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In addition to states in which definitive action has been taken, there have been varying degrees of activity in other states--as in Washington--directed toward developing a contemporary policy toward midwifery. In 1979, for example, the Texas legislature passed a bill (H.S. 635) that provided for the training and registration of midwives. The bill, however, was vetoed by the governor.⁶⁰ A bill introduced into the California legislature in 1978 addressed a variety of issues pertaining to professional midwives, including training, licensure, reimbursement, and others. Although the bill (A.B. 1896), as ultimately enacted, made no reference to midwifery, the legislature recommended that training programs be mounted as demonstration projects under an existing authority.⁶¹ At present, the rules and standards governing these projects are proceeding slowly through the state's administrative machinery.

The absence of a recognized and credible professional structure in terms of educational requirements, leadership organization, and governmental recognition has meant that midwifery outside of nursing has come to be viewed in some quarters as not having a part in the health system. Some--particularly within the medical profession--view its appearance as a step backwards to the days of the granny midwives. This negative opinion is further compounded by the issue of home birth, for it is in the home setting that most midwives offer their services. As mentioned in the previous chapter, home birth is an extremely emotional subject. Many are strongly opposed to it despite the mounting body of evidence that it can be a safe option for properly selected cases.

Because there has been little attempt to regulate or otherwise monitor the practice of midwifery outside of nursing, it is impossible to estimate the number of midwives, their backgrounds, or the characteristics of their practice with a high degree of accuracy. As for numbers, the only statement that we

can make at this time with any sense of confidence is that in the U.S. today the number of midwives is at least equal to, and probably greater than, the number of nurse-midwives--that is, one thousand or more.

The characteristics and practice patterns of midwives vary. Some are entirely self-taught, having done little more than attending births periodically (with or without an experienced partner) and reading a book or two on the birth process. These are the real "lay midwives." At the other end of the spectrum are those who have undergone several years of specialized training, including structured theoretical preparation and supervised clinical instruction. Washington's licensed midwives are generally among the latter group. In between lies a variety of backgrounds and skills. Practice patterns also differ. While some midwives conduct their activities completely separated from other established maternity care resources, others have developed working relationships with local providers (physicians, hospitals, and clinics) that enable them to provide a higher standard of care.

As we mentioned at the beginning of this report, it is precisely because of this great variance in preparation and practice that we have rejected the blanket reference of "lay midwife" in describing all midwives other than nurse-midwives. There are many, primarily the self-taught, to whom the term is properly applied. In discussing those who must undergo rigorous training and licensure requirements, however, the term can be misleading, inappropriate, and prejudicial.

In the following chapters, the focus will be on those broad policy issues which the legislature will have to address in reviewing the state's existing midwifery statute.

Chapter III

MIDWIFERY: THE POLICY QUESTIONS

General Perspective

This inquiry was undertaken to assist in the current legislative deliberations over the present state law which recognizes the practice of midwives other than nurse-midwives. It should be stated that our understanding was that the existing statutory authority would be continued in one form or another. This report has been based on that premise.

That midwives can be trained to deliver a high standard of maternity care without the prerequisite of a nursing education has been amply demonstrated over many years in Europe and elsewhere. Moreover it is a reality that has been recognized in the leadership circles of American nurse-midwives.⁶² Regardless of the type of educational preparation, however, the key element is that midwives are accepted by the health community and have ready access to all of the services necessary to the proper care of pregnant women and infants. Otherwise, the standard of service provided by midwives will be less than optimal no matter how excellent their training may be. This point bears special emphasis. In our view, the underlying issues in the current midwifery debate have more to do with psychological acceptance than with the feasibility of establishing a regulatory program that will produce competent midwives.

As stated above, this inquiry was conducted on the assumption that the state would continue to recognize the practice of midwives outside of nursing. Nevertheless, some believe that to do so is neither necessary nor relevant to the maternity needs of the population. Their views are not without merit. The main argument is that the conditions which gave rise to the midwifery statutes of the early 1900s--that is, the paucity

of qualified practitioners and other medical resources--no longer exist. This is undeniably true. Further, in the context of the controversy over obstetrical policies and practices, those who advocate repeal of the 1917 statute state that the health system is responding to the various demands for change. Hospitals are adopting more flexible and permissive policies, for example, birthing rooms, early discharge, family participating, and allowance for natural childbirth. The appearance of birth centers has increased opportunities for out-of-hospital birth. Indeed, the development of nurse-midwifery itself has expanded the choices available to prospective parents both in and outside of hospitals. It can be reasonably argued, therefore, that the established health care system is capable of meeting both the medical and personal needs of most families. To permit the practice of a second category of midwife, some contend, would fragment the delivery of maternity services and confuse the public.

On the other hand, should the existing statute be repealed or midwifery (other than nurse-midwifery) held to be illegal, persons active in the provision of non-traditional birth services may "go underground" and practice outside the law. Such persons would thus be lost to any attempts to ensure an acceptable level of competence. This is a very real concern to public officials in states where there is an active alternative childbirth movement.

The basic issues have to do with public safety and enforcement. As suggested in the discussion of home birth, it is fairly clear that--regardless of state law or medical custom--people will, if they so choose, seek and obtain unconventional birth services. Some fear that, without the regulatory mechanism for midwives, expectant mothers wishing to depart from traditional practices will be at a disadvantage in assessing the qualifications of those offering to assist them. The danger is that such women could fall victim to incompetent or unscrupulous practitioners with potentially disastrous consequences. As shown previously in Table 3 (see p. 15), approximately 20 percent of births occurring outside of hospitals were attended by unlicensed individuals. Had there not been licensed midwives active in this

state, it is probable that this percentage would have been higher.

On the question of enforcement, no matter what stance the legislature ultimately takes on midwifery, the state will never be able to effectively bar the provision of birth services by persons acting outside of the law. This is due to the relative infrequency of life-threatening complications and the fact that birth can take place in the privacy of a home. As one observer of childbirth and the law has noted, "The law is outcome oriented. Unless something goes wrong, the law is not likely to affect anything that people do in our society."⁶³ Moreover, the experience of the alternative childbirth movement suggests that parents who select home birth or non-traditional birth attendants will not bring suit in the event of an undesirable, or even tragic outcome. When prosecution does take place, it appears to be initiated at the urging of the local medical profession.⁵⁴ In view of this inability to effectively police the activities of birth attendants operating outside of the law, some argue that the state--by allowing for the practice of licensed midwives--would provide greater access to properly trained practitioners. The advantage seen here is to reduce the necessity for some parents to seek out individuals with uncertain credentials in order to have a birth experience that cannot be accommodated by the established health system.

In addition to the issues of public safety and enforcement, there are some who would urge the continuation and expansion of midwifery practice on the grounds that it could reduce the costs of maternity care. It is argued that midwives, by reason of their degree of training, income expectations, non-interventionist orientation, and willingness to practice in non-traditional settings, would offer a less costly alternative to hospital-based medical obstetrics. This view, for example, is held in some quarters of the third-party insurance industry in Washington. Others contend that the lower charges of midwives will introduce a competitive force that may exert a moderating influence on physician and hospital charges.

At present, it is not possible to determine clearly the impact of midwifery on the cost of maternity care. In the Seattle area, licensed midwives are currently charging approximately \$500 for complete maternity care. This compared with combined, average physician and hospital charges of around \$1,600 for normal maternity care.⁶⁵ These figures, however, do not tell the whole story. For one thing, a certain proportion of clients handled by midwives will develop complications that require referral to physicians or hospitals, or both, depending on the nature of the condition. The extent of such referrals is not known. Second, if third-party insurance coverage of midwifery services becomes generally available, it is probable that the fees of midwives will rise to some extent, since the incentive to restrain fee increases will be lessened when clients no longer have to bear the full economic costs of care. The product of both these factors will be to lessen the differential between the costs of midwifery services and the costs of maternity care offered by other providers.

Turning to the task of presenting strategies aimed at preserving the practice of midwives other than nurse-midwives, three alternatives may be considered. These are: (1) to take no action, (2) to amend the current statute maintaining its focus independent of nursing, and (3) combine in a single statute the regulatory provisions governing the practice of nurse-midwives and their counterparts outside of nursing.

Maintaining the Current Licensing Authority

There may be some benefit in delaying--for a time--any substantive change in the present licensing authority. There has been, after all, a great deal of activity without the assistance of legislative direction.

The provisions of 18.50 RCW are clearly outdated. Nevertheless, the Department of Licensing appears to have proceeded cautiously and prudently in the development of examinations that reflect modern obstetrical knowledge and standards and in the selection of suitable candidates for licensure. The Department has also secured professional consultation and assistance in various aspects of policy determination. In addition, there has been no evidence of incompetence or harmful practices by midwives licensed under the existing law. Hence, it seems that the existing statute has not presented a threat to public safety, the protection of which is the main purpose of all occupational credentialing provisions.

Apart from the operational aspects of the law itself, there has been movement in other areas that will influence the direction of public policy on midwifery. With varying degrees of success, licensed midwives have attempted to forge lines of communication and establish relationships with other groups with a role in maternity care: physicians, nurse-midwives, hospitals, third-party insurers and others. The Seattle Midwifery School, established in 1978, has been continually assessing and revising its curriculum and admission policies in order to promote high standards of performance among its graduates. The several legislative hearings on the subject of midwifery licensure have broadened the scope of the public debate in Washington. Finally, the actions of other states will no doubt add understanding and insight into an area of social policy in which there has been little precedent in this country.

The main advantage of delaying any specific action is to capitalize on events in this state and elsewhere that will facilitate the development of a public consensus of midwifery independent of nursing. The principal disadvantage of maintaining the current law is that, in a number of important areas, the statute is either vague or altogether silent. This could, under certain circumstances, jeopardize the progress that has been made in administering the law and the prospects for a sensible and credible successor to 18.50 RCW. The various shortcomings of the present law are detailed immediately below in discussing amendments to the statute.

Amending the Law

If the state is to continue to sanction the practice of midwifery independent of nursing, there are several arguments for revising the statute sooner rather than later. That the administration of 18.50 RCW appears to be functioning smoothly is due to the actions of responsible state officials and the voluntary cooperation of licensed midwives, nurse-midwives, physicians, and other concerned individuals. This favorable climate could change at any time as a result of a change in leadership in the Department of Licensing, an election, a legal challenge, or controversy that strains professional relationships. A new midwifery statute would establish responsibilities, procedures, and lines of authority that would be much less vulnerable to such unpredictable events.

In view of the many advances in maternity care since 1917, a desirable consequence of amending 18.50 RCW would be the opportunity to develop a definition of the scope of midwifery practice in keeping with contemporary knowledge and practices.

Revising the midwifery law would focus much needed attention on educational preparation and the standards for midwifery training

programs. These topics are barely dealt with by the current law which specifies only subject areas to be covered by the licensing examination and a fourteen month minimum duration of training.

At present, the Department of Licensing has neither the authority nor the resources to develop standards for training. While the Seattle Midwifery School has sought assistance from many sources in designing its program, it has been operating with no explicit guidelines encompassing the state's minimum expectations. Some believe that the School's current program is deficient in several areas--for example, hospital experience--that are necessary in the preparation of competent practitioners.

Developing a new midwifery statute would address another major weakness of the current law, namely, the absence of a professional body that would monitor administration of the law and the practice of midwifery itself. Common to other professions (e.g., boards of nursing, medical examiners), these statutory bodies can exercise responsibilities in the areas of education, discipline, the granting and renewal of licenses, special investigations, and liaison with other professional boards. Apart from the pooling of knowledge and insight in the performance of specific statutory duties, a major contribution of formally constituted midwifery body would be to lend respect and credibility to the credentialing process, and hence to the midwives themselves. This is particularly important with respect to the institutions and professional groups upon whose cooperation the success of midwifery practice will be in no small way dependent. For example, hospital officials and medical staffs have been reluctant to permit licensed midwives either to attend or simply accompany their clients when hospitalization becomes necessary. They have also been unwilling to commit any resources to the provision of supervised clinical instruction to student midwives. Similar reservations have been expressed by individual physicians, third-

party insurers, nurse-midwives, and others involved in maternity care. This hesitation is indeed understandable given that midwifery outside of nursing is unfamiliar to the health establishment and is lacking in definition, accepted standards of education and practice, and an organized, respected leadership component. Under a new midwifery statute, the establishment of a strong and visible regulatory body that will address the various areas of concern may do much to resolve the doubts and to open channels of communication that would otherwise remain closed.

In sum, the principal advantages of restructuring the present midwifery statute are to ensure the stability and integrity of the administrative process, to add specificity and definition in areas where they are needed, and to establish a credible regulatory authority that will both oversee and guide developments in midwifery in a manner that balances professional and public interests.

