ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1542 SHESS SB 747 (#2)

1542

SITKA COMMUNITY HOSPITAL

P. O. Box 500 • Sitka, Alaska 99835 • (907) 747-3241

March 25, 1982

We, the undersigned, are unalterably opposed to SB 747. We strongly endorse the position of the Alaska Nurses' Association and urge you to vote NO on the licensure of lay midwives.

If this bill passes, the state is endorsing and encouraging lay midwifery, and in effect, telling the people of the state of Alaska that the licensed individual is well qualified. Without extensive education and experience requirements and defined standards of practice this piece of legislation only creates a false sence of security for the consumer.

Sheryl Johnson RN Director of Nursing — Sheryl Johnson
Patricia Gomez RN Head Nurse — Patricia Gomez
Suzanne Fitts RN Staff nurse — Suzanne Fitts
[illegible] RN — [illegible]
Peggy Receptor Campbell RN — [illegible]
[illegible] RN [illegible] — [illegible]
Linda K. Cook RN OB Supervisor — Linda K. Cook
Jean M. Young RN — Jean M. Young
[illegible] RN — [illegible]
[illegible] — [illegible]

On next page

cc: Senator Charles Parr, Chairman, Health, Education and Social Services
Senator Terry Stimson
Senator Mike Colletta
Senator Vic Fischer
Senator Tim Kelly
Senator Dick Eliason
Rep. Ben Grussendorf

MSG 82-00016873 PRTY 1 03/26/82 09:56:03 ORIG: LS00 IN= 0004 OUT= 000
FROM: ELAINE TO: SUE
TARGET: LJH2 SUBJ: NAMES ON TELECOPY
PAGE 000

THE TELECOPIED MATERIAL ON "SITKA COMMUNITY HOSPITAL" LETTERHEAD IS SIGNED B

SHERYL JOHNSON, RN, DIRECTOR OF NURSING
PATRICIA GOMEZ, RN, HEAD NURSE
SUSANNE FILTEAU, RN, STAFF NURSE
RICHARD STAKLISTER (?), RN
PEGGY KEEGAN CAMPBELL, RN
JOANNE CLYDE, RN, INSERVICE C.S.C.H.
LINDA K. COOK, RN, O.R. SUPERVISOR
JEAN M. YOUNG, RN
DOROTHY A. DREIER, RN
DONNA HEBBELER, FNP

I WILL XEROX THE MESSAGE AND MAIL TO EACH LEGISLATOR COPIED; HOWEVER, PLEASE
GO AHEAD TO DISTRIBUTE TODAY PER REQUEST OF PEOPLE WHO BROUGHT IN THE MATERIA
THANKS.

(1

Dear Senator Fisher,

As a mother of three small children; who were all born at home; and as an apprenticing midwife, I ask you to support Senate Bill 747 "an Act Relating to Lay midwifery": I feel it adequetly regulates midwifes with a certain standard of care, while providing for freedom of choice, which is the ultimate issue at stake. The only point I wish would be changed is that there has to be a quota of births done to maintain licensure. As my knowledge there is no other health care professional who has to keep doing a certain number of procedures to be able to be licensed. Also the way Alaska's communities are so small and spread out the chances of that many births going on all the time is slim. Another point is ... that the records to be kept by the midwife should be confindential and not open for whoever to see. Other than these points I feel the bill should be passed and I will give it my full support and urge you to give it yours.

Thank-you,

Cristina Lorance

Box 2671
Homer Alaska
99603
March 8, 1982

Dear Mr. Fischer—

As one of your female constituents I am well aware that Senate Bill 747 "An Act Relating to Lay Midwifery" may directly affect me. Should I become pregnant this bill will either limit my options for the birthing process, if defeated, or allow me the freedom of choice, if passed. In the event that I am able to deliver a child I would want to be able to do whatever I think best for my child and myself. Therefore I urge you to vote yes on Senate Bill 747. I consider it a lamentable fact that women today do not have the option of giving birth in a manner that our ancestors have done for most of our history. The importance of this bill is to give women a choice in how they want to manage their delivery and in what kind of environment they wish to welcome their child. I cannot stress enough the importance of women

maintaining their power of choice over such an important and personal matter.

Thank you for your sincere consideration of this matter.

Sincerely,
Joyce Dey

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Senator Fischer,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

Alaska
Nurses
Association

~~528 Gold Street Room~~ 237 E. Third Avenue
~~Juneau Alaska 99801~~ Anchorage, AK 99501

...a constituent of American Nurses' Association

March 18, 1982

The Honorable Vic Fischer, Senator
Member, Committee on Health, Education
and Social Services
Pouch V, MS 3100
Juneau, AK 99811

Dear Senator Fischer:

On behalf of the Alaska Nurses Association I would like to thank you for your support of SB 660 which will fund the Family Centered Birth, Inc. of Juneau. The Alaska Nurses Association heartily endorses this bill.

I hope that you will continue to support this bill when it comes to the floor. I look forward to working with you on health care issues in the future.

Sincerely,

ALASKA NURSES ASSOCIATION

Melinda Law

Melinda Law, RN
President

ML:m

cc: Margaret Crawford

1811 Southern Ave
Fairbanks, Alaska 99701
March 17, 1982

Mr. Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like to write in support of your bill introduced to the Senate S.Bill 747: "An Act relating to Midwifery."

This bill's passing is very important to me not only because of the licensing of midwives but because it is a freedom of choice issue. If we choose to sit idly by the bill wouldn't pass and all women would be forced to have their babies in hospitals. Childbirth is an emotional happening and often spiritual as well — hospitals seem to lack compassion at times in how you or I would prefer a childbirth in these aspects. After all, at Christmas we celebrate a man's birth whose was the lowliest birth of all (— and certainly not the most sanitary!) and He survived it just fine.

I'm just one among many who support this bill. We can't blindly wait for its passage. Thank-you for you work —

Sincerely,

Mrs. Wendy J. Hogan

Box 2906
Homer, Alaska 99603
March 17, 1982

Senator Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sen. Fischer:

I am writing concerning the proposed legislation on midwifery. Specifically, I urge your support of Senate Bill 747.

As a concerned citizen & parent, I believe consumer demand for the service of midwives will continue. To best serve the public, it is essential to establish licensing procedures & stand rds within which midwives would function. I believe Senate Bill 747 provides the most appropriate legislation. If passed, prospective parents would be in a better position to make a wise choice among midwives & other caregivers. Furthermore, it is my opinion that funding should be provided for a peer regulating board to govern the work of midwives.

Thank you for your consideration.

Sincerely,
Carol Hult
CAROL HULT

cc: Charlie Parr
Brian Rogers
Albert Adams
Hugh Malone

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Ms. Baim,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

3-14-82

To Senators Vic Fischer, Charlie Parr, and anyone else involved in the Senate Bill 747 "an act relating to lay midwifery".

We are in favor of having lay midwifery because we feel that expectant parents should have a wide area of sources to choose from when considering how they want to have their children. (Sources ranging from doctors and hospitals, to nurse-midwifes and clinics, to lay midwifes and home births, ect.)

Lay midwifes have been delivering babies successfully for many generations and we feel they have a

right to continue doing so as long as people like us want and need them to deliver our children in the place we feel most comfortable, our homes.

