

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 86/2

1549 SHESS SB 747 (#3)

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

Historical Note

Former Section R9-16-205 repealed, new Section R9-16-205 adopted eff.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

R9-16-206

HEALTH SERVICES

Title 9

R9-16-206. Reports

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

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

Historical Note

Former Section R9-16-206 repealed, new Section R9-16-206 adopted eff.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

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

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

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

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

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

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

Historical Note

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

APPENDIX D

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

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

FILE CATEGORY:

REGULATION NO.: HED-80-3A (HSD)

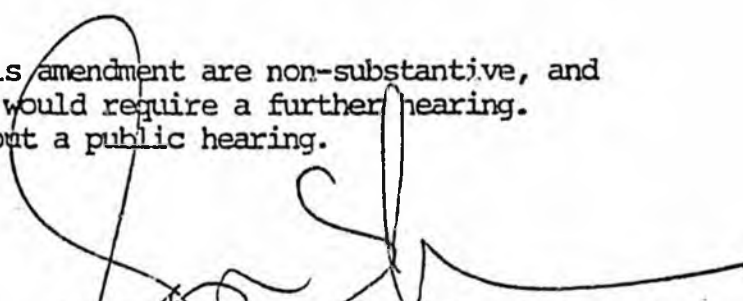
ORIGINATOR: Health Services Division

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

REASONS FOR ADOPTION:

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

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



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HED-80-3A(HSD)

REGULATIONS GOVERNING THE PRACTICE OF LAY MIDWIFERY

General Provisions

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

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

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

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

APPLICABILITY

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

REGISTRATION OF LAY MIDWIVES

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

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DIVISION OF ARCHIVES

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

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

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- 310.01. Submitting evidence of eight contact hours of continuing education annually;
 - 310.02. Submitting evidence of being current in practice in another jurisdiction;
 - 310.03. Applying for a lay midwife apprentice permit in order to obtain clinical experience to become current in practice as determined by the Department;
 - 310.04. Sitting any or all portion(s) of the qualifying examination as required by the Department; and
 - 310.05. Submitting renewal fee as prescribed by the Division.
400. FEES: From and after January 1, 1981, all applications for apprentice permit or provisional or regular registration must be accompanied by a money order payable to the Division in the amount of fifty dollars (\$50.00). Such fee provides for initial registration for the registration year, or part thereof, remaining. If the application is deemed insufficient, the fee will be returned.
- 400.01. Fee for annual renewal of provisional and regular registration shall be \$25.00 a year.
 - 400.02. Examination fee shall be \$25.00 and is not included in registration fee.
500. REVOCACTION OF REGISTRATION: The Division may refuse to issue, suspend for a definite period, or revoke a registration for any of the following causes:
- 500.01. Dereliction of any duty imposed by law;
 - 500.02. Incompetence;
 - 500.03. Conviction of a felony;
 - 500.04. Practicing while suffering from a contagious or infectious disease;
 - 500.05. Practicing under a false name or alias;
 - 500.06. Violation of any of the standards of practice set forth in Sections 800 and 905;
 - 500.07. Obtaining any fee by fraud or misrepresentation;

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

EDUCATION

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

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

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STATE BOARD OF NURSING

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

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

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

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	<u>Provisional Requirements</u>	<u>Regular Requirements</u>
602.05. Postpartum home visits (within 36 hours of delivery)	10	30
602.06. ECMC Department of Pediatrics MICU and Nursery (8 hours minimum). Other acceptable observations entities will be considered	May be done during registration period	Required at application
602.07. ECMC Department of Obstetrics and Gynecology High Risk perinatal Unit observation entities will be considered	May done during registration period	Required at application
602.08. Observation of one complete series of prepared childbirth classes	May be done during registration period	1-6 hour class series preferred
602.09. Observation of one complete La Leche League series	May be done during registration period	1 series of 4 meetings
602.10. Five experiences in each of categories 602.01, 02, 03 and 04 must be with an approved physician or certified midwife trainer. Required at application.		
603. <u>SUPERVISION OF CLINICAL EXPERIENCE:</u> Clinical experience may be obtained under the supervision of a physician, certified nurse-midwife or registered lay midwife. This must be direct, present in the same room supervision. Those providing supervision must be approved by the Division for training and should have had previous experience with home birth. Postpartum home visit supervision may be provided by an HSD public health nurse.		

604. CONTINUING EDUCATION: Continuing education is required for annual renewal of registration.
- 604.01. In each calendar year, eight contact hours of continuing education must be obtained. One hour each of management of antepartum, intrapartum, and newborn periods and one hour of recognition and management of emergency situations must be obtained: other hours may cover any topics applicable to midwifery practice.
- 604.02. Continuing education may be obtained through convention, conferences, area midwives meetings or other mechanism as approved by the Division.
- 604.03. In any calendar year the Department may require specific topics for continuing education based upon any problem areas indicated by registered lay midwives' semi-annual reports.
700. REQUIREMENTS OF EXAMINATION: Any person applying for regular registration, as a lay midwife must pass a qualifying examination administered under the auspices of the Department. The Department shall offer the examination at least twice a year.
701. FIELDS TESTED: The examination shall consist of three parts:
- 701.01. A written examination designed to test knowledge in theory regarding pregnancy and childbirth;
- 701.02. An oral examination designed to test clinical judgment in lay midwifery case management; and
- 701.03. A practical examination designed to demonstrate the mastery of skills necessary for the practice of lay midwifery.
702. SCOPE OF WRITTEN EXAMINATION: The written examination shall cover:
- 702.01. Theory regarding pregnancy and childbirth including but not limited to:
- 702.01.01. Anatomy and physiology of the female reproductive system, in both pregnant and non-pregnant states;

