ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672
1538 SHESS SB 747 (#1)

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:

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

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

$$\frac{\text{ADC}}{\text{50\% occupancy}} = \text{Future NSCN Bed Need}$$

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 5.7 percent in the number of Alaskan births. That same growth rate 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

	Alaska Births	NSCN Beds Needed	Current NSCN Beds Available
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 area 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 births to less than 1% of the total Anchorage occuring births.

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

effective use of ... ??

why all ?

I did not see the correlation between Goal 2.0 and Objective 2.2 and still don't. They have no data to substantiate this arbitrary move! Was told this was more to placate Dr Worley H.B

SR A BOX 2/13 copies memo
Anch. 99507

March 22, 1982

To Senator Charles Parr,

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

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

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

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

Sincerely,

Mrs. Karen Casassa
Anchorage Resident

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

747

March 22- 1982

Dear Senator Charles Parr,
and all other Legislatars,

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

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

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

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

741

Dear Senator Parr.

Please support senate Bill 747 an act relating to midwifery.

it should be within the Parents constitutional Rights to be able to have birthing with whome and where they want.

USA is a Free-country.

We are going to have a baby this fall and will not have it in the hospital with sick people.

Professionals are not interested to come and birth at our home,

and we are comfortable with an certain Lay midwife and are going to have birthing with her.

Do not make us criminals because of that. it is our Right as a parents to have our children with whome we are comfortable and we wish you would vote yes on Bill 747 for our sake and for the sake of so many others.

Thank you for your support.

Mrs J. Theis. 976 Homer Ak 99603

3/19/82

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

Sincerely:

[signature] R.N. S.N.

9936 Kimberlie ct
Anchorage AK 99504

3/19/82

Dear Sen Parr,
'and all other legislators'

As a father of two, one a very unpleasant hospital birth and the other a very rewarding and natural home birth, I strongly support SB 747.

I firmly believe in the freedom to choose the setting for birth.

I want to encourage all of you to pass SB 747 and get home birth above ground where we can all have the opportunity to seek competent licenced care and alternitives. Thank you

Sincerely
David R. Henderson
Box 573
Sitka, AK 99835

Mar 18, 1982

Dear Sen Parr,
and all other Legislators,

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

Sincerely,

Cathie D. Henderson
Box 573
Sitka, AK.
99835

Al Rushing
1403 E. 27th
Anchorage, Alaska9950
1-5-82

Carolyn Aoyama
Dept. of HSS MCH-1 PO
Room 222 Mackey Bldg
338 Denali St.

Dear Carolyn Aoyama:

I have requested information from you previously on several matters relating to perinatal health care and homebirths in Alaska. I have an interest in this information on an individual, personal basis as well as being a representative of Better Alaska Birth Experiences. B.A.B.E. is an organization dedicated to providing information regarding perinatal health care to the consumer and improving perinatal care.

You have failed to provide this information or to contact me, and I would like to be informed of the reason for this refusal on your part. As an Alaskan resident this information should be available to me, and as a representative of HSS it would seem you should be able to provide the information and cooperation.

I want to obtain accurate, honest and unbiased statistical information and hope that you find this matter of sufficient merit to respond to now:

1) In late August and early September I made numerous attempts to contact you regarding the Improved Perinatal Outcome and the Perinatal Advisory Committee investigation and eventual report on homebirths in late October. You contacted me two weeks after I began leaving plone messages for you and after I'd contacted Mr. Dwayne Peeples.

2) When I requested information from you regarding the above via phone you informed me that the PAC meeting was private, not open to the public or anyone not a member, that transcripts of the meetings were not available to the public and that any information regarding homebirths must be submitted through you.

3) When I pressed the issue you said that you were initially mistaken, that I could attend the meeting but you were not certain of the agenda, time or place of the meeting. I informed you of a research study that Chris Rushing and I completed in August. The study as of homebirth couples in the Anchorage Municipality. You responded that the information would have to be presented by you. I also reported that the project was completed under the auspices of our research methods class at UAA and with the cooperation of BABE. You also told me that I need only list some of the demographic and simple statistical information to provide to you which I did.

4) Unable to attend the Perinatal Advisory Committee meeting my wife Chris attended but was informed that she would not be able to speak at the meeting because she was not a member of the Committee.

During the same meeting Liz Gollogly of Fairbanks was allowed to speak as an "invited guest". Paula Korn was not an invited guest but was allowed to speak because she is a nurse-midwife. I would like to obtain additional information of this "policy". Chris was told the "public" could speak at 4:30 but 5:00 came around and the"public" did not have an opportunity to speak. Do the speakers have to be married to physicians as both of these people are ?

5) At the meeting you down played the homebirth study saying that it of course was "biased". If you had knowledge of the research process you would realize that doing a study in a special sub-group like this is not necessarily biased. We conducted a random survey done with the proper technigue under the guidance of Dr. Ender from the University who is well known for his research programs. This was not some survey thrown together; it is the only statistical information gathered on the homebirth group that has ever been done in Alaska. I had offered to go over the original data with you at your convenience anytime prior to the meeting. This offer was also made more than a month and a half prior to the date of the meeting. You apparently had no inclination to present an unbiased presentation of the homebirth picture in Alaska.

6) You personally promised me, prior to the meeting, any infomation you obtained regarding homebirths and perinatal statistics. You have failed to provide me the results of your "investigation."

7) You also apparently promised an objective presentation of infromation regarding homebirths and lay midwives in the Kenia Peninsula. I was informed that you promised information to them which they have not received either. You presented a brief profile of midwives in Alaska at the PAC meeting. I find it quite odd that you did not contact the midwives in Alaska that have the most experience and do the most births. Dr. Pettijohn has done hundreds of homebirths here in Anchorage, as have other lay midwives in the state. You contacted only the midwives that have the least amount of experience and background.

8) You made comments at the PAC meeting that my wife and I feel are mainly conjecture or personal opinion. I would like to know of resources that state that Birthing Centers will remove the demand or lessen it for homebirth. You also presented the number of birthing center births at Alaska Hospital as about 25% of the total births. You were using the total number of births since the opening of the ABC rather than a number per year which you quoted. The actual births are less than 10% most months but I'm sure your statistics made more of an impression!!

9) I have repeatedly requested information regarding the IPO and the PAC and its composition etc. I have also requested notification of meetings and transcripts of PAC meetings. You have not provided these, nor contacted me.

10) I also requested detailed statistical information regarding perinatal outcome in Anchorage area hospitals but have not received the information.

I hope that you will find it of sufficient importance to reply to this letter and the questions I've raised, at your earliest convenience. I promise that I will seek out this information through what ever means are available, with or without your assistance.

Sincerely,

A Rushing

279 0181

P.S. When speaking with you by phone several months ago I'd inquired as to your knowledge and thoughts regarding "Home Delivery and Neonatal Mortality in North Carolina" - (It appeared in JAMA Dec 19, 80 pgs 2741 - 2745) You denied knowledge of the study. - I believe I mailed one to you, but you failed to reply. With minimal State outlay the lay midwives realized a markedly lower neonatal mortality rate than did the physicians delivering infants in the hospitals. Even the hospital mortality rates are significantly better than those alive heard for Alaska. My honest feeling is that there is no interest in improving "infant perinatal outcome" in Alaska, or we would be much more aware of the State watching and questioning the mortality rates, as well as hospital and physician policies and practices in the perinatal field. We are all well aware of the fact that most neonatal births and deaths occur in the hospital. I would assume it a simpler and easier political maneuver to go after lay midwives though, as they have not the backing of hospitals and physicians, nor the influence.

Al Rusting
1403 E. 27th
Anch, Ak 99504

1-9-82

Mrs Charlie Parr, Chairman
Senate - Health, Education and Social Serv.
Pouch V, Juneau, Ak 99811

Dear Ms Parr,

My wife Chris Rusting, and I obtained some very interesting information as a result of a research project this last year. We compiled information on couples that had a homebirth in the Anchorage Municipality within the last three years. Approximately 115 people participated, although we had 99 when we first put the information into the computer.

We find it rather perplexing that neither Anchorage nor Alaska have apparently completed any such study in the past. While at the same time many allegations and innuendos are bantied about regarding the increasing homebirth "problem". The apparent rationale of this type of talk being that if you connect "problem" with any given subject often enough people will soon begin to assume the two are synonymous!

I have heard from several sources that Anchorage and Alaska are both "concerned" about the apparently increasing rate of homebirths. With no objective statistical data it seems premature to be initiating policies and practices that "discourage" or inhibit

Alaskans from freely choosing their birth setting and birth attendant. — Parts of the original SB 237 are case in point. The drug proposal of Health and Social Services plan for Anchorage is another example! (Their objective to "reduce the number of home births to less than 1% of the total Anchorage occuring births" is purported to enable them to achieve the goal to "improve prognosis and survival rates for high risk mothers and babies."

When I questioned the data to substantiate their rationale or line of reasoning, I was told that they had no such data! I asked how they arrived at these proposals and was informed that a physician on the committee or board insisted upon this, and in fact this was a compromise. The physician wanted home births eliminated. This strikes me as a rather ass backwards way of establishing policy!!

The physicians here in Anchorage often refuse prenatal monitoring of women planning or even considering to have a home birth. I have even heard physician refuse newborn checks on infants born at home. For choosing a home birth often suffer harassment and intimidation from physicians when they do seek assistance during the perinatal period.

When medical research state that the majority of all complications or problems of the perinatal period are detected during prenatal monitoring. How can Anyone really believe that physicians refusing care to mothers and infants are truly concerned merely

for their health and safety ?? This denial of basic health care does not seem congruent with concern for people's safety - but rather seems to be an open threat: Do as I say or do without.

I have also heard physicians claim that if they do prenatal monitoring of "homebirth" mothers - the physician becomes liable etc should the woman or infant suffer difficulties, complications or death during a homebirth. This did not sound rational to me so I questioned several lawyers (and a judge in Calif.) and was assured that this is bogus malarchy. The physician is liable only for wrongs either in care given or which should have been given. If the physician is opposed to homebirths he or she can state this to the women and tell her that the physician will not attend the homebirth - This relieves the physician of responsibility for the individuals decisions etc. It would seem that physicians would not be misinformed on this subject - but perhaps deliberately to mislead the public instead.

There have been a number of occasions reported to me that pregnant women have been refused lab work at the public clinics here in Anchorage. They were told that they must go to a physician instead for this basic blood work. Other people not planning homebirths are able to get the same blood work without encountering difficulties. When I have gone through "official" channels on this I have been told

there is no such "official" policy. On an off the record basis I have been informed through unofficial sources that when local physicians become aware that the clinics are doing lab work etc on pregnant women the physicians put pressure on the clinics and threaten to create political pressure to make procurement of funding difficult!

I have been told that neither Anchorage nor Alaska are trying to in any way hamper homebirth couples or their attendants — This is not born out in fact however. We continue to get "stonewalled" when attempting to obtain information, there is no interest in our research study, and we continue to be harassed by a number of physicians and associates of the established hospital birth system.