A Combined Midwifery Statute

There may be some advantage in considering a statute that provides a unified regulatory structure for both nurse-midwives and midwives outside of the nursing profession. As suggested by the earlier discussion of Europe, where individuals can qualify as professional midwives with and without basic nurse training, the distinction between the two groups may be artificial. Indeed, the term "nurse-midwife" appears unique to this country. The key factor is the level of training and expectations. When individuals can obtain equivalent competence through educational programs built upon nursing or separate from it, and when they are expected to perform the same functions, a single regulatory structure would appear to make sense. It could strengthen the state's oversight capacity in this occupational

category and minimize any confusion among the public as to who is and is not qualified to practice midwifery.

If the state is interested in advancing the practice of midwifery, a single regulatory apparatus may be useful. As mentioned earlier, there appear to be a positive professional relationship and common interests among practicing nurse-midwives and licensed midwives in this state. A combined midwifery statute might further focus and reinforce the efforts of these practitioners and lead to the strengthening of midwifery as a distinct component of maternity care in Washington.

The idea of a combined midwifery statute, however, may be premature at this time, given the current stage of development and acceptance of midwifery outside of nursing. The task of amending the existing law will probably be difficult enough without also attempting to include nurse-midwives under a new statute. Should midwifery, in general, become more firmly established in this state over the next several years, perhaps a combined statute would be more appropriate and feasible.

A New Midwifery Statute: The Critical Elements

Should the legislature decide to revise the current midwifery licensure statute, attention will focus on four key areas. These are the scope of practice (the activities a midwife may legally perform), training requirements, the credentialing process, and the relationship and degree of independence of midwives vis-a-vis other practitioners (the medical profession in particular).

In contemplating the proper public stance on these four parameters, it might be helpful to view the possible policy decisions as falling along a spectrum of minimum to maximum as illustrated in Table 4. Together, these decisions will represent the state's attitude and expectations with respect to midwifery outside of nursing.

Table 4

	<u>Scope of Practice</u>	<u>Educational Requirements</u>	<u>Credentialing Process</u>	<u>Independence</u>
MIN.	Prenatal care	General education	None	Direct supervision
	Intrapartum "			
	Postnatal "		Registration	Indirect supervision Prior approval of patient
	Neonatal care	Comprehensive midwifery training	Certification	Consultation agreement
	Family planning			
	Gynecol. care		Licensure	Refer emergent or complicated cases
MAX.	Other			

While each decision could be viewed separately, the scope of practice will largely determine the others. From the perspective of sound regulatory policy, the task of decision-makers is to match the requirements with the responsibilities. For example, if midwives are to be allowed a full scope of practice, it makes sense to require more rigorous education and credentialing procedures. In this instance, however, the arguments for requiring midwives to work under the direction of other professionals become less compelling. On the other hand, should midwives be restricted to a narrow scope of activities, training and credentialing requirements need not be as demanding. Under these circumstances, there would be a greater need to ensure the input of more highly skilled professionals so that all aspects of care are properly provided for.

The failure to strike a proper balance between responsibilities and requirements can have several consequences. If requirements of the scope of practice are too lenient, midwives may not obtain the knowledge and skills necessary to function according to expected standards of performance. If requirements are too strict, potential candidates may not come forward, or, more importantly, they may decide to ignore the law altogether and operate on their own with little chance of discovery or prosecution. In both cases, the consequences of a poorly

designed regulatory apparatus will fall most heavily on the mothers and babies whose health and well-being are at stake. It is important, therefore, that--whether by statute or by regulation--the decisions regarding midwifery be communicated with as much precision as possible. This will minimize any confusion or controversy that may arise in the administration of a new law.

The following chapters contain a more detailed discussion of the four major decision areas and several other topics relevant to the examination of public policy on midwifery outside of the nursing profession.

Chapter IV

SCOPE OF PRACTICE

The term "scope of practice" refers to the various activities and procedures that a practitioner is legally authorized to perform. Defining this range of activities is perhaps the central element in the area of occupational regulation.

As mentioned in the previous chapter, there is a broad spectrum of possibilities for specifying the scope of midwifery practice. At the minimum, a midwife may be limited to providing emotional support and general assistance during pregnancy and birth. This would be tantamount to legitimizing "lay" midwifery. Moving beyond the minimum, midwifery can be defined broadly to include a wide range of medical and non-medical skills applicable to all stages of childbirth. It can be further extended to encompass certain aspects of basic gynecological and family planning services. This broad view is more in keeping with the European concept of professional midwifery and also the philosophy of American nurse-midwives. In all cases, it should be emphasized again that the proper domain of midwifery is universally thought to be the basically normal, uncomplicated pregnancy.

Discussed below are the various phases of maternal and infant care and within each, the range of activities a midwife may properly perform, assuming a broad or maximum scope of practice (see Table 5, p.53). This comprehensive listing of possible functions and responsibilities can serve as a basis upon which the legislature pursues a definition of midwifery practice that best reflects the needs and conditions in Washington at this time.

The Prenatal Period

The prenatal period refers to the period from conception until the onset of labor. This period is important to the development of the fetus and also includes the preparation of the mother for childbirth and parenting. There is general agreement among obstetrical care providers that consistent prenatal care, averaging 12 visits during a pregnancy, contributes to increased chances of survival of the fetus and consequently to changes in infant mortality rates and to reductions in physical defects and mental retardation exhibited by the infant.

During the prenatal period, the midwife assesses the physical and psychosocial health of the pregnant woman and the likelihood of a normal delivery of a healthy child. Women who belong to various "high risk" categories or who develop complications at any time during pregnancy are referred to specialists for appropriate care and supervision.

The management of the pregnancy during the prenatal period includes the monitoring of weight gain, supervision of diet, and surveillance of physical vital signs and the collection and interpretation of blood and urine samples, monitoring of fetal growth and heart rate and intensive educational preparation of the parents for the labor and birth of the child. Several routine laboratory tests are also recommended during this period.

The information provided through regular testing and periodic physical examination alerts the midwife to changes in the progress of the pregnancy which may require the referral or transfer of a woman to a physician specialist.

The Intrapartum Period

The intrapartum period refers to the period commonly known as labor and birth. During the intrapartum period, the midwife may provide assistance to the woman through three stages: labor,

birth, and delivery of the placenta. The types of assistance during these stages may involve coaching, observation and assessment, intervention and manipulation, and administration of anaesthetic or analgesic medications under proper conditions.

Throughout labor a midwife will monitor the fetal heart rate and fetal position and determine if the fetus is aligned for the easiest, safest passage through the birth canal. During the birth phase, the midwife can perform the physical manipulations necessary to assist the emerging child. If needed, a midwife may also perform and repair an episiotomy--the cutting of the perineum to increase the diameter of the vagina through which the head of the newborn infant must pass. Episiotomies require the use of a local anesthetic for the comfort of the mother. As regards general pain medications (i.e., analgesics) which are widely used in obstetrical practice, midwives usually prefer to manage labor without them, substituting breathing and relaxation techniques for pain-killing medications. Finally, during delivery of the placenta following the birth, the contraction and involution process undergone by the uterus is monitored, and the placenta is examined upon expulsion. If necessary, oxytocic, antihemorrhagic medications may be used to hasten this stage of childbirth and control minor hemorrhaging that can occur.

Throughout these three stages, the midwife assesses deviations from the normal and determines the need for emergency measures and specialty assistance. Given the authority to do so, the midwife can initiate certain emergency procedures to decrease the risk of injury to or loss of life. Such measures may include intubation of the asphyxiated baby, mouth-to-mouth resuscitation, and the administration of oxytocic drugs.

The Postpartum Period

The postpartum period refers to the period following the birth and includes the immediate postpartum period--the first two hours after birth--and the early postnatal period--the first ten days after birth. During the postpartum period, the midwife continues to assess and manage the progress of involution of the uterus begun immediately after childbirth. The importance of early contact between the mother and the child and the father is emphasized in the practice of obstetrics by most midwives and consists of supervising and assisting the bonding process between the child and the mother and the father. Advice is given on nourishment and nurturing of both the mother and child. During the ten days following the birth, instruction is offered to the mother on care of the breasts, breast feeding, self-care, and care of the newborn, including identification of abnormal signs which should be reported to the midwife for evaluation and possible referral.

The Neonatal Period

The neonatal period refers to the newborn's first 28 days of life.

During the first two hours after birth, the midwife provides immediate care and supervision of the newborn. This includes clearing the air passages, evaluating and recording the physical condition of the baby, attending to the umbilical cord, performing eye prophylaxis, determining gestational age and the presence of any physical deformations or anomalies, and obtaining blood samples for routine newborn screening procedures. If necessary, the midwife can respond to emergency needs of the newborn and arrange for transfer of the infant to a specialty care setting.

Family Planning and Routine Gynecological Care

In many parts of the world, the scope of midwifery practice has begun to include the area of family planning. Increasingly, midwives are able to counsel and advise women concerning their reproductive cycle and the options that can be exercised in controlling the timing and number of pregnancies. The gynecological care of the normal woman during her non-pregnant periods is also an area into which midwifery is expanding in some countries. Involved here are routine gynecological examinations and the treatment of minor gynecological problems. Midwives are being trained to assess relevant reproductive medical history, general physical and emotional status, and to offer counseling with respect to contraception. While some midwives are able to fit or insert contraceptive devices, these services are largely rendered by physicians. Lastly, midwives can offer advice and referral to specialists for the management of infertility, sexual dysfunction, or hormonal imbalance problems.

Table 5

SCOPE OF PRACTICE

PRENATAL CARE

Assess relevant historical data regarding the client and her family.
Assess general physical and emotional status of the client.
Diagnose and assess pregnancy and its progress.
Assess the bony pelvis.
Obtain and interpret laboratory/diagnostic test data.
Perform nutritional assessment and provide counseling.
Identify deviations from normal and refer to a specialty physician.
Plan and conduct classes in preparation for childbirth and parenthood.
Counsel the pregnant woman regarding pregnancy and childbirth.

INTRAPARTUM

Assess relevant historical data about client.
Assess general physical and emotional status of client.
Assess status of fetus.
Diagnose and assess labor and its progress through the three stages.
Obtain and interpret laboratory/diagnostic test data.
Provide support/coaching during labor and delivery.
Administer appropriate medications/solutions during labor.
Manage normal spontaneous vaginal delivery.
Assess and manage newborn's adaptation to extrauterine life.
Manage placental expulsion.
Assess and repair birth canal trauma.
Facilitate beginning of maternal/infant/family bonding process.
Identify deviations from normal and institute appropriate emergency measures.

POSTPARTUM

Assess relevant historical data about client.
Assess general physical and emotional status of client.
Obtain and interpret laboratory/diagnostic data.
Assess progress of normal involutinal process throughout the puerperium.
Facilitate maternal/infant/bonding and breast-feeding process.
Provide anticipatory guidance regarding self-care, infant care, family planning, and family relationships.
Identify deviations from normal and institute specific emergency measures.

Table 5
(cont.)

NEONATAL

Assess relevant historical data about maternal and neonatal course.
Assess general physical status of newborn.
Assess gestational age of the newborn.
Assess nutritional status and needs of the newborn.
Obtain and interpret appropriate laboratory/diagnostic data.
Facilitate maternal/infant/family bonding process.
Identify deviations from normal neonatal course and provide appropriate intervention.

FAMILY PLANNING/GYNECOLOGICAL CARE

Assess relevant historical data about client/partner.
Assess general physical and emotional status of client.
Assess female pelvic organs.
Obtain and interpret appropriate laboratory/diagnostic test data.
Assess appropriateness of specific contraceptive method(s) for client.
Counsel for appropriate use of physiological, mechanical, or chemical methods of contraception.
Prescribe, fit, insert appropriate contraceptive agent.
Counsel/refer women/couples with unwanted pregnancies.
Counsel/refer women/couples with potential infertility problems.
Provide basic information on human sexuality including psychosocial aspects, reproductive functioning, and menopause.
Identify problems of sexuality and provide for appropriate follow-up.
Diagnose, manage and/or refer common gynecological problems.

Chapter V

EDUCATION AND TRAINING REQUIREMENTS

As suggested in Chapter III, the standards that are to govern the training of midwives under a new statute will depend upon the scope of practice provided for in the legislation. In addressing the question of standards, and midwifery education generally, mention should be made of several guiding principles endorsed by international professional bodies concerned with maternity care. Where midwifery training is concerned, countries are encouraged:

- to design programs making use of all available resources,
- to relate education and training to the tasks and functions to be performed,
- to legislate for the changing sphere of duties of the midwife, and
- to provide continuing education for all categories of midwives.⁶⁶

It must also be remembered that at issue here is the training of midwives outside of the nursing profession. As discussed earlier, while basic nurse training (i.e., an RN or LPN qualification) need not be a prerequisite for midwifery, there is general agreement that certain nursing skills are indeed important to the practice of a midwife. The relevant nursing instruction could be provided through arrangements whereby nursing schools allow student midwives to participate in only those courses applicable to their training. If this is not possible, the teaching of necessary nursing skills will have to be incorporated into the midwifery program itself. The European experience suggests that either approach is acceptable.

