something is done may be even more important than *what* is done, and they have found that the medical establishment has placed a very low priority on the emotional and spiritual experiences of the people it serves. This has forced couples to find new types of birth attendants, to learn for themselves what has formerly been the sacred domain of the experts, and to come to trust the knowledge of their own bodies, minds and intuitions.

The third key, then, in understanding the new homebirth is the recognition that birth is a spiritual process, one which has lasting psychological and physiological effects. Parents are demanding, from the moment of birth, the recognition that their child is a whole and sensitive person to be treated with care and respect. And although these realizations have so far been consciously formulated only by a minority of parents, the

¹Marion Sousa claims, "Fully 98 percent of the people now alive were born at home." *Childbirth at Home* (New York: Bantam, 1977), p. 15.

²See pp. 4-7 for documentation.

force of this realization has been so strong that it has already affected changes in many hospitals' procedures and will continue to transform the American way of birth.

RECLAIMING BIRTH: HISTORICAL ROOTS OF THE CHANGE

The reclaiming of the birth experience by women has been fueled by prepared childbirth classes and ignited by books such as Suzanne Arms' *Immaculate Deception*.³ It has transformed hospitals, led to the establishment of birth centers, and been the driving force behind the new homebirth. The recognition is emerging everywhere: birth is a joyful and spiritual process with lasting impact on everyone involved. To see how radical this statement really is, we have only to glance at the history of birth in the West.

For centuries birth was not only a painful, but also a dangerous prospect. In the Middle Ages, it is estimated that 60 percent of babies and 35 percent of mothers died in childbirth. The invention of forceps in 1598 began the gradual shift towards safer births, but also resulted in births being turned over to specialists, men who guarded the secret of forceps not only from women but from discovery by other doctors.

Queen Victoria's radical choice of using chloroform at the birth of Prince Leopold in 1853 was the start of overcoming the conviction, here expressed by a minister in 1855, that

Pain during childbirth is, in the majority of cases, even desirable! . . . Yet there are those bold enough to administer the vapor of ether, even at this critical juncture, forgetting it has been ordered that "in sorrow shall she bring forth."⁴

But the introduction of anesthetics didn't really change the conviction that birth was painful, and it left women even more passive and completely dependent on their obstetrician to deliver their baby.

The discovery by Semmelweis in the mid-nineteenth century that lack of antiseptic technique was responsible for the tremendous death rate in hospitals from "childbed fever" helped to make hospital births safer than they had been (although American hospitals were especially slow in adopting sterile methods, not using them for more than three decades after Semmelweis' discoveries).

By the 1930s, an increasing number of births were

being done in hospitals and more and more drugs were being used. In 1935, 37 percent of U.S. births were in hospitals. By 1950 the percentage had risen to 88 percent, and by 1960 it had reached 96 percent.⁵ Doctors discouraged homebirths because technicalization of birth and the shortage of civilian doctors during World War II required the equipment and centralization of the hospital environment. Birth had become a technological process, requiring experts to bring the baby out of a mother who was unconscious on the delivery table.

The counterswing to this trend has its roots in Grantly Dick-Read's *Childbirth Without Fear*, published in 1933 in England and in 1945 in America. But it was Marjorie Carmel's *Thank You, Dr. Lamaze* (1956) which first brought a large number of Americans the message that a woman could approach childbirth consciously and with dignity, without depending on drugs.

This was a remarkable shift, allowing women to make such statements as, "I gave birth to Thomas by the psychoprophylactic method called childbirth without pain. When friends say to me, 'Well, did you feel nothing?' I reply, 'Quite the opposite, I felt everything, and that is the wonderful part of it . . . the amazing experience in which each second has remained imprinted on my memory and in which pain has simply found no place.'"⁶

The next major step forward we owe to Dr. Robert Bradley, whose *Husband-Coached Childbirth* made the father an integral part of the birthing team and allowed him not only to be present but also to take an active role in the birth of his child.

But even though prepared childbirth leaves the woman awake and aware, it does so within a framework in which she is still a patient, under the authority of a doctor and subject to the schedules and indignities of hospital routine. The woman has not yet truly been recognized as the central, and hence responsible, person in the act of birth. Lamaze classes in this country, despite all the good they have done, have often become so watered down that neither obstetricians nor women feel that spinal anesthesia is incompatible with prepared childbirth. Although most Lamaze teachers will discuss how to ward off unwanted anesthesia, they ask for a permission slip from the woman's doctor to attend classes, then urge her not to be a martyr and to accept anesthesia if it hurts, rather than dealing squarely with the issues of feeling and experiencing her baby being born, and the effects of anesthesia on the baby.

³For complete information on all books mentioned herein, see the bibliography at the end of the book.

⁴Quoted in Thelma Clairmont, *A Short History of Obstetrics and Gynecology* (Springfield, Ill: Charles Thomas, 1960), p. 293.

⁵Neal Devitt, "The Transition from Home to Hospital Birth in the United States, 1930-1960," *Birth and the Family Journal* 4 (Summer 1977): 47.

⁶Fernand Lamaze, *Painless Childbirth: The Lamaze Method* (New York: Pocket Books, 1972), p. 17.

This compromise with anesthetics (unless necessitated by a *medical emergency*) is a far cry from Dr. Lamaze's injunction:

Those who still maintain that anesthesia should be used during delivery can never have seen the face of a woman who has herself brought her child into the world. No obstetrician or midwife can forget that face, radiant with joy and full of pride, as the mother sees her child being born.⁷

I will add, sees and feels her baby being born *by her own efforts*, not by forceps, which are usually necessary with regional anesthesia.

And while students of the Bradley Method on the other hand, do succeed in giving birth without drugs in over 90 percent of cases, Dr. Bradley still regards the "little woman" as a little girl who is "nuttier than a fruitcake" during pregnancy⁸ and needs to follow her husband's and obstetrician's more rational leads in areas such as routine episiotomy, for example.

NATURE OF THE CHANGE

Thus we see that self-awareness is not yet intrinsically present in prepared childbirth classes in this country. The completely new realization is the recognition by the couple that they themselves are the pivot and focus, the responsible parties and the intentional agents, of the birth process. As such they are seeking help, both inside and outside the medical system, in trying to understand themselves and birth, and they deserve all the respect, knowledge and acknowledgment that can be given them by friends, childbirth educators and birth attendants.

Does this mean they have turned their backs on medicine, technology and medical expertise? No, not at all. Couples involved with homebirth today are seeking to be informed, to make responsible decisions, and to have a skilled birth attendant present who is willing to work with them. They are seeking and demanding quality prenatal care, and if doctors are refusing them because of their plans to have a home delivery, they are forming their own self-help prenatal clinics or starting birth centers. People are coming to trust their bodies and their own ability to learn and make informed decisions. They are coming to feel that medical technology should be reserved for those cases in which it is required (i.e., high-risk pregnancies, which can be detected through prenatal care, and unforeseen complications, which occur in five to ten percent of prepared homebirths).

⁷Ibid., p. 173.

⁸Robert Bradley, *Husband-Coached Childbirth* (New York: Harper & Row, 1974), p. 117.

However, as is the case with all revolutions in consciousness, the people are changing faster than the institutions, and there are more couples involved with the new homebirth than there are medical people prepared to help them. Couples are searching for skilled birth attendants who not only regard birth as a normal physiological process, but who also encourage couples to share in decision-making rather than being "patients." Since so few doctors are either trained in normal birth⁹ or willing to enter into this new relationship with women, couples are turning to midwives as the "guardians of normal birth" and asking that doctors fulfill their role of medical experts by providing backup in the small percentage of births requiring medical intervention.

Although they are not turning their backs on technology, parents involved with the new homebirth have realized what doctors in Holland have always known: that birth is a natural human function, which in general works best if not meddled with (see Kloosterman's discussion, p. 5). Recently the evidence has been multiplying that the technological approach to birth not only robs a woman of a unique experience, but that it also has many health disadvantages. Just as people are coming to know that a blind devotion to industrial technology which does not recognize the integrity of the earth may become lethal, so we are coming to know that an overly medical approach to health has *iatrogenic*, or self-induced, counter-productive results.¹⁰ The new homebirth is an ecology of the body and an expansion of the spirit.

In summary, the driving force behind the new homebirth is the realization that, in order to be fully alive, it is necessary for us to participate actively in what we do, to bring our consciousness, feelings, sense of responsibility and decision-making ability to bear as fully as possible in every action of our daily lives, and especially in an event as momentous as birth.

THE ADVANTAGES OF HOMEBIRTH

You don't have to have your baby at home to participate in this new consciousness. Some women or couples may choose to deliver in a birth center or hospital, either because of risk factors or because they feel more comfortable in an environment where many factors are predetermined and emergency equipment is close at

⁹Many doctors who have become involved with homebirth have attended homebirths with midwives and learned from them the confidence and techniques of normal birth, which are sadly lacking in the curricula of medical schools and missing from the wards of teaching hospitals.

¹⁰For a discussion of iatrogenesis, see Ivan Illich's *Medical Nemesis: The Expatriation of Health* (New York: Pantheon, 1976).

hand. Wherever you give birth, I urge you to explore what it means to take responsibility and to be an informed medical "consumer" (or, better yet, "determiner").

I certainly do not advocate homebirth for everyone. Rather, I recommend that you give birth in the place where you feel best. But to help balance the scales against the counter-arguments that are so common, I would like to enumerate some of the advantages of giving birth at home.

SELF-DETERMINISM

In the comfort of your own home, you are not reduced to the status of a patient. You are in charge. You can do what you want in the way you want. Everyone is present at your request, including birth attendants, who are more likely to view birth as a normal process and share knowledge and decision-making with you.

STRENGTHENING OF THE FAMILY

The father can take an active role in the birth, rather than being "allowed" to be present in the delivery room. You can share in the intimacy of labor and birth without being interrupted by changing shifts of nurses or interns coming in to do exams. Some midwives will even help the father catch the baby as the mother delivers her to the outside world. If you choose, your other children can share in the birth and immediately bond with the baby, and no one has to be separated after the birth. The birth is an integrated part of your lives.

NO UNNECESSARY MEDICAL INTERVENTION

You can avoid the dangers and discomfort of routine spinal anesthesia and accompanying forceps, routine electronic fetal monitoring, use of pitocin or relaxants, and routine episiotomy. You do not require a pubic shave, routine enema or IV drip. You don't need to interrupt your rhythms by going from home to hospital or from labor bed to delivery room. You and your labor are granted much more individuality at home. In short, your baby is born without medical procedures which can be valuable in high risk cases but which, when used on the normal mother and baby, can actually jeopardize the health of both

CHOICE OF POSITION FOR LABOR AND BIRTH

Delivering on a narrow table with your legs strapped into stirrups (in the hospital in Los Angeles where I taught Lamaze classes they still strapped your wrists down as well) is not only uncomfortable and degrading but is

also the worst position for your perineal muscles and almost necessitates an episiotomy (cutting of the birth canal) to avoid tearing. Delivering in a more relaxed position at home with a skilled birth attendant, you almost never need an episiotomy (standard in 95 percent of hospital births) and you rarely tear. You can also be on your hands and knees or relax in the bathtub during labor if they help you feel comfortable, and squatting can often overcome lack of progress without the need for drugs or forceps.

ADVANTAGES FOR BABY

The baby is born without being drugged and dragged out by forceps. He or she is welcomed into a loving environment where the trauma of birth is eased by soft lights, gentle touch and reassurance. Immediately after the birth your baby can nurse and can bond with you both instead of being whisked off to be bathed, weighed, banded, footprinted, and so forth. Your baby is treated as an individual, and his or her uniqueness is clearly recognized and honored.

There is less chance of infection at home than in a hospital nursery, and your baby's every need is instantly satisfied when she or he is with you rather than being one of many under a nurse's care. Breastfeeding on demand helps your milk come in and prevents some common problems of nursing. It also results in a happier and more secure baby who doesn't experience separation, or having to wait for what must seem like eternity when she or he is hungry or in pain or lonely.

FOCUS ON QUALITY

You have the total attention of your birth attendant, rather than thirty minutes of your obstetrician's time and occasional help from nurses. Because your birth is the only thing happening in your home, the total focus of attention and energy of everyone present can be directed towards creating the emotional qualities you want. You are surrounded and assisted by people who love you, not by strangers. If you are more comfortable and more relaxed at home, your labor will go better.

The emotional, spiritual and transforming qualities are not something we have to add to birth—they are inherent in the nature and magnitude of this holy event. If we open to these qualities, we cannot help being transformed.

BUT IS HOME BIRTH SAFE?

A common misconception, fostered by well-meaning medical professionals, is that homebirth poses grave risks and dangers, while hospitals, with their immense

arsenal of equipment and emergency procedures, provide the safest birth money can buy. So strongly do they feel this that several state medical associations have been contemplating revoking licenses of physicians who participate in out-of-hospital births, and some hospitals revoke hospital privileges to any on their staff who even offer assistance to homebirth couples.

However, as the homebirth movement matures and more studies are completed on maternal and infant outcome, the results demonstrate that prepared homebirths (with prenatal care and a skilled birth attendant) not only have a mortality rate as good as or better than hospital births, but have a much better record in terms of complications and damage to the baby.

How can this be true? How can it be that all the tools of modern medicine don't improve on the simplicity of a homebirth?

Every farmer and veterinarian knows that interfering with an animal in labor will cause problems in the birth, but our medical system does not apply the wisdom of this benign non-interference to humans. Rather, it is moving towards ever-greater use of dangerous medical and surgical procedures (which may be helpful in high-risk situations) on what should be normal mothers and babies.

For example, the cesarean rate in U.S. hospitals ranges from 10 percent to nearly 50 percent, while the rate at The Farm in Tennessee, where prenatal care and delivery are done at home by "empirical" midwives, is only 1.2 percent. And in considering other populations as a whole, we find the cesarean ratio to be between two and five percent in Holland and England. There is abundant evidence of the damage and dangers inherent in cesarean sections, including risks of anesthesia, higher risk of pelvic infection, and risk of complications for the baby.¹¹ But rather than working to reduce the cesarean rate, the medical profession is encouraging c-sections by adopting routine use of electronic fetal monitoring.

The electronic fetal monitor (EFM) is perhaps the outstanding current example of needless and harmful meddling in normal labor. It requires that the mother lie flat on her back and involves premature artificial rupture of the amniotic sac and insertion of an electrode puncturing the baby's scalp. Studies such as that of Haverkamp¹² have shown that the use of EFM triples

the cesarean rate while not providing a single area of improved outcome.

The unfortunate dehumanization and mechanization of birth by American hospitals is thoroughly discussed by Doris Haire in *The Cultural Warping of Childbirth* and Suzanne Arms in *Immaculate Deception*. I will cite only one other example, the use of forceps in up to 65 percent of American hospital births. The incredibly high forceps rate in this country is necessitated by the lithotomy position for delivery, the use of regional anesthesia, and by the belief (not shared in other countries) that forceps have no deleterious effect on the baby.

The application of forceps and other procedures is being done with such vigor in an effort to improve maternal and infant outcome, and yet that doesn't happen—as evidenced by the fact that there are fifteen countries which have better infant mortality rates than the United States.

In The Netherlands, which has the third lowest rate in infant mortality,¹³ about two-thirds of all babies are born at home with trained midwives usually doing the deliveries. Transfers to the hospital occur at a rate of less than 2 percent for multiparas and about 8 percent for primiparas (mothers with first babies). Holland's cesarean rate is only 2.3 percent, and forceps are used only in about 3 percent of the births.¹⁴

OBSTETRICS IN HOLLAND

Dr. G. J. Kloosterman, chief of obstetrics and gynecology at Amsterdam University, describes the philosophy upon which Dutch obstetrics is so successfully based:

(1) Childbirth in itself, even in human beings, is a natural phenomenon that in the large majority of all cases needs no interference whatsoever, only close observation, moral support and protection against human meddlingness.

(2) A healthy woman who delivers spontaneously performs in the large majority of all cases a job that cannot be improved.

(3) This job can be done in the best way if the woman is self-confident and stays in a surrounding where she is the real center (as for example, in her own home).

¹¹A recent study by two Brown University researchers in Rhode Island has shown that the risk of maternal death is twenty-six times greater with a cesarean birth than it is for women who deliver vaginally. This was found in an eleven-year study of maternal death in cesarean sections by Dr. John R. Evans and Dr. Edwin M. Gold and reported in the *Journal of Obstetrics and Gynecology*. The percentage of cesarean births doubled in Rhode Island between 1965 and 1975, which is similar to the pattern nationally. Reported in *NAPSAC News*, Vol. 3, No. 3, Summer 1978, p. 19.

¹²Haverkamp's study and other data on EFM from Dr. Frederic Effner, "Hospital Obstetrics: Do the Benefits Outweigh the Risks?" in

21st Century Obstetrics Now! (Chapel Hill, N.C., NAPSAC, 1977), pp. 147-62. His list of complications induced by EFM includes scalp abscesses and cellulitis, infection, fear and pain in the mother, and fetal distress.

¹³Infant mortality figures for 1972 from the United Nations Office of Statistics.

¹⁴"Obstetrics in the Netherlands: A Survival or a Challenge?" address by G. J. Kloosterman, M.D. before the New Tunbridge Wells Meeting, 1975.