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- 702.01.02. Normal growth and development of fetus and placenta;
- 702.01.03. Normal progress of pregnancy, labor and delivery;
- 702.01.04. Comfort measures in the antepartum, intrapartum and postpartum periods;
- 702.01.05. Significance of laboratory studies in pregnancy and the neonatal period; and
- 702.01.06. Prenatal nutrition.
- 702.02. Patient teaching;
- 702.03. Special requirements of home delivery;
- 702.04. Risk factors in pregnancy;
- 702.05. Terminology used in the practice of lay midwifery;
- 702.06. Normal newborn characteristics and possible problems including anomalies;
- 702.07. Care of the newborn; and
- 702.08. Pertinent legislation and regulations for lay midwifery in New Mexico.
- 703. SCOPE OF ORAL EXAMINATION: The oral examination shall cover:
 - 703.01. Evaluation of judgment to cover areas of:
 - 703.01.01. Early recognition of abnormalities in the antepartum, intrapartum, postpartum and neonatal periods: their significance and possible sequelae if untreated
 - 703.01.02. Recognition and treatment of emergency situations
 - 703.01.03. Course and management of normal labor and selected normal antepartum situations (nutritional counseling, patient teaching, dealing with normal discomforts).

704. SCOPE OF PRACTICAL EXAMINATION: The practical examination shall cover basic observational skills:

704.01. Temperature, pulse, and respiration

704.02. Blood pressure

704.03. Fetal heart tones

704.04. Abdominal palpation

704.05. Cervical dilatation

704.06. Fetal position

704.07. Measurement of fundal height

704.08. Exam for edema

DUTIES AND RESPONSIBILITIES

800. COVERAGE: The registered lay midwife must assure that all women she plans to deliver receive required tests.

801. MEDICAL EVALUATION: The lay midwife must require the patient to have a risk evaluation and physical examination by a physician before a registered lay midwife assumes her care.

802. REQUIRED TESTS: Initial physician examination shall include clinical pelvimetry and the following laboratory tests -- VDRL, GC screen, blood type and group, hematocrit and hemoglobin, rubella titer and urinalysis. Hematocrit must be rechecked at 28 and 36 weeks gestation.

803. PRENATAL VISITS: Prenatal visits should be every 4 weeks until 28 weeks gestation, every 2 weeks from 28 until 35 weeks gestation and weekly from 36 weeks until delivery.

804. PHYSICIAN VISITS: Each woman must also have one prenatal visit with a physician at 36 to 40 weeks.

805. RECORDS: The lay midwife shall maintain records of physician's visit with evidence of his/her exam for the Division.

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806. ADVANCE PREPARATION FOR NEED: The registered lay midwife, prior to the onset of labor, must have:
- 806.01. Arrangements made for transport of mother and/or infant to a hospital; and
 - 806.02. Agreement for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.
807. INFORMED CONSENT: The registered lay midwife must inform any woman seeking home birth of possible risks of home birth and must obtain informed consent of the woman for home birth prior to the onset of labor on a form provided by the Department.
808. COMMUNITY RESOURCES: The registered lay midwife must be familiar with community resources for pregnant women such as prenatal classes, WIC program, La Leche League and HSD clinics.
809. LATE PREGNANCY PERIOD: The registered lay midwife will make a home visit no more than 4 weeks prior to the EDC to assess the physical environment, to ascertain that the woman has all necessary supplies to prepare the family for the birth and to instruct the family to correct problems or deficiencies.
810. NORMAL DELIVERY: The registered lay midwife must remain with the mother and infant for at least two hours postpartum, or until the mother's fundus is firm and lochia normal, the mother has voided and the infant has a normal temperature and is nursing well, whichever is longer.
811. HOSPITALIZATION: The registered lay midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and a verbal report to the physician assuming care. If possible, she should remain with the mother and/or infant to ascertain outcome.
812. PHYSICIAN EVALUATION OF NEWBORN: The registered lay midwife must recommend that any infant delivered at home be evaluated by a physician within 3 days of age, or sooner when it becomes apparent that the newborn needs medical attention.
813. POSTPARTUM VISITS: The registered lay midwife shall make postpartum home visits to evaluate the condition of mother and infant at least twice - once within 36 hours of birth and once on the fourth or fifth postpartum day. Additional visits shall be made as indicated.