It is not the intent of this chapter to devise or recommend detailed criteria and standards for midwifery training programs. That task is more properly the responsibility of an expert credentialing body that is likely to be constituted under any new midwifery statute (see p.66). Rather, the purpose is to comment in general terms on some of the areas that will be central to the formulation of training requirements for midwives.

Content of Instruction

In one form or another, the following subject areas are usually included in midwifery training programs:

- Anatomy and physiology of the female and the newborn
- Nutrition of the pregnant woman and the newborn
- Basic medical procedures
- Maintenance of medical records and statistics related to birth
- Basic observation and examination skills
- Family planning counseling techniques
- Parent education for prepared childbirth
- Provision of maternal care during the pregnancy and post pregnancy periods
- Management of birth and the immediate care of the mother and newborn
- Pharmacology as applicable to maternal and newborn health
- Recognition of early signs of possible abnormalities
- Recognition and management of emergency situations
- Information regarding the laws and regulations relating to the practice of midwifery in the state issuing the license to practice
- Information regarding newborn screening for phenylketonuria and other congenital birth defects
- Prevention of infant blindness
- Control and reporting of sexually transmitted diseases

The question of how and where the clinical skills may be obtained is important in the design of midwifery training programs. There are several options for the provision of the clinical component of education. It can take place under the direct supervision of a physician, a licensed midwife, or a certified nurse-midwife. Clinical training can be provided in a variety of settings, including hospital obstetrical services, birth centers, clinics, private offices, and private residences.

The number of deliveries required before a candidate is eligible for examination varies between countries and between states. The common standard is between forty and fifty deliveries conducted by the midwife--under supervision.

Continuing Education

Assuring that competency is maintained subsequent to initial qualification is an important goal of any occupational regulatory scheme. Continuing education requirements, in various forms, are widely used among the health professions as a means toward this end.

Since it is one of several mechanisms for promoting proficiency over time, and in view of the controversy over its efficacy, continuing education is dealt with in the next chapter as part of the discussion of continued competence (see p. 73).

Accrediting Educational Programs

Among the established health professions, developing educational standards and approving training programs are usually functions of national professional organizations--the American Medical Association, American Nurses Association, etc.

At present, there is no such organization representing midwives outside of the nursing profession. Nor does it appear

that the state can look to an existing professional body for the purpose of accrediting midwifery training programs. While the American College of Nurse-Midwives might seem a suitable choice, the College, as mentioned earlier, has not yet expressed an interest in assuming such a role. With regard to the medical profession, and particularly the American College of Obstetricians and Gynecologists, physician leaders have been outspoken in their endorsement of nurse-midwifery as the model for midwifery practice in this country. Moreover, the orientation of midwifery, in general, is toward minimal intervention and the normal pregnancy characteristics which set it distinctly apart from the ethos of modern medical obstetrics. It is unlikely, therefore, that organized medicine would possess the balanced and flexible perspective that is appropriate in setting educational standards for midwives independent of nursing.

Under these circumstances, the legislature may wish to include accreditation as a state-based function within the credentialing process established under a new midwifery statute. This approach has been taken by Arizona, New Mexico, and Rhode Island under their newly revised midwifery regulations. There is no reason why the state cannot effectively exercise this responsibility and, as will be discussed in the next chapter, there are some grounds for suggesting the state may be best suited to this task.

Public vs. Private Education

There is also the question of whether the training should be provided in private institutions or as part of a state's higher education or vocational education activities. If it is a state-funded program, should it be lodged in the university system or in the community college system?

Most foreign countries train midwives in two to three year programs at publicly supported schools, which fall under the auspices of either educational or health authorities. At present,

the only school offering midwifery training in the state of Washington is the Seattle Midwifery School, a private, non-profit school registered with the Washington State Commission for Vocational Education.

Because there is little experience in this country with the training of midwives outside of nursing, those charged with the responsibility of devising training standards under a Washington statute will need to approach this task with flexibility and inventiveness. While much can be learned from the educational practices of American nurse-midwives and midwives abroad, standards will have to fit what is possible and practiced in this state at the present time. An "ideal" program can evolve from an initially "adequate" one.

Chapter VI

THE CREDENTIALING PROCESS

In recent years, increasing attention has been focused on the issue of occupational licensure. This is particularly true with respect to the health professions, as increasing specialization has brought forth many new groups claiming recognition and legal sanction from the state. Many have begun to question whether licensure and other credentialing practices primarily serve their intended purpose of protecting the public against incompetence and fraud, or whether their principal effect has been to enhance the economic and professional status of the occupational groups concerned. As a result, federal and state governments are examining new approaches to licensure and other forms of credentialing. The aim is to provide an acceptable level of public protection while avoiding the imposition of artificially high standards that serve only to limit entry into an occupation, career mobility, and economic competition. Policy-makers are beginning to ask whether credentialing is necessary at all, and if so, what form should it take?⁶⁷

A detailed discussion of the ongoing developments in the area of credentialing is beyond the scope of this inquiry. Moreover, the present upsurge of interest in credentialing has to do with the emergence of the many new health-related occupations in recent years--the technicians, technologists, therapists, assistants, and the like. Out of this controversy have come ideas that are relevant to the state's current assessment of its stance toward midwifery outside of nursing. These are included in the discussion below.

Should the state decide to continue to sanction the practice of midwifery independent of nursing, three aspects of the credentialing process will be of principal importance in shaping a

new regulatory program. These are the credentialing mechanism (e.g., licensure, certification, registration, or none at all), the credentialing authority (e.g., an administrative agency, an autonomous professional board), and the provision for continued competency (e.g., reexamination, continuing education, peer review). As with educational requirements, the appropriateness of the credentialing process for midwifery (as for any occupation) depends to a large degree on the scope of practice specified and the potential for harm to the public. In general, the broader the scope of practice, the more rigorous and restrictive should be the credentialing requirements.

The Credentialing Mechanism

The existing statutory provisions under 18.50 RCW require that a license be obtained before a person can practice as, and use the title of, "midwife." In view of current thinking on the subject of occupational credentialing, state policymakers may wish to consider whether licensure is still the most suitable regulatory instrument or whether some other device can adequately serve to protect the public.

Licensure is the mechanism by which government grants permission to engage in an occupation or profession to individuals who have met predetermined standards that should reflect the minimum competence necessary to ensure that the public health, welfare, and safety are reasonably well-protected. To engage in such an occupation or profession without a license is unlawful.⁶⁸ Under typical licensing schemes, licenses are granted to individuals who satisfy requirements set down by a licensing board. These requirements usually deal with examinations, education, and experience. Licensing boards are often dominated by established members of the occupation in question. Entry of new members into a field, therefore, can be effectively controlled

by those already in it. Similarly, the behavior of existing members of an occupation can be influenced by the threat of suspension or revocation of a license.⁶⁹

Limited in the beginning to a few "learned professions" (law and medicine, for example) where the function and activities were mutually exclusive, occupational licensure has now grown to include a wide variety of fields, professional and non-professional alike. Moreover, in some fields, health being a good example, various categories of workers are entitled to perform the same or similar services. In maternity care, physicians, nurse-midwives, licensed midwives, emergency medical personnel, and some others are permitted to assist women during pregnancy and birth. Hence, the exclusivity once implied by the granting of licenses no longer exists in some fields; indeed, it may not be warranted.

There is also the issue of enforcement. The legal sanction, which is the principal distinction between licensure and other forms of credentialing, implies that the state will have the means to take action against those who break the law. If the state is unable to readily identify and prosecute individuals acting outside of the law (i.e., without a license), then licensure loses its meaning and cannot be truly said to protect the public.

In considering whether to maintain licensure as the credentialing mechanism in a future midwifery regulatory program, certain questions arising out of the debate over credentialing new health professions have direct relevance.

The first, and most important, question is in what way will the unregulated practice of midwifery clearly endanger the health and safety of the public, and is the potential for harm easily recognizable and not remote or dependent on tenuous argument?⁷⁰

Harm can be thought of along several dimensions of impairment: physical, mental, social, financial, and intellectual. The potential for harm can be judged in terms of the inherently dangerous nature of the functions of an occupation or the devices or substances used in performing those functions. It may also be associated with the frequent exercise of independent judgment by a practitioner for the purposes of identifying a problem, formulating a plan of care, or rendering services. The potential for harm can be documented by public testimony, research findings, and legal precedents. Generally speaking, the potential for harm can be viewed as remote when the instances of impairment are rare or minor in nature, and when they are due to secondary effects of the practice of the occupation.⁷¹

With respect to midwifery in general, the nature of the harm that could result from the practice of poorly-prepared or incompetent individuals is, in a sense, obvious. In the extreme, it could mean death or serious and lasting injury. Although tragic, mortality is fortunately a rare occurrence in modern times. This is due to the higher standards of living, general levels of education and awareness, the availability and capacity of medical science, and the general commitment to the welfare of mothers and infants on the part of all involved in the provision of maternity care. Apart from death or serious impairment, which are easily recognizable, the poorly managed pregnancy can have harmful consequences that may not be as readily apparent. These may have profound and irreversible effects on long term growth and development of the infant. As greater knowledge is acquired on the effects of birth outcome of smoking, alcohol, nutrition, obstetric medications and practices, and other factors, it is hoped that these more subtle hazards will be more clearly identified and effectively minimized.

From a more formal perspective, the nature of and potential for harm due to poorly controlled midwifery practice is directly

related to the definition of midwifery itself. Again, a critical variable is the state's determination of the scope of practice. If it is defined broadly in keeping with the concept and practice of midwifery as exists in other developed countries, more stringent regulatory provisions are called for. Clearly, if midwives are to perform tests and complex examinations, interpret results, diagnose abnormalities, administer medications, and carry out minor surgical procedures, the consequences of allowing ill-prepared practitioners into the field can be significant. In this case, the state is justified in imposing more formidable regulatory mechanisms.

On the other hand, if midwifery is defined narrowly so that practitioners are limited to doing little more than providing emotional support and "catching the baby," then the arguments for a more restrictive credentialing mechanism become less compelling. In the first place, no great degree of skill and learning is necessary. Second, as will be discussed in Chapter VII, a limited scope of practice would require provision being made for the input of more highly skilled personnel. In this way, the proper management of pregnancy will be assured and the likelihood of serious mishap will be greatly minimized. In this instance, a restrictive mechanism such as licensure does not appear necessary to protect the public interest.

In addition to assessing the likelihood of harm in determining an appropriate regulatory mechanism, a second relevant question is can the public be adequately protected by means other than licensure?⁷² At issue here is the extent of other controls on a practitioner's activities, either formal or circumstantial, that effectively safeguard the public. For example, is there supervision of practitioners by physicians or other more skilled personnel? Are the individuals in question employed primarily in licensed health facilities required to maintain competent staff? Do standards for professional performance exist and are they effectively enforced? Are the applicants for credentialing

graduates of accredited or approved training programs? Do laws exist that effectively govern the devices and substances used in the occupation?⁷³ If these conditions apply--in this case to midwives--then there may be less of a need for more restrictive credentialing requirements.

Should the legislature wish to explore alternatives to licensure, there are two other credentialing mechanisms that are considered credible in the area of professional regulation--namely, certification and registration.

Certification or registration is the process by which a government agency or private organization grants recognition, or certifies that a person has met certain predetermined qualifications specified by that agency or organization. These qualifications may include graduation from an accredited or approved training program, satisfactory performance on a qualifying examination, or completion of a certain amount of work experience. Certification and registration differ only in that there is a general perception that the former is associated with occupations involving higher levels of skills and knowledge, although this need not be the case.

Through the specifications of qualification, certification or registration can easily accommodate occupations requiring high levels of skills and knowledge, and, in practice, they are common credentialing mechanisms among the professions. In the health field, for example, there are many groups that are certified or registered, including nurse-midwives and other specialty nursing personnel, inhalation therapists, dental assistants, medical technologists, and others.

Both of these alternative credentialing mechanisms can be used to demand the same level of competence as under a licensure program. The only difference is that they lack the legal ramifications and enforcement capabilities associated with licensure. Moreover, the legal sanction may no longer be relevant in modern times when the incidence of genuine quackery

in health care is not the concern that it was when licensing laws were first instituted to safeguard the public. Furthermore, when the public expects and the system can provide qualified practitioners, it is reasonable to suggest that it is the education, training, and the shaping of professional ethics instilled by that process that will ensure high standards of practice, and not the remote threat of legal prosecution.

If the legislature decides to adopt a credentialing mechanism for midwifery other than licensure, efforts should be made to ensure that the public understands its meaning. Many are familiar with the concept of licensure but may be hesitant in relating to skilled practitioners acting under new models of authority. This would be particularly important, for example, in the case of the third party insurers, who are accustomed to paying for the services of practitioners acting "within the scope of their license." Steps might have to be taken to see that third party payers understood both the meaning and rationale for different patterns of credentialing, lest they refuse to deal with midwives due to legitimate doubts as to their qualifications and authority.