(4) It is possible during pregnancy, by thorough prenatal care, to divide the expectant mothers into two groups: a large one that shows no recognizable symptoms of pathology (the so-called low-risk group) and a much smaller one in which there are signs of slight or gross abnormalities.

(5) Only this last group, the group at risk, belongs in a highly qualified hospital under the care of specialists.¹⁵

The country with the lowest infant mortality rate, Sweden, has almost all births occurring in the hospital, so it obviously not the location per se that is at issue. Rather, it is the attitudes, procedures and approach toward birth that determine outcome and cause problems and dissatisfaction with hospital birth (it must be noted that in Sweden, all normal births use the Lamaze techniques with no anesthesia and are attended by midwives in the hospital).

Until the training and orientation of American doctors undergoes a profound shift in these areas, any attempt to humanize the hospitals by adding flowered wallpaper and an easy chair, while still welcome, will remain only superficial and fail to address the real issues. Hospital procedures can be life-saving when needed, but their routine application to low-risk births can be detrimental to the health of both mother and baby, as well as being emotionally unsatisfying for the mother and other members of the family.

HOME BIRTH SAFETY IN THE UNITED STATES

As already mentioned, the percentage of U.S. births taking place in hospitals rose from 37 percent to 96 percent between 1935 and 1960. Since outcomes improved considerably during this period as well, doctors often point to this as an indication of the effectiveness of their approach. In fact, however, homebirths were becoming safer during this period as well. A recent analysis of the studies done between 1930 and 1960 shows that even then the incidence of birth injuries and obstetric mortality was greater in hospitals than in homebirths—despite the poverty, ill health and frequent high-risk conditions of the women who delivered at home.¹⁶

For example, the Chicago Maternity Center delivered more than 12,000 babies at home without a single maternal death (despite the fact that fully 80 percent or more of home deliveries in poverty areas are high-risk births); at the same time the maternal death rate in hospitals was 7 per 1,000.

Despite all the brouhaha raised by the medical profession over techniques of labor and delivery, by far the most important factors in determining birth outcome

¹⁵Ibid.

¹⁶Neal Devitt, op cit., pp. 47-58.

are nutrition, prenatal care and preparation (like prepared childbirth classes). In fact, 66 percent of our perinatal mortality is due to low birth weight, and although medical science has improved in keeping premature and low birth weight babies alive, Devitt states that 75 percent of the recent reduction in neonatal mortality is due to the reduction in the rate of low birth weight, not to changes in obstetrical care.¹⁷

HOME BIRTH VS. HOSPITAL BIRTH: THE MEHL STUDY

The largest scientific study comparing outcomes of homebirth with hospital birth is Dr. Lewis Mehl and associates' "Home Birth Versus Hospital Birth: Comparisons of Outcomes of Matched Populations."¹⁸ In the study, 146 homebirths were compared with 1046 hospital births of equivalent populations in the U.S. For each home-delivered patient, a hospital-delivered patient was matched for age, length of gestation, parity, risk factor score, education and socio-economic status, race, presentation of the baby and individual major risk factors. The homebirth population had trained attendants and prenatal care.

Their study shows a three times greater likelihood of cesarean operation if couples gave birth in a hospital instead of at home with the hospital standing by. The data from their hospital population revealed twenty times more forceps, twice as much use of oxytocin to accelerate or induce labor, greater use of analgesia and anesthesia, and nine times greater incidence of episiotomy (while at the same time having more severe tears in need of major repair). The hospital sample showed six times more infant distress in labor, five times more cases of maternal high blood pressure, and three times greater incidence of postpartum hemorrhage. There was four times more infection among the newborn; three times more babies needed help to begin breathing. While the hospital sample had thirty cases of birth injuries, including skull fractures, facial nerve palsies, brachial nerve injuries and severe cephalohematomas, there were no such injuries at home.

The infant death rate of their study was low in both cases and essentially the same. There were no maternal deaths for either home or hospital. The main differences were in the significant improvement of the mother's and baby's health if the couple planned a homebirth, and this was true despite the fact that the homebirth statis-

¹⁷Neal Devitt, op cit., p. 51.

¹⁸Presented on October 20, 1976 before the 104th annual meeting of the American Public Health Association. For further information, contact the Institute for Childbirth and Family Research, 2522 Dana St., Suite 201, Berkeley, CA 94704.

tics of their study included those couples who began labor at home but ultimately needed to be transferred to the hospital.

STATISTICS FROM THE FARM, SUMMERTOWN, TENNESSEE

Perhaps the best example of a self-contained system of prepared homebirth within the United States is provided by The Farm, an intentional spiritual community founded and led by Stephen Gaskin. Beginning with his wife, Ina May Gaskin, The Farm gradually evolved a group of self-trained or "empirical" midwives. They have recently published their statistics for the 722 births managed by The Farm midwives between October 1970 and August 1977. These statistics include twenty-eight deliveries the midwives considered high-risk and which delivered at a nearby hospital.

Of the 722 births, 44 percent were babies of first-time mothers (primipara). Of all the births, 94 percent were delivered at home by the midwives; there were only nine cesarean sections (1.2 percent) and two forceps births (0.3 percent). The largest baby they delivered weighed 11 lbs. 4 oz., and the smallest living baby, 2 lbs. 10 1/2 oz. They have never had a mother die, and their total number of perinatal deaths (babies dying between 28 weeks gestation through 28 days after birth) was fifteen, a rate of 20.8/1000, which compares favorably to hospitals.

Of their nineteen breech births (buttocks first), eleven were first-time mothers and none required a cesarean. The most recent nine were all done at home or in The Farm Maternity Center. All of the breeches (except one of the first ones) were done without anesthesia, and thirteen of the nineteen were done with no episiotomy. This is in dramatic contrast to hospital practice, which in most hospitals results in a nearly-automatic c-section for breech births, with anesthesia and forceps for those who do delivery vaginally.

The Farm attributes some of their outstanding statistics to their vegetarian diet and healthy lifestyle. In birth they focus on the psychological and spiritual aspects and on having strong husband-wife and mother-midwife relationships.¹⁰

YOUR OWN BIRTH DECISION

We have just discussed birth statistics at some length. But when you have your baby, you are not a statistic.

¹⁰For more information see Ina May Gaskin, *Spiritual Midwifery* (Summertown, TN: The Book Publishing Company, 1978), pp. 474-5.

No one can say with absolute certainty that because most cases like yours have gone well, yours will; or, conversely, that just because your case is "high-risk" it will have problems. Since there are no guarantees in birth, your individual situation will be governed by your actions and decisions during pregnancy and at the time of birth and by forces coming together in that particular moment, not by national averages.

It is never possible to eliminate all risk from giving birth or from being alive. But it is up to you, the pregnant woman, to inform yourself, weigh the risks, and make a responsible decision based on minimizing risk and maximizing satisfaction for you and your family. This book is intended to help you to focus your ideas and come to a decision that best expresses your real feelings and attitudes.

Whatever your choice, studying the process of birth will be invaluable for you. Even if you prefer a homebirth but end up with a hospital delivery, your having informed yourself will ensure a hospital experience quite different from that of someone who has abnegated responsibility for the birth process.

This book is designed as a practical guide for pregnancy and homebirth. At the end of most chapters is a list of other books which explore in detail the issues involved in making the homebirth decision, give personal accounts of home deliveries, and so forth. Read! Confidence based on knowledge and certainty is one of the keys to a satisfying homebirth experience.

Talk with other couples. If there are homebirth classes in your area, be sure to attend them; no book can replace the first-hand information and emotional support they provide. Chapter 4 lists the national organizations providing such classes. If there are no classes specifically geared for homebirth couples in your area, start a homebirth study group. You'll be amazed at the number of interested people you will find. Informed Homebirth offers posters and suggestions for forming such a group based on its homebirth course, which is available on cassette tapes.

Above all, communicate with each other as a couple. If your partner is apprehensive about homebirth, really listening to his fears, discussing birth, reading and talking with other people will often help him to see things differently. After all, men in our culture are given very little support for being in touch with their bodies, and practically no information or feeling for their relationship to the normal birth process.

If, on the other hand, it is the man who is pushing for a home delivery, he should recognize that the ultimate decision needs to be his wife's. My experience has been that if a woman wants to give birth in a hospital, she will probably end up there one way or another. It is important for a homebirth that the couple be in agreement about what they are doing and have a high level of intention and responsibility.

Once you have made your decision to have a homebirth, there is still a great deal to do. Later chapters in this book discuss the issues of finding prenatal care, finding a midwife and preparing an emergency backup plan. The sooner these activities get underway, the better, especially if you live in an area without much support for homebirth.

Because we have all been culturally conditioned with so many irrational attitudes about birth, you may well encounter opposition to your plans at some point, whether from friends, family, doctors, or other members of the medical community whom you approach for health care. It is best not to argue with people if it fosters upset. Instead, focus your attention on building a community of support to help your intention strengthen and grow; you are not alone in your knowledge and convictions. If you encounter people who are worried but truly open-minded, recommend that they read some of the books on the subject.

We are living in a time of rapid change in our culture's attitudes about birth. You are part of that change. Our right to give birth as we choose is a right well worth reclaiming.

FOR FURTHER READING

Childbirth at Home by Marion Sousa. Provides a detailed discussion of the American way of birth and the advantages of homebirth. Afterword by Dr. Lewis Mehl on the management of complications in Santa Cruz home deliveries. Excellent for people considering the idea of homebirth.

Commonsense Childbirth by Lester Hazell. Presents birth as a natural, dignified, creative experience in which the mother has many choices; includes sections on homebirth and unexpected outcome.

The Cultural Warping of Childbirth by Doris Haire. A booklet detailing how American hospital practices have distorted the process of giving birth, with recommendations for change.

The Home Birth Book by Charlotte and Fred Ward. Essays by various contributors on the advantages of homebirth and why people from all lifestyles are choosing it. Beautiful photographic work. Excellent to give to relatives and friends.

Immaculate Deception by Suzanne Arms. An in-depth presentation of the way in which American hospital practices are robbing women of their birth experience; contrasts with birth in European countries.

Living-In: A History of Childbirth in America by Richard and Dorothy Wertz. A fascinating study of childbirth practices from colonial times to the present.

Safe Alternatives in Childbirth, David and Lee Stewart, eds. Proceedings from the first annual conference of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC).

Spiritual Midwifery by Ina May Gaskin. One of my favorite books, describing births as managed by midwives on The Farm in Tennessee ("Amazing Birth Tales," advice to parents, section for midwives). Although the active role of their midwives works well within a community of agreement and everyone gets high, if a male doctor came into one's home and did some of the same things, it would feel like gross interference and lack of respect. My own preference is for some of the insights of The Farm combined with the parents' maintaining an active role (see "The Birth of Phoebe Rose" after Chapter 8).

21st Century Obstetrics Now! David and Lee Stewart, eds. Proceedings from the 1977 NAPSAC conference; 2 volumes.

THE CASE FOR HOME BIRTH

Table One
Infant Mortality Rates*

Country	1977	1978
1. Sweden	8.0†	7.7†
2. Japan	8.9	8.9†
3. Denmark	9.1	
4. Finland	9.2	
5. Norway	9.5	9.5†
6. Netherlands	9.8	
7. Switzerland	11.4	10.6†
8. France	11.9†	11.7†
9. Belgium	12.4	12.6
10. Singapore	12.4	
11. Canada	12.5	
12. Australia	13.1†	13.2†
13. German Democratic Republic	13.5	11.6†
14. Hong Kong	13.7†	13.1†
15. England and Wales	14.1	13.6†
16. United States	14.2	
17. New Zealand	15.5	14.7†
18. German Federal Republic	15.6	15.1†
19. Spain	15.7†	
20. Ireland	16.9†	14.9†
21. Austria	17.6†	16.0†
22. Italy	17.8	15.1†
23. Israel	19.6†	18.7†
24. Czechoslovakia	20.3†	18.8†
25. Greece		

* Lowest 25 countries with population of 2,000,000 or more. Rates per 1,000 live births. United Nations data. Reprinted from Wegman, M.E., *Annual Summary of Vital Statistics*, J. Pediatr., 64:6, Dec. 1979.

† Provisional; 1978 figure from France excludes live-born infants dying before registration of birth.

‡ For a discussion of the definitions and ambiguities of statistics such as those given above, see Appendix C of this book.

the United States. [4,5,88] The characteristic features of American maternity care since 1940 have been doctors and hospitals. The characteristic features of Dutch maternity care have been midwives and home birth.

American physicians point out, in defense of their hospitals, that throughout this century birth related mortalities have fallen dramatically around the world with the increased hospitalization of birth. They conclude that there

is a causal relationship between the treatments and hospital care. They ignore other factors, independent of hospitals, which have brought about improvements much more satisfactory than any statistical study has confirmed. The fact that the home birth should be credited with the perinatal mortality reduction of the century. Kloosterman and Gasthuis, of Holland, commented that if one were to compare the home birth during the past decades the improvements are due to increased hospitalization. If the two seem to parallel, one could just as easily credit the improvements to global inflation. Inflation rates also seem to parallel the improvement in perinatal outcome. [164]

If the better outcomes of the world are due to higher rates of hospitalization, then the countries with the most hospitals should be at the top of the ranking and those with the most home births should be at the bottom. On an international scale, this has not been so. An inspection of Table One shows that the countries with the lowest infant mortality rates are at the top. Sweden used to have a home birth system based upon midwifery. It has since moved to midwives, but since the middle 19th century it has had nearly 100% hospital births. At the bottom of the ranking are the worst countries in Table One also have high home birth rates. Furthermore, Holland, which is in sixth place had 42% home births in 1977. Hence, the practice of total hospitalization does not statistically correlate with better perinatal outcomes. There is simply no such correlation. It should be noted here, in comparing the home birth in countries such as the U.S. (with a 14.2% home birth rate) and Holland (with what has traditionally been a 42% home birth rate) while both countries have enjoyed improvements in pregnancy outcome over the past several decades, the improvements of improvement have been much greater in Holland.

By comparing regions within the same country, we can get further insight into the relative safety of the home. If high rates of hospitalization

March 18, 1981

HB 11

Senator Charles Parr, Chairman
Senate Health, Education and Social Services Committee
Pouch V
Juneau, Alaska 99801

Dear Senator Parr:

I have just, tonight, learned of Alaska Senate Bill 237, submitted to the Senate Health, Education and Social Services Committee on March 4. Tomorrow I will contact Wally Richardson of our Legislative Affairs Office and request a copy of the bill in its entirety. I am requesting, in this letter, that a local teleconference be held on this bill that I might testify rather than a public hearing in Juneau which would be impossible for me to attend. I will follow-up on this request by contacting Wally Richardson and ask that I be notified well in advance of the teleconference date. If there is something further I can do to stress my position, I ask you to advise me. I realize an individual has little hope of an effective stand when the opposition is the powerful Alaska State Medical Association, but I am hoping that members of the Senate Health, Education and Social Services Committee will not make a decision without accurate statistics and information, nationally and internationally, on the many safe alternatives in childbirth and that each of you is fully acquainted with the many controversies in modern obstetrics. I hope the committee will not simply bow to the authority of the Alaska State Medical Association without considering that it is a union as much as a professional organization and financial gain is as much a factor in their position on this bill as the interest of maternal and child health.

I am opposed to SB237. I understand this bill will allow the State Medical Board to authorize who shall assist at childbirths. I would not be averse to this if the State Medical Board were moving in the direction of expanding safe alternatives in childbirth through the certification of lay midwives, with criterion to be met determined by skilled midwives rather than obstetrical surgeons, but I have no doubt the intent of this bill is to restrict rather than expand safe birthing options for the people of Alaska.

I am 32 years old, an education administrator and the mother of an eleven-month-old daughter. My master's degree is in education of the severely and profoundly retarded, with particular interest in the multiply handicapped. I am quite familiar with the many events which may occur during pregnancy, childbirth and the neonatal period which can damage the body and mind of an infant.

I approached pregnancy as I would any new experience in my life, by educating myself as completely as possible to be sure I made the best decision for my baby, my husband and myself. In the three years prior to my pregnancy and the subsequent nine months, I read countless texts and articles on pregnancy and childbirth. I talked with several doctors, nurses, midwives and parents and went through the standard hospital prepared childbirth course. I feel I am as competent as anyone on your committee to know what constitutes a safe alternative in childbirth.

I spent the first several months of my pregnancy trying to find a doctor who was not patronizing, but truly believed a normal, healthy birth is the rule and not the exception; one who believed it the woman's responsibility to prepare her body and

mind for the experience and believed in her ability to do so; one whose ego would allow him or her to "attend" a birth, yet maintain control over the desire to medicate, monitor and otherwise intervene unless it was medically necessary. I know such physicians exist, but I did not find one. In the seventh month of my pregnancy, following-up on a number of names I had encountered, I found a lay midwife with whom, after one afternoon's meeting, I knew I had found the person to attend the birth of my child.