We have had two children. One with doctors, nurses and the hospital; the other at home with the help of a lay midwife. The hospital birth went very well as far as a successful delivery, but there were interruptions from nurses and doctors, other women in labor, some screaming, everyone in a hurry. All this was very disturbing to us and made us feel that the birth of our child

was an impersonal experience for everyone but us. After the delivery our son was taken away from us for a couple hours so he could be cleaned up, etc.

Our home birth was also a successful delivery but with the help of a understanding lay midwife and a well read husband involved. The experience was much more enjoyable. The lights were dim, low classical music, comfortable bed that I was used to, good friends to help and to take pictures, and just an all round relaxed atmosphere.

We were involved in all aspects of the birth and post natal care from cutting the cord to checking apgar score, to cleaning baby up, to nursing our little girl right after birth. It was wonderful.

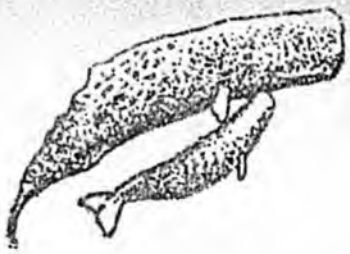
We reading that not all deliverys are without complication, but most potential problems can be detected before the actual birth which would put those people in a high risk category for home births, and lay midwifes that we know will not deliver for anyone who is a high risk. They want what is best for our children too.

We are now expecting our third child and are definitely considering another home birth. We hope that lay-midwifery will still be an option available to us so that we will have that choice if we so choose.

Thank you for listening to our opinions.

Susan L. Connor

+ Charles B. Connor



March 15, 1982

Dear legislature,

I am responding to Senate Bill 747 "An Act Relating to midwifery." I've in the past have sent in my suggested revisions for HB11 and see the changes reflected in SB 747. Although there are points I'm not comfortable with and am unclear about, I feel it's a bill that midwives and families can benefit from..

As a laymidwife, I have met much resistance and little support from the established medical system. I've been criticized for not having costly medical tools (I do not charge), lack of knowledge surrounding medical proceedures and the skills to use them (which if I did perform such a medical proceedure I face practicing medicine without license). Yet, it is these very people who aren't open enough to share and teach these skills and knowledge but make the charges if performed. I've been personally been pressured, blacklisted and verbally threatened to discontinue working with folks who seek me out. These folks do not want to birth with the medical system due to many reasons. Some reasons being cost, frontier spirit, non intervention, control and responsibility in decisions, comfortableness of their home environment, dislike of doctors and/or hospitals, feeling pregnancy and birth is a normal physiological process and not a medical proceedure or just their philosophy. By trying to eliminate laymidwives

will not stop home births. But enlarges the all ready existing gap for communication, screening for problems and medical availability when needed between care givers and families.

This gap could be lessened with this bill and all efforts should at least be made to not enlarge the gap. The established medical system is valuable and has its place, but need it control other forms of workable health care systems and philosophies? Isn't our constitution designed to protect its citizens from such an anarchy?

Because of the choices available for the birth of my next child, we are having to seriously consider leaving our home and state. We are not comfortable with asking a midwife to place herself in a legal vulnerable position, doing the birth by ourselves nor going to the practioners that have been out right hostile to me.

I plea as a mother who has birthed at home, a worker who has worked labor/birth in hospitals, a woman who has been called on to stand by birthing families and a person who sincerely wants to be a credible helping citizen, for you to listen and provide for your people. I urge you to support and pass SB747.

Most Caringly,

Kathleen Stier
Box 1136
Homer, Alaska 99603

March 16, 1982

Dear Vic

Thank you for your letter, it was informative and appreciated. I have been encouraging my friends and clients to voice themselves about SB 747. I will be at the March 25 tele conference. I have some questions about the apprenticeship I hope to have explanned then. Enclosed are some copies of studies I thought you might find helpful. I would appreciate if you would be sure that copies of them get sent to supportive and key persons. Also I enclosed a booklet that I thought you may find interesting, if not, amusing.

I understand the Alaska Hospital Ass. has a lobbiest. How much pull and effect does this have? Do we (who have had to function underground with little or no pay) realistically have a change for the bill to pass against a established organization with $ behind them?

Thanks again, I would appreciate being kept posted. I seem to be the contact for this area and do share the news.

Warmly,

Kathleen Stier

SR A BOX 293 copies memitted
Anch. 9950

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 jeopardize 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 Legislature,

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. Seymore
1433 A Street
Anchorage, Alaska 99501

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:

Victoria Sam 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 alternatives. 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

Box 1
Sutton AK 99674

March 16, 1982

To: Charlie Parr
Chairman of HESS committee
and all other legislatures

I am writing concerning Bill 747 dealing with legalization and certification of midwifery in Alaska.

I feel that it is the parents right to choose if they want a home birth or a hospital birth. I am currently three months pregnant and have chosen to have a home birth, if there are no complications. I have had a very difficult time finding a doctor to give me a prenatal blood test. I have been forced to go to one of the rural communities to obtain this. I feel that this rejection from the Open Door Clinic and some of the Doctors in Anchorage could be detramental to my health, my unborn babies health and the health and well being of other pregnant women who choose to have home births.

I am expressing my concern about this issue and want to make it known that I feel midwifery in Alaska should be legalized.

Sincerely,
Aleta P. Hebbins

note: please distribute copies to Helen Beirne and Mike Beirne

DEAR MR. PARR,
& LEGISLATIVE MEMBERS OF THE SENATE —

3-14-92

I AM WRITING IN SUPPORT OF BILL #747 CONCERNING THE REGULATION OF MIDWIVES HERE IN ALASKA. I AM VERY STRONGLY IN FAVOR OF THE BILL BECAUSE I BELIEVE IN THE OPTION TO CHOOSE A HOMEBIRTH & THUS RECOGNIZE THE NEED TO INSURE COMPETENCY IN THE UNIQUE INSTITUTION OF MIDWIFERY. I BELIEVE THIS CAN BE BEST ACHIEVED THROUGH THIS BILL. I BELIEVE THAT IF THE MIDWIVES HERE IN ANCHORAGE WERE SET UP TO REGULATE THEMSELVES, AS OTHER HEALTH PROFESSIONALS DO, THEY WILL BE ABLE TO SECURE A GREATER SUPPORT FROM THE MEDICAL FIELD, & THUS A GREATER INSURANCE OF SAFETY FOR THE MOTHER & CHILD. MY OPPINIONS ARE BASED ON PERSONAL BELIEFS, A POSSIBLE FUTURE PERSONAL-INTEREST, & ALSO A SEPARATE LOGICAL CONCLUSION. WHETHER HOMEBIRTHS/MIDWIFERY ARE LEGAL/NOT, REGULATED/NOT, RECEIVE A PHYSICIAN'S ACTIVE SUPPORT/NOT, THEY WILL CONTINUE TO EXIST. I BELIEVE THAT IS A FACT & THUS, SEPARATELY FROM MY OWN INTERESTS, BELIEVE THAT HOMEBIRTHING SHOULD BE MADE AS SAFE AS POSSIBLE. THE ONLY WAY TO DO THIS IS THROUGH REGULATION & THE BACKING OF THE MEDICAL FIELD, AND THE PASSING OF THIS BILL WOULD UNLOCK THE DOOR, SO TO SPEAK.