The Credentialing Authority

Under Washington's existing midwifery statute, the Director of Licensing is responsible for all decisions regarding the operation of the law, the administering of examinations, assessing an applicant's eligibility (including the adequacy of training), disciplinary matters, etc.

At present, there is no statutory provision for the ongoing input of midwives or related professional groups in the administration of 18.50 RCW. As mentioned earlier, the Department has so far been successful in securing professional assistance on an ad hoc basis. Criticism of this loose partnership has been twofold. First, the activities of the professionals involved

have not been highly visible or well understood. Second, there has been some concern about the identity, accountability, and influence of the various individuals involved. Clearly, the matter of professional participation will be an important aspect in framing a new midwifery statute.

In considering how a formal credentialing body might be constituted, the three key elements are its membership, duties, and level of autonomy.

The membership of a credentialing body is crucial to establishing the credibility of the midwifery regulatory process (and midwifery itself) in the minds of the public and the professional community. From the public perspective, the issues are clear. The membership must possess sufficient knowledge of the essentials of sound midwifery practice and maintain a balanced point of view. This latter point has become increasingly significant in recent years. Concern has been mounting that the domination of licensing boards and other credentialing bodies by professional associations and educational interests has resulted in the standards for entry into a field being set at a far higher level than is necessary for the protection of the public. The consequences of this are the restriction of career opportunities and higher costs of services to the public.

The membership of a credentialing body must also reflect professional concerns. Not only must professional participants be competent in their respective areas, they must also have the confidence and trust of the professional community. This is particularly important in the case of midwifery outside of nursing, an area about which there have been much uncertainty, skepticism, and even hostility among professional groups.

In structuring the composition of a credentialing body for midwifery two concepts that have emerged from the debate over occupational regulation are relevant--the inclusion of public members and related occupational groups. In the latter instance,

the goal is a better understanding of relationships among groups that perform the same or similar services, or services that are dependent on the cooperation of others. In both cases, the underlying rationale is to ensure that in the process of exercising credentialing authority, an occupational group does not put its own interest over that of the public.

The participation of public members on official credentialing bodies is a growing trend. In this state, the public is currently represented in the regulation of physicians, nurses, chiropractors, and several other groups. In addition, the midwifery bill considered during the 1980 legislative session made provision for a public member on the professional committee designed to assist in the administration of the law.

The level of public participation is a matter of subjective judgment. While it is common to find one public representative on credentialing bodies, there is no apparent justification for this limitation, and there might be circumstances which would warrant a greater public role. For example, if it were anticipated that a moderating influence would be needed, greater public representation might be desirable.

While it is not nearly as common as public representation, the participation of related occupational groups on credentialing bodies seems clearly appropriate in the case of midwifery. Although midwives should have a strong voice in governing themselves, there are other practitioners--particularly physicians--to whom midwives must relate in the proper conduct of their practice. The value of the multi-disciplinary approach has been recognized by the other states which have recently established regulatory programs for midwifery independent of nursing. In Arizona, New Mexico, and Rhode Island, the credentialing bodies for midwifery include physicians, nurse-midwives, nurses, and other professionals with an interest in maternity care.

With regard to physician participation in the regulation of midwives, obstetricians play a key role. Their expertise is important in making judgments as to normal vs. abnormal obstetrics, that is, the conditions in which midwives should seek specialist services for their clients. Obstetricians can also bring to a midwifery regulatory program information concerning new developments in maternity care that can be beneficial to midwifery practice. Furthermore, as the opinion leaders among the medical community in the area of birth practices, the representation of obstetricians would go far toward establishing the credibility of any new program designed to guide the practice of midwives outside of the nursing profession. Finally, given the probable pattern of midwifery practice (at least in the short run) it would seem desirable that assistance be sought from those physicians--obstetricians or otherwise--who are not philosophically opposed to the notion of out-of-hospital birth.

Of the various duties usually assigned to an occupational credentialing body, the determination of educational requisites and the approval or accreditation of training programs will be the most crucial under a new midwifery statute. This country has not developed a generally accepted model for the training of midwives outside of the nursing profession. The programs that do exist have largely been isolated, individual efforts with a local rather than national focus. While the European experience offers useful guidelines, the United States--and Washington in particular--has unique social, economic, and professional characteristics that will have to be accommodated in any midwifery regulatory scheme.

In the absence of both a general consensus on midwifery and a professional association that could be entrusted to develop reasonable educational standards, the task of approving training programs may rest, as it has elsewhere, with a credentialing body constituted at the direction of the

state. With a carefully selected membership, such a group should be able to design a credible program approval process.

In carrying out the program approval function, and indeed all other regulatory functions, it is important that a credentialing body have the capacity for flexibility in both devising and interpreting standards. Given the innovative nature of regulating the practice of midwifery independent of nursing, it will not be possible to "get it right the first time." Clearly, many factors related to midwifery practice may be evolving for years to come-- societal attitudes, professional relationships, educational and financial resources, practice patterns, and others. The challenge to those with regulatory responsibilities will be to pay careful attention to safety issues and, at the same time, to utilize existing resources and allow for change. It would be unfortunate if a credentialing body moved too far too fast and antagonized those individuals upon whose cooperation successful midwifery practice depends. Similarly, if it were too rigid or idealistic and set unnecessarily restrictive standards, the effect might be that no one would want to seek or, in fact, could obtain credentialing under a new statute. In both cases the ultimate intent of a new midwifery statute, namely, the protection of the public from unqualified birth attendants, would be seriously undermined.

On the question of autonomy, whether a newly constituted midwifery credentialing body should have ultimate decision-making authority or should be advisory to state government depends on the perceived need for public accountability. Autonomous, profession-dominated regulatory bodies have been criticized for allowing professional concerns to overshadow the public interest. As a consequence, much attention has focused on increasing the level of accountability in the credentialing process.

Almost without exception, occupational regulatory boards have been granted autonomous decision-making powers in carrying

out their statutory responsibilities. This pattern ostensibly has its origin in the belief that practitioners, because of their special knowledge and experience, are best suited to the task of defining educational requirements and standards of practice. Professional and non-professional groups alike have come to expect and to value the right to make these decisions free from direct public intervention.

In keeping with accepted patterns of occupational regulation, an autonomous midwifery board could be established to administer a new statute. Under this arrangement, the ability of midwives to pursue their own interests at the expense of the public could be minimized by a board membership that includes members of the public and of functionally-related groups (physicians, nurse-midwives, etc.). Moreover, autonomy is not absolute. Should a midwifery board exceed its authority or fail to fulfill its responsibilities, legislative remedy is available. The principal advantage of an autonomous board, of course, would be to protect the administration of the law and the practice of midwifery from arbitrary action by government or by powerful interest groups via the public process. It could not, however, safeguard against professional politics which can just as effectively thwart the administration of a law and which might be more of an issue, given the likelihood of a multi-disciplinary regulatory body under a new midwifery statute.

Under the present statute, the Director of Licensing is responsible for carrying out the provisions of the law. This line of authority has been maintained in the various legislative proposals that have been put forward to amend the current law. Recognizing the need for professional expertise, the several proposals have called for a professional "advisory" group to assist the Director in those areas where expert judgment is required. It should be mentioned here that Arizona, New Mexico, and Rhode Island have used the advisory committee concept in their recently established midwifery regulatory programs.

The use of a professional advisory group instead of an autonomous credentialing body may have several advantages. Since midwifery outside of nursing is a very controversial topic, granting the ultimate decision-making authority to an administrative agency could serve as a valuable moderating influence should the professional group adopt an extreme position in any direction. Second, given the innovative nature of a new midwifery statute, flexibility will be important during the initial years of its implementation. Placing decision-making power in an administrative agency might allow for more rapid responses to special situations as they occur and safeguard against any undue rigidity in the actions and decisions of the professional group. Finally, an administrative agency is likely to be more responsive than an autonomous body to legislative concerns as to the carrying out of legislative intent.

The major disadvantage of limiting the autonomy of a professional credentialing body is the danger of excessive or inappropriate interference in professional matters by the public official(s) having the ultimate authority. This could occur as a result of personality, ideology, or political pressure from various sources.

Should the legislature wish to use the advisory group approach, however, perhaps the best protection against unwarranted meddling by public officials is the selection of group members who are highly regarded by the professional community, the public, and the legislature. An advisory body of sufficient stature would be less vulnerable to manipulation or intimidation. Under extreme circumstances, the resignation of respected professional and public members would place an administrative authority in a difficult position both in terms of the operation of the regulatory program and accountability to the legislature.

Under an advisory group arrangement, therefore, the selection process should be designed to ensure the choice of highly regarded

individuals. Recent legislative proposals have called for members to be appointed directly by the Director of Licensing-- with no limitation on the Director's discretion. While this may be an adequate process when there are harmonious relationships and general agreement as to the interpretation of statutory provisions (as under the present law), these conditions might not always prevail. One alternative would be for the Director to consider members from nominating lists submitted by each group to be represented on the advisory committee. Another would be for the governor or a legislatively constituted body to consider candidates from lists of preferred individuals. Whatever method is chosen, the goal should be to provide a reasonable balance of power in the administration of a new midwifery statute.

Assuring Continued Competence

While initial credentialing procedures (licensure, certification, etc.) may be adequate to establish minimum standards of competence at the time of entry into a profession, they cannot be taken to guarantee acceptable standards of practice over the course of a practitioner's lifetime. In an era when knowledge is expanding at a rapid pace, there is a danger of professional obsolescence. It is for this reason that a growing number of professional groups and state credentialing bodies have been urging--if not requiring--individuals to demonstrate that they are keeping abreast of developments in their fields. The issue of maintaining competence is particularly significant in health-related occupations where the consequences of poor judgment can be devastating.

While a number of approaches are thought to signify continued competence, there has been little substantive research to indicate which methods are better than others.⁷⁴ Indeed, there is much controversy over whether much of what is being done under the banner of maintaining competence has any effect on the quality of care which--after all--is the only justification for such activities. Perhaps the best things that can be said of continuing competence requirements in general is that

they assure that practitioners are at least thinking about their standards of practice in some way. On the other hand, where such activities are clearly superfluous to direct patient care, they are a waste of time, energy, and money.

Of the various continued competence mechanisms in use, the most common is the requirement for continuing education. For the most part, credit hour requirements are set for a specified time period and can be fulfilled by attendance at various courses, lectures, conferences, professional association meetings, and the like. Meeting these requirements can be a condition of renewal of one's license, certification, association membership, etc., depending on the occupation in question.

Traditional didactic continuing education activities have proliferated because they are easy to devise and can reach large numbers of individuals. Yet, they are widely questioned for being, as a recent report stated". . . often unvalidated and of questionable relevance to continued competence."⁷⁵ In addition to classroom situations, however, other types of educational techniques, such as self-assessment tests, simulated clinical situations, and review of actual practitioner-patient relationships, might be worthy of exploration.⁷⁶ Because of the poorly understood correlation between continuing education methods and quality of care, a variety of alternatives should be considered. For the same reason, any standards set ought to be as flexible as possible.

Although very limited in its current usage, re-examination is another concept which is being increasingly discussed in the area of continued competence. When it is used, re-examination is never applied to the basic authority (e.g., a license) to practice a profession. Instead it is used in specialty certification. For example, the American College of Family Practice requires those physicians who wish to establish their credentials as family practitioners to retake its national board examination

every six years. Failure to perform satisfactorily on this examination means only that a physician loses the endorsement of the College, not the license to practice medicine.

Because of the severe consequences that it can have on the individual practitioners, and because tests themselves can be imperfect predictors of competence, re-examination probably should not be tied to the basic authority to practice midwifery under a new statute. At least, it should not be the single deciding factor. More information and experience with this particular regulatory mechanism is necessary before its proper use can be established. Developments in other professions will certainly help to clarify this issue as time goes on.

Peer review, formal and informal, is another mechanism for promoting continued competence. Peer review occurs as a matter of course when professionals work together in organized settings, for example, in hospitals and clinics where there is a constant exchange of ideas and information on a day-to-day basis. More formally there are case review conferences, utilization review committees, and other structured opportunities for practitioners to have standards of care assessed by others.

It is where individuals operate more or less independently that effective peer review becomes difficult to achieve. Since the midwives recognized under any new statute would probably not be working in established institutions (at least in the short run), the legislature may wish to consider the development of a recordkeeping and reporting system that would be more focused than the existing birth certificate data process. A reporting system could be used to monitor the practice of midwives under a new act. Such a system has been used in Arizona for several years and is presently being implemented in New Mexico. The health authorities in Arizona report that it has been successful in helping them to monitor practice, identify problems, and develop strategies for corrective action when this

has been found to be necessary.

The design of such a system should be as simple as possible, perhaps a single page form for every birth that could be submitted by midwives at regular intervals--quarterly, semi-annually, etc. Such a system could certainly be used for the initial years of a new regulatory program and could easily be abandoned when midwifery reached a certain level of maturity. It would add an element of peer review and oversight that would add to the public's understanding of this re-emerging occupational pathway.