After thoroughly educating myself, working hard to maintain a healthy, complication-free pregnancy, selecting a skilled birth attendant and preparing for emergency back-up, I chose a homebirth with a lay midwife. I do not, in any way, feel my choice was irresponsible; on the contrary, I did more research and gave more thought to this decision than most women give to a hospital birth. From all I have learned, I also believe my healthy and normal delivery would have been at greater risk had I subjected myself and my child to a "normal hospital birth". Most medical personnel would say my choice was foolish. One doctor told me it was "stupid to even consider a homebirth", yet statistics prove the opposite: a well-planned, well-screened homebirth, attended by a skilled midwife with arrangements for good emergency back-up is as safe as any hospital birth with the added benefits to homebirth of shorter labor, less complications and the opportunity for immediate family bonding with its long-term psychological advantages. From a very personal standpoint, it provides a feeling of such great joy and accomplishment, I cannot possibly describe it well enough and can only feel terrible sadness and a sense of loss for those who recall only an unpleasant birth experience.

What SB237 is really about is not safer births because statistics do not support physician-supervised births as being necessarily safer; rather, this bill is really about money.

The birth of my daughter cost \$350. Had I elected a routine hospital birth in Anchorage, the bill would have been \$2,000 to \$3,000 and would likely have included IV's, amniotomy, fetal monitors, episiotomy, labor room charges, delivery room charges, newborn nursery charges, an unnecessarily long hospital stay and perhaps, if I really went first class, a C-section -- they seem to be excessively popular these days. It is certainly to the doctor's economic benefit to have all births required, by law, to fall under his or her supervision. This is, I believe, the basis of the Alaska State Medical Association's request to the State Medical Board and to the Governor for the passing of SB237, and does, by virtue of the obvious financial gain to be had, present a question regarding the objectivity and sincerity of the request. I, on the other hand, experienced no financial gain through my deliberate and well-planned choice of a lay midwife, and my desire to see safe alternatives expand is based entirely on what I have learned about current obstetrical trends and what I believe to be good physiological and psychological health care and basic common sense. Had I delivered under a physician's supervision, regardless of the cost, my insurance company would have covered the birth. Because I elected an alternative other than the AMA approved method of giving birth, the insurance company denied my claim stating it did not coincide with their list of "reasonable, necessary and customary" maternity services. I am well aware of how the medical community manipulates private medical coverage -- will it now manipulate and dictate to the State of Alaska how and under what circumstances a woman may give birth?

The intent of my letter is not to encourage homebirth, lay midwifery, or any particular birthing alternative. I refer to these approaches because it was what I chose, as it was my right to choose, and that, Senator Farr, is the point of this correspondence, to stress the right of the individual to choose from a wide spectrum of safe

alternatives. Highly sophisticated modern obstetrical care must continue to be available for it sometimes becomes very necessary, but necessary, too, is the availability of the family doctor, the certified nurse midwife and the certified lay midwife, for somewhere in this range is the skill and philosophy which meets the needs of each family.

I am enclosing several recent, brief and informally written articles from a variety of sources which support points on which I have generalized. I would also like to recommend the following books as essential. They provide an in-depth statistical look at childbirth in this country and how we compare with other countries, as well as a good review of obstetrical history in the United States and a discussion on current controversies. Perhaps the committee is already familiar with this literature. If not, and if these titles are unavailable to you, I will send my own copies of those I presently have at hand, if you request.

Benefits and Hazards of the New Obstetrics, Tim Chard and Martin Richards

Lying-In: A History of Childbirth in America, Richard and Dorothy Wertz

The Cultural Warping of Childbirth, Doris B. Haire

Immaculate Deception: A New Look at Women and Childbirth in America,
Suzanne Arms

To attend a birth is a privilege, not a right to be determined by Alaska State Law; rather, an honor which should only be granted by the birthing parents, the ones who, let us not forget, must also pay for the service. Please acknowledge the individual intelligence and right of Alaskan families to plan their own birth experience; defeat Senate Bill 237. Help us expand safe alternatives in childbirth, not restrict them.

This has been a lengthy letter. Thank you for your time and patience. I can provide much more information if you feel it would be useful. You need only ask.

Sincerely,

Julie Gorham
Box 1037
Bethel, Alaska 99559

Enclosures: Five articles

cc: Representative Tony Vaska
Senator George Hohman

NBII
61

MSG #1-00009590 PRTY 1 03/24/81 16:57:14 ORIG: LA00 IN= 0016 OUT= 0068
FROM: LOU TO: JNU INFO
TARGET: LJH2 SUBJ: POM PAGE 0003

TO: ALL LEGISLATORS

SB237

FROM: JANET BALICE, 2156 ALDER STREET, ANC.99504 279-5803

I'M OPPOSED TO SB-327 BECAUSE IT RESTRICTS A WOMAN FROM GIVING BIRTH WITH ANY QUALIFIED BIRTH ATTENDENT OF HER CHOICE. I FEEL LICENSING OF BIRTH ATTENDENTS WHO ARE NOT PHYSICIANS, SUCH AS MIDWIVES IS NEEDED. BUT THIS BILL WOULD ONLY OUTLAW THEM AND RESTRICT HUMAN RIGHTS.

PUBLIC OPINION MESSAGE

HB11

NA

To: All Legislators

From: The Alaska Women's Resource Center
204 E. 5th suite 224
Anchorage, Alaska 99501

Concerning S.R. 237 (The Medical Practice Act)

*** **

The Alaska Women's Resource Center is against the revision that would limit to physicians only the right to attend or assist at childbirth. We believe it is the parents right to choose who assists at the birth of their children. This provision is unrealistic and impractical in rural Alaska.

Please send immediately.

Thank you,

Eileen Smith Levinson
AWRC Education Specialist

204 E. 5th
Anchorage, Alaska 99501
Tel: 907-260-0500



Legislative Affairs Office
1024 W. 6th Ave.
Anchorage, Ak. 99501

Attn: Public Opinion Message



InterNational
Association of
Parents & Professionals for
Safe
Alternatives in
Childbirth

NAPSAC

Post Office Box 267, Marble Hill, MO 63764
Telephone: (314) 238-2010

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Mekin Park, Illinois
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Philadelphia, Pennsylvania

April 12, 1981

Representative Brian Rogers
Pouch V
Juneau, Alaska 99811

Dear Representative Rogers:

Thank you for your letter and check for \$24 for two copies of the book, THE FIVE STANDARDS FOR SAFE CHILDBEARING. When I had last talked with your secretary, whose name I believe is "Ginger," she had said to send up one copy right away and a check for \$12 would be sent at the same time. Hence, one copy of the book has already been sent. Enclosed is your second copy.

As for licensing in general, NAPSAC's idea on this is contained in the book, COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH, Chapter 34, pp. 399-450, entitled, "Midwifery Licensing: Problems, Pitfalls, and Alternatives to Licensing," by Allen Solares. Instead of mandatory licensing for all health professionals in order for them to practice, freedom to practice is given to everyone--but what is mandatory is disclosure to the public of one's education, experience, practice policies, and results. Hence, a doctor or midwife can practice with or without certification, but must, by law, reveal their status to all. Every doctor or midwife must compile and make available to everyone--clients and the public alike, their results--perinatal mortalities, fetal deaths, cesarean rates, hemorrhage rates, etc. If parents have knowledge of a practitioners education, extent of experience, practice policies and statistical outcomes--then, and only then, do they have a rational basis for choice. To choose on the basis of whether or not a practitioner has a mandatory state administered license is not very useful information. Most of the most dangerous birth attendants in practice today are licensed medical doctors and many of the safest birth attendants are unlicensed lay midwives functioning outside the law. You and your aides should read this chapter.

As for my availability to testify, I would be pleased to do so and have some experience in more than several states in this regard. My expenses must be fully provided and although I charge no consultant's fee, as such, since I receive a salary from NAPSAC, I do ask for \$100 per day to be made payable to NAPSAC. This would be for total days absent from headquarters here--including travel time. This helps compensate NAPSAC for my absence and also helps maintain NAPSAC in its continued efforts to provide resources in this field for everyone, such as your office, to use.

Please let me know how things come out with your efforts. It was a pleasure talking with you via the phone and I was impressed with your understanding of the issues at stake.

Sincerely, David Stewart, PhD, Executive Director

David Stewart

over

Women and Children's Health Associates



Box 2101 Palmer, Alaska 99645

Wasilla Phone: (907) 376-3237

Palmer Phone: (907) 745-4711

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March 19, 1981

Representative Brian Rogers
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

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Dear Representative Rogers:

Thank you for your letter of February 4, 1981; I was out of town and have only recently returned to read through it.

I have reviewed your letter carefully and have once again gone over Senate Bill #4. I do appreciate that the purpose of the Bill was to make a little more liberal the insurance problems related to delivery in this State. This I can accept. However, there are still certain points within the proposed Bill which I think need extremely careful evaluation:

1. I do believe most firmly that advanced nurse practitioners certified to practice as nurse midwives must do so under the supervision of a licensed medical doctor in this State. No doubt you are aware of the problems which the State of California has had in home deliveries of babies by midwives. I believe a proposed Bill in California which would have allowed home delivery of babies by midwives was killed. I certainly think that untrained persons should not be given legal sanction to provide this type of health care and I do not see this in the proposed Bill as stated.
2. Why was the definition "provider" placed instead of physician? If medical care is to remain reasonably scientific, I believe it must remain within the hands of licensed medical doctors. I certainly see no reason to substitute the word "providers" for physicians in Senate Bill 4. I believe this does nothing but to water down the Bill and make possible interpretations of provision of medical care by other than licensed medical doctors.
3. An even greater serious problem is indicated in the definition of "provider" which I read on Page 5 of the Bill as meaning a "physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner". If I read the Bill correctly, this would mean that a certified nurse midwife (who might otherwise be very qualified and trained) could and would work under the direct supervision of an optometrist or a

Representative Brian Rogers

March 19, 1981

Page Two

chiropractor in provision of deliveries. If we are to continue to provide any modicum of quality in health care, I certainly do not believe that a chiropractor or an optometrist can take on a certified nurse midwife and allow that person to provide deliveries.

In my own practice, I have cared for a number of women who were planning to have a home delivery by an alleged midwife. These women came to a "real doctor" just for a final check-up prior to their home delivery. In evaluating these women, it became obvious that a number of them have extremely high risk problems, such as pre-eclampsia, severe anemia, gross obesity, prenatal history which is not conducive to a normal delivery, and estimated due dates which were not consistent with either physical exam or menstrual dates. Certainly to sanction the home delivery of these women is, in my judgement, a genuine step back in obstetric care in this State. Most of these women had no real idea about the competence or training of their "midwife".

I believe that until a person can substantiate that he is qualified to do deliveries inside or outside the hospital, that person should not do deliveries. I can assure you that we have problems enough within the hospital for those last-minute disasters which are completely unknown until the point of delivery.

My own feelings about the present surge of home births is that we ought to be making every available accessibility and convenience for parents to have their deliveries within hospitals. If I thought a home delivery could be carried out with safety, I would be doing them. I believe that most of the people doing home deliveries are doing them very uninformed. It has also been my experience in my office practice that when I discuss with a woman who plans a home delivery, she will elect a hospital delivery when she understands her risks.

No woman would deliberately choose to have an unsafe delivery. Those who choose a home birth, in my experience, are not sufficiently informed to make that kind of a decision. Those who do when they have been fully informed of all the risks and benefits and hazards often do so for religious or financial reasons.

To your question of what I think we can do to encourage patients to voluntarily choose the best health care for the birthing process, I would simply state that the medical profession must be in a position to provide more information to parents. We must liberalize our birthing policies within hospitals and we must develop better family oriented birthing centers. Most of this can be done within the constraints of already existing hospital environments as we have done at Valley Hospital.

I can only say to you that the statistics I understand indicate that 90% of the time a baby could be born almost anywhere and do all right.

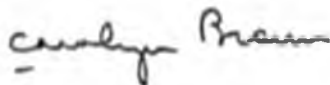
Representative Brian Rogers
March 19, 1981
Page Three

For that 10% of the time in which there will be a real problem or a near-disaster, the problem will not be known until just prior to delivery. For this to happen in an unsafe environment without available emergency care and life-supporting systems for both the mother and the child, to me is unconscionable. For that baby and that mother the 10% becomes a possible 100%.

I would like to at least strongly suggest that the definition of a "provider" be limited to a licensed medical doctor in this State. If we do not do this, I believe we are opening ourselves to increased quackery in this State.

Please let me know where I can be of further help.

Sincerely,



Carolyn V. Brown, M.D.

cVB/dd



Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

May 1, '981

Rep. Don Clocksin, Chairman
465-3797

Pouch 7
State Capitol
Juneau, Alaska 99811

TO: HESS Committee Members
FROM: Hollie Ploog, Staff Counsel
RE: SSHB 11 Highlights

1. Department of Commerce - Occupational Licensing Division - regulates and licenses midwives. Does not create new board.
2. Licensing is voluntary - bill is a consumer protection measure and sets out to the consumer all pertinent information regarding midwifery: education and training; services and fees; procedures for meeting medical emergencies; history of client infections; hemorrhage; hospital transfers; malpresentations and normal deliveries.
3. No third party insurance coverage
CSSB 4am allows 3rd party coverage to nurse midwives -
SSHB 11 deals with lay midwives
4. Licensure requires:
 - a - 18 years old
 - b - high school degree or equivalent
 - c - attend at least 20 births as mid-wife over 2 year period prior to date of application or completion of mid-wife apprenticeship. Proof is by affidavit if before 1/1/92.
 - d - pass exam administered by Department (written)
5. Renewal:
 - a - attend 20 births in previous 2 years or completed 20 hours of continuing education
6. Medications determined by Department - prescriptions from a consulting physician.
7. Apprenticeship - 50 births assist, 25 births primary responsibility under supervision of sponsor.

HP:sp

BACKUP MATERIAL AND GENERAL INFORMATION
REGARDING THE SS FOR HOUSE BILL 11

CONTENTS

1	HOUSE RESEARCH AGENCY INFORMATION
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3	GENERAL INFORMATION - HOMEBIRTH
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Licensing: The Myth of Government Protection

In most communities, if you want to cut hair, sell a candy bar, embalm a body—or argue a case in court, you need a license

Permits and licenses are ubiquitous features of modern American society. Activities as diverse as driving, building, barbering, lawyering, vending, nursing, embalming, selling liquor and polluting the environment all require some form of official governmental imprimatur.

In the occupational areas alone, states now license nearly 500 professions, amounting to 25 percent of the labor force in some parts of the country. During one recent year, New York City had over 70,000 licenses and permits outstanding for businesses ranging from garages, parking lots and junk shops, to theaters, cabarets and coffee houses. California's Department of Consumer Affairs licenses and regulates over 850,000 people in more than 100 occupations.

The popularity of the permit as a regulatory tool derives primarily from its apparent simplicity. Under the typical scheme, no one may engage in the regulated activity without a "permit" or "license" (as a practical matter the terms are interchangeable).

The government will not grant a permit unless the applicant meets minimum entry standards (e.g., education and experience), and will presumably suspend or revoke the permit if he fails

by David S. Baron

*Assistant Attorney General,
State of Arizona. © 1980*



to comply with performance standards (e.g., competence, fair dealing). Enforcement against violators of the permit requirement is supposedly easy because the only issue is whether they are properly licensed. In theory, then, the permit system identifies those who meet government standards and weeds out those who do not.

Unfortunately, the realities of permit regulation are far different from the theory. In many instances, permits are issued almost automatically upon filing an application, with little review of the applicant's qualifications. Where eligibility standards are employed, they frequently bear no relationship to legitimate governmental interests and are applied restrictively merely to limit competition. Administrative agencies devote so much time and attention to issuance and renewal of permits that they often have few resources to devote to monitoring and enforcement. Permits are almost never revoked, and violators of permit conditions and performance standards are rarely punished.

Consider the example of New York City. According to a 1966 research study, only six of the 70,688 licenses and permits outstanding in 1964 were revoked, and only 19 were suspended, despite the filing of over 4,300 complaints against licensees with the city that year. At the same time, the city's Department of Licensing had far more employees working on administration and license issuance than on enforcement. License issuance and renewal were almost automatic unless applicants had criminal records. In only one instance did the department require an examination to establish occupational skills—an applicant for a sightseeing guide license had to take a written test on points of interest in New York City.

THE CASE OF THE MORAL MANICURIST

Unreasonable entry restrictions are most common in the area of occupational licensing. The state of Ohio, for example, requires pawnbrokers, barbers, sanitarians and manicurists to be of "good moral character" in order to ply their trades. Funeral directors are deemed unqualified if they are not U.S. citizens. Landscape architects must graduate from an accredited four-year school of landscape architecture or have at least seven years of practical training. Barbers are required to graduate with at least 1,800 hours from

an approved school of barbering and complete an 18-month apprenticeship. At the same time, however, lawyers need no practical experience to be licensed and can handle serious criminal trials without ever before having set foot in a courtroom.

Licensing exams are particularly suspect. In a 1977 study, University of Tennessee economists Sidney Carroll and Robert Gaston found a direct correlation between pass rates and excess demand for professional services, concluding that occupational licensing boards often use exams to manipulate the supply of practitioners so as to maintain income levels for those already licensed.

Exams frequently test matters wholly unrelated to job capabilities, barring entry to the less formally trained and minorities. In some states, barber applicants must show generalized knowledge of anatomy, physiology and biology, and prospective architects must know about the history of architecture. Georgia requires auctioneers to be versed in the principles of land economics.