THANK-YOU,
ALLISON JAY

ALLISON JAY
2936 KIMBERLIE CT.
ANCH., AK.
99504

PH: 276-8926

1811 Southern Ave
Fairbanks, Alaska 99701
March 17, 1982

Mr. Charles Parr, Chair - Senate
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like to write to let you know that I support S. Bill 747: An Act relating to Midwifery" introduced by Senator Vic Fischer.

I believe in freedom of choice in how we are to ~~beak~~ our children. And more people are turning to a more natural, homey setting - why should this be refused them? And yet if this bill, which would make sure midwives are licensed before attending births, is not passed it will surely restrict our freedom in this matter.

Please, don't be swayed by hospital lobbyists - many are money hungry, because homebirths are a threat to them, but doesn't freedom of choice - something our country is built on - mean more?

Thank-you for your consideration.

Sincerely,

Mrs. Wendy J. Hogan

1660 Garden
Anchorage, AK 99501
March 20, 1982

Charles Parr
HESS Chairman
Alaska State Legislature
Pouch V
Juneau, AK 99811

RE: Senate Bill 747

Dear Mr. Parr:

I am writing to encourage the senate to pass Bill 747 which concerns the practice of midwifery in Alaska. After reading it carefully, I believe the bill is a good one. It has the potential of becoming a model for other states, on this extremely personal issue of being able to choose one's own birth attendant and to be able to check their qualifications if one chooses a

licensed midwife. It also does not prohibit a woman from choosing someone other than a licensed midwife, i.e., her husband, to attend her labor and delivery.

I thank you for your influence on this matter.

Sincerely,
Jane Lupo

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Senator Parr,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

19 Mar. 82

POBx 101833
Anch, Ak 99511

Senator Charlie Parr and
all legislators
Pouch V
Juneau, Ak 99811

Dear Sir:

I am a Registered Nurse & have worked in a variety of health care areas professionally. One of the problems I have noted in the health care field is that of people from within the system assuming that they know what is best for individuals seeking health related services.

Specifically - I am in support of S.B. 747 Peoples rights to chose birth attendants & birth sites should be protected.

There is a growing number of people choosing home births & other health care options. I feel they should be assured access to whichever services & attendant they chose regardless of their reasons.

Sincerely

Dodie Matchett RN

POUCH V
JUNEAU, ALASKA 99811

MARCH 17, 1982

DEAR CHARLES PARR,

PLEASE SUPPORT SENATE BILL NO. 747 - "AN ACT RELATING TO MIDWIFERY. MY WIFE AND I ARE HAVING OUR 2ND MIDWIFE ASSISTED HOME BIRTH AND ENJOY HAVING THE CHOICE OF BIRTHING PROCEDURES. WE NEED YOUR SUPPORT. THANK YOU FOR YOUR TIME + HELP.

SINCERELY,
MARK LANE
Mark Lane
STAR RT. BOX 520
SEWARD, AK 99664

S. 747

Gary & Carol Galbraith
P.O. Box 827
Cooper Landing, Alaska 99572
907 - 595-1226

3/8/82

Dear Chairman Parr,

I am writing to let you know that I am in full support of the Senate Bill # 747 — An Act Relating to Midwifery.

I believe in the freedom of choice in deciding whether to have a hospital a homebirth, and the licensing of midwives is a crucial stp toward providing the best and safest conditions for many women throughout Alaska.

It is very important that this bill passes, as more and more women, espeically in Alaska, are choosing homebirth (which allows a more personal and fullfilling experience) over a hospital birth involving the use of sometimes needless medication, strict regulations and surgery.

I am speaking from experience, and can only hope that you, as a man, will try to understand my feelings and desires.

The only unsafe factor in the practice of midwifery (which is as old as the human race itself) is when laws prohibit them, and professional people do not support them in their endeavor to make a woman's birthing experience a more positive, family-oriented and meaningful experience.

We need midwives as well as doctors, and the two working together can bring about a more complementary and effident service for the welfare of all concerned. (An excellent example of this is in the Netherlands and other European countries as well, who have a much lower infant mortality rate compared with the U.S.)

I hope you will "hear" what I'm saying and give the Senate Bill #747 your full support.

Sincerely yours,
Carol J. Galbraith

Senator Charlie Parr
HESS Committee
Pouch V
Juneau, Alaska
99811
Senator Charlie Parr and all other Legislators

Sir:

I am in support of SB 747 "An Act Related to Midwifery". I feel that pregnancy and childbirth is a natural physiological process and, in as much, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

Donald Ramsay
Shirley Ramsay

Star Rt 6 HPR
Sitka AK 99835

March 21, 1982

Senator Charlie Parr
HESS Committee
Pouch V
Juneau, Alaska
99811

Senator Charlie Parr and all other Legislators

Sir:

I am in support of SB 747 "An Act Related to Midwifery". I feel that pregnancy and childbirth is a natural physiological process and, in as much, a state of wellness rather than disease. For that reason, I feel that safe birthing alternatives such as midwifery within birthing center and home deliveries be offered as options as well as the hospital settings.

I urge you and other legislators to support passage of this bill, so families might exercise their freedom of choice in matters relating to safe, healthy childbirth.

Sincerely,

Beth Cox (Pres. SAFE-moms)
local napsac
group

BOX 878
SITKA
99835

747

Box 2671
Homer, Alaska 99603
March 13, 1982

Dear Mr. Parr,

As one of your female constituents I am well aware that Senate Bill 747 "An Act Relating to Lay Midwifery" may directly affect me. Should I become pregnant this bill will either limit my options for the birthing process, if defeated, or allow me the freedom of choice if passed. Of course there is always the option of going outside the law, but in the case of complications that would be much too risky for me. In the event that I should be able to deliver a child I would want to be able to do whatever I think best for my child and for myself. Therefore I urge you to vote "Yes" on Senate Bill 747. I consider it a lamentable fact that women today do not have the option of giving birth in a manner that our ancestors have used, and still remain within the law. The importance of this bill is to give women a choice in how they want to

manage their delivery and in what kind of environment they wish to welcome their child. I cannot stress enough the importance of women maintaining their power of choice over such an important and personal matter.

Thank you for your sincere consideration of this matter.

Sincerely,
Joyce Dey

747

CHARLIE PARR & ALL OTHER LEGISLATORS:

My NAME IS CHRIS RUSHING and I PRACTICE AS A LAY MIDWIFE IN ANCHORAGE ALASKA. I AM STRONGLY IN FAVOR of 747. (SENATE BILL) THESE ARE just SOME of my REASONS:

1) IN the North CAROLINA STUDY of 1981 the RESULTS SHOWED THAT UNATTENDED HOMEBIRTHS HAD A HIGHER INFANT MORTALITY RATE THAN BIRTHS ATTENDED BY the LAY MIDWIVES. By MAKING it difficult FOR FOLKS to ATTAIN A SELECTION OF LAY MIDWIVES I believe MORE FOLKS HAVE their BIRTH UNATTENDED BY A SKILLED ATTENDANT. People ARE GOING to CHOOSE HOMEBIRTH EVEN IF they ARE forced to do it themselves. By LICENSING LAY MIDWIVES it IS NOT ENCOURAGING Out of HOSPITAL BIRTHING - the NEED FOR LAY MIDWIVES IS ALREADY THERE - it HAS EXISTED AND PERSISTED FOR CENTURIES IN SPITE of SCORN and RIDICULE.