In Anchorage homebirths presently account for 4-5% of all births according to our best estimates. This is a sizable minority. Perhaps if the private sector remains too prejudiced to assist them as needed, the State should consider seriously, directing a reasonable amount of funding to groups or agencies that are responsive and willing to meet the homebirth couples needs.

Please bear in mind that it is difficult to obtain an accurate count of home births — Not all are recorded, in fact here in Anchorage we know that more than 25% go unrecorded. Many other areas of the State would record still smaller proportions. (the Calif study

recently - only 25% were recorded!) I know that we suffered difficulty recording my son's birth here in Anchorage 3 years ago. I had to call Juneau & work my way up the bureaucratic chain-of-command in order to record his birth! I am sure experiences such as this tend to discourage birth registration. Also Alaskans are noted individualists and many refuse to register their births because of personal philosophies.

It seems at least, to be unethical for physicians to attempt to equate homebirths with infant and maternal mortality. We all know that during the perinatal period infants and mothers are at increased risk - this is a natural fact. There has been though but one study I have seen that differentiated between homebirth planning statuses and stated whether assisted by experienced attendants or not (Home Delivery and Perinatal Mortality in North Carolina - JAMA 12-19-80) In this study lay midwives maintained enviable low mortality rates - much better than with physician attended hospital births! I thought it ironic, but at the same time approp. when I received word that in August of 81 (8 months after the report was published) that the State of N.C. stopped licensing lay midwives due to concerted pressure from physicians. The State is supposedly conducting their own research of homebirths but it will take several years they say.

When studies use the total of all "out-of-hospital" births as homebirths, many of the births are actually births planned hospital births. Because of this these people are unassisted, unprepared and often unknowledgable of normal birth process. Due to these reasons and the fact that many are premature births - the infant mortality ratio are quite high. It doesn't take many such cases to really affect the "home birth" mortality ratio negatively due to the proportionately smaller number of "out-of-hospital" and "homebirths".

I would welcome good legislation for lay midwives and homebirth couples. Alaska has so much potential, I hope this potential is realized and utilized in progressive home birth legislation.

If I can help in anyway in clarifying or assisting regarding home births and or lay midwifery, please contact me - I would be glad to assist.

Sincerely,
A. Gasking

1-11-82

P.S. I was just contacted today by the Open Door Clinic here in Anchorage and informed that they would no longer provide lab work for "home birth" pregnant women. Out of curiosity I telephoned the Anchorage Neighborhood Health Clinic and was told they would not do any blood work for pregnant women, although they do blood typing for other people. The CDC said they could do the entire blood work for anyone NOT pregnant!

HB11

JAMES A. REDDEN
ATTORNEY GENERAL

JAMES W. DURHA
DEPUTY ATTORNEY GENE

DEPARTMENT OF JUSTICE

100 State Office Building
Salem, Oregon 97310
Telephone: (503) 378-6368

June 17, 1977

No. 7468

This opinion is issued in reponse to questions presenced by Arleen Sergeant, R.N., M.S., Assistant Executive Director, State Board of Nursing.

FIRST QUESTION PRESENTED

Can a person be a midwife and assist in the normal delivery of children without being first licensed as a registered nurse and certified as a nurse practitioner midwife?

ANSWER GIVEN

Yes.

SECOND QUESTION PRESENTED

Assuming the answer to the first question is yes, can a lay midwife administer medications or perform an episiotomy?

ANSWER GIVEN

No.

DISCUSSION

A review of available nursing, medical and legal literature indicates that "midwives" and "midwifery" may be

the world's "second oldest profession." A midwife is a person who assists in childbirth and midwifery is the art or practice of assisting women in childbirth. (Webster's New 20th Century Dictionary, 2nd Edition.)

Since, according to Webster's, a further definition of midwifery is "obstetrics" and obstetrics is recognized as a branch of medicine pertaining to the care of women during pregnancy, parturition and puerperium[1], a basic question is whether the practice of midwifery is limited to persons licensed to practice medicine.

In Massachusetts, midwifery is considered within the practice of medicine, and its practice is limited to persons licensed as physicians. Commonwealth v. Porn, 196 Mass 326, 82 NE 31 (1907). The defendant in the Porn case was a licensed nurse. However, in some states the practice of midwifery is recognized as a licensed occupation separate and apart from both nursing and medicine. Bowland v. Mun. Ct. of Santa Cruz, 125 Cal Rptr 858, 556 P2d 108, (1976); Rock v. State, 6 Md App 618, 253 A2d 401 (1969). Yet other states have recognized midwifery as an occupation separate and distinct from medicine and nursing without requiring a license for its practice. People v. Hildy, 289 Mich 536, 286 NW 819, (1969); Banti v. Texas, 163 Cr 89, 289 SW2 244 (1956).

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[1] Stedman's Medical Dictionary, p. 1105 (2nd ed. 1966). However, Websters points out "obstetrics" is derived from the Latin "obstetrix," which merely means midwife.

Some courts have also concluded that pregnancy is a natural condition and childbirth is a normal function of womanhood and thus assisting in childbirth is not necessarily within the practice of medicine. Bowland v. Mun. Ct. of Santa Cruz, supra and Rock v. State, supra. This rationale was also recognized in 35 Op Atty Gen 1267 (1970).

Decisions referred to above concerning the practice of midwifery in other states were based upon the particular language of the state statutes involved. None of these decisions are directly on point, with the exception of the Banti case and possibly the Hildy case. Banti is particularly on point because it is based on law which parallels Oregon statutes.

Banti considered a Texas law which authorized "midwives," not licensed as either nurses or physicians, to sign birth certificates and put drops in the eyes of newborn infants. The court concluded that this constituted legislative recognition that a person could be a midwife without being licensed as a physician (or a nurse).

Oregon has similar statutes. ORS 432.205 and 432.210 state, respectively:

> 432.205. "(1) A certificate of every birth shall be filed with the local registrar or the registration district in which the birth occurred, within the time prescribed by the division, by either the physician or midwife in attendance at the birth or, if not so attended, by one of the parents; provided, that any birth certificate not containing

> the name of the father or on which the surname of the father is at variance with that of the child shall be filed with the division and not with the registrar of the district in which the birth occurred.
>
> "(2) If the mother is unmarried, the certificate of birth shall not show the name of the alleged father unless both the father and mother have filed an affidavit of paternity with the registrar." (Emphasis added)
>
> 432.210. "If neither of the parents of the newborn child, unattended by either physician or midwife, is able to prepare a birth certificate, the local registrar shall secure the necessary information for the preparation of a birth certificate from any person having knowledge of the birth." (Emphasis added)

The Oregon legislature has a long history of treating midwifery as an occupation distinct from the practice of medicine or nursing. In 1905 the legislature adopted the predecessor to ORS 432.205 and 432.210, providing that:

> "It shall be the duty of all physicians, accouchers[2] or midwives in the State to report. . . all births . . . which may occur under their supervision. . . ." 1905 c. 179 §3 (Emphasis added)

This act, with its reference to registration of births occurring under the supervision of midwives, indicates legislative recognition of a major role for midwives distinct from that of other medical practitioners.

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[2] "Accoucher" is defined as "one who assists women in childbirth; an obstetrician." by Websters New International Dictionary, Second edition, unabridged (1959). By 1915 this term had been deleted from laws governing registration of births, leaving only references to "midwives" and "physicians."

This act was in effect in 1911 when the legislature created the State Board of Examination and Registration of Graduate Nurses and made it unlawful to practice as a registered nurse without a certificate from that board. 1911 c. 32 §6. While the legislature has continued to tighten standards for licensing nurses, today requiring a license for all persons engaged in the practice of nursing (ORS 678.021), it has also retained statutes assigning duties to midwives "in attendance at birth". ORS 432.205, 432.210. Oregon has never required a license for midwives. From these facts we conclude that the legislature continues to view midwifery as an occupation distinct from nursing, and that a person engaged in this occupation need not be licensed as a registered nurse or certified as a nurse practitioner midwife.[3]

In reaching this conclusion we are not suggesting that a "lay midwife's" services are as skilled as those of a certified nurse midwife, or that a "lay midwife" has the education or training of a Board of Nursing licensee. We hold only that the legislature recognizes the practice of midwifery, that under present law midwives may assist during childbirth, and that such persons need not be licensed as nurses. For reasons

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[3] The Board of Nursing has by administrative rule provided for licensing registered nurses as Nurse Midwife Practitioners. OAR 681-30-001 to 851.30-003. However, we are not asked for any opinion concerning the proper scope of practice of such a Nurse Midwife Practitioner. A definition of such scope by the board based upon appropriate factual determinations would be prima facie valid.

set forth below, we interpret this assistance to be limited to so-called natural childbirth, without the use of drugs or surgical procedures.

In addition to the general question posed regarding midwifery, we are also asked whether a lay midwife can administer medications or perform an episiotomy. Although we conclude that the practice of midwifery is recognized by the legislature, it is restricted by statutes governing practice of medicine and nursing.

In 1895 the legislature first provided that "any person practicing medicine or surgery within the state. . . without first having obtained the (medical) license herein provided for. . . shall be guilty of a misdemeanor. . . ." L. 1895, p. 66 §8. This law was in effect in 1905 when the act referring to registration of births occurring under the supervision of a doctor or midwife was enacted. As noted above, Oregon has never required licensing of "midwives." The co-existence of these factors strongly suggests that the legislature did not consider assisting with childbirth (at least normal childbirth) to be "practicing medicine or surgery."

Since 1895 the legislature has further defined "practice of medicine" and has added a definition of "practice of nursing". ORS 677.085, 678.410. A lay midwife, not being licensed as either a nurse or physician, is prohibited from performing tasks included within either of these definitions. ORS 677.085(4), 678.021. We have held in previous opinions

that administration of medication constitutes practice of nursing. 34 Op Atty Gen 900 (1969); 37 Op Atty Gen 478 (1976). We thus conclude that a lay midwife, not being licensed as a nurse or physician, is prohibited from administering medications to another person.[4]

Our opinion is not changed by Health Division OAR 333-21-07[illegible] and OAR 333-23-134(1)(F), requiring the attending physician, nurse or other person acting under the direction of a physician attending birth to immediately instill silver nitrate into the eyes of newborn infants. Such action, no matter how simple the procedure or laudable its purpose, constitutes administration of medication and cannot be performed by a lay midwife. However, these rules apply only to physicians, nurses or other persons acting under the direction of a physician attendi[illegible] the birth. We assume that a doctor is usually not present a[illegible] births supervised by midwives, and in such situations these rules, as written, would not apply.