Just as the state is correct to demand a certain level of skill on the part of persons asking to enter certain professional categories, it is also reasonable for it to ask that steps be taken to ensure competence on an ongoing basis. However, given the tenuous connection between continuing competence activities and the quality of care, any requirements imposed by the state under a new midwifery statute should be flexible and within reasonable limits. Whatever method or methods are adopted, they should be readily available to the great majority of practitioners. Most importantly, they should be as directly related as possible to the actual tasks and functions performed by midwives.

Chapter VII

THE QUESTION OF INDEPENDENCE

In any revision of the state's midwifery statute, an important topic of discussion will be the nature of the relationship that should exist between midwives and physicians. Some may argue for direct, over-the-shoulder supervision by physician. Others will urge a less formal and more voluntary collegial association based on professional judgment. The current law takes the latter approach by declaring it to be ". . . the duty of a midwife to always secure the services of a legally qualified physician whenever any abnormal signs or symptoms appear either in the mother or the infant."⁷⁷

The discussion of midwives' relationships to physicians parallels that which has surrounded the emergence of several new categories of health professionals, namely, Physician's Assistants (PA's) and Nurse Practitioners (NP's). In general, these individuals perform functions that were once the prerogative of physicians only. Within certain limits, they are trained and authorized to engage in the diagnosis and treatment of illness. The independence of these practitioners varies according to state law. In Washington, Physician's Assistants may practice either under the direct or indirect supervision of a physician, that is, a physician's physical presence is not essential to the PA's normal activities.⁷⁸ Nurse Practitioners, for example, nurse-midwives, are not required to work under medical supervision and may operate independently within their scope of practice. However, most establish "collaborative" relationships with physicians, pharmacists and other professionals.⁷⁹ These

are voluntary arrangements made on an individual basis, and they will vary according to the situation and personalities involved.

With respect to midwives, there can be little doubt that they cannot perform adequately in total isolation from physicians and other resources of the health system. Clearly, it is in the interests of mothers and children that the services of obstetricians or other physicians be available to the midwife whenever the need arises. Midwives, licensed or otherwise, generally recognize the need for contact with physicians. In this state, many have been able to establish various kinds of working relationships with physicians for consultation and referral should complications arise during the pregnancy or birth. Some will not accept a client unless she can document a recent, complete physical examination by a physician or present a signed statement from a physician stating that he or she will provide consultation or assume management of the case in the event of complications or emergencies. Nevertheless, there are some (primarily among unlicensed birth attendants) who have chosen not to associate in any way with physicians or the established medical care system.

The issue, therefore, is not whether the physician/midwife relationship should be addressed under a new statute, but rather in what terms should it be specified. As indicated in Chapter III, the nature of this relationship can span a variety of arrangements under which midwives are, to a greater or lesser degree, dependent on physician approval and oversight as a condition of their right to practice their profession. While the number and characteristics of the possible arrangements can be many and varied, several general models may serve as the basis for consideration of this important issue. In the direction of dependent to independent, these include requiring:

- direct supervision by physicians,
- indirect supervision,
- a written protocol signed by a physician indicating the midwife's routine scope of activities and circumstances under which referral or consultation is to take place,
- the examination of pregnant women by a physician before care is assumed by a midwife, and perhaps at regular intervals thereafter,
- a written plan submitted to the credentialing authority by the midwife describing his or her arrangements and policies with respect to referral and consultation, and
- the securing of physician services as the need arises according to the midwife's professional judgment.

In deciding how dependent or independent midwives should be in their association with physicians, two important considerations are the standards of education and the scope of practice. If midwives are well-trained to render the services they are authorized to perform, then greater independence would appear to be appropriate. The level of preparedness among midwives will be a function of the credibility of the credentialing process devised under a new statute and the existence of training programs that meet the requirements established under the law. If the scope of practice is to include all services relevant to the care of the normal pregnancy, then the need for close medical supervision does not seem warranted.

The main argument for requiring physician direction and oversight is that it will serve to guarantee the quality of care. If the basic competence of midwives is in doubt, or if their scope of practice excludes any critical aspects of care, then a strong role for physicians is desirable. However, if the quality of care can be assured through proper training, a

comprehensive scope of practice and diligent oversight by a credentialing authority, then the need for medical direction becomes less apparent.

Several examples may serve to illustrate these different perspectives. In Europe, where midwives are well-trained and are permitted a broad scope of practice, they are not legally bound to physicians and may act independently within their authority. It is expected that their training and professional code of conduct will guide their judgment as to when to seek physician consultation. Failure to exercise proper judgment is a matter that is dealt with by the official midwifery regulatory apparatus.

In contrast are the regulatory programs of Arizona and New Mexico. In these states, there are no recognized midwifery training programs and the scope of midwifery practices does not include a number of services considered basic to the practice of normal obstetrics (e.g., diagnostic testing, the use of medications). In Arizona, a midwife must show evidence that a client has been examined at least once during the last trimester of pregnancy by a physician or other practitioner operating under the supervision of a licensed physician. The midwife is further required to have formal arrangements--prior to each delivery--for back-up medical care for the mother and infant (see Appendix C, p. 119). Through the cooperation of the Arizona Perinatal Program and the Newborn Intensive Care Program, clinical services, consultation, transportation, and emergency services are available to midwives and can serve to satisfy these requirements.⁸⁰ In New Mexico, midwives may care for low risk patients determined by physician evaluation and examination to be prospectively normal for pregnancy and childbirth. In addition to the initial physician assessment, a medical evaluation is required between the thirty-sixth and fortieth weeks of pregnancy. Midwives must also make prior arrangements for hospitalization and obtain agreements for referral should either become necessary (see Appendix D, p. 137).

The requirements for physician input reflect concerns of public officials as to the general level of competence of midwives in these states at this time, as do the limitations on the scope of practice. These concerns are also illustrated, particularly in the case of New Mexico, by regulations which set out in great detail various aspects of care and the conditions that necessitate referral to physicians (see Appendix D, pp. 137-44).

Should the Washington legislature decide to make midwives dependent in some way on physicians, then the issue of physician cooperation is a relevant factor. That is, it would be the assumption of the legislature that the medical community would generally be willing to cooperate with midwives in the manner specified in the statute (or subsequent regulations). If physicians' participation was not forthcoming, midwives would be effectively barred from practice unless some alternative mechanism could be found to provide the necessary medical expertise. Arizona's use of the hospital-based perinatal care resources, mentioned earlier, is one example of such an alternative.

Since midwifery outside of nursing is somewhat controversial, the issue of physician cooperation may warrant careful consideration. In New Mexico, for example, the sole company providing malpractice insurance recently threatened to withhold coverage from physicians cooperating with the state's registered lay midwives. As a result, health authorities decided to adopt a flexible attitude with regard to the various regulatory requirements for physician contact.⁸¹

Chapter VIII

RELATED ISSUES

This chapter will contain a discussion of three issues that inevitably arise in any discussion of midwifery: the use of medications, third party reimbursement, and hospital admitting privileges.

Medications

Should the legislature, in defining the midwives' scope of practice, decide to permit the use of medications, the question will arise as to how midwives shall obtain them. Should they be obliged to secure the allowed medications through another practitioner, for example, under the prescription of a physician? Alternatively, should they be permitted to obtain the necessary drugs under their own authority, through prescriptive authority or some other mechanism?

The state may wish to define drug authority very narrowly, permitting midwives to use only those medications that are applicable to the labor and delivery processes in cases of normal or low risk pregnancy. This was essentially the proposal contained in the H.B.2713 which was heard during the 1980 legislative session. The bill would have given midwives the authority to use three categories of drugs: eye prophylaxis (presently a state requirement for all births), antihemorrhagics, and local anesthetics. Such authority is consistent with midwifery practices abroad and should serve to prevent unnecessary or inconvenient transport to hospital in cases involving minor hemorrhaging or for the repair of episiotomies or minor lacerations which may occur during birth.

Many believe that these drugs are basic tools of child-birth and should be available to midwives on their own authority. Others contend that all medications used by midwives ought to be obtained under the authority of another health professional, principally the physician. The rationale for this view is often stated in terms of general presumptions about safeguarding the quality of care, although these are not spelled out in any detail. The pharmacists, however, have a specific concern--prescriptive authority. Having dealt solely with physicians until recent years, pharmacists are understandably concerned about the growing numbers of practitioners being granted the right to prescribe drugs. These include physician's assistants, nurse-practitioners, and now--possibly--midwives. Pharmacists question the adequacy of the pharmacological preparation of these new practitioners and their professional relationships with these individuals. As a result of court cases in which pharmacists have been held liable for adverse drug reactions involving prescription drugs, they are concerned about questions of liability vis-a-vis new health practitioners.⁸²

The three drugs mentioned above are widely used in modern obstetrical practice for the purposes indicated. The parameters governing their appropriate use are well understood. If midwives are granted the authority to use these substances and if the education and training requirements developed under a new statute provide adequate preparation in their use, a convincing rationale for making midwives dependent on physicians or other professionals does not become readily apparent. Further, given the medical community's general opposition to the practice of midwifery outside of nursing, physicians may not welcome being placed in a position of having to deal with midwives. If they refuse to do so, midwives will be deprived of a valuable tool. Mothers may be subject to unnecessary danger, inconvenience, and cost. Unpleasant legal challenges may arise, and the intent of the legislation may be generally undermined.

Should the legislature wish to grant midwives the authority to use these basic medications on their own authority, it can apparently be done without the granting of prescriptive rights. The critical factor is the difference between the "administering" and the "dispensing" of legend drugs.

Legend drugs, including those being discussed here, are those which state law requires "to be dispensed on prescription only."⁸³ Dispensing, according to state law, means "to deliver a legend drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner. . ." ⁸⁴ This is what occurs at local pharmacies where patients purchase drugs on prescription for use at a later time.

"Administering" means "the direct application of a legend drug whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject. . ." by a practitioner or a patient at the direction of a practitioner.⁸⁵ Prescriptive authority, therefore, is not necessary for a practitioner to be legally empowered to administer a legend drug. What would be necessary is statutory language that granted midwives the authority to "obtain and administer" a specified drug. In addition, midwives would have to be included in the definition of "practitioner" under the state's current drug laws.⁸⁶

It would be appropriate for new legislation to refer to categories of drugs (for example, local anesthetics), leaving the precise listing of substances to be developed by the responsible credentialing authority through rule and regulation. This would eliminate the need for new legislation every time developments in the pharmaceutical field warranted an addition to or subtraction from the list.

In this manner midwives would be able to establish a direct purchasing relationship with pharmaceutical wholesalers and distributors as do physicians and other office-based practitioners who must have certain medications on hand on a day-to-day basis.

Because midwifery legislation would be unique, it might be useful to mention such purchasing arrangements in the statute itself, so as to avoid any confusion over how midwives are to obtain the medications used in their practice.

Depending on how broadly the legislature defines scope of practice, other drugs may be considered appropriate for use by midwives. For example, there are antibiotics commonly used in the treatment of minor gynecological conditions. There are also analgesics used for the relief of pain. Whether prescriptive authority or medical direction (or both) is required depends largely on the nature of the drug and the circumstances under which it is used. In the case of antibiotics, prescriptive authority would probably be involved, since these drugs are not generally administered at the time of service. Prescriptive power would not be necessary in the case of analgesics (which are "administered"), although medical direction would be desirable. While midwifery's orientation toward the handling of pain usually emphasizes approaches other than the use of pharmaceuticals (e.g., exercise, breathing technique, emotional support), there are instances in which analgesics may be warranted. However, there seems to be widespread agreement among professionals that such cases should be handled in the hospital where medical consultation is readily available.

Health Insurance Coverage

The subject of health insurance coverage is relevant to the discussion of midwifery because of its heavy influences on the utilization of services and service providers.

The issue of coverage is not one that is really suitable for including in a basic practice act. However, as the state did in the case of registered nurses, chiropractors, and psychologists,⁸⁷ the state may wish to consider--separately--the possible extension of health insurance to the services for

midwives. Therefore, a brief overview of developments in the insurance industry is included.

In this state, the policy of insuring organizations toward reimbursement of licensed midwives seems to be directly related to the nature of its linkages with organized medicine. In general, the closer the linkages, the less favorable are the policies toward midwives.

At one end of the spectrum are the commercial insurance companies which have the least formal relationship with the medical profession. Like all parts of the insurance industry, the commercial groups are moving steadily toward the recognition of non-physician health practitioners. Policy language is being amended to include reimbursement for members of the "healing arts" professions. A number of commercial insurance companies in the state are currently paying for the services of licensed midwives. Others have taken no policy position--some because they have not had to deal with a claim from a licensed midwife and some who must rely for policy direction from company headquarters located in other states. In general, the commercial company representatives have expressed no basic reservations with respect to the practice of midwifery outside of nursing. Their key concern is that there be a formal licensing or credentialing process established by the state, including a specific statement of the scope of practice. As long as practitioners were duly credentialed and were acting within the scope of their authority, the commercial industry seems favorably inclined toward providing reimbursement.