2) THE definition OF the word "MIDWIFE" IS someone THAT IS "with A woman." Doctors and nurses continuously TRY TO ANALYZE the lay MIDWIFE'S ROLE FROM A medical perspective. CAN they HANDLE this emergency - can they recognize this problem? etc. THE lay MIDWIFE ATTENDS only normal births to give the couple MORAL support, companionship and to supervise the labor in SUCH A WAY THAT ALL minor and MAJOR ABNORMALITIES are recognized or at least suspected as early as possible. THIS does not require A medical BACKGROUND in my OPINION. AS A former registered nurse I can testify to the FACT that A medical BACKGROUND WHERE ONE CONCENTRATES ON WHAT can go WRONG is detrimental WHEN APPROACHING normal CHILDBIRTH AT HOME.

Under the governing BOARD of licensed MIDWIVES, exams can be given to ASCERTAIN the KNOWLEDGE of CANDIDATES in the AREA of normal CHILDBIRTH.

(3)

Licensing will not guarantee competency of lay midwives; the burden of responsibility will still be on the couple to determine the suitability of the individual. The practice of midwifery is not meant to challenge the advances in maternal child health nor intend to eliminate the vital role of the obstetrical specialist. Midwifery is the art of supporting and guiding a family through normal child-birth.

I want to see peoples free choice upheld in childbirth - please support Senate Bill 747

Sincerely

Chris Kesting
1403 E 27th Ave
Anch, AK
99504

SRA BOX 1245
Anchorage AK 99507

Dear Senator Parr,

I hope you will do your best to see that Senate Bill 747 passes.

Midwives who work independently of medical doctors provide valuable and needed services to a growing number of Alaskans. Lay midwives are the only choice at the moment for Alaskans wanting to give birth at home. We need to protect their right to assist at childbirth and help mother and child to be in the best of health. The art of midwifery is regaining popularity after having been displaced by the medical technological management of childbirth. Each may have a very different approach and techniques, but both are needed.

Unfortunately an atmosphere of mutual distrust and lack of cooperation is developing between the medical community and lay midwives. It would be to everyone's benefit if we could reverse this polarizing trend and foster attitudes of respect and willingness to work together in the best interests of the client. Recognizing and regulating independent midwives by means of the liscencing system proposed in Senate Bill 747 is admirably suited to promoting this needed cooperation.

We know Alaskans especially value their independence,

their self relrance and freedom to choose. We are also in recent years experiencing a growing awareness of the need to assume greater individual responsibility for such things as health, and thus to relate to health professionals as resource people rather than authority figures.

We should encourage this consumer responsibility. An offical lisencing system to assist the midwive's prospecive clients in judging thar competence, coupled with independent consumer education and referral programs, makes more sense today than restricting options and allowing the more powerful medical establishment to develop a monopoly of childbirth services, driving the lay midwife underground.

The usual argument of medical doctors against permitting lay midwives to assist at childbirth concerns their competency and the safety of their independent practice. That midwives have an excellent safety record, with or without the supervision of a physician, will be apparent to anyone who studies all the statistical evidence. It is very important, if one values truth and honesty, to be aware of how easily statistics can be manipulated to fit a particular bias, by omission and regrouping of certain measurements. We have some information focussed on Alaska, but plenty more from other states and especially foreign countries demonstrating the superior results of midwifery care for normal childbirth.

Essentially the difference between the midwives and the physician's methods of assistance at childbirth is a matter of attitude. The midwive sees her role as a support person, the M.D. tends to function as manager. Obstetricians can work wonders when health and life threatening situations develop, and midwives work best with healthy mothers. Both can learn from each other. Service improves with cooperation. Medical backup and good professional relations with hospital staff and M.D.'s are important for midwives. Obstetricians would be more efficient when not so overburdened with uncomplicated cases better handled by the midwives.

The issue of safety in childbirth can provoke some heated emotional arguments. All childbirth assistants who have their clients interests at heart are concerned with safety. Is the average obstetrician's view of the dangers of childbirth exaggerated? Medically trained professionals tend to favor strict control (doctors in charge of course) over who may assist at childbirth. How can such an obviously normal function of the human female come to be regarded as a process so fraught with danger that medical management is imperative in all cases? Medicine is a profession intended to help sick people. Medical training focusses on preparation for what <u>might</u> go wrong. Emphasis on control and intervention is a response to the expectation that the birth process is likely

I) to malpractice at any times. This attitude may be quite appropriate to abnormal cases, however, normal childbirth is not necessarily made any safer by this approach. In an atmosphere dominated by fear of what might go wrong, expectations of malfunctioning can become self fulfilling prophecies. Rather than stand by feeling helpless, waiting for the process to break down the temptation is to intervene. "Just in case" and "what if" influence decisions. Then the premature or unneccessary attempts to control the birth create their own problems. On the other hand, although confidence and faith support and enhance the birth process, it would be foolish to ignore danger signals. That is why cooperation, respect and good communication are so important between midwives and the medical professions. It certainly does NOT promote the safety of mother and child if physicians and midwives are afraid or unwilling to work together. Especially when one side or both sides are actively campaigning against the other. When motivated by competitive economic considerations none are likely to have their clients best interests at heart. We have to keep in mind that these are service professions.

Let us work to pass S.B. 747, and hope we are successful in estiblishing this needed cooperation.

Thank you

Sincerely,

Beryl J. Wardlaw

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 Rushing RN
276-8926
2936 Kimberlie Ct, Anch 99504

167

Dear Charles Parr & all other legislatures Mar. 10, 82

This letter is to express my support for SB # 747 & HB #11

I think certification of midwives in this state is a very neccasary move. It will benefit everyone involved... the parent will know who they are getting to help them with their birth because ~~if~~ they will be able to check on their attendant's credentials. The midwife would have credentials, she could get insurance, she could be paid thru clients insurance, she could give better prenatal care with the cooperation of the medical feild. Plus the doctors could stand to learn a few things like compassion & certain techniques that midwives use, that make them so special to so many expectant couples. Please pass these ~~bills~~ bills!

I would really like to see a teleconference happen ~~or~~ for this bill, it would be very beneficial for everyone. Please let me know if & when this is planned.

Thank you for your time

Sincerely,

Cathleen D. Horwitz
2601 Kona Lane
Anchorage, Ak.
99503

(1

Dear Senator Fisher,

As a mother of three small children; who were all born at home; and as an apprenticing midwife, I ask you to support Senate Bill 747 "an Act Relating to Lay midwifery": I feel it adequately regulates midwifes with a certain standard of care, while providing for freedom of choice, which is the ultimate issue at stake. The only point I wish would be changed is that there has to be a quota of births done to maintain licensure. As my knowledge, there is no other health care professional who has to keep doing a certain number of procedures to be able to be licensed. Also the way Alaskas communities are so small and spread out the chances of that many births going on all the time is slim. Another point is that the records to be kept by the midwife should be confindential and not open for whoever to see. Other than these points I feel the Bill should be passed and I will give it my full support and urge you to give it yours.