In the midst of this maze of entry restrictions and examination requirements, the monitoring and enforcement functions of permitting agencies are often forgotten. In the medical profession, for example, an estimated 16,000 incompetent or unfit physicians are in practice, according to a 1976 *New York Times* report. Despite this, an average of only 72 per year lost their licenses between 1971 and 1974. Although the number of revocations has since increased to over 400 annually, it still constitutes less than three percent of the total. A major part of the problem stems from lack of enforcement resources. As of 1976, New York state had only 7 investigators to monitor 55,000 physicians.

Recent statistics from Arizona provide further examples. There, the State Board of Technical Registration, which licenses professionals such as architects, engineers and geologists, did not revoke a single license between 1964 and 1978; the Board had over 6,500 licensees during the latter half of this period. The Arizona State Optometry Board revoked no licenses for violation of practice standards between 1975 and 1978, and issued only five suspensions, each for less than three days.

In Florida, most licensing agencies investigate fewer than one percent of

their licensees annually, according to data in a 1974 legislative study. The state barber board, with a budget of over \$140,000, conducted only 4 investigations in 1972, when 4,218 barber shop licenses were outstanding.

These examples are not mere aberrations. Government officials from all parts of the country have expressed concern about inadequate monitoring and enforcement by licensing agencies. Of course, unfairness and ineffective administration are not unique to permit systems; other forms of regulation can be abused as well. Licensing does have several basic flaws, however, that invariably undermine its effectiveness.

WHEAT TO THE LEFT CHAFF TO THE RIGHT

The most significant weakness is the inherent deceptiveness of the permit. A license or permit confers a veneer of legitimacy on the activity of the holder. The logical assumption is that a licensed person knows what he is doing and is acting in accordance with government standards. Indeed, a major function of permit systems is to assist everybody in separating legitimate practitioners, operators and businesses from the incompetents, frauds and criminals.

In reality, however, a permit does not guarantee that the holder is acting properly or that he is even minimally qualified. Rather, it merely indicates that—at one time—the holder met minimum requirements for entry into a business for the exercise of a privilege. Even the best of regulatory agencies cannot continuously monitor to ensure that licensees are immediately suspended or revoked when practitioners break the law, lose their skill or abuse their positions. Yet between regulatory reviews, the permit remains on the wall, creating the impression that all is well regardless of any impropriety that may in fact exist.

This sort of deception can affect even the regulators themselves. With limited resources, it is tempting for officials to presume that licensees are acting properly and to focus enforcement efforts on unlicensed activity. This is particularly true where the licensing and enforcement functions are performed within the same agency.

Officials who have certified a particular person as "competent" may well be reluctant to call into question the

same person's ability at a later date. Such officials may also see their primary function as controlling entry into a profession or activity, with careful screening acting as the principal tool for ensuring compliance with standards. Unfortunately, no screening system, however thoughtfully devised, can predict with certainty how people will behave after being licensed; there will always be those who violate standards.

A second basic defect in permit regulation is the inadequacy of the revocation or suspension threat as an enforcement device. For regulatory violations of minor or moderate severity, revocation is neither a realistic nor credible deterrent. Under contemporary notions of justice and fair play, a total bar on future activity by the licensee is simply too harsh a penalty for a noncritical transgression. Even where significant deficiencies are involved, revocation may be inappropriate if the violations stem from isolated imprudent acts rather than chronic non-compliance. A single violation does not necessarily show that the licensee is unfit to engage in the regulated activity. As both a punitive measure and a control device, permit revocation is too severe a sanction to be useful in most cases.

A third flaw of permit systems is their inefficiency in applying regulatory resources. Under the typical scheme, every person who wants to engage in the regulated activity must get a permit. This is necessary to effectuate the identification and exclusion functions of permits cited earlier. As a practical matter, however, many permittees will require no regulatory attention. Those who are truly competent, conscientious, law-abiding and diligent will comply with state standards whether or not there is a permit system. Inevitably then, permitting agencies will waste time and effort in licensing and supervising persons who already meet standards and who will continue to do so.

POLLUTION PERMITS PRESENT PROBLEMS

Permits also present special problems for the efficient administration of environmental laws. Pollution permits typically define specific control measures and compliance schedules for each polluter. The permit terms translate general statutory and regulatory mandates into particular requirements

for each factory or plant. Invariably, the process of negotiating (and sometimes litigating) permit terms is time-consuming and costly. During this period the applicant may well be in gross violation of standards, causing severe environmental degradation.

Even after the permit is issued, there is no guarantee that the permittee will comply with its terms. Thus, a second level of administrative action or litigation is often required to enforce the permit standards. The whole process can drag on for many years, during which time regulatory objectives are thwarted. The flexibility of case-by-case standard-setting may be desirable from a policy standpoint, but lengthy delays in attainment of substantive goals are inevitable in such a system.

Beyond inherent flaws, permit systems are particularly susceptible to manipulation by regulated groups for anti-competitive purposes. In the occupational licensing area, most state agencies are run by members of the regulated profession, either directly or through their professional associations. Legislatures mandate such self-regulation on the often mistaken belief that only practitioners possess the required expertise to properly regulate other practitioners. The entry control mechanism provides these board members with a powerful tool for limiting the supply of professional services and maintaining high incomes for themselves.

Regulations restricting practice location, solicitation and advertising are also used to stifle free competition. The result, according to economists Carroll and Gaston, is that licensing tends to raise costs for consumers while actually lowering service quality.

PLUSES OF AN ENFORCEMENT SYSTEM

The inefficiency of permit regulation suggests governmental goals might be better served by a more direct approach, such as the enforcement system. Under such a system, all standards for conduct of the regulated activity are set out in statutes and regulations. If anyone violates those standards, the state seeks appropriate sanctions against the wrongdoer. For minor or isolated violations, a fine will ordinarily be appropriate. For serious or chronic violations an order or injunction restricting or prohibiting future activity may be justified. A combi-

nation of sanctions can also be used depending on the circumstances.

In the enforcement scheme, government agencies focus the bulk of their resources on monitoring the activities of regulated parties and on swift prosecution of violators. Although officials might not investigate everyone in a given year, the threat of enforcement action has a substantial deterrent effect throughout the regulated community. There are no permits to mislead people into believing that anyone is presumptively qualified or acting properly at any specific time.

The enforcement system accomplishes most of the goals of a permit system, with few of the disadvantages. Heavy reliance on entry control to ensure quality is eliminated and replaced by a more vigorous monitoring program to ensure that standards are in fact being met. The hollow threat of permit revocation or suspension is replaced by a very real threat of punishment that can be tailored to fit the violation. Government officials can focus their efforts on suspected wrongdoers, without wasting time on those in compliance. Hopefully, too, the influence of



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regulated groups on administration of the laws is greatly weakened in a system requiring no licensing boards, and relying primarily on impartial enforcement officials for compliance review.

Of course, an enforcement system cannot totally replace the informational function performed by many permit systems. The entry screening process, although not always a fair or accurate method of ensuring quality, does assist in informing third parties of whether a person has met certain minimum standards. To a large degree, however, this informational function can be performed simply by requiring regulated parties to publicly disclose their backgrounds and qualifications. Validation by professional societies can also meet this need. Private validation standards would probably track existing licensing requirements, which are usually imposed by the professional societies or practitioners anyway through their control of licensing boards.

The notion that governmental validation is somehow more objective is belied by the substantial influence of regulated parties over regulatory agencies. At most, the government's role should be limited to voluntary certification of practitioners, leaving the consumer free to choose between the "certified" and "noncertified". This approach, advocated by economist Milton Friedman, minimizes the anticompetitive effects of licensing and avoids many of its costs.

An enforcement system also cannot totally replace the notification function of a permit system. The permitting process routinely identifies most parties engaged in a regulated activity. This greatly aids monitoring and enforcement efforts since officials need not spend time and money locating the people they are supposed to be regulating. An enforcement-only system does not identify all regulated parties; it works primarily on the basis of tips, complaints and spot checks.

In cases where identification of all regulated parties may be useful in an enforcement program, a simple registration system can serve the purpose. Under registration, anyone who enters the regulated field must notify (or register with) the government. There are no prerequisites to entry other than notification, although registrants ordinarily must inform the regulatory agencies of address changes. An enforce-

ment system with registration allows for identification of all regulated parties without the burdens and disadvantages of entry controls and licenses.

WRIST-SLAPPING INEFFECTIVE

As for the supposed ease of enforcement provided by permit systems, the advantage is largely illusory. Because of the high stakes involved, a proceeding to halt an unlicensed practice or revoke an existing permit is often more complicated than a simple penalty action. Administrative officials and judges will invariably demand evidence of actual incompetence or wrongdoing before completely depriving a person of his livelihood. Unless serious transgressions are shown, the remedy will likely be limited to a temporary suspension or imposition of a compliance schedule. As a practical matter, mere proof of a technical violation of the permit requirement is rarely adequate for meaningful enforcement under a licensing scheme.

Likewise, a permit system does not really provide a greater degree of administrative flexibility or control than an enforcement system. It is true that permits can be used to apply general regulatory requirements to specific cases, as in the environmental area. But enforcement actions do essentially the same thing with greater speed and finality. By seeking a judicial determination of a regulated party's responsibilities in the first instance, an agency avoids the double layer of adjudication often required for permits: one to decide on whether the permit terms are reasonable, and another to enforce them. Moreover, the compromising of competing interests and tailoring of regulatory standards to specific cases—ostensible advantages of permit regulation—are routinely and more conclusively accomplished through litigation.

The failure of licensing is largely attributable to its use in fields where it is genuinely not needed. The primary distinguishing feature of permit systems—the control of entry through examination or setting of minimum qualifications—seems appropriate only where it is objectively possible to distinguish the competent from the incompetent, where conduct of the regulated activity by an "unqualified" party can cause serious harm. Unless these criteria are met, permit regulation produces no benefit over other forms of regulation.

It makes no sense to license barbers, pawnbrokers, funeral directors and cabaret operators, when the "qualifications" for these jobs are nebulous, the potential harm from malpractice is limited, and the capacity of consumers to choose the competent is high.

Even where a permit system might otherwise be justified, it will be of questionable value unless the intent is to closely monitor the activities of every permittee. As already noted, a permit creates the impression that the permittee is currently in compliance with standards. Where 50,000 licenses are monitored by only 7 inspectors, it is pure deception to employ a regulatory scheme that pretends to allow license retention only so long as the holder is qualified and acts properly. Under such circumstances, the permit is no better than a certification, with the revocation sanction a meaningless threat that acts as a drain on other more effective enforcement tools.

The only areas in which permit regulation really makes sense are those that meet all of the criteria outlined above and that require fairly intense, constant governmental scrutiny. Nuclear power plants, for example, must be designed and operated by highly skilled scientists and engineers, and must be constantly monitored for safety and environmental hazards. The potential harm from incompetence or violation of standards is enormous, and citizens cannot realistically protect themselves from that harm.

Because there are very few nuclear power plants, the government can realistically and effectively regulate all of them by permit. Other ultrahazardous activities, such as disposal of toxic materials, may be in a similar category. Aside from activities creating major environmental risks, however, there are few areas in which permits appear either necessary or desirable for protection of the public or for regulatory efficiency.

Permits are supposed to ensure that an activity is closely regulated. But the permit itself accomplishes nothing in the way of guaranteeing quality or inducing compliance with standards. In most cases, it merely creates an illusion of regulation. Statutes and regulations will have little meaningful impact in advancing the public interest unless government officials forget their obsession with permits, and seek instead to vigorously enforce the law. ■

Regarding physicians referring prenatal care to women
contemplating home delivery vs. complications with malpractice
insurance.

I've previously contacted several lawyers regarding this
allegation. I was informed that a physician could not be
held liable for such care etc. If the physician did not
wish to participate in a home birth per se - this could
be stated and the physician would be entering into a
contract then only for providing prenatal care (and
perhaps the labor and birth - if it occurred in a hospital-
and only then!). I have been assured that by clearly
stating that the physician would not participate in a
home birth he/she would be clear of any liability, etc
regarding the birth. This logically would be the case.

Previously I had been informed that a number of
the health care and liability/malpractice insurance companies
are controlled by physicians. If this is in fact the case
it would appear that any question of malpractice
insurance "complications" would be a rather moot question
for referring care.

The obligation of danger to mother and infant doesn't
hold water as would be evident in studying the report
written on infant mortality in North Carolina Home births.
I believe I enclosed a copy of it to you - if not
I would be glad to send one.

Some physicians defend themselves by stating this
is not due to economic considerations or influences either.

This might also be questioned seriously. We estimate that well over 200 home births occur in the Anchorage Borough each year. If I recall correctly this is more than the total number of births in a number of other Boroughs including I believe Mat-Su. ^(≈ 300) I would predict that some of the midwives probably attend more births than physicians in many areas of the State! I can see where this would threaten a number of physicians regardless of what is said.

Tallying up information of the economic aspects only here in Anchorage (conservatively):

3,000 = approx cost of "normal" labor & delivery in area hospital including physician fees.

200 = approx # of homebirths.

600,000 income not accrued by area hospital & physicians assuming no C-sections etc. [$\$600,000$]

600,000
.70
 # 520,000

The C-section rate here is close to 30% if this is used the potential income increases drastically to [$\$820,000$].

5,000
60
 300,000
 + 520,000
 # 820,000

To me this works out to what I would consider a fair amount of money (even for Anchorage). I addressed only Anchorage and used rather conservative figures.

I believe it ought to assume that almost any group would work to perpetuate a virtue monogely, especially when it is so lucrative.

SB 237 last session would have made it illegal and extremely difficult for homebirth coaches to obtain the assistance of experienced help for their birth. There was language in it making the attendance of childbirth the practice of medicine. I had been informed that an area obstetrician had reported those parts of the original bill.

I honestly can not believe that such legislation is for the benefit of the consumer, nor are the battles against HB 327/SB 274. Economically there is no doubt that some competition would be beneficial to the consumer. I am also unaware of any progressive legislation ^{a suggested} proposed in Alaska or elsewhere by physicians, that is consumer oriented.

I believe that the above legislation and legislation similar to HB 11 are beneficial to the consumer in a variety of ways. One of the most obvious is the fact that people would not seek out those services if they their needs were being met by the established medical/physician care system. They should have the right to obtain the services they choose, whether this be a natural path or a midwife. I hope this will fight will be insured and protected.

Sorry for the long letter - have a lot of things to do to convey! Thank you very much for your time and assistance.

Sincerely,

at Anchorage
1403 E. 27
Anchorage, Ak 99504
1-9-82

Dr Mike Beirne, Chairman
House - Health & Soc. Services
Pouch V
Juneau, Alaska 99811

Dear Dr. Beirne,

I have a personal interest in the perinatal field, especially "home births", here in Alaska. Several of my sources have informed me that the Anchorage Municipality as well as the State of Alaska are concerned with the increased home births rate. I've been unable to obtain objective data that would demonstrate the need for this concern and some of the processes that are apparently being put in motion. From what I have been able to determine there have been no objective or depth studies completed in Alaska - of "planned and attended home births." Regardless of this fact I am hearing references made of the growing home birth "problem". Home births are apparently increasing - to the rate of approximately 4-5% in Anchorage presently.

I sincerely believe that any "concern" by Anchorage or Alaska should be to insure people, in choice of birth attendant and birth setting, and insure people of access to good perinatal care regardless of their choice of attendant or setting. Presently if a couple is planning or considering a home birth in Anchorage they are almost invariably refused perinatal monitoring by local physicians

These same people are often intimidated and harassed
should they seek care at any time through the private
sector. Expectant women have also been refused
lab work through local public clinics when it is known
they are planning a home birth. I do not believe
this prejudiced treatment is in the best interest of the
State, Municipality, the couple or the infant.

Physicians claiming their concern only for the
health and welfare of mother and infant - while
denying care - might well have their motives and
perhaps ethics questioned. We are told by medical
research that the majority of all perinatal complications
are detected through good perinatal monitoring.

I have attempted to trade information with
Mrs Carolyn Royama - (Dept HSS - P.I.C. - IPC) but have
been seriously disappointed with the endeavor. I had
her commitment that she would provide information this
Rushing and myself obtained from last year to the Perinatal
Advisory Committee. She was to make a report regarding
home births in Alaska, last October. Enclosed you
will find a copy of the letter I recently wrote to Mrs.
Royama. I would be glad to answer any questions.

I would be grateful for any assistance you may
be able to render on these matters. Thank you

Sincerely,
Al Rushing

5-6 The Washington Times, Sunday

Childbirth experiment goes well

by Peter Elsner
Associated Press

Fortaleza, Brazil — A pilot project that teaches basic health care to women in Brazil's poorest region may provide a Third World cure for the disease and death that threaten childbirth among the world's impoverished millions.

"The only pediatrician a new baby usually needs is its own mother," says Dr. Galba Araujo.

The Brazilian obstetrician has organized a network of traditional rural midwives who are taught methods that blend with traditional health care. They also learn to recognize warning signals in the few births which require a doctor's attendance.

"We've never had a woman die in childbirth," Araujo said in an interview. "The statistics show that 94 percent of the births were without complications."

With more than 8,000 births in five years, the project, supported by U.S. private money and Brazilian government funding, has also slashed the rate of infant death in one of the world's highest population growth areas.