We also have no hesitation in concluding that a lay midwife cannot perform an episiotomy. ORS 677.080, with limited exceptions, prohibits a person from practicing medicine without a license issued by the Board of Medical Examiners. A person practices medicine if he or she offers or undertakes

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[4] ORS 678.035 authorizes a nonlicensed person, until July 1, 1977, to administer noninjectable medications under the direction of various state licensed personnel. ORS 678.150 (7)(J) requires the Board of Nursing, after July 1, 1977, to adopt rules for the delegation of certain nursing tasks to nursing assistants. While these tasks may include administration of medications, they must be supervised by a licensed nurse.

to perform any surgical operation upon any person. ORS 677.085(3). An episiotomy is a surgical incision of vaginal tissues performed to prevent the harder to repair natural tearing which often occurs during childbirth. In an earlier opinion we concluded that an episiotomy was a surgical incision of human tissue falling within the definition of "surgical operation" for purposes of the Medical Practices Act. 35 Op Atty Gen 1267 (1972). Consequently, such an operation cannot be performed by a lay midwife not licensed as a physician or nurse.

JAMES A. REDDEN
Attorney General

JAR:ABS:DCA:am

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

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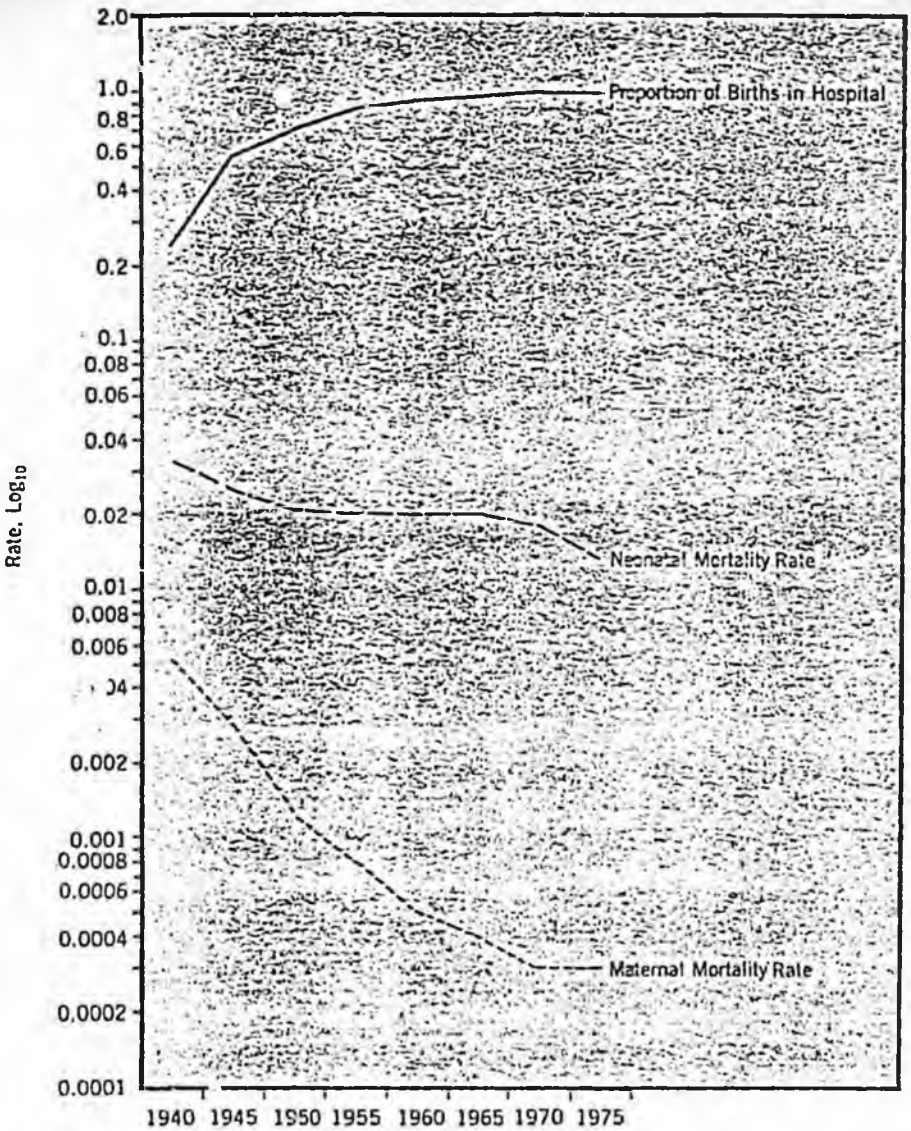

Proportion of births in hospital, neonatal mortality rate, and maternal mortality rate, North Carolina, 1940 to 1975.

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

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

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

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

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

In June 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.

Table 1.—Planning Status of All Home Deliveries*

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

*North Carolina, 1974 through 1976.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	Home Lay-Midwife, %	All Deliveries, %	Neonatal Mortality Rate† All Deliveries
Age, yr			
<20	40	24	14
20-24	34	35	11
25+	26	41	10
Race			
White	4	69	10
Nonwhite	96	31	15
Marital status			
Married	56	84	10
Unmarried	44	16	16
Education, yr			
<12	69	36	14
12	29	42	10
>12	2	22	9
Prenatal visits			
0-2	5	3	65
3-7	68	19	28
8+	27	78	5
Birth weight, g			
≤2,000	0	3	288
2,001-2,500	6	5	24
2,501-3,000	20	18	5
>3,000	74	74	2
N	467	159,333	...

*Home deliveries by lay-midwives vs all deliveries, and neonatal mortality rate for all deliveries North Carolina, 1975 through 1976.
†Neonatal deaths per 1,000 live births.

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

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

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

COMMENT

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

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

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

Unplanned home deliveries were associated with neonatal mortality even higher than deliveries en route to the hospital, although the difference was not statistically significant. After analyzing 100 consecutive cases of unattended home deliveries in England, Fraser[1] concluded that "while precipitate labour is an important factor, inadequate preparation and instruction of the patient are the commonest causes" of unattended home delivery.

Adequate prenatal care and provision of care appropriate to medical risk has been repeatedly associated with lower neonatal mortality. Montgomery[2] and later Levy et al[3] showed that a nurse-midwife program, which emphasized prenatal care for a medically underserved population, was associated with a notable decline in neonatal mortality followed by a sharp rise after discontinuation of the program. Zackler et al[4] have reported that a maternal and infant care project, which provided prenatal care to girls who conceived when they were younger than 15 years, was associated with lower neonatal mortality compared with a population that did not receive project services. In large-scale studies of vital statistics data, Kessner et al[5] in New York and Dott and Fort[6] in Louisiana found that adequate prenatal care was associated with less risk of low birth weight and neonatal mortality.

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

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

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

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

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

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

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

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

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CHAPTER FOUR

How To Find A Birth Attendant

Preparing for the Birth

YOUR BIRTH ATTENDANT

THE IMPORTANCE OF A SKILLED BIRTH ATTENDANT

Although 95 percent of low-risk births proceed completely normally without intervention, for the other 5 percent a skilled birth attendant is invaluable. She can help recognize the early signs of danger, offer advice about going to the hospital, and help with an emergency in the small percentage of cases when one arises. For even though prepared couples understand more about birth than couples previously have, it is still difficult, without extensive theoretical and practical skills and experience, to tell which situations are within the broad range of "normal" and which require medical attention.

Thus in a normal birth an attendant can help keep a homebirth at home through reassurance that everything is all right and by handling some situations which require attention without the need to go to a hospital. She can also help with coaching, especially when the father needs to eat or rest. And she can share her skills and compassion gained from attending many births and having had children herself (if your attendant is a man, it is still beneficial to have such a woman present as trusted friend, labor coach, etc.).

And having a skilled attendant can be especially important if something does go wrong; you have another opinion based on greater experience with birth and you can often save valuable time by early detection and action. In the event of a real emergency, your birth attendant should be skilled in emergency first-aid measures and may bring emergency equipment. In such a situation, having someone present who is skilled and experienced in birth and at the same time attuned with the current situation can be an invaluable and life-saving combination. I strongly urge that you find and use a skilled birth attendant, without giving up your responsibility to her, to help reduce the risks of homebirth to the inevitable minimum of nature.

DIFFERENT KINDS OF ATTENDANTS

Depending on where you live, you may have many kinds of birth attendants to choose from. If there is a doctor in your area who has a homebirth practice, make an appointment to talk with him, find out who he is and what his practice involves. The advantages of a doctor are continuity of care (in case of emergency he should have hospital privileges), greater familiarity with emergency equipment and procedures, and the ability to handle certain complications at home (suturing, etc). The disadvantages can be less familiarity with normal birth and more tendency to intervene or to want standard procedures such as prepping, enema, etc. And few doctors are willing to become involved in your labor as a midwife does.

In some states chiropractors are licensed to do deliveries, and osteopaths are able to do births in many states and may be more open to homebirth than M.D.s.

Many states license certified nurse-midwives to do deliveries as part of an obstetrical team. You may find them doing homebirths under a doctor's auspices or working in a birth center. Midwives have the orientation of helping a woman throughout pregnancy, labor and delivery, and if they are doing homebirths they probably haven't lost their orientation to normal birth during their training. They are able to administer drugs for hemorrhage, they can do episiotomies, suturing, etc., and they are trained in other emergencies, such as infant resuscitation. Because they are usually doing

homebirths under a doctor's guidance, they have emergency backup and could remain with you in the hospital should any complications arise.

Lay or empirical midwives are women who are skilled in birth without first becoming a nurse. Although training programs are beginning to develop in several states, most empirical midwives have gained their training through self-study, apprenticing with another midwife, and through experience (hence the designation *empirical*). Laws in individual states may determine whether a lay midwife is able to practice openly, has doctor backup, carries emergency equipment, charges for her services, etc. Advantages tend to be an orientation toward normal birth, involvement in the entire labor and delivery, respect for the parents' decisions and experience; disadvantages can be lack of experience with complications, lack of good backup, and needing to go to the hospital for situations such as suturing.

Lay midwives are allowed to practice openly in twenty states: Alabama, Alaska, Arkansas, Arizona, Delaware, Florida, Hawaii, Louisiana, Maryland, Minnesota, Mississippi, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Washington and Wyoming. Some of these states have requirements for certification; others make no mention of midwifery. To find out the status of nurse and lay midwives in your state, you can contact your local health department.

If no one is openly doing homebirths in your area, you will have to do some searching to find your birth attendant. But with a bit of effort, it's surprising what resources you can discover.

How to Find a Skilled Attendant

Your first lead might be to talk with childbirth educators and La Leche League leaders and asking who is doing homebirths, which doctors are sympathetic for prenatal care, and so forth. (La Leche League has the official policy of never endorsing or recommending anything, but leaders tend to know everything that's happening in a community). Get their numbers from doctor's offices, hospitals, or the Red Cross.

In my opinion, it is good to talk to doctors about homebirth—it lets them know what consumers want. But remember that you are doing it as a service to them and don't be discouraged by the lectures you may receive. And who knows, you may be the one to radicalize a doctor, especially if he comes to know you through prenatal care first.

Next, talk to everyone you meet who looks like they might be involved with homebirth. Maybe they'll know someone. You can write up index cards stating something like, "I'm having my baby at home and would appreciate information from women who have had homebirths, or from anyone who has experience with births." Put these up in health food stores, free clinics, bookstores or wherever there are appropriate bulletin boards.