DEPARTMENT OF HEALTH
PUBLIC RECORDS ARCHIVES

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

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STATE COMMISSION OF
HUMAN RESOURCES ARCHIVE

- 819.06. Has symptoms of vaginitis.
- 819.07. Has symptoms of urinary tract infection.
- 819.08. Has vaginal bleeding before onset of labor.
- 819.09. Has premature rupture of membranes.
- 819.10. Noted decrease in or cessation of fetal movement.
- 819.11. Has inappropriate gestational size.
- 819.12. Has demonstrated anemia by blood test (hematocrit less than 30%).
- 819.13. Has a fever of 100.4 degrees F. or 38 degrees C for 24 hours.
- 819.14. Has effacement and/or dilatation of the cervix prior to 36 weeks gestation.
- 819.15. Has polyhydramnios or oligohydramnios.
- 819.16. Has excessive vomiting or continued vomiting after 24 weeks gestation.
- 819.17. Is found to be Rh negative.
- 819.18. Has severe, protruding varicose veins of extremities or vulva.
- 819.19. Is 36 years of age or older.
- 820. INTRAPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the intrapartum period:
 - 820.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.
 - 820.02. Develops severe headache, epigastric pain or visual disturbance.
 - 820.03. Develops proteinuria.
 - 820.04. Develops a fever over 100.4 degrees F or 38 degrees C.
 - 820.05. Develops respiratory distress.

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

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STATE COMMISSION OF
PUBLIC RECORDS & ARCHIVES

- 821.04. Does not void within 6 hours of birth.
- 821.05. Develops a fever greater than 100⁴⁰F. 38⁰C on any 2 of the first 10 days postpartum excluding the first 24 hours.
- 821.06. Develops foul smelling lochia.
- 822. NEWBORN PROBLEMS: The registered lay midwife will refer for medical evaluation and/or care any infant who:
 - 822.01. Has an Apgar score of 7 or less at 5 minutes.
 - 822.02. Has any obvious anomaly.
 - 822.03. Develops grunting respirations, retractions or cyanosis.
 - 822.04. Has cardiac irregularities
 - 822.05. Has a pale, cyanotic or grey color.
 - 822.06. Has an abnormal cry.
 - 822.07. Weighs less than 5 1/2 pounds or 2500 grams or weighs more than 9 pounds or 4100 grams.
 - 822.08. Shows signs of prematurity, dysmaturity or postmaturity.
 - 822.09. Has meconium staining.
 - 822.10. Does not urinate or pass meconium in the first 12 hours after birth.
 - 822.11. Is lethargic or does not nurse well.
 - 822.12. Has edema.
 - 822.13. Appears weak or flaccid, has abnormal feces or appears not to be normal in any other respect.

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

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

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

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

SUPERVISION BY DIVISION

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

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

1000.02. One certified nurse midwife;

1000.03. Two regularly registered lay midwives;

1000.04. One member at large.

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

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

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

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

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

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



RULES AND REGULATIONS
FOR
LICENSING OF MIDWIVES

State of Rhode Island and Providence Plantations

Department of Health

March 1978

APPENDIX E

INTRODUCTION

These rules and regulations are promulgated pursuant to the authority conferred under sections 23-13-9 and 23-1-1 of the General Laws of Rhode Island of 1956, as amended, and are established for the purpose of defining the minimal standards for the licensure of midwives and the practice of midwifery.

Compliance with these rules and regulations in no way conveys assurance of the quality of care but rather provides the basic capabilities for adequate performance.

900.0 DEFINITIONS

Wherever used in these regulations, the following terms shall be construed as follows:

- 900.1 "Midwifery" shall mean the practice of performing the service of a midwife or the practice of attending women in childbirth for hire.
- 900.2 "Midwife" shall mean a person who has successfully completed an Approved Educational Program in Midwifery and is licensed to practice midwifery in Rhode Island.
- 900.3 "Director" shall mean the Director, Rhode Island Department of Health.
- 900.4 "Council" shall mean the Advisory Council on Midwifery as established by the Rules and Regulations herein.
- 900.5 "Approved Educational Program in Midwifery" shall mean an academic and practical program of midwifery approved by the American College of Nurse-Midwives or an equivalent program approved by the Director of Health.
- 900.6 "Physician" shall mean an individual licensed under the provisions of Chapters 5-36 and 5-37 of the General Laws of Rhode Island 1956, as amended, to practice medicine or osteopathy with current obstetrical privileges in a licensed hospital.

901.0 LICENSE REQUIREMENT

- 901.1 Any person practicing or offering to practice midwifery shall be required to submit evidence that such person is qualified to practice and shall be licensed as herein provided, in order to safeguard the life and health of the people. It shall be unlawful for any person to practice or to offer to practice midwifery in this state or to use any title, abbreviation, sign, card or device to indicate that such a person is practicing midwifery unless such person has been duly licensed as a midwife in accordance with section 23-13-9 of the General Laws of Rhode Island 1956, as amended, and the Rules and Regulations herein.

902.0 ADVISORY COUNCIL ON MIDWIFERY

- 902.1 Within the Division of Professional Regulation in the Department of Health, there shall be established an Advisory Council on Midwifery which shall meet at least once a year, and consist of five (5) members; two (2) physicians; two (2) midwives, one of whom shall be a nurse-midwife; and one (1) consumer.

902.2 Members of the Council shall be appointed by the Director of Health: two (2) to serve for one (1) year; two (2) to serve for two (2) years; and one (1) to serve for three (3) years. The first two midwives appointed shall be considered to have met the requirements for licensure pending actual fulfillment of the requirements herein.