There seems to be no strong objection to mandating benefits. The issue had little significance for those companies already paying for the services of licensed midwives. There is also consensus among companies that the coverage of midwifery services would provide a net savings to their clients. However, some insurance representatives suggested that any legislative directive mandate that companies "offer" midwifery coverage to their clients rather than impose such coverage without clients' consent.

On the other end of the spectrum are the medical service bureaus (Blue Shield) which are closely tied to local medical societies. In formulating their reimbursement policies, they rely heavily on the prevailing opinions of the medical community and--in particular--the specialty groups. Since the obstetrician leadership has been opposed to the practice of midwives outside of nursing, it is unlikely that the service bureaus will choose to reimburse for the services of licensed midwives unless they are compelled to do so--either by law or by strong competitive pressures.⁸⁹

Somewhere in between lies the Blue Cross organization. Because of increasing attention focused on midwifery in this state, Blue Cross has initiated an internal policy analysis process to clarify its position on the payment of midwives in general, nurse-midwives, and licensed midwives. It is expected that a position will be drawn up and presented to the Blue Cross governing body late in 1980.⁹⁰

Public sector reimbursement practices are also relevant to the midwifery debate. State government, through its Medicaid program, is a major purchaser of maternity services. At present, Medicaid does not reimburse for the services of licensed midwives. Program officials have moved cautiously on the payment of new health practitioners. Their concerns are the standards of training, the provision for medical consultation and referral, and--in some instances--the costs of services. If the state's midwifery statute is revised, Medicaid's current policy toward midwives might be examined in light of the new law's potential for ensuring a high standard of care for public patients.⁹¹

Another development is a recent action by the State Employees Insurance Board. At its March meeting, the Board decided to include the services of licensed midwives as a covered benefit under its statewide uniform medical plan which is underwritten by Blue Cross. This plan is offered to all state employees as one of several benefit package options.⁹²

A final item concerns the impact of federal legislation on the authority of a state to mandate benefits. At issue is the interpretation of Section 514 of the Employees Retirement Income Security Act of 1975 (ERISA) which deals with the federal and state role in the regulation of the insurance industry. Arguing that the mandating of benefits goes beyond the regulatory authority of the states as defined by ERISA, employer groups in several states have brought suit challenging state laws imposing new benefit coverage. The federal versus state role will ultimately be determined by the U.S. Supreme Court. As to midwifery, the relevant issue is whether requiring the reimbursement of practitioners providing a widely covered service (i.e., maternity care) is considered the mandating of a new benefit. On the surface, it would not appear so, but the answer is presently unclear.⁹³

Hospital Privileges

Aside from the issue of whether midwives, other than nurse-midwives, will ever find employment opportunities in hospitals, there is the more sensitive subject of obstetrical admitting privileges for midwives practicing independently outside of hospitals. Many believe that--as in other countries--midwives should be permitted to arrange for the hospitalization of their clients when necessary and provide care within the institutions when appropriate. Some would like to see this authority mandated in legislation.

Under the regulations governing hospitals, the responsibility for ensuring the competence of patient care personnel (both employees and independent medical practitioners) is vested in the governing boards or boards of trustees. Hospital boards have delegated the task of granting admitting privileges to independent practitioners (until recently--only physicians) to the hospital medical staffs who are very protective of this privilege.

Hence, should any attempt to statutorily require hospitals to grant admitting privileges to midwives would probably run afoul of existing law, not to mention the strong opposition it would produce in the medical community. Should the legislature determine that independently practicing midwives should be able to hospitalize their clients when necessary, it would appear more appropriate for a new statute to declare that it is within the scope of a midwife's authority to practice in hospitals. This would allow agreements to be reached at the community level between individual practitioners and institutions.

Given the realities of professional and institutional policies and preferences, midwives are unlikely to secure obstetrical admitting privileges very easily. Indeed, nurse-midwives in independent practice have often had great difficulty in obtaining privileges.

The acceptance of non-nurse midwives by hospitals may increase, albeit very slowly, if psychological and informational barriers can be overcome. Much will depend on the attitudes and personalities of the individuals involved at the local level. Much will also depend on a statute which provides a clear definition of midwifery practice, a credible credentialing process, and acceptable standards of training. In Washington, examples of local accommodation can be found in the admitting privileges granted by the University Hospital (at the University of Washington) to a licensed midwife and a nurse-midwife providing home birth services and to several nurse-midwives based in freestanding birth centers.

Chapter IX

CONCLUSIONS

This report has attempted to analyze issues that have a direct bearing on the possible development of legislation to supplant the state's current midwifery statute enacted in 1917. Legislators' interest in a new midwifery law is the result of several factors. These include changing birth patterns, the appearance of candidates who have completed the requirements for licensure under present law, and the varied activities of midwifery advocates and supporters.

The controversy surrounding the recent movement toward a new midwifery practice act has little to do with the subject matter at hand. Indeed, midwifery--once a necessity for the poor and the isolated--is increasingly being viewed as a viable choice for the urban middle classes. The essence of the controversy lies in the fact that a new bill would give recognition and sanction to the practice of midwifery outside of nursing. To one degree or another, nurse-midwifery has been recognized in virtually every state. Most health care professionals believe that nursing education is essential to training of a competent midwife. However, there is good reason to believe that substantial numbers of people rendering midwifery services are not nurses nor members of other established professions. Yet few educational opportunities have been established for these individuals, and few states have attempted to regulate their practice so as to ensure a minimum level of competence necessary for the protection of the public.

That midwives can be trained to render a high standard of services without having first undergone basic nursing education seems clearly established by the experience of European countries.

In Europe, where both forms of practice are recognized, there has been no suggestion that the quality of services rendered by nurse-midwives is any greater than that provided by midwives trained independent of nursing (and vice versa). Moreover, the recommendations of international health professional groups have not called for nursing to be a prerequisite for midwifery practice. Instead there has been a general recognition that certain basic nursing skills are relevant to midwifery and ought to be included in the training of professional midwives. The decision of European countries to recognize nurse midwifery, independent midwifery, or both has had more to do with historical developments than with any observed differences in the caliber of services rendered by either group.

Therefore, the first major question to state policymakers--that is, can midwifery be safely practiced outside of nursing--seems to be answerable in the affirmative. This assumes, of course, adequate training and ready access to necessary back-up and support services, and general acceptance by the public and the health community. The second question--what to do with respect to the existing midwifery statute--is much more difficult to answer, since what is needed or desirable depends on how the problem is defined.

From the all-important perspective of public safety, no major problem is readily apparent. To date, the Department of Licensing seems to have acted cautiously and prudently in administering the current law. Furthermore, there has been no indication that midwives licensed under the present statute have jeopardized the health or wellbeing of those under their care. Finally, while there might be more legitimate concerns about the activities of unlicensed practitioners, the number of births involved is small.

The related questions of credibility and acceptance seem to be more of an issue. Within the professional community, some are wholly opposed to the idea of midwifery independent of nursing.

However, even among those who are inclined to be more tolerant of this concept, there are serious concerns about various aspects of the present law. Without widespread confidence and respect in the credentialing process, midwifery cannot flourish.

From yet another perspective, there is increasing discussion of the desirability of promoting more competitiveness and freedom of choice in the delivery of health services. Our medical care system has been criticized for being monopolistic and costly. In view of the experience with physician's assistants, nurse-practitioners (including nurse-midwives), and others, many urge that, where quality can be maintained, practices showing promise of greater patient satisfaction and lower cost should be encouraged. Perhaps this consideration is relevant to the debate over the current midwifery statute.

As in other complex areas of social policy, the legislature will have to decide on midwifery based on its best reading of the circumstances and mood in this state. This present investigation has not revealed compelling circumstances to indicate whether the state should move in a more restrictive or permissive direction on the practice of midwifery as distinct from nurse-midwifery. The state, therefore, may wish to consider allowing the present statutory authority to continue for a time in order to provide more information and perhaps greater insight as to the proper public stance toward midwifery. On the other hand, several years have already elapsed since this issue first attracted legislative attention. The discussion and events that have occurred during this period have highlighted a number of areas of general concern (e.g., professional participation, training standards), and so there may be ample grounds for prompt action.

Regardless of when the legislature decides to enact a new midwifery statute, a spectrum of choices will be available. At the minimum, the state may wish to do little more than legalize the practice of lay midwifery, subject to certain basic requirements. Conversely, state policymakers may wish to allow for the

practice of more highly trained professional midwives similar to those recognized in other countries. This would, of course, entail a higher level of training and practice standards.

Wherever the legislative consensus falls along this spectrum, several provisions would seem to be desirable in any new midwifery practice act. The first is a clear definition of the scope of midwifery practice. This can be embodied either in a statute or an administrative regulation, in which case the statutory language should indicate the direction of legislative intent. A second component would be the establishment of a credentialing body, representative of the professionals and the public, that could be relied upon to draw up a reasonable set of standards for the education and practice of midwives. In the absence of established patterns and standards of practice, the third element would be basic reporting requirements that would allow the state to monitor the development of midwifery practice, at least in the initial years of the new regulatory program. Lastly, consideration might be given to imposing certain minimal continued competence requirements that are directly relevant to the functions and responsibilities of midwives.

In the design and implementation of a new midwifery regulatory program, it is important that flexibility be allowed for and encouraged. Innovation emerges incrementally, and within the bounds of public safety decision-makers ought to be free to take advantage of gains already made as well as those that lie ahead.

Whatever approach the legislature decides to take with respect to the practice of midwifery outside of nursing, its first concern will be the welfare of the citizens of this state. Nevertheless, it should be recognized that the action taken in Washington will be of keen interest in other states where similar issues are continually being debated.

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APPENDIX A

REVISED CODE OF WASHINGTON

Chapter 18.50
MIDWIFERY

Sections	
18.50.010	Definitions—Gratuitous services—Duty to call physician.
18.50.020	License required.
18.50.030	Exemptions.
18.50.040	Application—Eligibility requirements
18.50.050	Application—Examination fee.
18.50.060	Examination.
18.50.070	Recording license—Penalty for failure.
18.50.080	Recording—County clerk's duties.
18.50.100	Refusal and revocation of license—Grounds—Hearing.
18.50.120	Unlawful practice—Penalties.
18.50.130	"Certificate" and "license" synonymous.
18.50.900	Repeal and saving.

Reviser's note: "Director" and "director of licenses" have been substituted for "board", "board of medical examiners" and "secretary of the board" throughout this chapter, since the state board of medical examiners was abolished by 1921 c 7 § 135 and its powers and duties were transferred to the director of licenses by 1921 c 7 § 96 (RCW 43.24.020), which powers and duties subsequently devolved to the business and professional administration within the department of motor vehicles. See note following Title 18 RCW digest.

Abortion: Chapter 9.02 RCW.

Adoption of children through hospitals, doctors, midwives, etc.: RCW 26.36.040.

Crimes relating to pregnancy and childbirth: RCW 9A.32.060.

Filing certificate of birth: RCW 70.58.080.

Record as to patients or inmates for purposes of vital statistics: RCW 70.58.270.

18.50.010 Definitions—Gratuitous services—Duty to call physician. Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid to a woman in childbirth for a fee or compensation or who shall advertise as a midwife by signs, printed cards or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to always secure the immediate services of a legally qualified physician whenever any abnormal signs or symptoms appear either in the mother or the infant. [1917 c 160 § 8; RRS § 10181. Formerly RCW 18.50.010, 18.50.030, part, and 18.50.090.]

18.50.020 License required. Any person who shall practice midwifery in this state after July 1, 1917, shall first obtain from the director of licenses of the state of Washington a license so to do, and the said director is authorized to grant such license after examination of the applicant as hereinafter provided. [1917 c 160 § 1; RRS § 10174.]

18.50.030 Exemptions. This chapter shall not be construed to interfere in any way with the practice of religion, nor be held to apply to or regulate any kind of treatment by prayer. [1917 c 160 § 12; RRS § 10185. FORMER PART OF SECTION: 1917 c 160 § 8, part; RRS § 10181, part, now codified in RCW 18.50.010.]

Gratuitous services exempted: RCW 18.50.010.

18.50.040 Application—Eligibility requirements. Any person seeking to be examined shall present to the said director, at least ten days before the commencement of the said examination, a written application on a form or forms provided by the said director setting forth under affidavit the name, age, nativity, residence, moral character and time spent in obtaining a common school education or its equivalent; that the candidate has received a certificate or diploma from a legally incorporated school on midwifery in good standing, granted after at least two courses of instruction of at least seven months each in different calendar years or a certificate or diploma in a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued. The diploma must bear the seal of the institution from which the applicant was graduated. Foreign applicants must present with the application a translation of the foreign

certificate or diploma made by and under the seal of the consulate of the country in which the said certificate or diploma was issued. The application must be endorsed by a duly registered reputable physician of the state of Washington. [1917 c 160 § 2; RRS § 10175.]