You may feel as if you're the only person in your area who cares about homebirth, but it isn't true. I am convinced that if you have strong intention and put out the energy, you will be given exactly the help you need. For example, when I first came to Boulder, Colorado, no one knew of anyone except one osteopath who was openly doing home deliveries. Within a few months of teaching classes, I had discovered two foreign-trained midwives who had each delivered 5,000 babies, and other people who would help at home deliveries including three obstetrical nurses, two physician's assistants, three lay midwives, and one M.D. who would occasionally do homebirths.

What if you don't find any help? You might be satisfied with delivering at a birth center or doing a hospital delivery with a sympathetic doctor and then going home a few hours after the birth (signing yourself out "against medical advice" if necessary). Athough I can't recommend homebirth without a skilled attendant, I recognize that some couples will be determined to do it even though they haven't found help. (Most unattended homebirths are not due to the couple's negligence, but result from the fact that doctors and legislators in many states refuse to recognize the rights of couples to give birth in their own homes with competent medical aid and emergency backup.) My advice in this case is that you *please* don't attempt it with just the two of you. There's too much to know and do, even in a normal birth, for the husband to be able to handle everything comfortably. And if complications occur, you can be in real trouble. At the very least involve friends, including women who have given birth, so that there will be help with coaching, cooking, looking after children, and so there will be help in an emergency situation (like taking the mother to the hospital in the knee-chest position, watching the baby if the mother has third-stage complications, etc.). And as a group, meet together often, study and prepare yourselves as much as possible. Be as responsible as you can, and don't stop looking for the help and information you need!

Skills of a Birth Attendant

With diligence and clear intention, most couples are able to find several sources of possible help. Having an experienced birth attendant is important, but it's equally important that you have a realistic appraisal of your attendant's skills and orientation toward birth. Our cultural conditioning is to accept unthinkingly the superiority of the expert and to discount our own knowledge and intuition. Doing this at a birth, whether the "ex-

pert" is an obstetrician or your next-door neighbor, will very likely lead to disappointment or disaster.

At a minimum, your birth attendant should be able to:

1. Recognize which prenatal factors place a woman or baby at risk and may contra-indicate a home delivery.
2. Know how to monitor labor, including checking dilation, the position of the baby, fetal heart tones and maternal blood pressure.
3. Recognize variations from a normal labor and know whether they can be managed at home or require hospitalization. (She also needs to participate in formulating your emergency backup plan.)
4. Know how to help the head to be born without tearing the perineum or vagina. She should know how to recognize degrees of tearing, should they occur, and be able to get them handled.
5. Check the placenta, umbilical cord and membranes.
6. Check the uterus for contraction after the birth and be able to recognize and handle hemorrhage.
7. Know how to check the newborn and recognize health problems.
8. Know how to handle critical emergencies such as shock, hemorrhage, shoulder dystocia, and how to give cardio-pulmonary resuscitation to the baby.

Ideally, there should be an almost telepathic sense of unity with your birth attendant. After all, you are going to be sharing one of the most intimate experiences of your life with this person.

SELECTING A SKILLED ATTENDANT

Once you have found someone who is helping with home deliveries (or who has the necessary skills and might be persuaded to help you), it is a good idea for you and your partner to meet with her or to invite her to your house for dinner. Find out who she is—what her experience is, what her attitude is, what her procedures are—and let her find out who you are. If it is a doctor who has a homebirth practice, you may have to make an appointment for an interview first. Get to know each other so you can both decide if it is appropriate for you to be working together.

Of course, your prospective birth attendant will also be getting to know you, too. And she may even decide, for whatever reason, that she dosn't want to be working with you. It can be quite discouraging, after finally locating a potential source of aid, to have her not come through or refuse you. But in fact, if a birth attendant does not want to work with you, you are better off not working with her.

The following points certainly can't all be covered in a single meeting (don't give her the third degree!), but prior to your delivery you should know the following about your attendant.

1. *Training and Experience.*

What training has she had? How much home and hospital experience? What is her orientation toward birth? (Has she ever apprenticed with a midwife? Why does she do home deliveries?)? How many births has she attended, and at how many was she the primary attendant? There are differences between a friend with some birth experience, someone who has caught ten babies, and someone who has caught 100, 350 or 3000. Some sources say that your birth attendant should have had experience at some minimum number of births, but I feel that, rather than relying solely on numbers, you should gain a realistic appraisal of this person's level of experience (as well as an intuitive estimation of her ability to act with calm and clarity in any situation) and evaluate her skills against what you feel are the risks and what you feel you need from a birth attendant.

2. *Complications and Emergencies.*

Find out what complications and emergencies she has seen, and how they were dealt with. Find out what she can handle at home. She should be able to recognize danger signs and know what is beyond her ability. What would she do if you were bleeding and went into shock? What would she do if the baby was born white and limp and didn't start to breathe? Can she do suturing? Get a realistic idea of her areas of competency and inexperience.

3. *Medical Backup.*

If your birth attendant is an M.D. or osteopath, does he have hospital privileges? If a midwife, does she have a doctor whom she can call with questions or who will meet you at the hospital? If not, you should have your own backup (through prenatal care) and/or be familiar with the emergency room procedures of your hospital (see Emergency Backup, p. 50). Will she be able to accompany you and serve as consumer advocate at the hospital, or does she need to leave you once you are on your way to the doctor's or hospital? Does she have a pediatrician for backup (or do you)?

4. *Equipment.*

What equipment does she bring? She should have a fetoscope, bulb syringe for suctioning the baby, cord clamps or ties (or hemostats for emergencies), a disinfecting agent for scrubbing up, and sterile gloves. What does she expect you to have on hand? What emergency equipment does she bring: Oxygen? Ergotrate tablets or

methergin to handle postpartum hemorrhage? Any other herbs or medications? Does she bring a scale for weighing the baby? Does she have silver nitrate or Ilotycin for the baby's eyes?

5. *Procedures.*

Does she bring an assistant? Some doctors and midwives have a very medical view of birth and bring lots of equipment (see Seth's birth account). When does she cut the cord? Will she let your husband assume an active role in the delivery if that's what you want? In what capacity are you having her be present: To advise you if anything is wrong? To actually deliver the baby? If you want to use LeBoyer's or other special means of welcoming your baby, does she understand and is she in agreement? What percentage of the women she works with tear and require stitching?

6. *Fees.*

Does she charge a fee? Do you think it is reasonable? When does she want payment, and is it to be in cash or supplies or some kind of trade? What if she doesn't make it to the birth? What if you end up having to go to the hospital? If the fee includes prenatal care, delivery and six-week checkup, it should be quality prenatal care as described in Chapter Two. If she does not provide her own prenatal care, she should be involved with your records and lab results and should meet with you several times prior to the birth. When does she want to be notified and when does she come during labor? Does she visit you in the days following the birth? How much is she willing to invest in you and your well-being?

7. *Communication.*

Communicate with her about who you are and what you expect from a birth attendant. Some birth attendants are encouraged by the fact that you are taking responsibility and wouldn't agree to be there under any other conditions; others who are used to being in charge may want a more "professional" relationship.

Also try to feel how open and willing she is to communicate with you, now and during labor and delivery. How involved will she be in your labor, or will she be primarily focusing on the birth? See how willing she is to explain things to you, to help you see the consequences of your choices, but to let you make your own decisions. Does she teach childbirth preparation classes or recommend someone with whom you can work?

If she is bringing an assistant, can you get to know her as well? It's also important that all of the people who will be present meet with your attendant(s) and with each other to get to know one another and so you can discuss what is important to you. Share this book with your attendant so she understands part of your preparation.

8. *Attitude.*

What is her attitude toward birth? Does her attitude mesh with yours? Is she warm, confident and caring? Does her spiritual orientation mesh with yours? Do you like her and feel good about her participating in your birth?

You won't be able to find the *ideal* birth attendant (the one of your best imaginings). Instead you will find real men and women who are concerned with the quality of birth and are, either tentatively or boldly helping with homebirths. The more you can communicate with your attendant, the better friends you will become, and the fewer surprises you are likely to have at the birth itself.

No Praise and No Blame

Many times throughout this book I stress the importance of parents maintaining responsibility for their own birth, and of not entering into a dependent relationship with their birth attendant, their pediatrician, or whomever. More than this, I advocate a sense of friendship, trust and unity among all the people present at a birth. If this is maintained, there will be the sense of a group of people united in a common effort, each contributing what he or she has to offer, all participating in a group process which is unique to that moment.

This shared sense of everyone doing his or her best, combined with the recognition of the uniqueness and non-repeatability of each situation, could, I am convinced, go a long way towards eliminating the aura of fear, blame and guilt which is unfortunately so prevalent in our health-care system today. It might reduce the fear of lawsuits, censure, and astronomical malpractice insurance which keeps many doctors from being involved in homebirth and leads to such a high cesarean rate in our hospitals.

Likewise, the recognition of the uniqueness of each situation should help to keep us from comparing, from saying, "If only I'd had my baby in the hospital" or "If only I'd had my baby at home." The woman who says, "I hemorrhaged after the birth in the hospital. If I'd been at home, I would have died" doesn't realize that had she been doing a homebirth, the situation would have been completely different (e.g., she wouldn't have had any drugs, her birth attendant would have been different, delivery of the placenta would have been managed differently, etc.). The same is true when some difficulty arises at home. It's impossible to say whether it or some other situation would have arisen in a hospital delivery; everything would have been different.

In making the decision to be alive and have a baby, you are admitting that there are no guarantees, either at home or in the hospital. Life is an inherently risky venture into the unknown. You can reduce risks as much as possible by being as responsible as you can. And whomever you ask to help you, whether an obstetrician, a midwife or a group of friends, you must know that all the people present are sharing and doing their best, based on their experience and their ability to be aware (and to keep each other aware), and that the "results" are dependent on something higher than ourselves, and hence go beyond praise or blame for the individuals involved.

PLANNING YOUR EMERGENCY BACKUP

Unless you can find someone who is able to give you continuity of care (prenatal, home delivery, and hospital privileges), you will also need to think about what you will do in case your delivery is among the small percentage requiring hospital care. It's important to think about these things now, so in case of an emergency you will have worked out all of the details and can quickly get the help you need.

It is helpful if your birth attendant has hospital privileges, or is a midwife with her own doctor, but you should still go through the following two pages so you will have all the information you need should your birth attendant not make it to the birth on time. Most homebirths proceed without incident, but being responsible means having considered all of the possibilities.

To help you with your emergency backup plan, fill in the following worksheet, and then fill in the numbers you will want to have posted by your telephone, and tape them to the wall *a month before your due date.*

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

TO: Representative Joe McKinnon January 14, 1980

FROM: Christine Johnson, Research Analyst CEJ
House Research Agency

THROUGH: Duncan L. Read, Director
House Research Agency

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

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

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

CJ/bf
Encl.s

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

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	Practice supervised by physician or surgeon (physician's presence not required); cases of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortions.
	Special Statutory Provisions	Requirements for censure are left up to appropriate boards and committees. In general, California's statutes establish the confines of the practice.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CONNECTICUT (377.20-35)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Graduate of school of midwifery.
	Limitations on Practice	Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drugs, instruments, nor perform version or attempt to remove adherent placenta. Shall not attend woman in labor until after seventh month of gestation.
	Special Statutory Provisions	Examination required for licensing.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

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

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

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

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

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

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

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

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

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

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

Original sponsors: Rogers and Vaska

Offered: 5/22/81
Referred: Finance

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 11 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to midwifery."