902.3 Successors to members of the Council whose term expires shall be appointed in such year by the Director to hold office for three (3) years or until their respective successors are appointed.

902.4 The Director may remove any member of the Council for neglect of duty or incompetency and may fill vacancies which occur for any purpose for the remainder of the unexpired term.

903.0 FUNCTIONS OF ADVISORY COUNCIL

903.1 The Council shall serve in an advisory capacity to the Director in matters pertaining to the licensing of midwives and the practice of midwifery. The Council shall advise the Director on such matters as policies affecting examination, qualifications, issuance and renewal, denial or revocation of licenses, and the development of rules and regulations.

904.0 ADMINISTRATION

904.1 The Administrator of Professional Regulation shall be responsible for the administrative functions required to implement the provisions of sections 23-13-9 and 23-1-1 of the General Laws of Rhode Island 1956, as amended, and the Rules and Regulations herein including such duties as: maintaining a register of all licensed midwives; maintaining all records pertaining to the licensing of midwives; conducting examinations as required; staffing the Council; and discharging such other duties as may be warranted.

905.0 QUALIFICATIONS OF MIDWIVES

905.1 Applicants for a license to practice as midwives in Rhode Island shall submit evidence that said applicants are of good moral character, are in satisfactory physical and mental health, and have been graduated from an Approved Educational Program in Midwifery.

906.0 LICENSING OF MIDWIVES

906.1 BY EXAMINATION:

Applicants shall be required to pass written and/or oral examinations in such subjects as determined by the Council and approved by the Director. Upon successfully passing such examinations, applications shall be eligible for licensure.

- 906.1.1 The Council, in concert with the Administrator of Professional Regulation, with the approval of the Director of Health, shall determine the type, scope, subjects and form of licensing examinations and shall determine the minimal passing score of each examination administered, which shall be the same for all candidates.
- 906.1.2 Examinations shall be given at least twice a year at such time and place as designated by the Administrator of Professional Regulation.
- 906.1.3 All applications and supporting credentials as required in section 905.1 herein shall be filed with the Administrator of Professional Regulation at least thirty (30) days prior to the date of the examination for which the application is filed.
- 906.1.4 Confidential identification numbers shall be assigned to each candidate by the Administrator of Professional Regulation and the names shall not be made known to the Council until the scores have been recorded.
- 906.2 WITHOUT EXAMINATION:
- A license to practice midwifery may be issued without examination to an applicant who has been duly licensed by examination as a midwife under the laws of another state or territory, if, in the opinion of the Council, the applicant meets the qualifications required of a licensed midwife in this state.
- 906.3 FOREIGN TRAINED MIDWIVES:
- All midwives prepared in a midwifery program outside the United States of America shall submit evidence of having graduated from a midwifery program and of holding a license in midwifery from a given foreign country and in addition shall be required to have completed a supplementary refresher course in the United States approved by the Director of Health and shall furthermore be required to satisfactorily pass an examination for licensure in this state in accordance with section 906.1 herein.
- 906.4 RE-EXAMINATION:
- In case of failure of any applicant to satisfactorily pass an examination such applicant shall be entitled to a second examination. In the event of a second failure, opportunity for re-examination(s) shall be subject to the applicant's completion of additional requirements as recommended by the Council.

907.0 RENEWAL OF LICENSE

907.1 On or before the first day of August of every second year commencing in 1979, the Administrator of Professional Regulation shall mail an application for renewal of license to every midwife to whom a license has been issued or renewed for the period ending 1 September 1979 and for each two (2) year period thereafter. Every person so licensed who intends to engage in the practice of midwifery during each ensuing two (2) years shall apply for a license by application to the Administrator of Professional Regulation.

907.1.1 Such renewal application shall include documentary evidence satisfactory to the Council of practice as a licensed midwife within the past two (2) years including the performance and/or supervision of deliveries; or documentary evidence of completion within the past two (2) years of a refresher course or its equivalent, satisfactory to the Council and approved by the Director.

907.2 Upon receipt of the application and accompanying documentation required herein, the accuracy of the application shall be verified and the Director may grant a license renewal effective 1 September and expiring the thirty-first day of August in the odd numbered year following the issuance of such license and shall render the holder to be a legal practitioner of midwifery for the period stated on the license renewal unless sooner revoked.

907.3 Any licensee who allows his or her license to lapse by failing to renew the license by the appropriate date may be reinstated upon submission of an application with the accompanying data as required herein and as approved by the Director.

907.4 Any person practicing midwifery after lapse of licensure shall be considered an illegal practitioner and subject to the penalties of the provisions of section 23-13-9 of the General Laws of Rhode Island 1956, as amended.

907.5 Persons possessing valid licenses as of the effective date of these Rules and Regulations shall continue to be licensed subject to the relicensure provisions herein.

908.0 PRACTICE OF MIDWIFERY

908.1 The license to practice midwifery authorizes the holder to attend cases of normal childbirth, to provide prenatal, intrapartum and postpartum care, including the immediate care of the newborn, in continual collaboration with a physician and in accordance with acceptable standards of practice.