Thank-you,

Cristine Lorance

Box 2671
Homer Alaska
99603
March 8, 1982

Dear Mr. Fischer—

As one of your female constituents I am well aware that Senate Bill 747 "An Act Relating to Lay Midwifery" may directly affect me. Should I become pregnant this bill will either limit my options for the birthing process, if defeated, or allow me the freedom of choice, if passed. In the event that I am able to deliver a child I would want to be able to do whatever I think best for my child and myself. Therefore I urge you to vote yes on Senate Bill 747. I consider it a lamentable fact that women today do not have the option of giving birth in a manner that our ancestors have done for most of our history. The importance of this bill is to give women a choice in how they want to manage their delivery and in what kind of environment they wish to welcome their child. I cannot stress enough the importance of women

maintaining their power of choice over such an important and personal matter.

Thank you for your sincere consideration of this matter.

Sincerely,
Joyce Day

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Senator Fischer,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

Alaska
Nurses
Association

~~528 Gold Street Room 1~~ 237 E. Third Avenue
~~Juneau, Alaska 99801~~ Anchorage, AK 99501

...a constituent of American Nurses' Association

March 18, 1982

The Honorable Vic Fischer, Senator
Member, Committee on Health, Education
and Social Services
Pouch V, MS 3100
Juneau, AK 99811

Dear Senator Fischer:

On behalf of the Alaska Nurses Association I would like to thank you for your support of SB 660 which will fund the Family Centered Birth, Inc. of Juneau. The Alaska Nurses Association heartily endorses this bill.

I hope that you will continue to support this bill when it comes to the floor. I look forward to working with you on health care issues in the future.

Sincerely,

ALASKA NURSES ASSOCIATION

Melinda Law

Melinda Law, RN
President

ML:m

cc: Margaret Crawford

1811 Southern Ave.
Fairbanks, Alaska 99701
March 17, 1982

Mr. Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sir:

I would like to write in support of your bill introduced to the Senate S.Bill 747: "An Act relating to Midwifery."

This bill's passing is very important to me not only because of the licensing of midwives but because it is a freedom of choice issue. If we choose to sit idly by the bill wouldn't pass and all women would be forced to have their babies in hospitals. Childbirth is an emotional happening and often spiritual as well — hospitals seem to lack compassion at times in how you or I would prefer a childbirth in these aspects. After all, at Christmas we celebrate a Man's birth whose was the lowliest birth of all (— and certainly not the most sanitary!) and He survived it just fine.

I'm just one among many who support this bill. We can't boldly wait for its passage. Thank-you for your work.

Sincerely,

Ms. Wendy J. Hogan

Box 2906
Homer, Alaska 99603
March 17, 1982

Senator Vic Fischer
Pouch V
Juneau, Alaska 99811

Dear Sen. Fischer:

I am writing concerning the proposed legislation on midwifery. Specifically, I urge your support of Senate Bill 747.

As a concerned citizen & parent, I believe consumer demand for the service of midwives will continue. To best serve the public, it is essential to establish licensing procedures & standards within which midwives would function. I believe Senate Bill 747 provides the most appropriate legislation. If passed, prospective parents would be in a better position to make a wise choice among midwives & other caregivers. Furthermore, it is my opinion that funding should be provided for a peer regulating board to govern the work of midwives.

Thank you for your consideration.

Sincerely,
Carol Hulst

cc: Charlie Parr
Brian Rogers
Albert Adams
Hugh Malone

P.O. Box 2792
Dillingham, Alaska 99576
March 18, 1982

Dear Ms. Baim,

I am writing you to voice my support of S.B. No. 747 entitled "An Act Relating to Midwifery". This bill is more definitive towards the needs of both the consumer and the Lay Midwives than H.B. 11 and should replace it. I have been involved in home birth as an apprentice Lay Midwife and have a first hand knowledge of the specific needs of people who want to have their children in a natural environment.

Presently due to existing pressures of the Allopathic medical community, there is a real danger for women who want to deliver at home. This danger lies in the denial of lab work for pregnant women, and the denial of back up support systems at local hospitals for the Lay Midwives who attend these mothers wanting home births. This is happening <u>now</u> in Alaska. There have been many cases, where in emergency situations, both the mother, the father, and the Midwife have met with uncalled for and unnecessary sub-professional treatment by un-ethical medical staffs in hospital emergency rooms. This is due to arrogant egotism based on ignorance.

Statistical studies within the last 10 years of the resurgence of home birth in America have proven that not only are home births safe when attended by a trained Lay Midwife, but preferred in comparison with hospital births. Prior to 40 years ago, most women delivered at home attended by Lay Midwives or

Family Practitioners. Why then is there this sudden shift in thought to make people believe that it is dangerous? Human birth is a natural process, not an illness, and should be centered in the home, and not in the hospital where there are sick people. Today the majority of people in the world are still being born at home.

Since a positive experience of natural home birth has been proven to be of supreme benefit to the whole family, and since the family is the nucleus of a good and healthy society, it is necessary that support of home birth be made available and encouraged in Alaska. Couples who want this experience in life should have the choice made available to them, and have compassionate, supportive and trained attendants. The manner in which a woman chooses to deliver her child must not be dictated by an economically motivated group of practitioners.

Taking into consideration the recent budget cuts involving hospitals (therefore affecting the quality of care provided) and the soaring costs of medical care, it is unjust for pregnant coupled to be forced to accept a hospital birth as the only choice. Here in Alaska, geographically it is unfeasable to assume that the existing medical community can attend pregnant women in remote areas. Various countries in the world in developed nations such as Holland and Denmark, and undeveloped nations such as Latin America have encouraged the training of Lay Midwives for the benefit of pregnant women. Lay Midwifery is encouraged and endorsed by the World Health Organization.

The key is good health care for mother and child. It is my sincere wish that you give S.B. No. 747 your full support for Lay Midwives, birthing couples, and a healthier Alaska.

Sincerely,

Camille Martinez

Camille Martinez

3-14-82

To Senator's Vic Fisher, Charlie Parr, and anyone else involved in the Senate Bill 747 "an act relating to lay midwifery".

We are in favor of having lay midwifery because we feel that expectant parents should have a wide area of sources to choose from when considering how they want to have their children. (Sources ranging from doctors and hospitals, to nurse-midwifes and clinics, to lay midwifes and home births, ect.)

Lay midwifes have been delivering babies successfully for many generations and we feel they have a

Home Delivery and Neonatal Mortality in North Carolina

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

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

(*JAMA* 1980;244:2741-2745)

SUMMARY reports of state vital statistics have traditionally classified births as occurring in-hospital and out-of-hospital. Fetal and infant mortality has also been reported using this differentiation. Being the best that is generally available, such information has been quoted in defending the argument that in-hospital delivery is safer than out-of-hospital delivery. However, with increasing interest in home delivery, the places and circumstances of delivery should be more precisely classified before attributing mortality risks to them. This article provides an analysis of neonatal mortality in North Carolina during 1974 through 1976, with attention given to the places and circumstances that characterized out-of-hospital deliveries.