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

* Section 1. FINDINGS AND INTENT. The legislature recognizes the unique physical and emotional aspects of childbirth, and the need to protect and enhance the religious, cultural, and individual freedoms in the manner, setting, and cost of childbirth. The legislature finds that the traditional and cultural use of midwives continues and that the demand for midwifery service is increasing in Alaska (without adequate regulation and licensure) Therefore, the legislature intends that midwifery be regulated in the public interest to assure that users of midwifery services are aware of the competency levels of their health care providers, and that licensing of midwives does not remove from the parents the responsibility for choosing where, when, how, and with whom to deliver their babies.

* Sec. 2. AS 08 is amended by adding a new chapter to read:

CHAPTER 69. MIDWIFERY.

Sec. 08.69.010. LICENSED MIDWIFE PRACTICE. A person who practices as a licensed midwife shall obtain a license granted by the Department of Commerce and Economic Development as provided in this chapter and shall practice midwifery in accordance with this chapter.

Sec. 08.69.020. UNLAWFUL REPRESENTATION. It is unlawful for a person to represent oneself as a licensed midwife or use any designation that implies that the person is licensed or certified by the state to act as a midwife unless the person is currently licensed under this chapter. A violation of the provisions of this section is a violation

as described in AS 11.81.250(a)(6).

Sec. 08.69.030. DUTIES OF THE DEPARTMENT. The department shall

(1) license persons to practice midwifery;

(2) prepare and administer examinations which test competence in midwifery;

(3) prescribe a ~~biennial~~ 5 LAW license fee for licensed midwives not to exceed $25;

(4) develop, publish, and make available to interested parties at a reasonable cost, a bibliography and guide to the examination administered to applicants;

~~(5) require the compliance of licensed midwives with vital statistic recording requirements;~~

~~(6) require licensed midwives to maintain statistics relating to births they attend;~~

Sec. 08.69.040. LICENSURE AS A MIDWIFE. A person is eligible for licensure as a midwife if that person

(1) is at least 18 years of age;

(2) furnishes proof of having attended at least ~~50~~ 20 births as a (midwife in) the ~~two-year period immediately~~ preceding the date of application or has completed a midwife apprenticeship under AS 08.69.-150; proof is by affidavit of the applicant for births ~~which occurred before January 1, 1982;~~

(3) passes an examination administered by the department meeting the requirements of AS 08.69.060;

(4) pays the license fee prescribed in this chapter.

Sec. 08.69.050. LICENSURE BY ENDORSEMENT. A person who is licensed as a midwife by another state (country) may be licensed as a midwife if the requirements for that license are essentially the same as the requirements for licensure under AS 08.69.040.

Sec. 08.69.060. EXAMINATION OF APPLICANTS. (a) The examination for licensure as a midwife shall be administered at times and locations selected by the department.?

(b) Subjects examined by the examination shall include, and are limited to, Newborn examination

(1) anatomy of the pelvis and female genital organs;

(2) physiology of the female genital organs;

(3) recognition and management of pregnancy;

(4) understanding fetal presentations and positions;

(5) mechanisms and management of normal labor;

(6) management of puerperium;

(7) injuries to the genital organs following labor;

(8) sepsis and antisepsis in relation to labor;

(9) preparation and management of the delivery site and lying-in area;

(10) hygiene of mother and infant;

(11) asphyxiation, convulsions, malformation, and infectious diseases of the newborn;

(12) causes, effects, and prevention of opthalmia neonatorum;

(13) emergency occurrences requiring the attention of a physician;

(14) requirements of vital statistics law relating to reporting of births and infectious diseases of the newborn;

(15) the pharmacology of drugs used in emergency maternity care for both mother and infant following childbirth;

(16) nutrition as it relates to the prenatal, partal and postpartum period;

(17) management of breast feeding;

(18) knowledge of the bonding process and family interrela-

tionships;

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

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

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

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

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

(e) The department? shall establish requirements which must be met before a license may be renewed, which must include a requirement that an applicant for renewal has attended ~~20~~ births in the previous ~~two~~ ~~years~~ and has completed ~~20~~ 50 hours of continuing education. Continuing education shall include childbirth-related postsecondary coursework, workshops, or any combination of training and experience or a combination of experience and continuing education. ^ correspondence courses

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

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

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

(3) (the licensed midwife has engaged in unprofessional conduct; or ?)

(4) (the licensed midwife has engaged in intentional or negligent conduct that results in a significant risk to the health or safety of a client or that results in injury to a client.?)

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

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

(1) recognition of pregnancy and management of prenatal Newborn examination care;

(2) preparation and management of the delivery site and lying-in area;

(3) management of the birth process and delivery of the infant;

(4) clamping and severing the umbilical cord;

(5) delivery of the placenta, with anti-hemorrhage techniques;

(6) recognition of an emergency labor or delivery situation involving the mother or infant;

(7) emergency procedures for asphyxiation, convulsions, malformation, and infectious diseases of the newborn;

(8) administration of preventive prophylaxis for ophthalmia neonatorum;

(9) postnatal care of mother and infant;

(10) suturing;

(11) routine laboratory investigation for normal prenatal care.

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

(1) intramuscular injections for maternal hemorrhage;

(2) penetration of human tissue for emergency episiotomy, repair, and severing the umbilical cord;

(3) oxygen use.

(c) (The department? shall designate the medications, therapeutic agents, and techniques which a licensed midwife is authorized to administer and the circumstances under which those medications, therapeutic agents, and techniques may be administered.?) ^

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

(1) philosophy of practice;

(2) education and training;

(3) experience;

(4) services and fees;

(5) procedures for meeting medical emergencies.

(b) The licensed midwife shall inform the client that the statistical information required by AS 08.69.110 is maintained by the licensed midwife and is available for inspection.

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

(1) infections;

(2) hemorrhage;

(3) hospital transfers;

(4) malpresentations;

(5) normal deliveries;

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

(b) The statistical information required shall be filed with the department? every (12) ~~six~~ months on a form prescribed by the department.

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

(1) the mother's name and address;

(2) the mother's date of birth;

(3) the mother's gravidity and parity;

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

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

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

(7) APGAR administered to infant;

(8) immediate postpartum progress of mother and infant;

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

~~(10) other information required by the department~~.

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

((1) ensure that if reasonably possible before the onset of labor the mother has received a general physical examination by a physician or a nurse midwife;?)

(2) recommend that the mother be transferred to the care of

a physician if a medical emergency is indicated; and

(3) have transportation reasonably available during labor and delivery to transfer the mother to a hospital or physician if a medical emergency requires it.

Sec. 08.69.140. POSSESSION OF DRUGS. A licensed midwife may possess and administer in accordance with a prescription from a consulting (pharmacist) ~~physician~~ agents used to stop maternal hemorrhage, oxygen, and antibiotic eye drops.

Sec. 08.69.150. MIDWIFE APPRENTICESHIP. (a) A person may complete a midwifery apprenticeship by observing and assisting in the management and care of the mother and infant in at least (20) ~~30~~ births. In the course of (10) ~~20~~ of those births, the apprentice must assume primary responsibility, under the supervision and observation of the sponsor, for the prenatal, intrapartal, and postpartal management and care of the mother and child. (A person undertaking a midwifery apprenticeship shall register with the department? at the beginning of the apprenticeship.?)

(b) A midwife apprenticeship must be under the immediate supervision of a sponsor. A sponsor may not supervise more than three apprentice midwives simultaneously. The sponsor shall secure the compliance of the apprentice midwife with this chapter.

Sec. 08.69.160. DEFINITIONS. In this chapter

(1) "department"? means the Department of Commerce and Economic Development;

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

(3) "normal childbirth" means a normal physiological state of health in which the expectant mother is in a stable condition with-

Suggested Revisions for House Bill No. 11

by Kathleen Stier
Box 1136
Homer, Ak 99603
235-7654

KEY
pg ... page
(#) ... line number on pg
—— ... eliminate
( ) ... change
? ... question
^ ... addition

Sec. 1

pg 1 (13) this is demeaning to the present practioner, those who may choose not to be licenced and anyone not qualified due to low birth attendance.

Sec. 08.69.010

(22-23) who will make up the board in the Dept of Commerce and Economic Developement. All other health care occupations are self-regulatory. The board should be made up mainly of licenced lay midwives; parents and an unlicence lay midwife should also be included. Physicians, nurse midwives etc should only serve as advisor to the board.

Sec. 08.69.030

pg. 2 (2) refer to pg 1 (22-23) 08.69.010

(3-5) this needs to be clarified to ensure these test will indeed be given and how often.

(6) 5 year period would cut red tape and costs. Also many practitioners are having babies themselves. What about illnesses, accidents and schooling? 5 years would give time off plus time to qualify.

pg 2 (11-14) Include this in informed consent because this should be parents option as to whether or not they choose to be statistics, citizens privacy must be protected! refer to pg 6 Sec. 08.69.100 (11-14)

(18-22) Time limits and 30 births is alot for those practicing in sparcely populated areas. This could mean many if not several years to qualify for licence. or limits licence midwives to more populated areas, thus neglecting areas that would most benefit from them.
"as a midwife" should read "in a responsible capacity" this would be more applicable as not everyone active in birthing is called a midwife.

Sec. 08.69.050
(27) or country would include individuals that may have the needed skills.

Sec. 08.69.060
pg 3 (3) refer Sec 08.69.010 pg.1 (22-23)

^ New born exam needs to be added, without this knowledge the skills of a midwife are incomplete

(20-21) need to include knowledge to handle emergencies if physician isn't available due to distance and weather.

Sec. 08.69.070
pg. 4 (5) 5yrs refer to pg 2 (6)
(13) refer to Sec. 08.69.010 pg.1 (22-23)
(15) other health care occupations are not required to meet a minimum or quota of cases in a set amount of time.

This places emphasis on quantity, not quality, which is not a measure of competency.

pg 4 (16) 50 hours in 5 years or 10 hours per year minimum. Its important in any occupation to have continual education. This will encourage keeping up on new information, learning new skills, encourage enthusiasm, discourage stagnation and ultimately raise competency.

(19) continuing education should also include correspondence courses in our spacious state

Sec 08.64.080 (21) refer to pg 1 (22-23)

(28) do other health related occupations have this type of clause? If not, why not and why is this bill an exception?

pg 5 (1-3) This clause can be a catchall and leaves us on an undefined tightrope. What is intentional or negligent conduct?

(4) refer to Sec 08.64.010 pg 1 (22-23)

Sec 08.64.090

(8) This section again need to include the newborn examination

pg 6 (7-10) This clause is another catchall. There is a need for guidelines but this assumes that the midwife does not have the knowledge or the ability to determine which techniques are needed in particular situations. Other practices experience controversy when determining which medications, agents and techniques to use and this clause would eliminate personal choice. There needs to be more clarity, also allowances for alternative health care techniques (such as herbs, accupuncture, etc.)