908.1.1 All complications shall be referred to the physician immediately.

908.1.2 No midwife shall attend at childbirth unless transportation is immediately available for the transfer of the mother or newborn to a hospital.

908.2 Licensed midwives shall conform to all state laws pertaining to the conduct of childbirth and management of the newborn, including the provisions of: sections 23-13-4, Ophthalmia Neonatorum; 23-13-12, "Phenylketonuria"; and 23-3-10, "Birth Registration" of the General Laws of Rhode Island 1956, as amended.

909.0 RECORDS AND REPORTS

909.1 A medical record for each mother and newborn shall be maintained which shall include documentation of all care rendered.

909.2 All medical records shall be retained for a period of five (5) years in accordance with the provisions of section 23-3-26 of the General Laws of Rhode Island 1956, as amended, except in the case of minors (17 years of age and under) which medical records shall be kept at least five (5) years after such minor has reached the age of eighteen (18) years.

910.0 DENIAL AND REVOCATION OF LICENSE

910.1 The Director is authorized to deny or revoke the license of any midwife who: (1) is found guilty of fraud or deceit in procuring or attempting to procure a license to practice midwifery; (2) is unfit or incompetent by reason of negligence, habits or other cause; (3) is guilty of unprofessional conduct; (4) is mentally incompetent; (5) is habitually intemperate in the use of alcohol or is addicted to drugs; (6) has aided, abetted or permitted any illegal act or conduct adverse to health, welfare and safety of mothers and infants; (7) has willfully and repeatedly violated state laws; (8) has failed to report to a physician the occurrence of complications during pregnancy, labor or the immediate postpartum period and (9) has failed to comply with the Rules and Regulations herein.

910.1.1 Complaints charging a person with violation of any rule herein or state law, shall be maintained on file by the Administrator of Professional Regulation and shall be considered in rendering determination to deny or revoke the license of a midwife.

910.2 Upon receipt of a complaint charging a person with violations of the provisions of section 23-13-9 of the General Laws of Rhode Island 1956, as amended and the Rules and Regulations herein, an investigation of the charges shall be initiated by the Administrator of Professional Regulation or the Director, thence referred to the Council for recommendation to the Director for appropriate action.

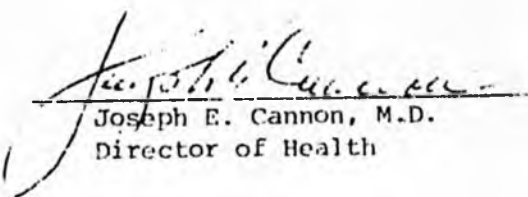
910.3 Whenever an action shall be proposed to deny or revoke the license, the Administrator of Professional Regulation shall notify the person by certified mail setting forth the reasons for the proposed action and the applicant or licensee shall be given an opportunity for a prompt and fair hearing in accordance with the provisions of Chapter 42-35 of the General Laws of Rhode Island 1956, as amended.

910.4 Furthermore, when it appears to the Director after due process that a person is violating any provisions of section 23-13-9 of the General Laws of Rhode Island 1956, as amended, or any of the Rules and Regulations herein, the Director may initiate an action in accordance with the provisions of such statute.

911.0 SEVERABILITY

911.1 If any provision of these rules and regulations or the application thereof to any person or circumstances shall be held invalid, such invalidity shall not affect the provisions or application of the rules and regulations which can be given effect, and to this end the provisions of the rules and regulations are declared to be severable.

The foregoing Rules and Regulations after due notice and opportunity for hearing are hereby adopted and filed with the Secretary of State this 6th day of March 1978, to become effective twenty (20) days thereafter, in accordance with the provisions of sections 23-13-9 and 23-1-1, and Chapter 42-35 of the General Laws of Rhode Island, 1956, as amended.


Joseph E. Cannon, M.D.
Director of Health

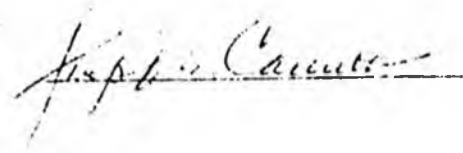
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Filed: 3/6/78

(Robert F. Burns)
Secretary of State

Attest: A true copy





STATE OF MICHIGAN

William G. Milliken, Governor



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**PLANNED
HOME
CHILDBIRTHS:**

PARENTAL PERSPECTIVES

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PLANNED HOME CHILDBIRTHS:

PARENTAL PERSPECTIVES

By

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Being pregnant with you was one of the most beautiful and weird experiences I have had, and to bring it to a climax in a hospital, drugged and intimidated and frightened and at the mercy of the medical profession was too much for me to handle. That's why I decided to have you at home....

A mother's letter to her infant

Anne Gardon
Research Assistant

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Preface

During a series of Fall 1979 meetings, the Maternal and Child Health Nursing Consultants of the Michigan Department of Public Health identified a trend toward increasing home deliveries as an area for public health concern. It was from those meetings that this study was conceived.

Initially, only a small, informal survey was conducted. With the help of local public health nurses, a brief questionnaire was administered to women who had delivered at home in 1975. The responses were thought provoking in light of the advances made in the obstetrical field. As a result, the need was demonstrated for an expanded, systematic study. This was undertaken in 1977 and is presented in this text.