"Underdeveloped countries have been imitating the developed countries in providing health care," Araujo said in an interview. "They have been adopting technology at high cost. But nobody can afford to pay."

The pilot project here stresses inexpensive methods which require minimal training, and also provides local training in family planning and birth control — a sensitive subject in this predominantly Roman Catholic country.

U.S. population specialists, based in Brazil, praise Araujo's work. With two-third of the world's people living without adequate medical care, these specialists say, the project may have major implications in the coming decades.

Araujo cited U.N. statistics which show that, if present trends continue, there will be three billion births worldwide between now and the year 2000. The statistics also indicate that one billion of those infants will die, an additional 20 million will not reach a year of age and 100 million women will die in the birth cycle.

Araujo, medical director of the Maternity Hospital in Fortaleza — an Atlantic coast city of 1.3 million 1,000 miles north of Rio de Janeiro — says the data he is gathering show at least 15 percent of pregnant women

very ill at any one time," said Araujo, who has sponsored international forums on health care and has lectured in the United States and elsewhere.

Araujo's project, which receives grant money from the Ceara State government, federal health officials and the Kellogg Foundation of the United States, has established a series of regional and local health clinics. He and other physicians enlist the help of traditional midwives and offer them group training.

The project advocates the use of "birthing stools," either at home or in a clinic, instead of giving birth lying down. The birthing stools — which can be as simple as a wooden chair with part of the seat removed — place the mother in a squatting position so that gravity aids the birth process.

Three hundred midwives have been trained in Ceara state, learning about problems of infection and about modern preventive care. They also are taught warning signals of birth problems and can refer mothers to local "satellite clinics" for better care. The satellite clinics, in turn, can refer patients to "base hospitals" for more sophisticated help.

There are now eight satellite centers and three base hospitals. Araujo says he and the state health department plan to double the number by 1983, with eventual plans to cover the entire state.

Ceara, with a population of more than five million, is in Brazil's drought-stricken northeast poverty belt. The birth rate here is higher than the national rate of 36 per 1,000 and the infant mortality rate higher than the national rate of 109 per 1,000.

The statistics at the satellite center at Aquiras, 25 miles from Fortaleza, are markedly better. Since the clinic opened on May 1, 1977, there have been 2,079 admissions and 1,000 births. An additional 229 cases were referred to the Fortaleza center and other women received pre- and post-natal care. There were 25 infant deaths among the 1,000 births, a death rate of 12 per 1,000 — one-eighth of the national average and lower than the U.S. infant mortality rate of 15 per 1,000. The overall statistics in the Ceara project are similar, Araujo said.

The coordinator of the Aquiras Center, Dona Teresinha Pereira Lima, herself a traditional midwife, said the clinic has been able to convince reluctant local residents that the free health service works.

"I began learning (to be a midwife) from my grandmother when I was 21," she said. "When I got here, everything was different. But now, everyone is used to it and we deliver 50 to 70 babies a month."

Araujo said the northeastern project has important lessons for more developed areas of Brazil, as well as for countries like the United States.

HOME BIRTH—HOW SAFE IS IT?

by Robert E. Brooks, PhD, former professor of Quantitative Analysis, University of Southern California.

One of the most common assumptions which doctors make when criticizing home birth is that they are much more dangerous than births in the hospital. Note that we say "assumptions" because, in fact, there is no proof at all to support such assertions.

According to Wegman (1975) the United States ranked 15th in infant mortality rates for 1973. (See Table 1)

The differences between the top six countries and the U.S. is quite substantial: the U.S. infant mortality rate is more than 50% higher than the sixth placed country, Norway. Yet this can hardly be blamed on home birth since only about 3% of births in the U.S. occur at home.

In fact in nearly all of the top twenty countries most births take place in some type of hospital or maternity home. The one exception to this fact is Holland where fully 53% of births took place at home. Huygen (1976) in his classic paper on home deliveries in Holland cited statistics showing the perinatal mortality rate for home births in 1973 to be only 6.9 per 1000 live births compared to 33.8 per 1000 for hospital deliveries. Since high-risk mothers are usually referred to hospitals for their births in Holland, one cannot conclude from these statistics that home birth is five times safer than hospital birth. On the other hand one can certainly conclude that it is possible to have a system

wherein a low risk mother can have her baby at home with an extremely high chance for a safe birth.

In addition Huygen states that he has "serious doubts about the desirability and safety of hospital for normal deliveries. Home births offer important advantages from an emotional and psychological point of view. Research has made it clear that many women prefer to have their babies at home." And regarding the technology available in the hospital, "I feel that these advantages in technology at the same time carry with them the risk of unnecessary intervention."

Even though the percentage of home births in the U.S. has been small, it has experienced a rapid growth in the past few years. Statistics on the entire population of home births are not available. Some studies have been done, however, which can be used to indicate what kind of safety one can expect from home births.

Dr. Lewis Mehl's analysis of 1147 elective home births in northern California revealed the following outcomes (see Table 2).

In this study the incidence of infant mortality is less than half as much for home birth as it is for all births in California in 1973. While the total number of home births represented in this study is not large enough to statistically conclude that home birth is twice as safe as hospital birth, it is certainly indicative that the physicians' assumption that home birth is much more dangerous must be seriously questioned.

TABLE 1 - INFANT MORTALITY RATES (1973)

Country	Deaths per 1000 Live Births	% Hospital	Attendee
Sweden	9.6	100	Midwife
Finland	10.0	99.9	Doctor or Midwife
Japan	11.3	89.9	Doctor
Netherlands	11.5	47	Doctor or Midwife
Denmark	11.5	85	Midwife & Doctor
Norway	11.8	99.4	Midwife
Switzerland	13.2	99	Midwife
France	15.5	97	Doctor
Canada	15.8	97	Doctor
German Democratic Repub	16.0	98	Doctor
New Zealand	16.2	100	Doctor
Australia	16.5	most	Doctor
Hong Kong	16.8	76	Midwife
England & Wales	16.9	96	Midwife
Belgium	17.0	98	Midwife & Doctor
United States	17.7	97	Doctor
Ireland	18.0	85	Midwife
Czechoslovakia	21.2	99	Nurse-midwife
German Federal Repub	22.7	97	Midwife
Israel	22.8	100	Midwife

Sources: Wegman, M. "Annual Survey of Vital Statistics-1974"

Pediatrics, 56: 960-966, December, 1975

IFGO and JCM, Maternity Care in the World, 2nd Edition, 1976

TABLE 2

	Number	Rate	All California Birth rate-1973
Total Births	1152		
Live Births	1147		
Fetal Deaths	5	4.3	10.3
Neonatal Deaths	6	5.2	10.3
Total Perinatal Deaths	11	9.5	20.3
Low Birth Weight (2501g)	15	1.3%	6.4%

Source: L. Mehl, "Outcome of Elective Home Birth: A Series of 1147 Cases", Infant Health Unit, California State Department of Health, Berkeley, CA Birth Notes, Vol. 2, No. 2, page 6

Home Delivery and Neonatal Mortality in North Carolina

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

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

(JAMA 1980;244:2741-2745)

SUMMARY reports of state vital statistics have traditionally classified births as occurring in-hospital and out-of-hospital. Fetal and infant mortality has also been reported using this differentiation. Being the best that is generally available, such information has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery. However, with increasing

interest in home delivery, the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them. This article provides an analysis of neonatal mortality in North Carolina during 1974 through 1976, with attention given to the places and circumstances that characterized out-of-hospital deliveries.

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

Most of the medical profession

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

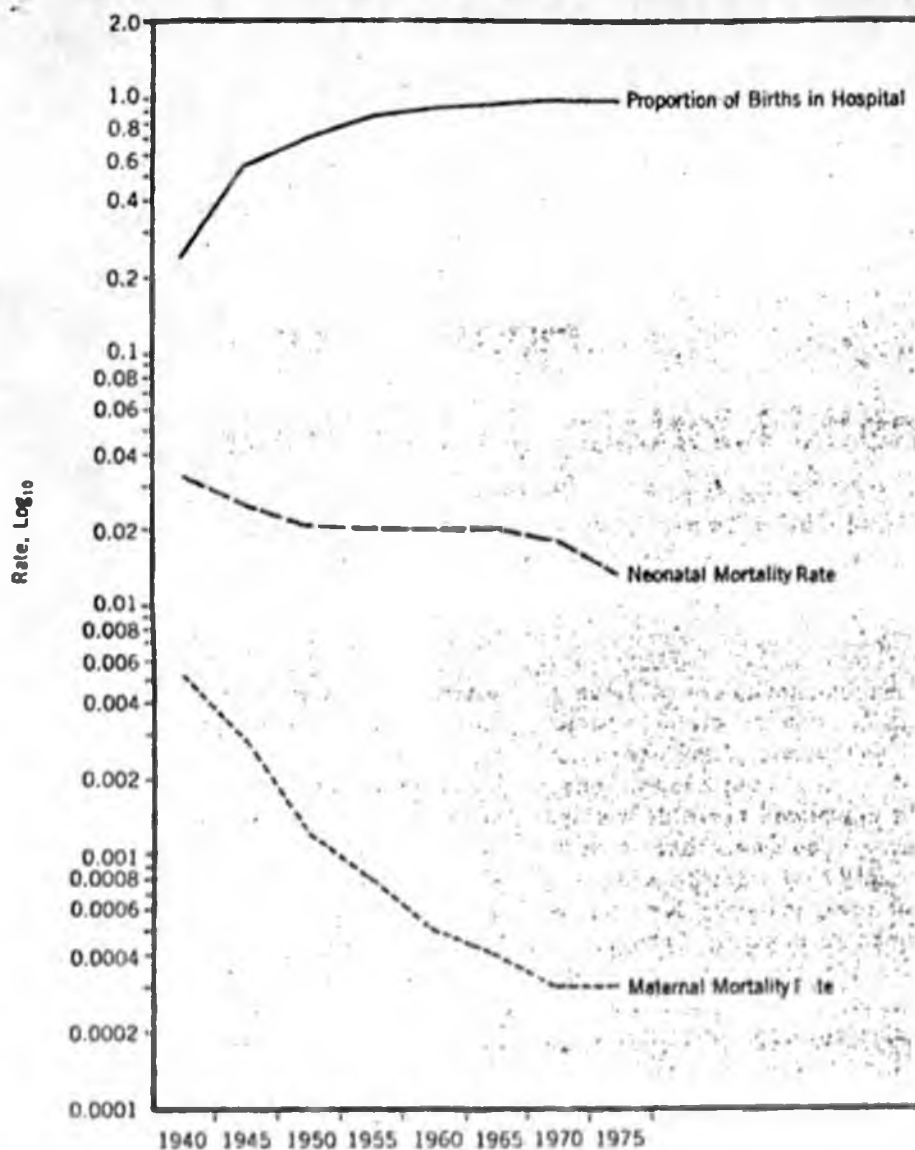
Lay-midwives legally attend home deliveries in some counties of North Carolina. The practice of these lay-midwives is regulated by county health departments. Prenatal care involving physician-supervised screening for risk factors must be provided by the health department for each patient, and every home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

MATERIALS AND METHODS

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

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

Reprint requests to Northeast Health District, 488 N. Millidge Ave., Athens, GA 30601 (Dr. Burnett).



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

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

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

Emphasis was placed on determining the planning status of those home deliveries that resulted in neonatal death. Misclassification of a small number of these deaths would have had a notable effect on reported neonatal mortality rates. Therefore, these deaths were indi-

vidually reviewed by examination of the birth and death certificates as well as by discussion with county health department staff and, when necessary, the attendant at the home delivery.

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

Our second assumption was that home deliveries of infants weighing 2,000 g or less at birth and not attended by a lay-midwife were precipitate and unplanned.

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

In June 1978, birth certificate copies of the remaining unclassified home deliveries were sent to the health department of the county of residence of the mother. A brief questionnaire accompanied each certificate requesting that health department staff determine the reason for home delivery and identify the attendant present. Four reasons for home delivery were provided: precipitate, intended, failure to plan for health care, and unknown. Field work by county health department staff was necessary when no detailed record described the circumstances of the birth.

RESULTS

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

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

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

	No.	%
Planned	934	72
Lay-midwife (assumed planned)	768	
Classified by questionnaire	168	
Unplanned	250	19
Birth weight $\leq 2,000$ g (assumed unplanned)	51	
Classified by questionnaire	199	
Unknown	112	8
Total	1,296	100

*North Carolina, 1974 through 1976.

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

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

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

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

The planning status of 112 home

	Deaths, No. (%)	Births	Rate†
Planned	6 (17)	934	6
Infant normal	3 (8)		
Congenital anomaly	(3) (8)		
Unplanned	30 (83)	250	120
Precipitate	23 (84)		
No alternative	2 (6)		
Suspected homicide or neglect	5 (14)		
Total	36 (100)	1,184	30

*North Carolina, 1974 through 1976.

†Neonatal deaths per 1,000 live births.

	Deaths	Births	Rate†
Home—planned, attendant physician	0	651	0
Home—planned, attendant lay-midwife	3	768	4
Hospital	1,005	242,246	12
Clinic or office	15	949	16
Home—planned, attendant not physician or lay-midwife	3	1001	30
Enroute	12	177	68
Home—unplanned	30	2501	120
Total	2,098	244,544	12

*North Carolina, 1974 through 1976.

†Neonatal deaths per 1,000 live births.

‡Excludes 112 home deliveries with unknown planning status and 11 planned home deliveries with unknown attendant.

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

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

Table 3 shows all neonatal deaths for the three-year period by place and circumstances of delivery, in rank order from the lowest to the highest neonatal mortality rate. The 112 home deliveries with unknown planning status and 11 planned home deliveries with an unknown attendant are not included in the births column or in the denominators of the neonatal mortality rates. The rates ranged

from zero neonatal deaths for planned home deliveries attended by a physician, to 120 neonatal deaths per 1,000 unplanned home deliveries. Planned home deliveries, prenatally screened as low risk and attended by lay-midwives, were associated with a neonatal mortality rate of 4/1,000 live births. However, all three deaths following delivery by lay-midwives were associated with congenital anomalies and may not have been preventable.

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

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

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

	Home Lay-Midwife, %	All Deliveries, %	Neonatal Mortality Rate† All Deliveries
Age, yr			
<20	40	24	14
20-24	34	35	11
25+	26	41	10
Race			
White	4	69	10
Nonwhite	96	31	15
Marital status			
Married	56	84	10
Unmarried	44	16	16
Education, yr			
<12	69	36	14
12	29	42	10
>12	2	22	9
Prenatal visits			
0-2	5	3	65
3-7	66	19	28
8+	27	78	5
Birth weight, g			
≤2,000	0	3	268
2,001-2,500	6	5	24
2,501-3,000	20	16	5
>3,000	74	74	2
N	467	159,333	...

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

†Neonatal deaths per 1,000 live births.

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

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

Planned Home Deliveries Without a Trained Attendant.—Contrasted with women delivered by lay-midwives, women who delivered without a trained attendant had a low-risk

demographic profile: 5% were younger than 20 years, 78% were white, 90% were married, and 48% were educated beyond high school. While they were at high risk with respect to prenatal care (38% with two or less prenatal visits), their deliveries were at low risk with respect to infant birth weight (only 2% of the infants weighing 2,000 g or less). Even with these favorable characteristics, their neonatal mortality rate was eight times that of lay-midwife home deliveries.

COMMENT

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

Medically selected women delivered at home by lay-midwives were at high demographic but low medical risk. The screening process carried out through physician-supervised prena-

tal care at local health departments was apparently effective.

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

Unplanned home deliveries were associated with neonatal mortality even higher than deliveries en route to the hospital, although the difference was not statistically significant. After analyzing 100 consecutive cases of unattended home deliveries in England, Fraser⁷ concluded that "while precipitate labour is an important factor, inadequate preparation and instruction of the patient are the commonest causes" of unattended home delivery.

Adequate prenatal care and provision of care appropriate to medical risk has been repeatedly associated with lower neonatal mortality. Montgomery⁸ and later Levy et al⁹ showed that a nurse-midwife program, which emphasized prenatal care for a medically underserved population, was associated with a notable decline in neonatal mortality followed by a sharp rise after discontinuation of the program. Zackler et al¹⁰ have reported that a maternal and infant care project, which provided prenatal care to girls who conceived when they were younger than 18 years, was associated with lower neonatal mortality compared with a population that did not receive project services. In large-scale studies of vital statistics data, Kessler et al¹¹ in New York and Dott and Fort¹² in Louisiana found that adequate prenatal care was associated with less risk of low birth weight and neonatal mortality.

Several limitations of this study suggest cautious interpretation of its findings. Inferences regarding the safety of home births should await prospective controlled studies. Potential deficiencies of this study include the following: home delivery practices in North Carolina were not necessarily representative of practices in other states; there was a small number of neonatal deaths in the study; there

were possible errors in classifying the true place and circumstances of birth; underreporting of home births and neonatal deaths may have occurred.

Two factors restricted the scope of this study. First, home deliveries and hospital deliveries attended by nurse-midwives were not represented, but are an increasing proportion of deliveries in other states.⁷ Second, lay-midwives practicing in North Carolina during the study were initially certified in 1964 or before and had at least ten years' experience with home deliveries.