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

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

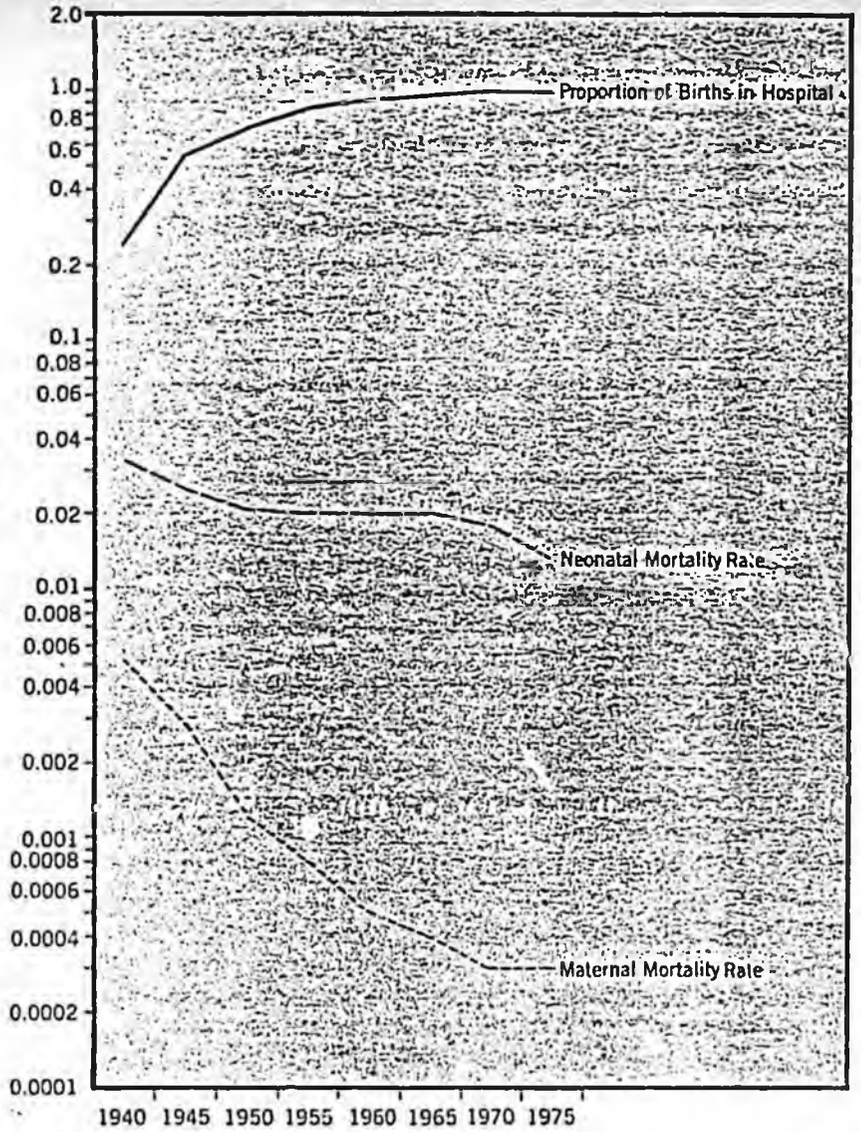
Lay-midwives legally attend home deliveries in some counties of North Carolina. The practice of these lay-midwives is regulated by county health departments: Prenatal care involving physician-supervised screening for risk factors must be provided by the health department for each patient, and every home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

MATERIALS AND METHODS

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

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

Reprint requests to Northeast Health District, 408 N Milledge Ave, Athens, GA 30601 (Dr Burnett).



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

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

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

Emphasis was placed on determining the planning status of those home deliveries that resulted in neonatal death. Misclassification of a small number of these deaths would have had a notable effect on reported neonatal mortality rates. Therefore, these deaths were 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 unintended 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	38	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[3] and later Levy et al[2] 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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STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU ALASKA 99811
907-465-3600

MEMORANDUM April 8, 1982

SUBJECT: Laboratory testing for women planning home births. (SB 747)

TO: Senator Charles H. Parr

FROM: Tamara Brandt Cook
Legislative Counsel TBC

You have asked in general what liability a physician might incur by authorizing laboratory tests for a woman who is planning a home birth, assuming the physician does not render any other medical service to the woman related to the pregnancy or birth.

Under general principals of tort law, a physician would be liable for injuries resulting from the negligent performance of a medical service. Negligent conduct is conduct that violates the actor's duty of care, a duty to act with the amount of care that a reasonably prudent person (in this case, a reasonably prudent physician) would use under similar circumstances. Swenson Trucking and Excavating, Inc. v. Truckweld Equipment Co., 604 P.2d 1113 (Alaska 1980) Among the elements necessary to make out a claim for relief based on negligence is a reasonably close causal connection between the conduct and the resulting injury, that is "proximate cause". Sharp v. Fairbanks North Star Borough, 569 P.2d 178 (Alaska 1977) A causal connection is not deemed to be a legal cause of injury unless it is a substantial factor in bringing about the harm. Ketchikan Gateway Borough v. Saling, 604 P.2d 590 (Alaska 1979)

Applying these principals to the situation posed by your question is difficult since each case of alleged negligence is decided upon the particular facts of that case. Some fact situations that could result in liability on the part of a physician who orders laboratory tests include:

1. failure to order the correct test or all the tests that are necessary;

2. improper interpretation of the test results;

3. if during the process of authorizing the tests the physician examines the patient, failure to discover a condition needing treatment or posing a hazard or, if the condition is discovered, failure to inform the patient of the need for treatment or of the hazard posed.

However, in any fact situation the conduct of the physician must be a proximate cause of the injury before the physician may be held liable. The physician would not be liable for problems experienced during a home birth that are not connected to the service rendered by the physician in authorizing the laboratory tests.

You have asked whether a laboratory must have the authorization of a physician before it may test a medical sample. Nothing in the statutes forbids a laboratory from conducting tests without the authorization of a physician. AS 18.05.040(a)(17) requires the commissioner of health and social services to adopt regulations for the voluntary certification of laboratories that perform diagnostic analyses on specimens from persons "submitted by licensed physicians and nurses for analysis". However, nothing in the statute appears to preclude the laboratory from performing tests on specimens submitted by other persons as well. A certification process for laboratories is established in 7 AAC 27.360, and the regulations contain no requirement that the laboratory only accept samples from physicians. AS 18.15.150 requires any person permitted by law to attend a pregnant woman but not permitted to take a blood sample to have the sample taken by a physician and to submit the sample for testing for syphilis. Since this provision requires a person other than a physician to submit a sample to a laboratory, it would make little sense for the laboratory to be precluded from testing the sample. On the other hand, a private laboratory is not required by law to accept all samples for testing.

I hope this answers your questions. If you have a specific situation in mind, please let me know and I will look into the matter further.

TBC:jdn

STATE OF ARIZONA

DEPARTMENT OF HEALTH SERVICES

ARTICLE 2. LICENSING OF MIDWIFERY

R9-16-200. Reserved

R9-16-201. Minimum qualifications

An application for a license to practice midwifery shall submit:
1. An application on a form prescribed by the Department;
2. Evidence satisfactory to the Director of the Department of Health Services showing successful completion of a course of instruction meeting the requirements of R9-16-203;
3. The initial license fee prescribed by A.R.S.§36-754;
4. A request to undertake the next available qualifying examination to be administered by the Department.