18.50.050 Application—Examination fee. If the application is approved and the candidate shall have deposited an examination fee determined by the director as provided in RCW 43.24.085 as now or hereafter amended with the director, the candidate shall be admitted to the examination, and in case of failure to pass the examination, may be reexamined at any regular examination within one year without the payment of an additional fee, said fee to be retained by the director after failure to pass the second examination. [1975 1st ex.s. c 30 § 51; 1917 c 160 § 3; RRS § 10176.]

18.50.060 Examination. The director of licenses is hereby authorized and empowered to execute the provisions of this chapter and shall hold examinations in midwifery on the first Monday in January and July, at such places as the director may select, from ten o'clock a.m. to five o'clock p.m., and at such other times as the said director may deem expedient. The examinations may be oral, written, or both, and shall be in the English language; if desired in any other language, an interpreter may be provided by said director upon notification of the director at least ten days before examination. The cost of said interpreter shall be defrayed by the applicant for the license.

Examinations shall be held on the following subjects:

- (1) Anatomy of pelvis and female genital organs.
- (2) Physiology of menstruation.
- (3) Diagnosis and management of pregnancy.
- (4) Diagnosis of foetal presentation and position.
- (5) Mechanism and management of normal labor.
- (6) Management of puerperium.
- (7) Injuries to the genital organs following labor.
- (8) Sepsis and antisepsis in relation to labor.
- (9) Special care of the bed and lying-in room.
- (10) Hygiene of mother and infant.
- (11) Asphyxiation, convulsions, malformation and infectious diseases of the new-born.
- (12) Causes and effects of ophthalmia neonatorum.
- (13) Abnormal conditions requiring attention of a physician.
- (14) Requirements of the vital statistics laws pertaining to the reporting of births and the rules of the state board of health relative to ophthalmia neonatorum or other infectious diseases of the newborn.

Said examination shall be sufficient to test the scientific and practical fitness of candidates to practice midwifery and the director may require examination on other subjects relating to midwifery from time to time. All application papers shall be deposited with the director and there retained for at least one year, when they may be destroyed.

If said examination is satisfactory, said director shall issue to such candidate a license entitling the candidate to practice midwifery in the state of Washington: *Provided*, That said license shall not authorize the holder to

prescribe any drugs or medicine except some household remedy after the birth of the infant. [1917 c 160 § 4; RRS § 10177.]

Reviser's note: The last paragraph of 1917 c 160 § 4 reads: "If said examination is satisfactory, said board shall issue to such candidate a license with the certified copy signed by its president and secretary, and attested by its seal, entitling the candidate to practice midwifery in the state of Washington. *Provided*, That said license shall not authorize the holder to prescribe any drugs or medicine except some household remedy after the birth of the infant." This paragraph has been changed to refer to the "director of licenses" as the board of medical examiners was abolished and its powers and duties transferred to the director of licenses, which powers and duties subsequently devolved to the business and professional administration within the department of motor vehicles. See note following Title 18 RCW digest.

18.50.070 Recording license—Penalty for failure. Every person holding a license authorized in this chapter must have the same recorded in the office of the county clerk in the county in which the holder is practicing her profession, and the fact of such recording shall be endorsed on the certificate by the county clerk recording the same. Every such person, on a change of her residence, must have the license recorded in the county to which she shall have removed. The absence of such record shall be prima facie evidence of the want of possession of such certificate; and any person practicing midwifery in this state without first having filed her certificate with the county clerk as herein provided, shall be deemed guilty of a misdemeanor. [1917 c 160 § 5; RRS § 10178.]

18.50.080 Recording—County clerk's duties. The county clerk shall keep in a book provided for the purpose, a complete list of the certificates recorded by him, with the date of the record, and such book shall be open to public inspection during his office hours. [1917 c 160 § 6; RRS § 10179.]

18.50.100 Refusal and revocation of license—Grounds—Hearing. Said director may refuse to grant or may revoke any license herein provided for, for any of the following reasons: Persistent inebriety; the practice of criminal abortion; the commission of any crime involving moral turpitude; presentation of a certificate or diploma for registration or license illegally obtained; application for examination under fraudulent misrepresentation; neglect or refusal to make proper returns to the health officer or health department of births or of puerperal contagion or infectious diseases within the required limit of time; failure to record her license with the clerk of the county in which the licentiate resides or practices; failure to secure the attendance of a reputable physician in a case of miscarriage, hemorrhage, abnormal presentation or position, retained placenta, convulsions, prolapse of the cord, fever during parturient stage, inflammation or discharge from the eyes of a new-born infant, or whenever there are any abnormal or unhealthy symptoms in either the mother or the infant during labor or the puerperium.

In complaints of violations of the provisions of this section, the accused shall be furnished with a copy of the complaint and be given a hearing before said director in person or by attorney. Any midwife refused admittance to the examination or whose license has been revoked who shall attempt or continue the practice of midwifery, shall be subject to the penalties hereinafter prescribed. [1917 c 160 § 7; RRS § 10180. Formerly RCW 18.50.100 and 18.50.110.]

Abortion: Chapter 9.02 RCW.

18.50.120 Unlawful practice—Penalties. Any person hereafter practicing midwifery in this state without first complying with the provisions of this chapter, shall be guilty of a misdemeanor and shall be punished by fine of not less than fifty dollars nor more than two hundred fifty dollars, or by imprisonment in the county jail for not less than ten days nor more than six months, or both, at the discretion of the court. [1917 c 160 § 9; RRS: § 10182.]

18.50.130 "Certificate" and "license" synonymous. The words "certificate" and "license" shall be known as interchangeable terms in this chapter. [1917 c 160 § 11; RRS § 10184.]

18.50.900 Repeal and saving. All acts or parts of acts inconsistent with the provisions of this chapter may be and the same are hereby repealed: *Provided*, This chapter shall not repeal the provisions of the vital statistics laws of the state, but shall be deemed as additional and cumulative provisions. [1917 c 160 § 10.]

APPENDIX B

MIDWIFERY LEGISLATION

DECEMBER 1979

1 AN ACT Relating to midwifery; amending section 7, chapter 56, CR80B
 2 Laws of 1975-'76 2nd ex. sess. and RCW 7.70.020; amending P
 3 section 8, chapter 160, Laws of 1917 and RCW 18.50.010; H
 4 amending section 2, chapter 160, Laws of 1917 and RCW -2713
 5 18.50.040; amending section 4, chapter 160, Laws of 1917 ;1
 6 as amended by section 43, chapter 158, Laws of 1979 and PARTA
 7 RCW 18.50.060; amending section 7, chapter 160, Laws of ;4
 8 1917 and RCW 18.50.100; amending section 21, chapter 266, 10
 9 Laws of 197, ex. sess. as last amended by section 100, 10
 10 chapter 158, Laws of 1979 and RCW 43.24.06.; adding new 12
 11 sections to chapter 18.50 RCW; repealing section 5, 13
 12 chapter 160, Laws of 1917 and RCW 18.50.070; repealing 14
 13 section 6, chapter 160, Laws of 1917 and RCW 18.50.080; 15
 14 and making an appropriation. 15

15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON: 16

16 Section 1. Section 7, chapter 56, Laws of 1975-'76 2nd 18
 17 ex. sess. and RCW 7.70.020 are each amended to read as follows: 19

18 As used in this chapter "health care provider" means 20
 19 either: 20

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

29 (2) An employee or agent of a person described in part 26
 30 (1) above, acting in the course and scope of his employment, 27

1 including, in the event such employee or agent is deceased, his 27
 2 estate or personal representative; or 27
 3 (3) An entity, whether or not incorporated, facility, or 28
 4 institution employing one or more persons described in part (1) 29
 5 above, including, but not limited to, a hospital, clinic, health 29
 6 maintenance organization, or nursing home; or an officer, 30
 7 director, employee, or agent thereof acting in the course and 30
 8 scope of his employment, including in the event such officer, 31
 9 director, employee, or agent is deceased, his estate or personal 32
 10 representative. 32

11 NEW SECTION. Sec. 2. There is added to chapter 18.50 34
 12 RCW a new section to read as follows: 34

13 Unless the context clearly requires otherwise, the 35
 14 definitions in this section apply throughout this chapter: 35

- 15 (1) "Department" means the department of licensing. 36
- 16 (2) "Director" means the director of licensing. 37
- 17 (3) "Midwife" means a midwife licensed under this 38
 18 chapter. 38

19 NEW SECTION. Sec. 3. There is added to chapter 18.50 39
 20 RCW a new section to read as follows: 39

21 The midwifery advisory committee is created. 40

22 The director shall appoint the members of the midwifery 41
 23 advisory committee. The committee shall be composed of one 43
 24 consumer, one midwife licensed under this chapter, one certified 43
 25 nurse midwife licensed under chapter 18.88 RCW, one physician 44
 26 licensed under either chapter 18.57 or 18.71 RCW, and one person 44
 27 who is active in health education. The members serve at the 45
 28 pleasure of the director but may not serve more than three 46
 29 consecutive years or more than five years in total. The terms 46
 30 of office shall be staggered. Members of the committee shall be 47
 31 reimbursed for travel expenses as provided in RCW 43.03.050 and 48
 32 43.03.060 as now or hereafter amended. 48

33 NEW SECTION. Sec. 4. There is added to chapter 18.50 49
 34 RCW a new section to read as follows: 49

35 The midwifery advisory committee shall advise and make 50
 36 recommendations to the director on issues including, but not 51

1 limited to, continuing education, mandatory reexamination, and 52
 2 peer review. The director shall transmit the recommendations to 52
 3 the social and health services committees of the senate and 53
 4 house of representatives on an annual basis. 53

5 Sec. 5. Section 8, chapter 160, Laws of 1917 and RCW 55
 6 18.50.010 are each amended to read as follows: 56

7 Any person shall be regarded as practicing midwifery 57
 8 within the meaning of this chapter who shall render medical aid 58
 9 for a fee or compensation to a woman ~~((in-childbirth-for--a--fee~~ 59
 10 ~~or--compensation))~~ during prenatal, intrapartum, and postpartum 59
 11 stages or who shall advertise as a midwife by signs, printed 60
 12 cards, or otherwise. Nothing shall be construed in this chapter 61
 13 to prohibit gratuitous services. It shall be the duty of a 62
 14 midwife to always attempt to secure the immediate services of a 63
 15 legally qualified physician whenever any ~~((abnormal))~~ life- 63
 16 threatening signs or unhealthy symptoms appear either in the 64
 17 mother or the infant. 64

18 Sec. 6. Section 2, chapter 160, Laws of 1917 and RCW 66
 19 18.50.040 are each amended to read as follows: 67

20 [1] Any person seeking to be examined shall present to 69
 21 the ~~((said))~~ director, at least ~~((ten))~~ forty-five days before 70
 22 the commencement of the ~~((said))~~ examination, a written 71
 23 application on a form or forms provided by the ~~((said))~~ director 71
 24 setting forth under affidavit ~~((the--name--age--nativity~~ 72
 25 ~~residence--moral-character-and-time-spent-in-obtaining-a--common~~ 73
 26 ~~school--education))~~ such information as the director may require 73
 27 and proof the applicant has received a high school degree or its 74
 28 equivalent; that the candidate has received a certificate or 74
 29 diploma from a ~~((legally--incorporated-school-on-midwifery-in~~ 75
 30 ~~good-standing--granted-after-at-least-two-courses-of-instruction~~ 76
 31 ~~of-at-least-seven-months--each--in--different--calendar--years))~~ 77
 32 midwifery program accredited by the director and registered 77
 33 under chapter 28B.05 RCW, when applicable, or a certificate or 78
 34 diploma in a foreign institution on midwifery of equal 79
 35 requirements conferring the full right to practice midwifery in 80
 36 the country in which it was issued. The diploma must bear the 81

1 seal of the institution from which the applicant was graduated. 82
 2 Foreign applicants must present with the application a 83
 3 translation of the foreign certificate or diploma made by and 84
 4 under the seal of the consulate of the country in which the 85
 5 ((said)) certificate or diploma was issued. ((The--application 85
 6 must-be-endorsed-by-a-duly-registered-reputable-physicians-of-the 86
 7 state-of-Washington)) 87

8 (2) The director shall promulgate standards under 88
 9 chapter 34.04 RCW for accrediting midwifery programs. The 88
 10 standards shall cover the provision of adequate clinical and 89
 11 didactic instruction in all subjects specified in RCW 18.50.060 89
 12 and noncurriculum matters including, but not limited to, 90
 13 staffing and teacher qualifications. In developing the 92
 14 standards, the director shall be assisted by the midwifery 92
 15 advisory committee. 92

16 Sec. 7. Section 4, chapter 160, Laws of 1917 as amended 94
 17 by section 43, chapter 158, Laws of 1979 and RCW 18.50.060 are 96
 18 each amended to read as follows: 96