This study of planned home births benefited from the encouragement and assistance of many individuals to whom we wish to express our gratitude. From the Michigan Department of Public Health, R. Gerald Rice, M.D., Chief, Bureau of Personal Health Services and Jeffrey R. Taylor, Ph.D., Chief, Division of Maternal and Infant Health, supported this project by their professional counsel. Also of the Michigan Department of Public Health, Sheila Ward, R.N., Chief,

Maternal and Child Health Nursing, was instrumental in identifying home births as a relevant focus of concern. Her continued interest, critical suggestions and provocative questions encouraged us to expand the brief, informal study to a more comprehensive project.

We are also grateful to Professor Murray Wylie, M.D., Department of Health Planning and Administration of the School of Public Health, University of Michigan, and to J. Robert Willson, M.D., Department of Obstetrics and Gynecology, University of Michigan Medical School, for their thoughtful comments in reviewing this manuscript.

Anne Gardon provided the research assistance to this project. Her efforts in developing the codebook, in the coding itself, in writing an annotated bibliography and in assisting in the analysis of the data and the preparation of this manuscript were invaluable. Her critical insight and keen perception provided a real challenge and made working with her a professional and personal delight.

From the Michigan Department of Public Health, George Van Amburg, Chief, Office of Vital and Health Statistics, and Janet Eyster, Chief of Technical Services, supported the project from its inception. In addition, Statistician Dennis Dodson provided considerable assistance in sampling and data management. His prompt response to innumerable requests for computer printouts greatly facilitated this project.

Our field interviewer, Jane McNamara Ronk, was untiring in her efforts to contact and locate respondents. We are very appreciative of her perseverance in conducting the interviews. Additionally, the public health nurses who participated in the preliminary study contributed significantly to the initial effort.

Throughout the study period we have been fortunate to have the expert secretarial assistance of several people but especially of Mary Jane Belsito. We are grateful for her efforts in preparing numerous drafts during the completion of the manuscript.

Finally, we wish to acknowledge and thank the many families who were interviewed and whose responses are the basis of this survey.

**PLANNED
HOME
CHILDBIRTHS:**

PARENTAL PERSPECTIVES

INTRODUCTION

Most births in the United States occur in a hospital, but this has not always been the case. In 1935, only about 40% of all deliveries took place in a hospital; by 1978 the rate had increased to over 99%. This substantial growth in the number of hospital deliveries has been the result of a determined effort on the part of health care professionals. Their conviction that a hospital is the safest place to deliver is shared widely by the American public. The increase in hospital deliveries has been paralleled by a decline in maternal and infant mortality due, at least in part, to the supervision by health care professionals and the increasingly sophisticated obstetrical technology which characterizes the hospital.

In spite of the strong preference for a hospital, a small yet increasing number of women are electing to deliver their babies at home. The National Center for Health Statistics (1978) reports a recent substantial increase in the number of home deliveries. In Michigan the percentage of out-of-hospital births has increased from 0.21% of all births in 1970 to 0.41% of all births in 1976 (see Appendix A). Similar increases are reported for other states. This small yet important trend has been interpreted as a growing preference for home confine-

ment as distinct from an increase in the number of emergency home births. The movement has been met with surprise and concern by most health professionals. When one considers the extensive efforts of the preceding decades to make hospital facilities available to every pregnant woman, their concern is understandable. This present study of planned home births was undertaken in an effort to understand the preference of families for home births. Before presenting the survey results, the current thinking on home births is briefly reviewed.

The American College of Obstetricians and Gynecologists (ACOG) has been outspoken in its criticism of the home birth movement and has adopted the policy that

labor and delivery, while a physiological process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation.*

ACOG has been so concerned over the increasing interest in home births that it asked all state health departments to collect statistics about the number of home births and deaths associated with out-of-hospital deliveries. In its analysis of the information received, ACOG argued that mortality rates associated with home deliveries are several times higher than for hospital births.

A study of home births in North Carolina (Burnett, et. al., 1977), which included a control group of hospital deliveries, concluded tentatively that home delivery for some women is associated with increased risk. The neonatal mortality rate** for home births in the study was computed to be 35 per thousand, while that for hospital deliveries was 5 per thousand. Emery (1973) reports several mortality measures for California, all indicating high rates for home births. Neonatal mortality for 1973, for example, was 10.2 per thousand for the state and 17.8 for out-of-hospital births.

* "Statement on Home Deliveries." American College of Obstetricians and Gynecologists statement of policy as issued by the executive board in May 1975 and reaffirmed in 1976.

** Neonatal mortality rate is the number of deaths during the first 28 days of life per 1,000 live births.

In order to interpret these statistics accurately, it is necessary to examine what is being measured. While it is essential to assess the risks associated with home delivery, it is equally important that the risks measured are those associated with planned, as distinct from unplanned, home deliveries. We need to know whether home deliveries that occur out of choice are more dangerous than those that occur in a hospital. The subject of emergency out-of-hospital births and the undoubtedly high risk associated with them is a separate concern.