Sec 08.69.100

pg 6 (11~~9~~) Needs to include lines from pg 2 (11-14) Sec 08.69.030 and pg 7 (26-28) Sec 08.69.130

(11) & (23) refer to Sec 08.69.010 pg 1 (22-23)

Sec. 08.69.110

pg 7 (4-5) This clause and attitude indicates that midwives must justify our ability. It also means dependency on an availble and/or supportive physician which could be a hardship on the mother and midwife.

(7) 12 months is more reasonable and saves paperwork for all. This is also a pettypoint to disqualify one's license.

Sec 08.69.120

(8) refer to Sec 08.69.010 pg 1 (22-23)

(8-22) What if our practice and philosophy is for the parents to keep their records, can this be included as an exception. refer to 08.69.030 pg 2 (11-14)

(19) or other approved infant evaluation

(23) must be defined! It can be a catchall.

Sec 08.69.130

(26-28) Again indicates incompetency in midwifery skills and ability. This should be a parental choice and be included under informed consent form 08.69.100 pg 6 (7-10) This can be an unnecessary burden on the mother and her family due to finances, travel, time, etc.

Sec 08.69.140

pg. 8 (7) pharmacist should be substituted. Medications is their specialty and they know & understand their administration even more thoroughly than a physician. If a physician is not availble or supportive in obtaining these

drugs, then we go without.

Sec 08.69.150

(11) 20 births refer to 08.69.030 pg 2 (18-22)

(12) 10 births " " " " " "

(16) refer to pg 1 (22-23) 08.69.010

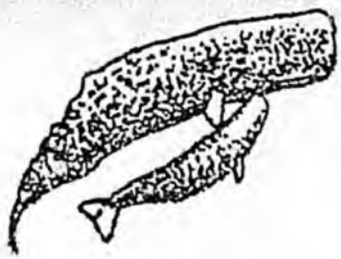
(15-16) A person could have begun their apprenticeship elsewhere or gotten involved in birthing without the intention of becoming a licensed midwife, therefore would not be able to register with the dept prior to apprenticeship Does this mean when they do register that they are starting from scratch?

Sec 08.69.160

(23) refer to 08.69.010 pg 1 (22-23)

pg 9 (4-7) refer to 08.69.080 pg 4 (28)

Nancy -



February 1982

Dear people,

I am writing in concern of HB11 "An Act Relating to Midwifery" I have been active in homebirths in Alaska for 4 years. Through my experience I have gained a knowledge and understanding of what it means to be a lay midwife, what the needs of homebirth parents are, why they choose a lay midwife and what practicing in rural Alaska is like.

In a time of concern over the strength of the American family, I've seen that birth is an issue that effects society fundamently. The past few years have seen many positive changes in the obstectrics in the direction of family-bonding-oriented childbirth and a relatively non-interfering approach. While I applaud the responsiveness of the medical establishment, I would like to point out that the "new childbirth" and resultant benefits to babies and mothers has its roots in the homebirth movement. It has been through the courage and action of parents who chose to bring birth back home to the center of the family that medicine has realized the inadequacy of the highly technological births that the last generation endured.

Assisting these parents at home, where most physicians refused to attend or even support, are a growing number of lay midwives, trained empirically, self taught or privately schooled. The spirit and function of midwives is to ensure that parents have the forethought and knowledge to make good decisions concerning their births. The role of the midwife in pregnancy and birth is that of a teacher,

counselor, nurturer, advisor with heart and hands, she guides and guards the family through the passage of birth.

A midwive is a lover of life. She understands ebb and flow. She has real reverence for the totality of experience. Ultimately, responsibility for birth rest with the parents. It's up to them to be well informed and choose assistants with energy and competence to suit them. Once done, parents take the liability, both physical and emotional, what ever the outcome. They also open doors to unprecedented joy and ecstacy. And by claiming the right to experience the intimate event of birth as they choose, they begin to become strong and sensitive mothers and fathers.

The attitude of the medical establishment is continueing wanting lay midwives to justify themselves. Birth is a physiological function (a non medical event) of women. In a small 5 precent of births, aneed for medical techniques and medicine may arise. When this is recognized by medicine, midwifery, parents and babies will greatly benefit. Until then, it will continue to be a struggle instead of a cooperate goal to improve the outcome of birth. Both lay practice and medicine have alot to learn from each other.

One problem with traditional medicine schooling is the pathology oriented approach, so that ones learns not only to recognize but also to expect complications. This often results in general disreguard for the power of <u>life</u> force, plus infatuation with drugs and instruments.

The question of safety in childbirth is closely related to the mother's comfort and ease with her enviroment and attendants. Grantly Dick-Read, one of the first medical proponents of natural childbirth, discovered that fear (or psychological discomfort) during labor creates pathology. Fear activates the sympathetic nervous system, which stimulates the release of adrenalin and cause blood to flow to the extrem-

ities and away from the uterus. This results in the dangerous condition of "white uterus" which means a reduced supply of blood and oxygen to the baby. Recent research has revealed that fear causes certain hormones to be released which directly inhibit dilation by causing uterine muscular constriction. Women who choose homebirth may not be aware intellectually of this physiology, but they intuit their needs for comfort through simple nesting instinct. Even if the nest ~~[illegible]~~ is nearly isolated from medical facilities.

I do not support this bill as it stands now. The majority of laymidwives would not beable to qualify for license because of numbers and not to competency. This wouldn't stop homebirths. It will discourage homebirth being attended by anyone with midwifery skills and direct connections with any medical system or back up. Therefore jeopardize homebirth as a highly potential poor out come instead of improving it.

Please seriously consider my suggested revisions of HB 11 that I have enclosed.

Most sincerely concerned,

Kathleen Stier
Box 1136
Homer, Alaska 99603

Alaska State Legislature

Senate Committee on State Affairs

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

Official Business

March 3, 1982

Kathleen Stier
Box 1136
Homer, Alaska 99603

Dear Kathleen:

Thank you for your eloquent and compassionate letter regarding midwifery in general and House Bill 11 in particular.

I am enclosing a copy of Senate Bill 747. House Bill 11 has been replaced with a Sponsor Substitute identical to SB 747. I believe this legislation addresses the concerns expressed in your letter.

The complexity and awkwardness of the bill you sent resulted from attempts to assure midwives were not regulated by the medical or nursing board and to avoid establishing a costly new regulatory body.

I was asked to introduce SB 747 by midwives and consumers after HB 11 sponsors became convinced a self-regulating board of midwifery was the only reasonable way to go under current practice and law.

HB 11 will be heard before the House Finance Committee tommorrow. When it passes it goes to the floor of the House for a full vote. SB 747 will be scheduled before the Senate HESS Committee, chaired by Senator Charlie Parr, within the month.

The money needed to establish and operate the board will be a major stumbling block for this legislation. The first controversy will be over dollars. The next will be, of course, hostility of other health care providers towards lay or empirical midwives.

I would appreciate it greatly if you would send your comments on this legislation and solicit input from your acquaintenances and clients. I am working closely with Representatives Vaska and Rogers and will share any information or correspondence with them.

Thanks again and please keep in touch.

Best regards,

Vic

Senator Vic Fischer

cc: Representative Vaska
Representative Rogers
Senator Parr

Enclosure

March 12, 1982

747

Dear Mr. Parr,

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

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

Sincerely,
Ann Reising RN
276-8926
2936 Timberlie Ct, Anch 99504

CC: Nancy

PAUL L. ENEBOE, M.D.
A PROFESSIONAL CORPORATION
P.O. BOX 194
HOMER, ALASKA 99603
TELEPHONE 235-8586

March 12, 1982

Senator Vic Fischer, Chairman
Senate Committee on State Affairs
Pouch V
Juneau, AK 99811

Dear Senator Fischer:

Thank you for your letter of March 3, concerning lay midwives. I appreciate the time you have taken, and the thought provoking questions and points you have raised.

Regarding the question of the infant death in our community. It is my contention that in all probability this death would not have occurred had the birth and infant care been attended by a physician or Certified Nurse-Midwife rather than a relatively untrained and unskilled "lay" person. It is my point that this death was preventable. The Coroner's Jury has ruled that the death was natural causes, and assigned no blame. I understand, at this time, that the issue is under consideration by the District Attorney's Office. Whether they will choose to pursue it further, I do not know.

Regarding your question as to "If the infant had died in the hospital under the care of a physician would criminal charges have been filed?". This is a very interesting point. It is rare, indeed, that criminal law reaches into the hospital, usually only after repeated, rather gross violations. However, it is highly likely that had such a death occurred at the hands of a physician and in the hospital, individual litigation would occur. Also, in such an instance, a physician usually receives reprimand or disciplinary action by the hospital medical staff; particularly if he were to have handled an obstetrical case as this one appears to have been.

As you point out, the crux of the lay midwife issue is really home births. You have rightly observed that there is a significant demand for home births, and that for the most part this demand has not been met by the medical profession. You may be interested to know that I have been rather quietly doing home births for most of my medical career, not always by choice. First, as a Public Health Service Physician in Bethel during the mid 1960's, I was frequently on field trips to isolated villages on the Bering Sea and the Yukon-Kuskokwim delta. Many times during these trips I did deliveries, often under quite primitive conditions.

When I opened my practice in Homer, in 1968, I occasionally would be called to a cabin or an isolated fishing site to do, or help with, a delivery. Over the years I have had occasion to do deliveries in cabins, a fishing boat, an airplane, a winnebago, and a pick-up truck.

Initially my home delivery experience was attending emergency births in unexpected situations. However, the last few years I have done between one and four planned home births a year on carefully selected low-risk patients. I have never lost an infant in home delivery, nor have I had an untold event or seriously distressed infant. I attribute this somewhat to good luck, but mostly to careful preparation and unrepentant cowardice on my part. I insist that any home birth I attend immediately move to the hospital with the slightest sign of complication; and that I will only do a home birth when there are no known risk factors. For every home birth I do, I decline at least two others because I feel the risk is too great.

I feel that home deliveries can be safe. I can attest that a home birth is one of the most enchanting and rewarding of medical and human experiences. They also tend to be quite fattening, in that it is a rare home birth, indeed, that is not accompanied by an inordinate amount of goodies to sustain the physician and his accomplices along the way. I like home births, and hope to keep on doing them.

Although I have been willing to do home births on selected people, I by no means do the majority of home births in our area. Most are done by a variety of lay midwives of different skills. Some of whom I respect more than others, and none of whom I feel are really safe.

In 1975, after a series of home birth tragedies at the hands of lay attendants, I surveyed the obstetrical experience in the Homer Recording District with the help of our local recorder. At that time we found there had been 77 home deliveries in the previous 5 years, and 11 infant deaths were recorded from among those 77 home deliveries. This is an infant mortality rate of 15%, more than 10 times that of the hospital delivery experience.