19 (1) The director of licensing is hereby authorized and 98
 20 empowered to execute the provisions of this chapter and shall 99
 21 ((hold)) offer examinations in midwifery ((on-the--first--Monday 99
 22 in--January--and--July)) at least twice a year at such times and 100
 23 places as the director may select ((7--from--ten--o'clock--a.m.--to 101
 24 five--o'clock--p.m.--and--at--such--other--times--as--the--said--director 102
 25 may--deem--expedient)). The examinations ((may)) shall be 102
 26 ((ornt)) written((7--or--both)) and shall be in the English 103
 27 language((7--if--desired--in--any--other--language--an--interpreter--may 104
 28 be--provided--by--said--director--upon--notification--of--the--director 105
 29 at--least--ten--days--before--examination;--The--cost--of--said 106
 30 interpreter shall be defrayed by the applicant for the licenser 107

- 31 Examinations shall be held on the following subjects: 108
 32 (1)--Anatomy of penis and female genital organs 109
 33 (2)--Physiology of menstruation 110
 34 (3)--Diagnosis and management of pregnancy 111
 35 (4)--Diagnosis of foetal presentation and position 112
 36 (5)--Mechanism and management of normal labor 113

1	{6}--Management-of-<u>puerperium</u>	114
2	{7}--<u>Injuries-to-the-genital-organs-following-labor</u>	115
3	{8}--<u>Sepsis-and-antisepsis-in-relation-to-labor</u>	116
4	{9}--<u>Special-care-of-the-bed-and-lying-in-room</u>	117
5	{10}--<u>Hygiene-of-mother-and-infant</u>	118
6	{11}--<u>Asphyxiation,--convulsions,--malformation---and</u>	119
7	<u>infectious-diseases-of-the-new-born</u>	120
8	{12}--<u>Causes-and-effects-of-ophthalmia-neonatorum</u>	121
9	{13}--<u>Abnormal---conditions--requiring--attention--of--a</u>	122
10	<u>physician</u>	122
11	{14}--<u>Requirements--of--the---vital---statistics---laws</u>	123
12	<u>pertaining--to--the-reporting-of-births-and-the-rules-of-the-state</u>	124
13	<u>board--of--health--relative--to--ophthalmia--neonatorum--or--other</u>	125
14	<u>infectious-diseases-of-the-newborn</u>)).	125
15	((said)) <u>{2} The director, with the assistance of the</u>	127
16	<u>midwifery advisory committee, shall develop a licensure</u>	128
17	<u>examination in the subjects that the director determines are</u>	128
18	<u>within the scope of and commensurate with the work performed by</u>	129
19	<u>a licensed midwife. The examination shall be sufficient to test</u>	130
20	<u>the scientific and practical fitness of candidates to practice</u>	131
21	<u>midwifery ((and--the--director--may--require--examination--on--other</u>	132
22	<u>subjects--relating--to--midwifery--from--time--to--time)). All</u>	133
23	<u>application papers shall be deposited with the director and</u>	134
24	<u>there retained for at least one year, when they may be</u>	135
25	<u>destroyed.</u>	135
26	<u>{3} If ((said)) the examination is ((satisfactory))</u>	136
27	<u>satisfactorily completed, ((said)) the director shall issue to</u>	137
28	<u>such candidate a license entitling the candidate to practice</u>	137
29	<u>midwifery in the state of Washington((---PROVIDED,--That--said</u>	138
30	<u>license--shall--not--authorize--the--holder--to--prescribe--any--drugs--or</u>	139
31	<u>medicine--except--some--household--remedy--after--the--birth--of--the</u>	140
32	<u>infant)).</u>	140
33	<u>{4} No midwife licensed under this chapter may prescribe</u>	141
34	<u>any drugs or medications: PROVIDED, That a licensed midwife is</u>	142
35	<u>authorized to acquire and administer those drugs and medications</u>	142
36	<u>necessary to protect the mother and infant. Those drugs and</u>	143

1 medications shall be limited to: 143

2 (a) Eye prophylaxis: 144

3 (b) Anti-hemorrhagic; and 145

4 (c) Local anesthetics. 146

5 Sec. 8. Section 7, chapter 160, Laws of 1917 and RCW 148

6 18.50.100 are each amended to read as follows: 149

7 ((Said)) The director may refuse to grant or may suspend 150

8 or revoke any license ((herein-provided-for)), may reprimand or 151

9 censure a license holder, or may place on probation subject to 152

10 reasonable remedial conditions a license holder for any of the 152

11 following reasons: Persistent inebriety; the practice of 153

12 criminal abortion; the commission of any crime involving moral 154

13 turpitude relevant to the practice of midwifery; presentation of 154

14 a certificate or diploma for registration or license illegally 155

15 obtained; application for examination under fraudulent 156

16 misrepresentation; mishandling drugs authorized by this chapter; 156

17 neglect or refusal to make proper returns to the ((health 157

18 officer-or-health)) department of social and health services of 157

19 births or of puerperal contagion or infectious diseases within 158

20 the required limit o. time: ((failure-to-record-her-license-with 159

21 the-clerk-of-the-county--in--which--the--licentiate--resides--or 160

22 practices;)) failure to attempt to secure the ((attendance)) 161

23 services of a ((reputable)) physician in a case of 161

24 ((miscarriage;--hemorrhage;--abnormal--presentation-or-position; 162

25 retained-placenta;--convulsions;--prolapse--of--the--cord;--fever 163

26 during-parturient-stage;--inflammation-or-discharge-from-the-eyes 164

27 of--a--new-born-infant;--or-when-ever-there-are)) any ((abnormal)) 165

28 life-threatening or unhealthy symptoms in either the mother or 166

29 the infant ((during-labor-or-the-puerperium)). 166

30 In complaints of violations of the provisions of this 167

31 section, the accused shall be furnished with a copy of the 168

32 complaint and be given a hearing before ((said-director--or 169

33 person-or-by-attorney)) a hearing examiner, with right of appeal 169

34 to the director. Any midwife refused admittance to the 170

35 examination or whose license has been revoked who shall attempt 171

36 or continue the practice of midwifery((7)) shall be subject to 172

1 the penalties hereinafter prescribed. 172

2 NEW SECTION. Sec. 9. There is added to chapter 18.50 173

3 RCW a new section to read as follows: 173

4 Registered nurses and nurse midwives certified by the 174

5 board of nursing under chapter 18.88 RCW shall be exempt from 175

6 the requirements and provisions of this chapter. 175

7 NEW SECTION. Sec. 10. There is added to chapter 18.50 176

8 RCW a new section to read as follows: 176

9 Nothing in this chapter shall be construed to apply to or 177

10 interfere in any way with the practice of midwifery by a person 178

11 who is enrolled in a program of midwifery approved and 179

12 accredited by the director: PROVIDED, That the performance of 179

13 such services is only pursuant to a regular course of 180

14 instruction or assignment from the student's instructor, and 181

15 that such services are performed only under the supervision and 181

16 control of a person licensed in the state of Washington to 182

17 perform services encompassed under this chapter. 182

18 NEW SECTION. Sec. 11. There is added to chapter 18.50 183

19 RCW a new section to read as follows: 183

20 The director, with the advice of the midwifery advisory 185

21 committee, shall develop a form to be used by a midwife to 185

22 inform the patient of the qualifications of a licensed midwife. 186

23 NEW SECTION. Sec. 12. There is added to chapter 18.50 188

24 RCW a new section to read as follows: 188

25 Every person licensed to practice midwifery shall 189

26 register with the director of licensing annually and pay an 190

27 annual renewal registration fee determined by the director as 191

28 provided in RCW 43.24.085 as now or hereafter amended on or 191

29 before the licensee's birth anniversary date. The license of 192

30 the person shall be renewed for a period of one year. Any 193

31 failure to register and pay the annual renewal registration fee 194

32 shall render the license invalid. The license shall be 194

33 reinstated upon written application to the director, payment to 195

34 the state of a penalty fee determined by the director as 196

35 provided in RCW 43.24.085 as now or hereafter amended, and 197

36 payment to the state of all delinquent annual license renewal 197

1	fees.	197
2	<u>NEW SECTION.</u> Sec. 13. There is added to chapter 18.50	199
3	RCW a new section to read as follows:	199
4	Every licensed midwife shall develop a written plan for	200
5	consultation with other health care providers, emergency	201
6	transfer, transport of an infant to a newborn nursery or	201
7	neonatal intensive care nursery, and transport of a woman to an	203
8	appropriate obstetrical department or patient care area. The	203
9	written plan shall be submitted annually together with the	204
10	license renewal fee to the department.	205
11	<u>NEW SECTION.</u> Sec. 14. There is added to chapter 18.50	207
12	RCW a new section to read as follows:	207
13	The director shall promulgate rules under chapter 34.04	208
14	RCW as are necessary to carry out the purposes of this chapter.	209
15	Sec. 15. Section 21, chapter 266, Laws of 1971 ex. sess.	211
16	as last amended by section 100, chapter 158, Laws of 1979 and	212
17	RCW 43.24.085 are each amended to read as follows:	213
18	It shall be the policy of the state of Washington that	214
19	the director of licensing shall from time to time establish the	215
20	amount of all application fees, license fees, registration fees,	215
21	examination fees, permit fees, renewal fees, and any other fee	217
22	associated with licensing or registration of professions,	217
23	occupations, or businesses, administered by the business and	218
24	professions administration in the department of licensing. In	218
25	fixing said fees the director shall, insofar as is practicable,	219
26	fix the fees relating to each profession, occupation, or	219
27	business in such a manner that the income from each will match	220
28	the anticipated expenses to be incurred in the administration of	220
29	the laws relating to each such profession, occupation, or	221
30	business. All such fees shall be fixed by rule and regulation	221
31	adopted by the director in accordance with the provisions of the	222
32	administrative procedure act, chapter 34.04 RCW: PROVIDED, That	222
33	(1) In no event shall the license or registration	223
34	renewal fee in the following cases be fixed at an amount less	223
35	than five dollars or in excess of fifteen dollars:	224
36	Barber	225

1	Student barber	226
2	Cosmetologist (manager-operator)	227
3	Cosmetologist (operator)	228
4	Cosmetologist (instructor-operator)	229
5	Apprentice embalmers	230
6	Manicurist	231
7	Apprentice funeral directors	232
8	Registered nurse	233
9	Licensed practical nurse	234
10	<u>Midwife</u>	235
11	Charitable organization	236
12	Professional solicitor;	237
13	(2) In no event shall the license or registration	238
14	renewal fee in the following cases be fixed at an amount less	238
15	than ten dollars or in excess of twenty dollars:	239
16	Dental hygienist	240
17	Barber instructor	241
18	Barber manager instructor	242
19	Psychologist	243
20	Embalmer	244
21	Funeral director	245
22	Sanitarian	246
23	Veterinarian	247
24	Cosmetology shop	248
25	Barber shop	249
26	Proprietary school agent	250
27	Specialized and advance registered nurse	251
28	Physician's assistant	252
29	Osteopathic physician's assistant;	253
30	(3) In no event shall the license or registration	254
31	renewal fee in the following cases be fixed at an amount less	254
32	than fifteen dollars or in excess of thirty-five dollars:	255
33	Architect	256
34	Dentist	257
35	Engineer	258
36	Land Surveyor	259

1	Podiatrist	260
2	Chiropractor	261
3	Drugless therapeutic	262
4	Osteopathic physician	263
5	Osteopathic physician and surgeon	264
6	Physical therapist	265
7	Physician and surgeon	266
8	Optometrist	267
9	Dispensing optician	268
10	Landscape architect	269
11	Nursing home administrator	270
12	Hearing aid fitter;	271
13	(4) In no event shall the license or registration	272
14	renewal fee in the following cases be fixed at an amount less	272
15	than fifty dollars or in excess of two hundred dollars:	273
16	Engineer corporation	274
17	Engineer partnership	275
18	Cosmetology school	276
19	Barber school	277
20	Debt adjuster agency	278
21	Debt adjuster branch office	279
22	Debt adjuster	280
23	Proprietary school	281
24	Employment agency	282
25	Employment agency branch office	283
26	Collection agency	284
27	Collection agency branch office	285
28	Professional fund raiser.	286
29	<u>NEW SECTION.</u> Sec. 16. There is appropriated to the	288
30	department of licensing from the state general fund for the	289
31	biennium ending June 30, 1981, the sum of sixty-five thousand	289
32	dollars or so much as may be necessary to carry out the purposes	290
33	of this 1980 act.	290
34	<u>NEW SECTION.</u> Sec. 17. The following acts or parts of	292
35	acts are each hereby repealed:	292
36	(1) Section 5, chapter 160, Laws of 1917 and RCW	294

1	18.50.070; and	294
2	(2) Section 6, chapter 160, Laws of 1917 and RCW	296
3	18.50.080.	296

APPENDIX C

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).

2/28/78 Supp. 78-1

R9-16-202. Renewal application

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

Historical Note

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

R9-16-203. Course of instruction

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

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

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

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

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

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

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

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

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

Historical Note

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

R9-16-204. Qualifying examination

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

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

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

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

Historical Note

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

R9-16-205. Responsibilities of the midwife

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

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

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

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

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