Unfortunately, statistical analyses based on birth certificates cannot differentiate between elective and unplanned home births. Birth certificate information distinguishes between hospital and out-of-hospital births and, within the latter category, between births that occur in the home of the mother and births that occur in other locations outside of a hospital. But there is no category on the certificate that states whether the out-of-hospital location was or was not planned. Statements by ACOG and findings by Burnett, et. al. (1977) that infant mortality rates^o for home births are higher than those for hospital deliveries are based on birth certificate information and, therefore, do not measure the risks associated with planned home births. They are a combined measure of the hazards of planned and unplanned home confinements. Given the lack of distinction between planned and emergency home births, comparisons of home and hospital births based on birth certificate information are likely to yield misleading findings about the risks associated with planned home births. One would expect emergency out-of-hospital births to be more dangerous than planned ones, causing the combined measure of neonatal mortality to be high. For example, an analysis of the mortality statistics of home births indicates that low birth weight and prematurity are common. These are more likely to be associated with emergency home births than with those that are planned. In order to distinguish the mortality rates specifically associated with planned home births, data other than those obtained from birth certificates are required.

In a study of home births using the medical records of five home birth services in Northern California, Mehl, et al. (1976,

^o Infant mortality rate is the number of deaths in the first year of life per 1,000 live births.

p. 8) calculated a perinatal mortality rate* of 9.5 per thousand for the study population which compared favorably with the rate of 20.3 per thousand for California as a whole. These figures include information on women who began labor with the intention of delivering at home but who had to be transferred to the hospital because of complications. This is an important point, for a complete examination of planned home births should include all women who enter labor with the intention of delivering at home and not only those who do actually deliver at home. Ignoring the women who had to be taken to the hospital would only partially present the experience of women who choose home birth.

Mehl (1976, p. 1) concluded that for a self-selected, medically screened population, home delivery can be a reasonable alternative. Yet, as he himself is ready to admit, more studies are needed before the home birth phenomenon can be fully understood. Mehl's work is a valuable beginning on the study of planned home births, but an examination of the experiences of five home delivery services does not provide representative information about planned home births, even in California. There also are difficulties with the reliability of a retrospective chart review which uses recordings made by different types of health care providers. Moreover, it cannot be assumed that all women have the supportive health care facilities that existed for Mehl's study population.

As home births are increasing, it is important to carefully examine the risk factors and to determine whether there are conditions under which elective home confinements are safe for both mother and child. It would indeed be useful, as Annas (1977) suggests, to establish a national demonstration project to test the proposition, advanced by the supporters of alternative childbirth, that home deliveries are cheaper and safer than those occurring in a hospital. For a valid comparison of the risks of hospital versus planned home births, one would want a sample of women with a wide range of characteristics to be assigned at random to a home birth or a hospital. Furthermore, the experiment should include controls for the type of

* Perinatal mortality rate in the State of California is neonatal deaths per 1,000 live births plus fetal deaths per 1,000 live births.

services provided under each treatment. Planned home births can take place under a variety of circumstances: under medical supervision with pre- and post- delivery attendance of a nurse, with a lay midwife or without the attendance of any health professionals. Variations also exist in the type of hospital setting. Such experimental research would be extraordinarily complex and time consuming; but it is important to recognize that in the absence of tightly controlled studies, conclusions about the comparative risks of planned home births versus hospital deliveries will always remain tentative in character.

Although the comparison of risks is important, it is equally important to understand more thoroughly why an increasing number of women decide to have a home confinement. Some proponents of the movement view the increased interest in elective home births as an expression of growing consumer consciousness and as a new willingness to assume responsibility for the management of one's own health. Choosing a home birth also is believed to represent a greater concern for involving the fathers and family in the birthing experience, for maintaining close contact between newborns and their mothers and for providing a nurturing, supportive atmosphere to both mother and newborn. Often it stands for an explicit rejection of the technology-dominated atmosphere of a hospital and its mechanistic, impersonal procedures. But while the broad philosophy of the home birth movement has become widely known through a growing number of popular articles and books and through the representatives of several organizations with a focus on alternatives in childbirth, there is, nonetheless, very little known about the type of people who choose home birth and their actual reasons for avoiding a hospital.

Literature reviews of socio-demographic characteristics likewise leave some uncertainty as to who elects home birth. In her study of the attitudinal profile and social background of 300 home birth parents in California, Hazell (1974, p. 8) concluded that couples who plan a home birth are average people with middle class lives. Kendall (1972) and Edwards (1973), on the other hand, have associated the home birth movement with the counter-culture. In Burnett's (1977) North Carolina study, 80% of the mothers in the sample were black in contrast to a black population of 21.9% in North Carolina as a whole. Even taking into account that the study population in North

Carolina included both emergency and planned home births, this racial composition differs from the predominantly white Californians reported by Hazell (1974) and Mehl (1976). It may be that the reasons for choosing a home delivery vary by social class and region and that the health consequences of a home birth differ accordingly. However, the only two major research projects on planned home births have been conducted in California and we know relatively little about planned home births in other parts of the United States.

The relevance of economic factors should also be determined. With rising costs of hospital care and medical insurance, some women may elect a home delivery primarily because they cannot afford hospital care. If the thrust of the planned home birth movement is economically motivated, policy responses would have to be different in nature than if the major reasons related to a general rejection of hospital procedures and the technical-medical model.