While I feel that home births can be a very wonderful experience, and that safe home births can be done in Alaska, I feel very strongly that there is no place for lay midwives in a home birth program. I feel they are dangerous dilettantes, who cause great harm. Lay midwives are filling a need in this state; but they are doing so at great risk to the mother, and an even greater risk to her child.

People have the right to seek health care as they would, free from interference from any person or agency. It is one thing when a consenting adult decides on a course of action which may be hazardous to his health and well-being. It is another matter when an infant, who has no say and no defense, is placed in

jeopardy. No legislation should ever be enacted to force someone to seek medical attention, or to force a person into a situation against their will. Yet, I am bothered by the infant. Who speaks for him, or should anyone? Where do the rights of an infant lie? Do parents have the right to hazard their unborn child's life and well-being? Where is the line between emotional needs of the parents and the physical needs of the child?

Someone has to speak to the protection of the infant and its well-being. It would seem to me that that someone has to be the state. That being the case, I do not think that the state should sanction well-meaning, but unskilled amateurs in the practice of obstetrics. If there is such a demand for home deliveries that the legislature feels called upon to address this, the need should be met by encouraging home delivery services under the auspices of physicians and Certified Nurse-Midwives.

It is unfortunate that the medical profession has not responded to the legitimate and clearly spoken desires of parents wishing home deliveries. Physicians respond slowly to consumer demand, and for the most part have turned a deaf ear to these young families. Why this is so, is easy to understand. Home deliveries are time consuming. They take a busy, and often over committed physician away from his practice, and from the hospital. To be done safely home deliveries require a tremendous commitment, careful planning and preparation, and a rather extensive amount of equipment. Also there is fear of chastisement and criticism by colleagues, loss of insurance, the threat of malpractice, and reprimand by the state. These are potent weapons, indeed, and enforce conformity very effectively. Physicians in private practice are not great innovaters, particularly so in this day and age. I have been able to do home deliveries, and to step a bit out of the norm, because I have practiced in a rural community; and was fortunate enough to have some excellent teachers. Namely, a few patients who were tough enough, and mean enough; and who wouldn't let me say no.

In summary, I urge the defeat of Senate Bill 747 establishing the licensing and recognition of lay midwives. Do not dignify well-meaning amateurs who hazard mother and infant into a profession. I encourage you to support some type of exploration regarding the ligitimate needs of those who wish a home delivery, and urge you to encourage and endorse the establishing of home delivery services under the auspices of interested, skilled, physicians and Certified Nurse-Midwives.

Thank you very much for your time and efforts.

Yours,

Paul Eneboe, M.D.
Homer, Alaska

PLE:vls

David and Penelope Schneider
Box 424
Homer, Alaska 99603

March 17, 1982

Dear Senator Vic Fischer,

In reference to Senate Bill 747 "An Act Relating to Midwifery" we, David and Penelope Schneider, would like to encourage you to support its passage. We feel this proposal is a progressive step in giving parents responsibility of their health care in the natural birth process. We also feel our supportive position of this act reflects the wants and needs of our peers in Homer and in many communities around Alaska and the United States as well.

Our personal experience as parents of two children born in Alaska, one child in the hospital with a medical doctor and the second in our home with a lay midwife, has made us see the need for having midwives available in all communities for those of us who choose to care for ourselves with the assistance of these fine ladies. The quality of care in terms of education, intimacy and the allowance of the natural birth process is uncomparable for we who relate to life in this gentle way.

The provisions in the bill for the "Board of Midwifery" for maintaining competent midwives is adequate and receives our support for any tax dollars needed.

The issue is essentially this: we people who want home births will have them; we want to be legal and have our lay midwives in attendance. It is our right. It is fact that the "professionals" have the money and power to loby against this bill, it is in their financial interest.

Please accept our most sincere support in Senate Bill 747 and allow our lives to be enriched in its beginnings.

Sincerely,

David M Schneider
Penelope Schneider

American Academy of Pediatrics

Alaska Chapter

Chairman
Marian T. Witt, M.D.
3300 Providence Drive
Anchorage, 99504
907/279-6461

March 10, 1982

Health, Education & Social Services Committee
State Legislature

Dear Sirs:

The Alaska Chapter of the Academy of Pediatrics feels obligated to comment on Senate Bill #747, an Act entitled, " An Act Relating to Midwifery". In this Act, there is an apparent attempt to license midwives, however, in reading the Act, it becomes clear that it is also the attempt to license "lay" midwives. That is, this Act would legitimize the attendance of birth by people who have had no formal medical training, which is quite clear when the requirements which this Act would establish for licensure are reviewed.

The Health, Education & Social Services Committee should be aware of several factors which are important considering a bill such as this. The impetus for such licensure seems clearly related to the increasing popularity of home births. Although, programs for home birth have been established in other areas of the country and also in the world, these programs are always coordinated with the established medical services in the area. First of all, well trained, licensed medical professionals (either physicians or certified midwives) are in attendance at these births and secondly, there is a good cooperative system established with the hospitals and ambulance services in the area to insure that unexpected complications can be quickly and adequately handled. In Alaska, neither of these conditions exist. This is not to say that sometime in the future, a more favorable environment for considering home births might not exist, but this is certainly not the case today.

The Alaska Chapter of the Academy of Pediatrics strongly urges you to reject further consideration of this Act which we feel would be contrary to the interests of newborn infants and children in Alaska.

Sincerely,

Marian Witt M.D.

Marian Witt, M.D.

MW/sgw

PAUL L. ENEBOE, M.D.
A PROFESSIONAL CORPORATION
P.O. BOX 194
HOMER, ALASKA 99603
TELEPHONE 235-8586

March 2, 1982

Senator Vic Fischer
Alaska State Senate
Juneau, Alaska 99811

Dear Senator Fischer:

Greetings from Homer!

It has recently come to my attention that you are sponsoring Senate Bill 747 to regulate and license lay midwives. I am a Certified Nurse-Midwife, licensed in Alaska to provide midwifery care. I am opposed to a bill which creates and regulates a new level of health care provider when there already exists an avenue for licensure as a professional Midwife in this state.

Nurse-Midwives have been working in the U.S. since 1925, and are presently active in hospital, birth center and home deliveries throughout the country. The American College of Nurse-Midwives, our professional organization, has carefully developed core competencies in education, safe standards of maternal and newborn care, and guidelines for practice.

I realize it is frustrating for consumers (families) to locate birth attendants who support alternatives in birth settings. I do support and offer my clients home birth as a reasonable alternative, but cannot support unqualified and unsupervised attendants. As an advanced Nurse practioner functioning as a Nurse-Midwife, I must provide evidence of: 1. Licensure as an R.N. in Alaska, 2. Graduation from an accredited 1 - 2 year advanced clinical and academic program, 3. Statement of a collaborative relationship with a physician and outline of scope of practice, approved by the Board of Nursing. These are stringent requirements for licensure, as they should be to assure the public of minimal standards of education of and care by Midwives.

In summary, it would be redundant to regulate different levels of Midwives; and I suggest that aspiring Midwives seek training in Nurse-Midwifery. I look forward to working with professional Midwives to offer safe alternatives in childbirth in a responsible manner. Our mothers and babies deserve the best. Let us not legislate less than that.

Yours,

Mary Lou Kelsey, CNM

Mary Lou Kelsey, Certified Nurse-Midwife

MLK:vs

Cathie Henderson - Sitka

Table Two
SUMMARY OF RESULTS OF MATCHED POPULATION STUDY
OF PLANNED HOSPITAL BIRTH WITH HOME BIRTH*

Matching Criteria:

- From a large pool of thousands of hospital and home births, 1046 hospital births were matched with 1046 home births for maternal age, parity, socioeconomic status, education, and risk factors.
- The home birth data are for all couples planning a home birth, including those who were eventually transferred to a hospital because of complications in labor.
- Most couples in both groups had taken childbirth classes.

Birth Attendants:

- In the hospital group, 75% were attended by obstetricians, 25% by family physicians. There were no midwife-attended births.
- In the home group, 62% were attended by family physicians, 36% by lay midwives, and 2% by nurse-midwives. There were no births at home attended by board certified obstetricians.

Length of Labor:

- Overall length of labor at home was longer.
- First stages of labor (for para 0-1) were 1.5 times longer (12 hours compared to 8 for hospital).
- Second stages were 1.7 times longer (72 minutes vs. an average of 43 for hospital).
- Third stage, expulsion of placenta, averaged 1.2 times faster in hospital (21 minutes for home, 5 minutes for hospital).
- These differences are explained in terms of the customary hospital procedures that hasten labor (oxytocin, amniotomy, forceps, fundal pressure and traction in 3rd stage, etc.) whereas at home, labor was customarily allowed to progress at its own natural pace without such interventions. The very poor outcomes of the home birth group would suggest that the philosophy of hospital obstetrics to rush and shorten labors is not in the best interest of safety.

Neonatal Outcomes:

- In the hospital, 3.7 times as many babies required resuscitation.
- Infection rates of newborns were 4 times higher in the hospital.
- There was 2.5 times as many cases of meconium aspiration pneumonia in the hospital group.
- There were 6 cases of neonatal hungwater syndrome in the hospital and none at home.
- There were 30 birth injuries (mostly due to forceps) in the hospital group and none at home.
- The incidence of respiratory distress among newborns was 17 times greater in the hospital than at the home.
- While neonatal and perinatal death rates were statistically the same for both groups, Apgar scores (a measure of physical well-being of the neonate) were significantly worse in the hospital.

Table Two Cont'd

Complications of Labor:

- In the hospital there was 6 times more fetal distress.
- 5 times more instances of maternal high blood pressure.
- 3.5 times more meconium staining.
- 8 times more shoulder dystocia.
- 3 times more postpartum maternal hemorrhages.

Procedures Utilized:

- The cesarean rate of the hospital group was triple that of the home group. (2.7% for the couples planning a home birth; 8.2% for those who planned a hospital birth.)†
- There were 22 elective inductions of labor in the hospital group none among the homebirth group.
- In the hospital, there was 2.5 times as much use of oxytocic stimulants during labor while in the third stage, 95% of hospital mothers received such drugs compared to 24% at home.
- Amniotomy (artificially breaking the bag of waters) was much more prevalent in the hospital. In the hospital, there were 5n cases of ruptured membranes without labor and only 6 at home.
- Regarding episiotomies, the rate was 9 times higher in the hospital (87.4% in the hospital compared with 9.8% at home.) This surgical procedure is supposed to reduce the incidence of severe tearing and yet, the hospital rate of 3rd degree tearing was 5.5 times greater, their rate of 4th degree tearing (into the rectum) was 14.6 times higher, and their rate of cervical tearing was 10.7 times higher.
- Less than 5% of the home birth group needed or received analgesia or anesthesia, while such drugs were administered to over 75% of the hospital group. The home group receiving such drugs were those transferred to the hospital during labor.
- Forceps were used only 17 times (1.6%) in the home while the hospital application of these instruments was 21.4 times greater (366 times, or 35% of the deliveries).
- Oxygen was administered to the baby in only 13 cases at home (1.2%) while it was given to the hospital born babies in 93 instances (8.9% of the time). This is over 7 times the use of oxygen for newborns in the hospital as compared to the home.