Historical Note

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

R9-16-202. Renewal application

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

Historical Note

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

R9-16-203. Course of instruction

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

1. Information regarding the laws and Regulations concerning midwifery in Arizona;

2. Basic course in aseptic techniques, basic observational skills, recognition and management of emergency situations, and special requirements of home delivery;

3. Clinical courses covering the knowledge and skills necessary for:

a. Provision of care during the antepartum, intrapartum, postpartum and newborn periods, and

b. Management of birth and the immediate care of the mother and newborn infant;

4. Observation of a minimum of ten (10) births;

5. Delivery of a minimum of fifteen (15) women, under direct supervision by a licensed physician, licensed midwife or certified nurse-midwife, and verified by a written statement from the supervisor that competence has been demonstrated.

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

Historical Note

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

R9-16-204. Qualifying examination

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

1. A written examination designed to test knowledge of the subjects required in the course of instruction;

2. An oral examination designed to test clinical judgment in midwifery case management;

3. A practical examination designed to demonstrate the mastery of skills necessary for practice in midwifery, meeting the requirements of R9-16-203.

Historical Note

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

R9-16-205. Responsibilities of the midwife

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

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

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

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

1. Maternal conditions:

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

t. Excessive pain or discomfort during or after labor;
u. Shortness of breath;
v. Seizures;
w. Wishes of the client.
2. Conditions of the infant:
a. Weight less than 2,500 g or 5½ pounds;
b. Congenital anomalies;
c. Apgar score less than 7 at 5 minutes;
d. Respiratory distress;
e. Irregular heartbeat;
f. Signs of immaturity, prematurity, or postmaturity on physical assessment;
g. Jaundice;
h. Abnormal cry;
i. Pale, cyanotic or gray color;
j. Excessive edema.

3. Any other abnormal condition not listed above that might endanger the woman or infant.

D. At the time of delivery the midwife shall:

1. Place two drops of 1 percent silver nitrate solution into each of the infant's eyes (or in lieu of silver nitrate, any other preparation specifically approved by the Director) in accordance with R9-6-115;

2. Inspect the umbilical cord for the appropriate number of vessels and record on the birth record;

3. Inspect the placenta and membranes to note their completeness;

4. Inspect the perineum for laceration.

E. The midwife shall observe both mother and infant for a minimum of two (2) hours following birth.

F. The midwife shall file a birth certificate with the local Registrar within ten (10) days after birth.

G. The midwife shall reevaluate the condition of the mother and infant between 36 and 72 hours of delivery to determine whether physician consultation is required.

H. All equipment used in the practice of midwifery shall be maintained in an aseptically-clean manner and in working order.

I. The midwife shall maintain records of each patient attended and make them available for audit and review as requested by the Director or his staff.

Historical Note

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

R9-16-206. Reports

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

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

Historical Note

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

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

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

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

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

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

5. History of birth injury to either mother or previous child;
6. History of difficult delivery and/or depressed baby at birth.

C. The midwife will not perform any operative procedures other than that of clamping and severing the umbilical cord.

D. The midwife will not use any artificial, forcible or mechanical means to assist birth, nor may the midwife attempt to correct fetal presentations by external or internal version.

E. Except as provided in R9-6-205.D.1. the midwife will not administer any drugs, medications or herbs.

Historical Note

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

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

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

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

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

REASONS FOR ADOPTION:

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

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

GEORGE S. GOLDSTEIN, Ph.D., Secretary
Health and Environment Department
Post Office Box 968
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Health Services Division
725 Saint Michael's Drive
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HED-80-3A(HSD)

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

General Provisions

100. LEGAL BASIS: The regulations set forth herein are promulgated by the Secretary of Health and Environment by authority of 9-7-6(F) NMSA 1978 and 24-1-3(R) NMSA 1978. Administration and enforcement of these regulations is the responsibility of the Health Services Division of the Health and Environment Department. Enforcement is provided by 24-1-21 NMSA 1978.

101. PURPOSE: These regulations establish policies, standards and criteria relating to registration, practice and continuing education of persons who practice lay midwifery. These regulations do not apply to any licensed medical or osteopathic physician or certified nurse midwife.

102. GUIDELINES: In the absence of specific direction in these regulations as to standards of practice or ethics, the Standards of Care of the American College of Obstetricians and Gynecologists and procedures and policies of the Health and Environment Department and Health Services Division are established as guidelines.

103. OTHER LAW AND REGULATIONS: These regulations are subject to the provisions of the Health and Environment Department's Regulations Governing Promulgation of Regulations and Regulations Governing Public Access to Department Records. In addition, department regulations on related subjects include: registration of nurse midwives; prevention of infant blindness; newborn screening for phenylketonuria and other congenital malfunctions; registration of births, deaths and fetal deaths, and control of diseases and conditions of public health significance. Copies of regulations may be obtained by writing to the Health Services Division, Post Office Box 968, Santa Fe, New Mexico 87503. Appeal of an adverse decision of the Division shall be in accordance with the Uniform Licensing Act, 61-1-1 thru 61-1-28 NMSA 1978.

104. DEFINITIONS: As used in these regulations, the following terms shall have the meaning given to them, except where the context clearly requires otherwise:

104.01. "Apprentice permit" means a permit issued by the Division to authorize a person desiring to become a lay midwife and pursuing the required course of study to obtain clinical experience under supervision of a physician, certified nurse midwife or registered lay midwife.

104.02. "Certified nurse midwife" means a graduate nurse licensed to practice in this state who has been certified by the American College of Nurse-Midwives and registered with the Divisic pursuant to the provisions of the Department's Nurse-Midwife Regulations.

104.03. "Contact hour" means a unit of measurement to describe 50-60 minutes of an approved, organized learning experience or two hours of planned and supervised clinical practice which is designed to meet professional educational objectives.

104.04. "Continuing education" means participation in an organized learning experience under responsible sponsorship, capable direction and qualified instruction and approved by the Division for the purpose of meeting requirements for renewal of registration under these regulations.

104.05. "Division" means the Health Services Division of the Health and Environment Department.

104.06. "Lay Midwifery" means the provision of health care services in pregnancy and childbirth by a person not a licensed physician or a certified nurse-midwife.

104.07. "Physician" means a person licensed to practice medicine or osteopathy in this state.

104.08. "Registered lay midwife" means a person who is currently registered and in good standing on the registry of lay midwives maintained by the Division.

104.09. "Registration" means a document issued by the Division identifying a legal privilege and authorization to practice within the scope of these regulations. Registration under these regulations is not transferable.

104.10. "Registration year" means the period from December 31 of any year through December 30 of the following year; initial registration may be issued at any time but shall expire on the following December 30; apprentice permits may expire at any time but no later than the following December 30.

104.11. "Supervision" means the coordination, direction and continued evaluation at first hand of the person in training or engaged in obtaining clinical experience or engaged in direct delivery of lay midwifery services within the scope of these regulations.