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

Retrospective classification of birth regarding intent to deliver in the place and circumstances in which delivery actually occurred is difficult at best. Intended home deliveries followed by neonatal death may have

been misclassified as precipitate and unplanned. Women who chose home delivery but developed a problem during labor may have gone to the hospital to deliver. Hospitals are appropriately the intended place for most high-risk deliveries. This fact confounds comparison of the neonatal mortality of hospital and home deliveries.

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

In conclusion, there has been a dramatic shift from home to hospital delivery in the last 40 years in North Carolina. The potential risk of delivery at home may be unacceptable to most women. However, some women still prefer or economically need an alternative to a high cost physician-

hospital delivery. Indeed, cost and preference accounted for more than three fourths of the reasons for the dangerous planned home deliveries not attended by a physician or lay-midwife.

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

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**Table
Neonatal and Infant Deaths of
Anchorage Residents, 1970-1979**

	<u>Neonatal</u> <u>Deaths/Rate</u>		<u>Infant</u> <u>Deaths/Rate</u>		<u>Number Live</u> <u>Res. Births</u>
1970	55	17.2	74	22.5	3285
1971	36	11.6	52	16.3	3192
1972	36	11.6	51	16.4	3119
1973	39	13.5	51	17.5	2917
1974	36	11.6	46	14.8	3132
1975	13	4.0	36	11.3	3260
1976	25	6.4	47	12.0	3968*
1977	22	5.9	43	11.6	3720
1978	39	10.3	58	15.3	3825
1979	39	10.3	56	14.7	3823

* estimated

Resident neonatal and infant death rates dropped dramatically from 1970 to 1975, but have started climbing slowly gain. Because numbers are small the effect of each change may be misleading. Until 1978 local rates were below those of the nation. Since 1979 local rates (14.7) have exceeded national rates (13.6). The State Health Systems Plan recommends maintaining a neonatal mortality rate of no more than 9.0 per 1,000 live births, and an infant rate of no more than 15.0 per 1,000 live births. Further and careful review of Anchorage rates is necessary.

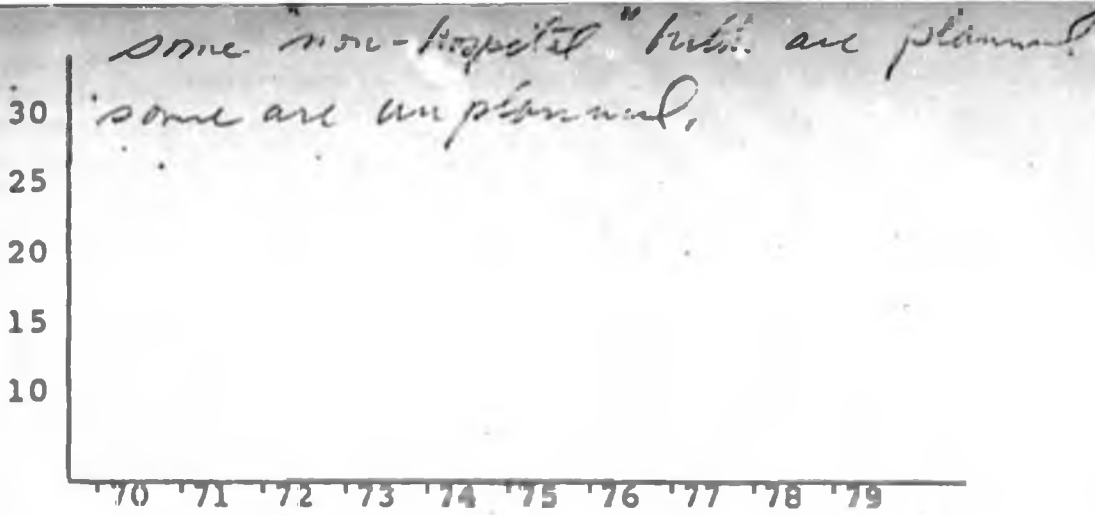
**Table
Neonatal and Infant Mortality for Anchorage, Southcentral
and Alaska, 1970-1979**

<u>Year</u>	<u>Infant Mortality Rates</u>			<u>Neonatal Mortality Rates</u>		
	<u>Anchorage</u>	<u>Southcentral</u>	<u>Alaska</u>	<u>Anchorage</u>	<u>Southcentral</u>	<u>Alaska</u>
1970	22.5	17.2	23.4	17.2		
1971	16.3	20.3	18.3	11.6		12.6
1972	16.4	16.7	17.0	11.6		11.1
1973	17.5	21.8	19.9	13.5		13.0
1974	14.8	19.2	18.8	11.6		12.6
1975	11.3	13.7	14.3	4.0		9.4
1976	12.6 *	15.3	16.1	6.4		9.2
1977	11.6	13.9	14.8	5.9		8.2
1978	15.3		14.6	10.3		9.6
1979	14.7		147 6.1	10.3		9.1

*estimated

*State chart
may have this
data available.
Data does not
agree with data
from other source*

*yes!
yes!
why??*



- Anchorage
- Southcentral
- Alaska

Home Births and Perinatal Mortality. Growing numbers of Alaskan women are choosing to have their babies at home or at least outside of an acute setting. Table 7 shows the number of Alaskan and Anchorage births which occurred in a setting "other" than a hospital or clinic.

Table

Number and Percent of Births Occuring Outside a Medical Facility
Anchorage and Alaska 19 - 1979

	1976		1977		1978		1979	
	#	%	#	%	#	%	#	%
Anchorage					32	1.2	75	1.8
Alaska							302	3.3

It is not clear at this time exactly how many women who intended a home birth, developed complications and actually delivered in a hospital. Indicators of the incidences of problem deliveries are minimal. However, Annual Surveys of Anchorage hospitals indicate that from 15 to 30 percent of all hospital deliveries are classified (ICD-9-CM) as "Complications of Pregnancy, Childbirth and Puerperium." While that classification code may include relatively minor complications, it does indicate need for medical attention beyond that which occurs during a normal delivery. In addition, some physicians estimate that about one of every four women identified as low risk throughout pregnancy, experience (maternal or fetal) complications during delivery. The inference from these data is that there is sufficient risk to mother and infant during the perinatal period to question the advisability of home births. Features such as alternative birthing rooms and centers,

*What
of
5% of total
the majority
being detected
during prenatal
monitoring*

WHAT DATA ?

liberal policies regarding attendance during birth and post-partum care, 24 hour rooming-in, and shorter lengths-of-stay are now available. Such services are offered to create a more personal, family-centered experience for all involved, while assuring sound medical monitoring and treatment when needed.

Estimates of Service Requirement and Needs

Assumptions and Methodologies. Estimates are based upon the bed need projection formula as described below. Estimates assume that the use rate is appropriate for this service and that population estimates are valid. Anchorage NSCN units serve native and non-Natives, from Anchorage, Southcentral and the rest of Alaska. Better patient origin data is needed to more realistically determine future bed needs. For now the formula used will be:

$$\text{NSCN Use Rate (1979)} = \frac{\text{NSCN Pat. Days, 1979}}{\text{Health Service Area Births (State)}}$$

$$\frac{\text{Use Rate} \times \text{No. State Births in 198x (1000)}}{365 \text{ days}} = \text{Projected Average Daily Census}$$

ADC
50% occupancy = Future NSCN Bed Need

Estimates of Service Needs. Calculation of projected need for NSCN beds required estimating future numbers of live births in the State. Table shows projected state births and beds needed applying a 1979-base use rate of 283. Since 1973 there has been an average annual increase of 3.7 percent in the number of Alaskan births. That same growth has been applied to projections from 1981 to 1990, although future developments in the state may render these projections conservative.

Table
Projected Alaskan Births and Need for
NSCN Beds 1981 - 1990

	<u>Alaska Births</u>	<u>NSCN Beds Needed</u>	<u>Current NSCN Beds Available</u>
1981	10,198	16	20
1983	11,393	18	
1985	12,728	20	
1990	16,790	26	

Current total supply of NSCN beds would appear to meet demands generated by the service area. However, closer look at utilization of the two existing units shows that the 14

bed Providence unit is operating close to the 50 percent minimum occupancy standard recommended; whereas the 6 bed Alaska Hospital unit is operating below 20 percent occupancy. National guidelines recommend that for maximum efficiency and effectiveness minimum size for an NSCN unit is 15 beds. Recommendations regarding the appropriate distribution and supply of NSCN beds, as well as other Level I, II and III resources, are due by fall 1981 from the Perinatal Services Technical Advisory Group. Those recommendations will be proposed for public review, followed by amendment to this HSP.

Goals

Goal 1.0: Implement a regionalized system for perinatal care.

Objective 1.1: By 1983, establish a regional system for perinatal services with appropriate linkages at each level (I, II and III), that are responsive to consumer needs and meet the following criteria:

- *Average annual occupancy of at least 75% in Level II/III units;
- *at least 1500 annual live births in each Level II/III unit;
- *no more than 4 intensive and intermediate care beds per 1000 live births in the service area;
- *no fewer than 15 beds per unit;
- *ongoing outreach and continuing education for providers in the service are regarding appropriate referral procedures.

Goal 2.0: Improve prognosis and survival rates for high risk mothers and babies.

Objective 2.1: By 1983, increase by 10% the number of in-utero transports to Anchorage Level II/III Perinatal Center.

Objective 2.2: By 1983, reduce the number of home occurring births to less than 1% of the total Anchorage occurring births.

Objective 2.3: By 1982, to improve personnel skills with and effective use of electronic fetal monitoring in all labor and delivery settings.

operational use of ... ??

No data to correlate connection between Goal 2.0 and Objective 2.2 available. Told this was a consequence to pressure for expansion of services.

VAR20

RATE HOSP BIRTH

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
POOR	1.	18	18.2	32.7	32.7
UNSATISFACTORY	2.	18	18.2	32.7	65.5
UNDECIDED	3.	1	1.0	1.8	67.3
SATISFACTORY	4.	16	16.2	29.1	96.4
<u>GREAT</u>	5.	2	2.0		100.0
NOT APPLICABLE	8.	44	44.4	MISSING	100.0
TOTAL		99	100.0	100.0	
MEAN	2.382	STD ERR	0.177	MEDIAN	2.028
MODE	1.000	STD DEV	1.312	VARIANCE	1.722
KURTOSIS	-1.291	SKEWNESS	0.471	RANGE	4.000
MINIMUM	1.000	MAXIMUM	5.000		

VALID CASES = 55

MISSING CASES = 44

less than 1/2 satisfied!

HOMEBIRTH

FILE = BABE (CREATION DATE = 08-13-81)

VAR24

RATE HOME BIRTH

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SATISFACTORY	4.	8	8.1	8.1	8.1
<u>GREAT</u>	5.	91	91.9		100.0
TOTAL		99	100.0	100.0	
MEAN	4.919	STD ERR	0.028	MEDIAN	4.956
MODE	5.000	STD DEV	0.274	VARIANCE	0.075
KURTOSIS	7.917	SKEWNESS	-3.124	RANGE	1.000
MINIMUM	4.000	MAXIMUM	5.000		

VALID CASES = 99

MISSING CASES = 0

all satisfied!

HOMEBIRTH

FILE = BABE (CREATION DATE = 08-13-81)

VAR25

WHO CAUGHT BABY

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
NATURO DR	2.	32	32.3	32.3	32.3
<u>FATHER</u>	3.	19	19.2		51.5
LAY MIDWIFE	4.	42	42.4	42.4	93.9
FRIEND	5.	2	2.0	2.0	96.0
SELF	6.	3	3.0	3.0	99.0
	9.	1	1.0	1.0	100.0
TOTAL		99	100.0	100.0	
MEAN	3.293	STD ERR	0.119	MEDIAN	3.361
MODE	4.000	STD DEV	1.380	VARIANCE	1.900
KURTOSIS	4.393	SKEWNESS	1.371	RANGE	7.000
MINIMUM	2.000	MAXIMUM	9.000		

VALID CASES = 99

MISSING CASES = 0

VAR29

MEDICAL INSURANCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	47	47.5	47.5	47.5
NO	2.	52	52.5	52.5	100.0
TOTAL		99	100.0	100.0	
MEAN	1.525	STD ERR	0.050	MEDIAN	1.548
MODE	2.000	STD DEV	0.502	VARIANCE	0.252
KURTOSIS	-2.031	SKEWNESS	-0.103	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	99	MISSING CASES	0		

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR30

MEDICAID INSURANCE

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	13	13.1	13.1	13.8
NO	2.	81	81.8	86.2	100.0
MISSING	9.	5	5.1	MISSING	100.0
TOTAL		99	100.0	100.0	
MEAN	1.862	STD ERR	0.036	MEDIAN	1.920
MODE	2.000	STD DEV	0.347	VARIANCE	0.120
KURTOSIS	2.590	SKEWNESS	-2.30	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	94	MISSING CASES	5		

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR31

INCOME AFFECTS HB

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
YES	1.	1	1.0	1.0	1.0
NO	2.	98	99.0	99.0	100.0
TOTAL		99	100.0	100.0	
MEAN	1.990	STD ERR	0.010	MEDIAN	1.995
MODE	2.000	STD DEV	0.101	VARIANCE	0.010
KURTOSIS	99.000	SKEWNESS	-9.950	RANGE	1.000
MINIMUM	1.000	MAXIMUM	2.000		
VALID CASES	99	MISSING CASES	0		

61.3% had medical coverage which would have covered the expenses for a hospital birth - but instead they chose to pay out of pocket for a home birth! Most insurance plans will not cover births attended by midwives, some will cover any home births.

VAR26

INCOME 1980

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
LESS THAN 10,000	1.	14	14.1	14.1	14.1
10,000 TO 20,000	2.	19	19.2	19.2	33.3
20,000 TO 30,000	3.	27	27.3	27.3	60.6
30,000 TO 40,000	4.	17	17.2	17.2	77.8
40,000 TO 50,000	5.	16	16.2	16.2	93.9
GREATER THAN 50,000	6.	2	2.0	2.0	96.0
	8.	2	2.0	2.0	98.0
	9.	2	2.0	2.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	3.303	STD ERR	0.172	MEDIAN	3.111
MODE	3.000	STD DEV	1.711	VARIANCE	2.928
KURTOSIS	1.679	SKEWNESS	1.011	RANGE	8.000
MINIMUM	1.000	MAXIMUM	9.000		
VALID CASES	99	MISSING CASES	0		

HOMEBIRTH

FILE BABE (CREATION DATE = 08-13-81)

VAR27 COUPLE OR SINGLE INCOME

CATEGORY LABEL	CODE	ABSOLUTE FREQ	RELATIVE FREQ (PCT)	ADJUSTED FREQ (PCT)	CUM FREQ (PCT)
SINGLE INCOME	1.	5	5.1	5.1	5.1
COUPLE INCOME	2.	92	92.9	92.9	98.0
	7.	2	2.0	2.0	100.0
	TOTAL	99	100.0	100.0	

MEAN	2.091	STD ERR	0.103	MEDIAN	1.934
MODE	2.000	STD DEV	1.021	VARIANCE	1.043
KURTOSIS	42.453	SKEWNESS	6.388	RANGE	8.000
MINIMUM	1.000	MAXIMUM	9.000		
VALID CASES	99	MISSING CASES	0		

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

IN THE LEGISLATURE
of the
STATE OF WASHINGTON



CERTIFICATION OF ENROLLED ENACTMENT

SUBSTITUTE HOUSE BILL NO. 316

CHAPTER NO. 22

Laws of 1981
47th Legislature

Effective Date:
Except Sections 1, 2, 3, 4, 8, 9, 10,
11, and 12 through 17, which take effect
January 13, 1982

Passed the House on MARCH 30, 1981, the 1.

Yea 25 Nays 22

Passed the Senate on APRIL 14, 1981, the 1.

Yea 42 Nays 5

CERTIFICATION

I, Frederick T. Church, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the enrolled Substitute House Bill No. 316 as passed by the House of Representatives and the Senate on the dates herein set forth.

Frederick T. Church
Frederick T. Church
Chief Clerk

SUBSTITUTE HOUSE BILL NO. 316

State of Washington
47th Legislature
1983 Regular Session

by Committee on Human Services (originally
sponsored by Committee on Human Services
and Representatives Troutman and Bang)

Read first time March 6, 1981, and passed to Rules for second reading.

1 AN ACT relating to midwifery; amending section 7, chapter 36,
2 Laws of 1975-'76 2nd ex. sess. and RCW 7.70.030; amending
3 section 8, chapter 160, Laws of 1917 and RCW 16.50.010;
4 amending section 3, chapter 160, Laws of 1917 and RCW
5 16.50.040; amending section 4, chapter 160, Laws of 1917
6 so amended by section 43, chapter 189, Laws of 1979 and
7 RCW 16.50.040; amending section 7, chapter 160, Laws of
8 1917 and RCW 16.50.100; amending section 21, chapter 366,
9 Laws of 1971 ex. sess. as last amended by section 100,
10 chapter 188, Laws of 79 and RCW 43.34.005; adding new
11 sections to chapter 16.50 RCW; repealing section 3,
12 chapter 160, Laws of 1917 and RCW 16.50.070; repealing
13 section 4, chapter 160, Laws of 1917 and RCW 16.50.080;
14 providing an effective date; and making an appropriation.