* The data given in the above table is taken from Mehl, L.E., *Selectable Research on Childbirth Alternatives: What it Tells Us About Hospital Practice*, in Stewart & Stewart, eds., *21st Century Obstetrics Now!*, 2nd edition, Vol. 1, pp. 171-208, NAPSAC International, Marble Hill, 1978.

† The hospital cesarean rate given in this study (8.2%), even though 3 times higher than the rate for home births, is quite low by today's standards. The data for the table above was gathered over the years, 1975-77. In 1968 the U.S. national cesarean rate was 5%. In 1977 it was 12.9%. In 1980 it was 18%-20% and still rising. The rate of 8.2% given above was close to the national average of the time.

Statistics For 1200 Births Managed By The Farm Midwives

October 8, 1970 to July 20, 1980

Total Births	1200	
Single Mothers	175	14.6%
Non-Farm Residents	551	.6%
First-Time Mothers	520	43%
Doctor present at home birth with midwife delivering	48	4%
Doctor deliveries at home, hospital, or Farm Maternity Clinic (FMC)	70	5.8%
Delivered at home	1096	91.3%
Delivered at FMC	49	4.1%
Delivered at hospital, by doctor or midwife	55	4.6%
Vertex presentation	1108	92.3%
Face up presentation	16	1.3%
Brow presentation	3	
Breech Presentation	42	3.5%
Footling Presentation	9	
Tranverse lie presentation	2	
C-Sections	22	1.8%
Forcep deliveries	5	
Birth with anesthesia	24	1.9%
Induced Deliveries	**21**	**1.7%**
Death in utero (Pitocin IV)	4	
Mild pre-eclampsia (snorted pitocin at FMC)	1	
Early rupture of membranes (used pitocin)	4	
Castor oil	12	
Breeches	**42**	**3.5%**
Home	10	
FMC	17	
Hospital	15	
By C-Section	2	
With anesthesia	3	
Without anesthesia	39	
Frank breeches	30	
Footling breeches	9	
Complete breeches	3	
With episiotomy	20	
With tear	6	
Without episiotomy or tear	14	
First-time mothers	24	
Mothers over 30	9	
Average weight breech baby	6 lbs. 9 oz.	
Largest breech baby	8 lbs. 6 oz.	
Premature and breech	6	
External versions breech to vertex	4	
Premature (at least 4 weeks)	**36**	**3%**
Home	21	
Hospital	9	
FMC	6	
Doctor deliveries at home	**15**	**1.3%**
Breech	6	
Prolonged second stage	2	
Twins	2	
Pudental block	1	
Pre-eclampsia, induced	1	
Other[1]	3	
Reasons for transfer to FMC	**49**	**4.1%**
Breech	14	
Suspected breech	1	
Twins	8	
Suspected twins	2	
Suspected premature	9	
Mild pre-eclampsia (induced)	1	
Uterine infection	2	
Premature separation of placenta	1	
Flu	1	
Mother's choice	4	
Fetal stress	1	
Video	1	
Mother anemic	1	
Mother thin	1	
Mother handicapped	1	
Prolonged first stage	1	
Reasons for transfer to hospital	**54**	**4.5%**
Breech	13	
Pre-eclampsia	2	
Abruptio placenta previa	3	
Marginal placenta previa	2	
Cephalo pelvic disproportion	4	
Prolapsed cord	1	
Mother had infection	1	
Mother had previous uterine surgery	1	
Mother had previous C-Section	3	
Mother had previous C-Section baby delivered naturally	2	
Fetal distress	1	
Prolonged second stage	4	
Suspected multiple gestation	1	
Mother had fever in labor	2	
Premature	2	
Death in utero	4	
Anencephalic baby	1	
Failure to progress, with meconium staining	1	
Failure to progress, with premature rupture of membranes	1	
Other[2]	1	
Complications of Pregnancy	**37**	
Polyhydramnios	4	
High-blood pressure	1	
Pre-eclampsia	3	
Endometriosis	1	
Bleeding during pregnancy	2	
Glucose in urine	1	
Anemic, iron therapy did not work	4	
Severe edema	3	
Toxemia	1	
Severe varicose veins	3	
Kidney infection	2	
Incompetent cervix	3	
Uterine infection	1	
Previous uterine surgery	1	
Infection	1	
Placental insufficiency	1	
Hernia	1	
Malnutrition	2	
Parasites in mother, treatment postponed because of pregnancy	2	
Other Maternal Conditions of Pregnancy	**23**	
Congenital epidermolysis bullosa	2	
Congenital epidermolysis bullosa and handicapped	1	

Emotional Instability	3	
Sixteen years or under	3	
Herpes II	10	
Paralytic polio in childhood	1	
Retro-bulbar optic neuritis (blindness during pregnancy)	1	
Double uterus	2	
Maternal Complications of Labor (12 ladies had 2 complications)	66	5.5%
Post-partum infection	39	3.3%
Hemorrhage requiring transfusion	8	
Retained placenta	8	
Subcutaneous pneumothorax	1	
Inverted uterus	1	
Prolapsed uterus	1	
Prolapsed cervix	3	
Severe tear	5	
Torn cervix	1	
Torn artery	2	
Premature separation of placenta	2	
Marginal placenta previa	5	
Abruptio placenta previa	2	
Treated at home	49	
Treated at FMC	4	
Treated at hospital	13	
Injuries to birth canal	0	
Cystoceles	0	
Rectoceles	0	
Maternal Mortality	0	
Meconium Staining	82	
with complications	26	
without complications	56	
Total Perinatal Deaths[3]	16	1.3%[4]
Fetal Deaths	9	.75%
Deaths in utero		
Toxemia	1	
Placental infarcation	1	
Cord accident	2	
Cause unknown	1	
Deaths during labor		
Anencephalic	1	
Prolapsed cord	1	
Premature separation of placenta	1	
Hydrocephalic	1	
Neonatal Deaths	7	.58%
Premature	1	
RDS (premature)	2	
Lethal congenital defects (2 unknown, but probable)	2	
Respiratory failure	1	
Crib death, possible suffocation	1	
Neonatal complications in living babies	27	2.3%
Septicemia	1	
RDS	7	
Hemolytic anemia (ABO incapatability requiring transfusion	1	
Congenital Abnormalities		
supernumery digits	1	
spina bifida	1	
polycystic kidneys	2	
harelip	2	
one outer ear missing	1	
congenital heart abnormality	1	
congenital disease	1	
closed fontenals and sutures	1	
hypoplastic femur	1	
phocomelia	1	
Down's Syndrome	1	
Birth Injuries	2	
broken arm	2	
cephalohematoma	2	
pneumomediosternum	1	
Prolonged Second Stage (3+ hours)	23	
delivered at home	19	
delivered at hospital	4	
Shoulder Dystocia	11	
Biggest baby	11 lbs. 8 oz.	
Smallest living baby	2 lbs. 10½ oz.	
Oldest mother	42	
Youngest mother	16	
Average weight		
boys	7 lbs. 8 oz.	
girls	7 lbs. 4 oz.	
Mother's averge weight gain	25.6 lbs.	
Average age of mothers	25	
Average length of labor		
First-time mothers (for 398)	11 hrs. 6 min.	
1st stage (for 193)	10 hrs. 24 min.	
2nd Stage	56 min.	
3rd Stage	13 min.	
Longest labor	72 hrs.	
Shortest labor	1½ min.	
No tear or episiotomy	597	49.8%
Tear	334	27.8%
1st degree	219	
2nd degree	111	
3rd degree	4	
Episiotomy	337	28%
1st degree	235	
2nd degree	91	
3rd degree	11	
Apgar (recorded for 696 births)		
Apgar of 10-10	322	14%
Apgar of 10 after 5 minutes	538	77%
Apgar of more than 6 at 1 min.	614	88%
Nursing mothers		99%
Ladies who had babies on The Farm and left them	11	
Babies returned by The Farm to parents or relatives	5	
Post partum depression	17	
Births with anesthesia	25	
Births without anesthesia	1175	
Births without continuous fetal monitoring		99.9%
Cerebral Palsy	0	

Footnotes

1. One was our midwife at our Wisconsin Farm. There was no other midwife available. Two Mennonite ladies from our area were delivered by our doctor. Now they are delivered by our midwives.
2. Normal term delivery by midwife. The doctor wanted it done in a hospital because of drugs he had given earlier to stop premature labor.
3. Many hospitals and clinics would not include in their statistics those cases which were transferred to another institution. Of the 1145 babies delivered at home or in the FMC, there were 9 perinatal deaths, a rate of .79% (3 fetal deaths and 6 neonatal deaths, 2 of which were lethal congenital defects.)
4. Perinatal Mortality was calculated as the sum of neonatal deaths (those babies living up to 7 days greater or equal to 500 grams) and the number of fetal deaths (greater than or equal to 500 grams) divided by the sum of live born and fetal deaths.

Ladies of other countries or cultures delivered by Farm Midwives

England	1	Nicaragua	1	Canada	11	Germany	2	Puerto Rico	4	Holland	2	Penabscot Nation	1
Wales	1	Guatemala	1	New Zealand	1	Australia	2	Italy	1	Mozambique	1	Mennonite	8

POSITION PAPER/Department of Health & Social Service

REVISED POSITION PAPER
SENATE BILL NO. 747

"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 tenents 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.

Recommended by: E. S. Rabeau

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

Date: March 24, 1982

Approved by: Helen D. Beirne

Helen D. Beirne, 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. Senate Bill No. 747 (Revised)
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 3/24/82 PREPARED BY David Spence, M.D. 1cc
AGENCY Health & Social Services
PHONE 465-3100

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

11 changes

Original sponsor: Fischer

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 747 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to midwifery."

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

* Section 1. FINDINGS AND INTENT. The legislature recognizes the unique physical and emotional aspects of childbirth, and the need to protect and enhance the religious, cultural, and individual freedoms in the manner, setting, and cost of childbirth. The legislature finds that the traditional and cultural use of midwives continues and that the demand for midwifery service is increasing in Alaska without adequate regulation and licensure. Therefore, the legislature intends that midwifery be regulated in the public interest to assure that users of midwifery services are aware of the competency levels of their health care providers, and that licensing of midwives does not remove from the parents the responsibility for choosing where, when, how, and with whom to deliver their babies.

Sec. 2. AS 08.01.010 is amended by adding a new paragraph to read:

(24) Board of Midwifery.

* Sec. 3. AS 08.03.010(c) is amended by adding a new paragraph to read:

(21) Board of Midwifery (AS 08.69.030) -- June 30, 1987.

* Sec. 4. AS 08 is amended by adding a new chapter to read:

CHAPTER 69. MIDWIFERY.

Sec. 08.69.010. MIDWIFE PRACTICE. (a) A person who practices as a licensed midwife shall obtain a license as provided in this chapter and shall practice midwifery in accordance with this chapter.

(b) Nothing in this section prohibits the practice of midwifery in the state without a license.