APPLICABILITY

200. LIMITATION: Lay midwifery in New Mexico is limited in scope to practice as outlined in these regulations.

201. SCOPE: The lay midwife may provide care to low risk patients determined by physician evaluation and examination to be prospectively normal for pregnancy and childbirth. Such care includes:

201.01. prenatal supervision and counseling;

201.02. preparation for childbirth;

201.03. supervision and care during labor and delivery and care of the mother and the newborn in the immediate postpartum period, so long as progress meets criteria generally accepted as normal.

202. REQUIREMENT OF REGISTRATION: From and after July 1, 1980 no person shall hold him/herself out as a lay midwife or offer, for compensation or otherwise, any services which constitute lay midwifery unless currently registered as a lay midwife under these regulations, or holding a provisional or apprentice permit issued by the Division. Violation of this provision is subject to prosecution or civil action as may be provided by law.

REGISTRATION OF LAY MIDWIVES

300. TYPES OF PERMITS AND FEES: Upon application, meeting requirements and payment of fees, a person subject to these regulations may be issued an apprentice permit, a provisional registration permit, or a regular registration permit, as applicable, in accordance with these regulations. Permits shall be issued without fee through December 31, 1980; thereafter fees, new or renewal, shall be submitted in accordance with the fee schedule prescribed in Section 400. hereof.

301. APPRENTICE PERMIT: An apprentice permit may be issued to any person for a period not to exceed one year and may be renewed once only for an additional one-year period. Education and clinical experience required for regular registration may be obtained during the apprentice period.

302. PROVISIONAL REGISTRATION PERMIT: Upon application a provisional registration permit may be issued to:

302.01. Any person who under former regulations of the Division is currently permitted to engage in lay midwife practice under the supervision of the District Health Officer, or,

302.02. Any person who presents satisfactory evidence of education, training and experience; such person shall submit:

302.02.01. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;

302.02.02. Evidence of satisfactory completion of required clinical experience cited in Section 600.

302.02.03. Evidence of satisfactory completion of a Health Services Division approved course in prenatal nutrition (may be completed during provisional registration period);

302.02.04. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting (may be completed during provisional registration period);

302.02.05. Current physician's statement certifying absence of communicable disease;

302.02.06. Satisfactory reference from a physician, certified nurse midwife or midwifery instructor;

302.02.07. Fee as prescribed by the Division.

302.03. A provisional permit may be issued for a period not to exceed one year and may be renewed once only for an additional one-year period.

302.04. The requirements of section 600 hereof may be met during the provisional registration period.

303. REGISTRATION UNDER REGULAR PERMIT: Upon meeting the requirements of Section 600, a person holding an apprentice or provisional permit may apply for regular registration as a lay midwife and shall submit:

303.01. An application to sit the next qualifying examination;

303.02. Evidence of completion of at least a four year high school course of study or equivalent as determined by the Department;

303.03. Evidence of satisfactory completion of a course in theory of pregnancy and childbirth;

303.04. Evidence of satisfactory completion of required clinical experience;

303.05. Evidence of satisfactory completion of an HSD approved course in prenatal nutrition;

303.06. Evidence of satisfactory completion of a course in prepared childbirth applicable to the home birth setting;

303.07. Evidence of satisfactory completion of a certified course in cardiopulmonary resuscitation of the adult and newborn;

303.08. Current physician's statement certifying absence of communicable disease;

303.09. Four recommendations (one each from a physician or certified nurse midwife, a midwifery instructor, a consumer and a member of the community); and

303.10. Fee as prescribed by the Division.

304. FOREIGN EXPERIENCE: Applicants for registration as a lay midwife who lack the required clinical experience in New Mexico, but who have equivalent experience from another jurisdiction, may apply to sit the qualifying examination after submitting evidence of experience and of all other requirements. Action of the Division on the request may be appealed under the provisions of the Uniform Licensing Act.

305. LIMITATION: Registration as a lay midwife in New Mexico is not to be construed as valid in any other jurisdiction.

306. EXAMINATION REQUIRED: Registration as a lay midwife in New Mexico is by examination only; there is no reciprocity with other jurisdictions.

307. RENEWAL OF REGISTRATION: Every lay midwife registration must be renewed annually. An applicant for renewal of registration shall submit to the Department:

307.01. A renewal application on the form prescribed by the Department;

307.02. Evidence of completion of eight contact hours of continuing education as required by Section 604; and

307.03. Renewal fee as prescribed by the Division.

308. GRACE PERIOD: Delinquency in renewal of registration of 6 months or greater shall result in termination of registration.

309. INACTIVE LIST: Any person registered as a lay midwife in New Mexico who moves from the state may retain registration by fulfilling the requirements previously described. Absence from the State of New Mexico for longer than 10 years shall result in termination of registration.

310. RECERTIFICATION: Any person previously registered as a lay midwife in the State of New Mexico whose registration has been terminated may be recertified as a registered lay midwife by:

310.01. Submitting evidence of eight contact hours of continuing education annually;

310.02. Submitting evidence of being current in practice in another jurisdiction;

310.03. Applying for a lay midwife apprentice permit in order to obtain clinical experience to become current in practice as determined by the Department;

310.04. Sitting any or all portion(s) of the qualifying examination as required by the Department; and

310.05. Submitting renewal fee as prescribed by the Division.

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

400.01. Fee for annual renewal of provisional and regular registration shall be $25.00 a year.

400.02. Examination fee shall be $25.00 and is not included in registration fee.

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

500.01. Dereliction of any duty imposed by law;

500.02. Incompetence;

500.03. Conviction of a felony;

500.04. Practicing while suffering from a contagious or infectious disease;

500.05. Practicing under a false name or alias;

500.06. Violation of any of the standards of practice set forth in Sections 800 and 905;

500.07. Obtaining any fee by fraud or misrepresentation;

500.08. Knowingly employing directly or indirectly any suspended unregistered person or persons not holding an apprentice permit to perform any work covered by these regulations;

500.09. Using or causing or promoting the use of any advertising matter, promotional literature, testimonial, or any other representation however disseminated or published, which is misleading or untruthful.

500.10. Representing that the service or advice of a person licensed to practice medicine will be used or made available when that is not true, or using the words "doctor," "clinic" or similar words, abbreviations or symbols so as to connote the medical profession when such is not the case;

500.11. Permitting another to use his registration;

500.12. Directly or indirectly giving or offer to give, or permitting, or causing to be given money or anything of value to any person who advises another in a professional capacity as an inducement to influence him or have him influence others to use the services of the registration or permit holder, or to influence persons to refrain from seeking services elsewhere; or

500.13. Violating any of the provisions of these regulations.

EDUCATION

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

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

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

		Provisional Requirements	Regular Requirements
600.09.	Special Requirements of home delivery	May be done during provisional registration period	Required at application
600.10.	Information regarding the laws and regulations relating to the practice of midwifery in New Mexico	Required by both the registration levels	

601. LIMITATION: The course of study must not include the independent, medically unsupervised use of any drugs in the antepartum, intrapartum, postpartum or newborn periods except for prophylactic treatment of the eyes; and the course must not contain any training in any surgical procedures other than the procedure for repair of a first or second degree laceration.

602. CLINICAL EXPERIENCE: Clinical experience in lay midwifery may be obtained in any setting (i.e., office, clinic, hospital, maternity center, home). Clinical experience must include at least the following types and numbers of experiences:

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