15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

16 Section 1, Section 7, chapter 36, Laws of 1975-'76 2nd
17 ex. sess. and RCW 7.70.030 are now amended to read as follows:

18 As used in this chapter "health care provider" means
19 either:

20 (1) a person licensed by this state to provide health
21 care or related services, including, but not limited to, a
22 physician, osteopathic physician, dentist, nurse, optometrist,
23 podiatrist, chiropractor, physical therapist, psychologist,
24 pharmacist, optician, physician's assistant, NURSE,
25 osteopathic physician's assistant, nurse practitioner, or
26 physician's trained mental health care personnel, including,
27 in the event such person is deceased, his estate or personal
28 representative;

29 (2) An employee or agent of a person described in part

Sec. 1

1 (1) Above, noting in the course and scope of his employment,
2 including, in the event such employee or agent is deceased, his
3 estate or personal representative) or

4 (2) An entity, whether or not incorporated, facility, or
5 institution employing one or more persons described in part (1)
6 above, including, but not limited to, a hospital, clinic, health
7 maintenance organization, or nursing home; or an officer,
8 director, employee, or agent thereof acting in the course and
9 scope of his employment, including in the event such officer,
10 director, employee, or agent is deceased, his estate or personal
11 representative.

12 NEW SECTION, Sec. 2. There is added to chapter 18.10
13 WCM a new section to read as follows:

14 Unless the context clearly requires otherwise, the
15 definitions in this section apply throughout this chapter:

16 (1) "Department" means the department of licensing.

17 (2) "Director" means the director of licensing.

18 (3) "Nurse" means a nurse licensed under this
19 chapter.

20 NEW SECTION, Sec. 3. There is added to chapter 18.10
21 WCM a new section to read as follows:

22 The advisory committee is created.

23 The committee shall be composed of one licensed physician (a
24 nurse, a podiatrist, a pharmacist, a psychologist, a
25 physician who certified nurse anesthetist, a licensed under chapter
26 18.00 DCU, a nurse anesthetist licensed under this chapter) and one
27 public member who shall have no financial interest in the
28 rendering of health services. The committee may seek other
29 consultants as appropriate, including persons trained in
30 statistical operations and perianthology or ophthalmology.

31 The members are appointed by the director and serve at
32 the pleasure of the director but may not serve more than three
33 consecutive years or more than five years in total. The terms
34 of office shall be staggered. Members of the committee shall be
35 reimbursed for travel expenses as provided in WCM 43.03.050 and

1 43,03,060 as now or hereafter amended.

2 NEW SECTION. Sec. 4. There is added to chapter 18.50
3 RCW a new section to read as follows:

4 The midwifery advisory committee shall advise and make
5 recommendations to the director on issues including, but not
6 limited to, continuing education, mandatory recertification, and
7 peer review. The director shall transmit the recommendations to
8 the social and health services committee of the senate and the
9 human resources committee of the house of representatives on an
10 annual basis.

11 Sec. 5. Section 8, chapter 180, Laws of 1917 and RCW
12 18.50.010 are each amended to read as follows:

13 Any person shall be regarded as practicing midwifery
14 within the meaning of this chapter who shall render medical aid
15 for a fee or compensation to a woman (~~the obstetrician~~ ~~for~~ ~~the~~
16 ~~purpose~~) SUBLE NORMAL, DISTRICT, SO DISTRICT
17 ALONE or who shall advertise as a midwife by sign, printed
18 cards, or otherwise. Nothing shall be construed in this chapter
19 to prohibit obstetric services. It shall be the duty of a
20 midwife to (~~obtain~~ ~~the~~ ~~proper~~ ~~license~~) SIGNALL
21 with a legally qualified physician whenever (~~the~~ ~~obstetrician~~ ~~is~~
22 ~~present~~) SOLE, SO, SIGN, SIGN, DISTRICT
23 from normal is either the mother or the infant.

24 Sec. 6. Section 2, chapter 180, Laws of 1917 and RCW
25 18.50.010 are each amended to read as follows:

26 All any person seeking to be examined shall present to
27 the (state) director, at least (seven) SEVEN days before
28 the commencement of the (month) examination, a written
29 application on a form or forms provided by the (state) director
30 seeking funds under affidavit (~~from~~ ~~the~~ ~~state~~ ~~director~~)
31 ~~certifying~~ ~~that~~ ~~the~~ ~~applicant~~ ~~is~~ ~~qualified~~ ~~to~~ ~~practice~~ ~~midwifery~~
32 ~~and~~ ~~that~~ ~~the~~ ~~applicant~~ ~~is~~ ~~not~~ ~~under~~ ~~any~~ ~~other~~ ~~order~~ ~~of~~ ~~the~~ ~~state~~ ~~director~~
33 ~~preventing~~ ~~the~~ ~~applicant~~ ~~from~~ ~~practicing~~ ~~midwifery~~ ~~in~~ ~~the~~ ~~state~~ ~~of~~ ~~Washington~~
34 ~~equivalent~~ ~~to~~ ~~that~~ ~~of~~ ~~the~~ ~~state~~ ~~of~~ ~~Washington~~ ~~and~~ ~~that~~ ~~the~~ ~~applicant~~ ~~is~~ ~~not~~ ~~under~~ ~~any~~ ~~other~~ ~~order~~ ~~of~~ ~~the~~ ~~state~~ ~~director~~

1 1. If the candidate has received certificates of diploma
 2 from a (legally incorporated school on a salary in good
 3 standing granted after at least two years of instruction of
 4 at least seven months in a different school years)
 5 and if the candidate has received a certificate of diploma
 6 from a member of the American Association of Colleges or
 7 diploma in a foreign institution on a salary of equal
 8 requirements conferring the full right to practice midwifery in
 9 the country in which it was issued. The diploma must bear the
 10 seal of the institution from which the applicant was graduated.
 11 Foreign (applicants) shall present with the
 12 application a translation of the foreign certificate or diploma
 13 made by and under the seal of the consulate of the country in
 14 which the (name) certificate or diploma was issued. (The
 15 applicant must be endorsed by a duly registered respectable
 16 physician of the state of Massachusetts)

17 (2) The candidate shall meet the following conditions

18 (a) possessing a diploma from a "legally" training for
 19 at least three years including the study of the following
 20 subjects: the department shall prescribe by rule. However, if
 21 the applicant is a registered nurse under Chapter 18, 28, 29, 3
 22 limited practical nurse under chapter 18, 28, 29, or has had
 23 previous academic education or practical midwifery experience,
 24 the required period of training may be reduced depending upon
 25 the extent of the candidate's qualifications as determined upon
 26 examination by the department. In no case shall the training be
 27 reduced to a period of less than one year.

28 (b) possessing a diploma from a (legally incorporated school
 29 of nursing or midwifery) or a diploma from a (legally incorporated school
 30 of nursing or midwifery) or a diploma from a (legally incorporated school
 31 of nursing or midwifery) or a diploma from a (legally incorporated school
 32 of nursing or midwifery) or a diploma from a (legally incorporated school
 33 of nursing or midwifery) or a diploma from a (legally incorporated school
 34 of nursing or midwifery) or a diploma from a (legally incorporated school
 35 of nursing or midwifery) or a diploma from a (legally incorporated school
 36 of nursing or midwifery) or a diploma from a (legally incorporated school

1 sufficient to test the scientific and practical fitness of
2 candidate to practice midwifery (one-year-course-require-
3 examination-require-requirements-midwifery-graduate-
4 exam). All application papers shall be deposited with the
5 director and there retained for at least one year, when they may
6 be destroyed.

7 AND IF (REVISED) THE EXAMINATION IS (POST-EXAMINATORY))
8 REQUIREMENTS COMPLETED (REVISED) THE DIRECTOR SHALL ISSUE TO
9 EACH CANDIDATE A LICENSE ENTITLING THE CANDIDATE TO PRACTICE
10 MIDWIFERY IN THE STATE OF VERMONT (POST-EXAMINATORY-REQUIRE-
11 MENTS-REQUIREMENTS-REQUIREMENTS-REQUIREMENTS-REQUIRE-
12 MENTS-REQUIREMENTS-REQUIREMENTS-REQUIREMENTS-REQUIRE-
13 MENTS).

14 ALL APPLICANTS FOR A LICENSE TO PRACTICE MIDWIFERY IN THE
15 STATE OF VERMONT SHALL BE SUBJECT TO THE EXAMINATION AND
16 REQUIREMENTS PREVIOUSLY ESTABLISHED FOR THE PRACTICE OF
17 MIDWIFERY IN THE STATE OF VERMONT BY A LICENSED MIDWIFE.
18 THE BOARD OF HEALTH SHALL HAVE THE RIGHT TO REVOKE OR
19 REVOKE A LICENSE TO PRACTICE MIDWIFERY IN THE STATE OF
20 VERMONT.

21 Sec. 8, Section 7, Chapter 10, Law of 1913 and
22 1930-1931 are each amended to read as follows:

23 (REVISED) THE DIRECTOR MAY REFUSE TO GRANT OR MAY DENY
24 OR REVOKE ANY LICENSE (HEREIN-PROVIDED-HERE), MAY REVOKE OR
25 DENY A LICENSE HOLDER, OR MAY TAKE ANY ACTION WITHIN HIS
26 JURISDICTION PROVIDED BY LAW. A LICENSE HOLDER FOR ANY OF THE
27 FOLLOWING REASONS: PROVIDED HOWEVER, THE PRACTICE OF
28 OR OTHER ACTIONS THE COMMISSION OF ANY OTHER VIOLATING WORK
29 VIOLATING LAWS OR THE DECISION OF A BOARD OF HEALTH OR
30 A CERTIFICATE OF DISQUALIFICATION OR LICENSE (HEREIN-
31 PROVIDED) APPLICATION FOR REGISTRATION UNDER PROVISIONS
32 HEREIN-PROVIDED WITHIN HIS JURISDICTION BY HIS OFFICE
33 SUPERVISOR OR FAILURE TO MAKE PROPER RETURNS TO THE (HEREIN-
34 PROVIDED) DEPARTMENT OF HEALTH AND WELFARE, SECTION OF
35 DIVISION OF GENERAL CONSUMPTION OR INFECTIOUS DISEASES WITHIN

Sec. 3

1 the required limit of time; ((feature-to-retain-her-licensure-with
2 the-acts-of-the-act--in-which--the--licensure--is--revoked--or
3 process)) failure to ((cover-the-attitudes-of-reputable))
4 consult with a physician in a case of ((miscellaneous-conditions
5 covered--by--this--act--and--the--rules--thereunder--and--the--rules--of--the--board--of--nurses--and--the--rules--of--the--board--of--midwives))
6 ~~any other condition of the body, or any part thereof, or any
7 organ, or any part thereof, or any part of the system of circulation,
8 or any part of the respiratory system, or any part of the digestive
9 system, or any part of the excretory system, or any part of the
10 nervous system, or any part of the reproductive system, or any part of the
11 mother or the infant ((except-when-otherwise-provided)).~~

11 In complaints of violations of the provisions of this
12 section, the accused shall be furnished with a copy of the
13 complaint and be given a hearing before ((the-director--or
14 person--by--whom--the--hearing--shall--be--held--with--right--of--appeal))
15 or, at the discretion of the director, before the board of nursing or the board of midwifery. Any midwife refused admission to the
16 examination or whose license has been revoked who shall attempt
17 or continue the practice of midwifery((s)) shall be subject to
18 the penalties ((prescribed--in--this--act--and--the--rules--thereunder)) prescribed under this chapter.

19 ~~SECTION 16. There is added to chapter 18, RCW
20 a new section to read as follows:~~

21 Registered nurses and nurse midwives certified by the
22 board of nursing under chapter 18, RCW shall be exempt from
23 the requirements and provisions of this chapter.

24 ~~SECTION 17. There is added to chapter 18, RCW
25 a new section to read as follows:~~

26 Nothing in this chapter shall be construed to apply to or
27 interfere in any way with the practice of midwifery by a person
28 who is enrolled in a program of midwifery approved and
29 accredited by the director, PROVIDED, That the performance of
30 such services is only pursuant to a regular course of
31 instruction or assignment in the student's instructor, and
32 that such services are performed only under the supervision and
33 control of a person licensed in the state of Washington to
34 perform services encompassed under this chapter.

Sec. 14

1 RCW SECTION, Sec. 12. There is added to chapter 18.50
2 RCW a new section to read as follows:

3 The director, with the advice of the midwifery advisory
4 committee, shall develop a form to be used by a midwife to
5 inform the patient of the qualifications of a licensed midwife.

6 RCW SECTION, Sec. 13. There is added to chapter 18.50
7 RCW a new section to read as follows:

8 Every person licensed to practice midwifery shall
9 register with the director of licensing annually and pay an
10 annual renewal registration fee determined by the director as
11 provided in RCW 43.24.085 as now or hereafter amended on or
12 before the licensee's birth anniversary date. The license of
13 the person shall be renewed for a period of one year. In
14 failure to register and pay the annual renewal registration fee
15 shall render the license invalid. The license shall be
16 reinstated upon written application to the director, payment to
17 the state of a penalty fee determined by the director as
18 provided in RCW 43.24.085 as now or hereafter amended, and
19 payment to the state of all delinquent annual license renewal
20 fees. Any person who fails to renew his or her license for a
21 period of three years shall not be entitled to renew such
22 license under this section. Such person, in order to obtain a
23 license to practice midwifery in this state, shall file a new
24 application under this chapter, along with the required fee.
25 The director, in the director's discretion, may permit the
26 applicant to be licensed without examination if called upon
27 the applicant meets all the requirements for licensure in this
28 state and is competent to engage in the practice of midwifery.

29 RCW SECTION, Sec. 14. There is added to chapter 18.50
30 RCW a new section to read as follows:

31 Every licensed midwife shall develop and maintain a
32 cooperation with other health care providers, emergency
33 services, and other health care providers in the community.
34 The director, in the director's discretion, may permit the
35 applicant to be licensed without examination if called upon

1 1 written: shall be submitted jointly together with the

2 2 license application to the department.

3 3 Confession of Judgment

4 4 RCW SECTION 18.15. There is added to chapter 18.15

5 5 a new section to read as follows:

6 6 The director shall promulgate rules under chapter 24.04

7 7 renewal fees, permit fees, renewal fees, and any other fee

8 8 RCW as are necessary to carry out the purpose of this chapter.

9 9 Sec. 14. Section 21, chapter 246, Laws of 1971 en. sess.

10 10 as amended by section 100, chapter 135, Laws of 1979 and

11 11 RCW 49.26.095 are each amended to read as follows:

12 12 RCW shall be the policy of the state of Washington that

13 13 the director of licensing shall from time to time establish the

14 14 amount of application fees, license fees, registration fees,

15 15 examination fees, permit fees, renewal fees, and any other fee

16 16 associated with licensing or registration of professions

17 17 and occupations; and

18 18 professions, occupations, businesses, administered by the business and

19 19 professions commission to the department of licensing. In

20 20 establishing such fees the director shall, insofar as is practicable,

21 21 fix such fees relating to each profession, occupation, or

22 22 business in such a manner that the income from such will match

23 23 the anticipated expenses to be incurred in the administration of

24 24 the law relating to such profession, occupation, or

25 25 business. All such fees shall be fixed by rule and regulation

26 26 promulgated by the director in accordance with the provisions of the

27 27 administrative procedure act, chapter 34.05 RCW; provided, that

28 28 such fees shall be fixed by rule and regulation

29 29 in accordance with the following rules:

- 30 30 a. Notary
- 31 31 Registered letter
- 32 32 Communication (operator)
- 33 33 Communication (operator)
- 34 34 Communication (operator)
- 35 35 Communication (operator)
- 36 36 Communication (operator)
- 37 37 Communication (operator)
- 38 38 Communication (operator)
- 39 39 Communication (operator)
- 40 40 Communication (operator)
- 41 41 Communication (operator)
- 42 42 Communication (operator)
- 43 43 Communication (operator)
- 44 44 Communication (operator)
- 45 45 Communication (operator)
- 46 46 Communication (operator)
- 47 47 Communication (operator)
- 48 48 Communication (operator)
- 49 49 Communication (operator)
- 50 50 Communication (operator)

- 1 Registered nurse
- 2 Licensed practical nurse
- 3 Charitable organization
- 4 Professional solicitor
- 5 (2) In no event shall the license or registration
- 6 renewal fee in the following cases be fixed at an amount less
- 7 than ten dollars or in excess of twenty dollars:

- 8 Mental hygienist
- 9 Nurse anesthetist
- 10 Nurse anesthetist instructor
- 11 Psychologist
- 12 School nurse
- 13 Funeral director
- 14 Bachelor of Science
- 15 Veterinarian
- 16 Cosmetology shop
- 17 Barber shop
- 18 Proprietary (school) agent
- 19 Specialized and career registered nurse
- 20 Physician's assistant
- 21 Occupational physician's assistant

(3) In no event shall the license or registration renewal fee in the following cases be fixed at an amount less than fifteen dollars or in excess of thirty-five dollars:

- 25 Arbitrator
- 26 Notary
- 27 Engineer
- 28 Land Surveyor
- 29 Millwright
- 30 Printer
- 31 Calligrapher
- 32 Engine thespian
- 33 Detachable physician
- 34 Occupational physician and surgeon
- 35 Physical therapist
- 36 Physician and surgeon

Sec. 18

- 1 Optometrist
- 2 Dispensing optician
- 3 Landscape architect
- 4 Nursing home administrator
- 5 Hearing aid fitter

6 (4) In no event shall the license or registration
7 renewal fee in the following cases be fixed at an amount less
8 than fifty dollars or in excess of two hundred dollars:

- 9 Engineer corporation
- 10 Engineer certificate
- 11 Sanitary exam
- 12 Barber exam
- 13 Bond adjuster agency
- 14 Bond adjuster branch office
- 15 Bond adjuster
- 16 Proprietary school
- 17 Employment agency
- 18 Employee agency branch office
- 19 Collection agency
- 20 Collection agency branch office
- 21 Professional fund raising.

22 REVISIONS, Sec. 17. There is appropriated to the
23 payment of printing from the state general fund for the
24 session ending June 30, 1953, the sum of thirty thousand and
25 no/100 dollars or as much as may be necessary to
26 carry out the purposes of this act.

27 REVISIONS, Sec. 18. The following acts or parts of
28 acts are hereby repealed:

- 29 (1) Section 5, Chapter 105, laws of 1911 and 1912
30 in 1913, and
- 31 Section 6, Chapter 105, laws of 1911 and 1912
32 in 1913, and

33 REVISIONS, Sec. 19. Sections 1, 2, 3, 4, 5, 6,
34 and 10 thereof of this act shall have effect January 15,

1953

1953

Page 18

2 APR 21

Passed the House March 25, 1961.
Will. H. Hall
Speaker of the House.

Passed the Senate April 19, 1961.

Strom Thurmond
President of the Senate.

Approved April 21, 1961

Walter Hall
Governor of the State of Washington

RECEIVED

APR 23 1961
7:27 AM
SENATE OF WASH

Senate Law Commission
Office of the Code Reviser
Legislative Building
Olympic, Washington
great

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

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE - AMENDED

I. REQUEST

Bill/Resolution No. 2d SSHB 11
Title An Act relating to midwifery.
Requested by Rogers Date 2-11-82

II. FISCAL DETAIL

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

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		27.9	27.9	27.9	27.9	27.9
200 TRAVEL		9.4	10.3	11.4	12.5	13.7
300 CONTRACTUAL		16.0	17.4	18.9	20.6	22.4
400 COMMODITIES		5	5	5	5	5
500 EQUIPMENT		2.8				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		56.6	56.1	58.7	61.5	64.5

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		56.6	56.1	58.7	61.5	64.5
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

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

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

PERSONAL SERVICES - FY'82 salary schedule and benefits.

1 Licensing Examiner I, range 12, gen. gov't., 12 mos. 27.9

TRAVEL - 10% inflation factor projected.

Board of Midwifery, 5 members (anticipate 1-Anch, 1-Fbks, 1-Southeast, 1-Kenai area, and 1-Nome area); 3 meetings per year (1 ea. in Anch, Fbks, & S.E), travel costs plus 3 days per diem @ \$80/day \$6,000.00

Department staff: 1-licensing examiner to attend meetings of the Board of Midwifery, travel costs plus per diem 1,200.00
1-regulations specialist to hold hearings and assist board in promulgation of regulations, travel and per diem 1,200.00
1-investigator, travel and per diem costs to investigate complaints concerning lay midwifery; average 1 trip every 4 months @ \$200/trip plus per diem @ \$80/day 1,000.00

IV. DATE March 25, 1982

PREPARED BY Margie Odland
AGENCY Division of Occupational Licensing

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

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
	<hr/> 1,887.00
	X 3
	<hr/> \$ 5,661.00

Room Rental for examinations: 2 exams per year., 1 day each.	200.00
Proctors for examinations: .	
Head Proctor - \$50/day	100.00
Monitor - \$35/day	70.00

Rental Space - 1 licensing examiner position: 60 sq.ft X \$1.70 X 12 mos. = 1.2

COMMODITIES

General supplies needed by licensing examiner such as tapes for meetings, file folders, paper etc. .5

EQUIPMENT - one time cost in FY'83.

1 desk, double pedestal 60" x 30"	426.92
1 chair, posture without arms (contour)	170.57
1 typewriter, correcting selectric, dual pitch	1,028.81
1 typewriter table	101.92
1 credenza, 90" x 62"	470.90
1 side chair	95.15
2 file cabinets, 4 drawer legal	505.20
	<hr/> \$2,799.48



P.O. BOX 1330
FAIRBANKS, ALASKA 99701

Fairbanks
MEDICAL ASSOCIATION



February 17, 1982

Barbara Wilkins, Assistant
House Committee on HESS
c/o Representative Mike Beirne
Pouch V
Juneau, AK 99108

Dear Ms. Wilkins:

I have received your letter of 1-23-82 to the Alaska Medical Association. This letter was presented at the Fairbanks Medical Society Meeting of 2-11-82. At that time, the members of our medical community who deliver babies were polled, and we were unable to document any cases of expectant mothers being denied prenatal care because they contemplated home delivery. This has not been a problem in the Fairbanks area that we know of.

If you have any evidence to the contrary, please bring it to my attention.

Sincerely,

Richard G. Parry, M.D., F.A.C.S.
President

RGP/co

SECTIONAL ANALYSIS FOR CS 2d SS HB 11

Purpose: The purpose of this legislation is to establish a Board of Midwifery, license and regulate lay midwives. There has been controversy over the scope of the statutorily mandated practice, over the means of regulation and examination, over the informed consent form, the extent of educational background, and formation of a collaborative relationship with physicians, and voluntary versus mandatory nature of licensure.

Changes:

Page 2, line 8: Changes the two elective members to one physician and one elective member appointed by the Governor.

Page 3, line 12: Adds the requirement of two years of nursing school or its equivalent to educational requirements.

Page 6, line 14: Adds the following sentence: "The form shall contain notice that injuries sustained during a home birth may not be covered by malpractice insurance even if a midwife or physician is in attendance." This section is purely experimental. It has been objected to in light of the 1978 SLA repeal of sections of law which mandated malpractice insurance for medical doctors. The collaborative nature of physician/midwife practice will eventually concern liability and may be one area of concern between the professions.

Page 8, line 10: Adds a section to the obligation of a midwife in that the midwife is responsible to establish and maintain a collaborative relationship with a physician. The scope is generally on referral, advice, and rarely in emergencies. However, the language would seem inadequate to reflect an ongoing professional relationship.

Page 9, line 8: Enlarges the definition of sponsor to add, "and authorized to act as a sponsor by the board." This was to ensure a responsible supervisor who must be board endorsed.

4-1-81

SBS 717
Health Educ.

MS 11

Larry Trueger - O.L.

10 Cost Name midwifery in State

6000 RN + LPN lic. !

Dir of O.L. wants Bd to help.

Don Koch - Dir of INS. !

l/ cut out - no. open,

SBS 276 - no Bd lic



Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

A G E N D A for April 1, 1982

— House Bill 412, Relating to Preventive Dental Program
Representative Buchholdt

— House Bill 111, Relating to Optometry

— Senate Bill 650, Relating to Licensing of Facilities
John Pugh, Director, Family and Youth Services

House Bill 11, Relating to Midwifery ✓

House Bill 327, Relating to Naturopathy ✓

3/24/82

REVISED POSITION PAPER
2d Sponsor Substitute for House Bill No. 11

"An Act relating to midwifery."

WHAT THE BILL DOES

This bill creates an examining and licensing Board of Midwifery and establishes criteria to be used in issuing such licenses. However, since a license would not be required to practice midwifery, it would create three levels of midwifery care: (a) certified nurse (under 12 AAC 44.400), (b) licensed midwife, and (c) unlicensed midwife.

DISCUSSION

Historical Background - Alaska, like many states, had existing policies and procedures concerning lay-midwifery practice in the early part of this century. Before widespread availability of medical facilities, adequate transportation and professional providers, this Department promoted training for birth attendants in remote village areas through maternal and child health nurse consultants. In 1968, specific training was discontinued because of the establishment of the Community Health Aide training program by the Alaska Native Health Service. This program emphasizes the Community Health Aide's collaborative relationship with the Alaska Native Health physicians, which has resulted in moving the vast majority of village home births to the protected environment of hospitals.

Current Situation - While it is difficult to summarize the states' laws in this area, it can be stated that 13 states have licensure statutes for lay midwives. Some of these, while remaining on the books, are not operational in terms of issuance of new licenses. Of the remaining 37 states, approximately 8 have statutes which prohibit practice of lay midwifery. This information is summarized from a survey of states' laws printed in Mothering, Fall 1981, p. 63. There are three states (Washington, South Carolina, and New Hampshire) that have passed legislation within the last year dealing with this issue. These states have established midwifery regulatory boards which have the authority to establish licensure criteria and procedures. Typically, these boards include physician(s), certified nurse midwives and consumers in addition to lay midwives.

Problem areas of this bill - Assisting with childbirth is both an art and a science. In most instances the process proceeds to a normal outcome with nothing more than artful support and non-intervention. In some instances, however, the process requires utmost scientific knowledge and skill. Since it is not possible to know in advance which cases will require this higher level of care, it is in the best interest of Alaska's citizens to require quality care in as many births as possible. The licensure criteria in this bill are simply not adequate to assure that the licensee would have the judgment needed to recognize and refer the problem cases.

These deficiencies are in both formal education and in practical supervised training and experience. A required period of 9 months of formal training and participation in at least 50 births have been suggested by the National Midwives Association. The Washington law calls for 3 years of training and 100 births.

This Department has recently been appraised of the problem that lay midwives are having in getting prenatal blood tests performed. AS 18.15.150, currently addresses the legal issues in this matter. This bill (p. 5, line 28) will solve this problem only for the licensed midwife. This illustrates a much larger problem - that of the collaborative relationship between a lay midwife and a physician to whom any problems would be referred. This relationship is required for physician's assistants and for certified nurse midwives. Once a woman in labor develops a problem requiring referral there is not sufficient time to start searching for a physician with whom to consult. One of the basic tenets of midwifery practice is to handle only normal or low risk clients. This risk assessment can best be approached through a collaborative relationship with a physician. The collaborating physician should be protected by statute from liability related to the care of a client not directly under his supervision.

POSITION

This Department is opposed to passage of this bill as written. Inclusion of requirements for formal as well as practical training and a requirement for a collaborative relationship with a licensed physician are essential features. In addition to the Board members stated in Sec. 08.69.030(a), there should be a licensed physician who is a practicing obstetrician and a certified nurse midwife. Any contemplated legislation should include requirements for these practitioners to comply with AS 18.15.150 and AS 18.15.200 regarding prenatal blood work and newborn metabolic testing respectively.

"attempt to est. a coll. rel."

Recommended by:

E. S. Rabeau
E. S. Rabeau, M.D., Director
Division of Public Health

Date:

March 24, 1982

Approved by:

H. D. Birne
Helen D. Birne, Commissioner
Department of Health and
Social Services

Date:

3-24-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. 2d Sponsor Substitute for House Bill No. 11
Title "An Act relating to midwifery."
Requested by Commissioner's Office Date 3/17/82

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
Program Category Affected Health/Public Health
BRU, Program, Or Subprogram(s) Affected _____
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

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

IV. DATE 3/19/82 PREPARED BY David Spence, M.D.
AGENCY Health and Social Services
Original: Legislative Finance PHONE 465-3109
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/8.)

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 11

An Act Entitled "An Act relating to midwifery".....

DISCUSSION

Before widespread availability of medical facilities, adequate transportation and professional providers, the Department promoted training for birth attendants in remote village areas through maternal and child health nurse consultants. In 1968, specific training was discontinued because of the establishment of the Community Health Aide training program by the Alaska Native Health Service. This program emphasizes the Community Health Aide's collaborative relationship with the Alaska Native Health physicians, which has resulted in moving the vast majority of village home births to the protected environment of hospitals.

Since that time there has been increasing demand for alternative birthing situations, including increased use of nurse midwives and birth attendants. This growing phenomenon is happening primarily in urban Alaska and is due to both economic reasons and to the desires for a family oriented birthing experience. Analysis of birth statistics (with an approximation for the number of unreported home births) in 1979 indicates that 200-300 out of 9,000 births probably occurred at home. These home births occurred primarily in Anchorage, Fairbanks, Homer and Juneau. The few home births that occurred in remote areas were primarily due to medical emergencies and hazardous travel conditions.

Alaska is attempting to address the needs of these individuals by:

1. expanding Medicaid coverage for maternity care;
2. extending general relief medical assistance for those not eligible for Medicaid;
3. providing support for family centered birthing attitudes and procedures in hospitals;
4. providing medical care assistance through Improved Pregnancy Outcome and high risk pregnancy projects; and
5. supporting the practice of nurse-midwives.

Alaska recognized the advanced nurse practitioner role by adopting regulation 12 AAC.44.400 which addresses the scope of practice and certification requirements. These increased training and educational requirements for nurse midwives have evolved to assure competent, quality, alternative health care for pregnant women.

RECOMMENDATIONS

Section 06.69.010 provides that a person who practices as a licensed midwife shall obtain a license. Since there is neither specific language requiring birth attendants to be licensed nor disciplinary action for practicing without a license, as presently worded only birth attendants who want to represent themselves as licensed midwives need to obtain a license. We question if this is the intent of licensing this field, when non-licensees are not prohibited from practicing.

Section 08.69.040 establishes requirements for licensure which include a minimum of 20 births or a completion of an apprenticeship and passing an examination administered by the Department of Commerce. Since the specific purpose of regulation of a profession is to limit entry to those persons qualified to administer the services and to protect the consumers (in this instance mothers and children), these proposed statutes may be insufficient to assure that birth attendants will have the minimum base skill level necessary to practice safely. The National Midwives Association regards training and experience as essential components to any regulation, and they recommend a minimum of 50 births with a practicing midwife for licensure. Arizona, which has birth attendant licensure, requires attendance at 15 births. These statutes are seen to be highly deficient by the National Midwives Association. The Department recommends that an apprenticeship be required for all persons who have not completed a course of study that includes a period of apprenticeship.

Section 08.69.070 provides for the renewal of birth attendants licenses. The proposed statutes require an applicant to have attended 20 births in the previous two years or to have completed 20 hours of continuing education. Since the practice of birth attendants is based both in knowledge and skills, the Department recommends that both continuing practice and continuing education be required for license renewal. It is recommended that continuing education requirements be in childbirth related courses only, and that practice with a midwife be deleted as a substitute for continuing education.

Section 08.69.08 outlines the conditions under which a license may be revoked or suspended, or the licensee may be reprimanded, censured, or disciplined. The Department recommends that a section be included that covers intentional or negligent conduct that results in a significant risk to the health or safety of a client or in injury to a client. This would be similar to the proposed statutes in Senate Bill No. 238 "An Act relating to the practice of nursing".

Section 08.69.130 outlines the conditions under which the birth attendant may practice. It provides that the client of a birth attendant must have a general physical examination by a physician, and that the mother be transferred to the care of a physician if a medical emergency is indicated. The Department recommends that:

- (1) a required general physical examination of client be done by a physician or a nurse midwife. This will allow more flexibility, and the nurse midwife is qualified to perform a general physical exam.

(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".

Section 08.69.160 provides for definitions. The Department recommends that Section 08.69.160(4) be revised to read "sponsor" means a physician or a nurse midwife licensed to practice in this State. As presently written, a birth attendant (lay midwife) could serve as a sponsor to another birth attendant; this may become problematic in terms of assuring that the apprentice is trained by a practitioner with sufficient knowledge and skills to be a trainer. The Department believes the minimum skill level necessary to serve as sponsor are those possessed by nurse midwives or a physician.

DEPARTMENT POSITION

In order to assure clients a safe, alternative to physician services, nurse midwives have to meet specific educational, apprenticeship, and collaborating physician requirements. The Department fully supports the mode of nurse midwife practice and recommends that birth attendants (lay midwives) should have similar requirements in order to assure clients of an optimal outcome.

Recommended by:

David Bruce
David Bruce, Deputy Director
Division of Public Health

Date:

April 30 1981

Approved by:

Helen D. Beltrone
Helen D. Beltrone, Commissioner
Dept. of Health & Social Services

Date:

7/30/81

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 11
 Title "An Act Relating to Midwifery"...
 Requested by HOUSE HESS Date 4/28/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health
 BRU, Program, or Subprogram(s) Affected Family Health
 (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					
200 TRAVEL	0					
300 CONTRACTUAL	0					
400 COMMODITIES	0					
500 EQUIPMENT	0					
600 LAND & STRUCTURES	0					
700 GRANTS, CLAIMS, ETC.	0					
TOTAL	0					

FUNDING (Thousands of Dollars)

GENERAL FUND	0					
FEDERAL FUNDS	0					
OTHER (Specify Fund Source)	0					
	0					

POSITIONS

FULL TIME	0					
PART TIME	0					
TEMPORARY	0					

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

IV. DATE 4/30/81 PREPARED BY Vernellia Randall-Phillips
 AGENCY Division of Public Health
 PHONE 465-3100
 Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) M&B Approval [Signature] Date 7/30/81