This report will present findings from a study of planned home births in Michigan in 1976. Although the outcomes of deliveries are reported, this is not intended to be a comparison of risks associated with planned home birth versus hospital deliveries. The study's major purpose is to describe the characteristics of women in Michigan who choose to deliver at home and to understand the basis for their decision as well as the circumstances of the birth. Insight into these issues will permit both consumers and health professionals to acquire a common background of fact as they struggle to improve maternal and child health.

METHODOLOGY

The study is based upon survey interviews with 74 women in Michigan who had a planned home delivery in 1976. The study design and questionnaire were pretested in a small exploratory study conducted with women who had a home delivery in Michigan during 1975.

Sample Selection

The major goal in sampling was to interview a sufficiently large number of women so that meaningful descriptive state-

ments could be made about the experience of women who had a planned home delivery in 1976 in Michigan. Birth certificates were used as the starting point for the sampling process because they provide the only existing data base for a study that seeks to be representative. However, since birth records do not record whether a birth was planned to take place at home, but merely whether it did or did not take place in a hospital, it was necessary to go through a screening process to determine which families were eligible for inclusion in the study. This was accomplished by randomly sampling certificates of out-of-hospital births. Then the selected parents were contacted by mail and/or by phone to determine whether the delivery was a planned home birth.

Contacting families selected through the random sample of out-of-hospital births was accompanied by major difficulties. Even though the telephoning was done both during the day and in the evening, it was not possible to reach some people. In other cases, telephone numbers could not be obtained. In a few instances, the physician listed on the birth certificate was contacted to ascertain whether the home birth had been planned. In general, however, the entire process was complicated by the fact that at least a year had elapsed since the home birth.*

As a result of these difficulties, it was necessary to go through three waves of random selections of out-of-hospital birth records in order to meet the predetermined quota of approximately 75 interviews. Moreover, births to unwed women could not be included in the study because these records were confidential in Michigan at the time of the sampling and were unavailable for study purposes.

Since 123 of a total of 539 out-of-hospital births in Michigan in 1976 were to unwed mothers, the basic universe of the sample was 416. Of these, 276 certificates were selected in three successive waves of random sampling. A total of 163 women who had delivered out of a hospital could be located, the remaining 113 were not traceable. After telephone con-

* As a result of letters written to the families of our sample, several lengthy replies were received from couples who had moved out of Michigan since 1976. Two of these letters are quoted in full in Appendix B. These letters reflect the receptivity of many people to our interest in home births.

tacts with these 163 women, 74 qualified as having had a planned home birth and were interviewed while 76 indicated that their out-of-hospital birth had been involuntary. The other 13 women were eligible for interviewing but refused.

Interviewing

One female interviewer conducted the entire field work, thus assuring maximum uniformity and consistency of interviewing. In addition to instruction in interviewing techniques, her training included review of the 1975 home birth study and basic instruction to understand the process of pregnancy, labor, delivery and the various complications that may arise in connection with birth. The interviewer also participated in the final stage of developing the questionnaire and, thereby, became well acquainted with the goals and purposes of the study. Interviews were conducted between June and September 1977.

Although 13 respondents refused to participate in the study, the interviewer was generally well received by the participants, in many instances with the warmest hospitality. For many women the interview seemed to be a welcome opportunity to speak with another adult during the day or to have a chance to discuss personal problems. Many people were excited and anxious to tell about their birth experience. On the other hand, several did not seem to care one way or another if they were interviewed. They answered all the questions but gave the impression of being uncomfortable and looking forward to the end of the interview. Some respondents were suspicious that "the state" was interested in them and their home birth. One woman, for example, asked if her child's behavior and development would be followed through school. A major difficulty with the interviewing was locating the respondents' residences which were located throughout the state.

The Questionnaire

The initial version of the questionnaire was based on the exploratory study of 1975 home births. It was revised to accommodate more open-ended questions in the hope of eliciting detailed information on the reasons women chose a home delivery. It was pretested in the Lansing, Michigan area and finalized in April 1977 (see Appendix D).

HOME BIRTH PARENTS

Since the decision to have a home birth stands in stark contrast with the societal norm that women who are about to give birth belong in a hospital, it seems plausible to expect that this decision is made by a group of people who have rejected existing social norms more generally. Kendall (1972) has argued that home birth parents are part of the commune culture, whereas Hazell (1974, p. 8) concluded that the majority of the women who deliver at home are "quite average people," and that only ten percent of them are members of the "hip" culture. Our study reveals that the home birth parents come from a variety of socio-economic, educational and religious backgrounds, but almost all are white Americans.

INCOME AND HOSPITAL INSURANCE

The average income of the home birth parents was \$16,770 as compared to a \$15,258 average family income for the state of Michigan.* Almost 20% of the families in the sample

* Michigan average income was obtained from U.S. Department of Commerce, Bureau of Census, "Household Money Income in 1975, by Housing Tenure and Residence for the United States, Regions, Divisions and States" (Spring 1976 Survey of Income and Education), Current Population Report, Series P-60, Consumer Income No. 108, November 1977, prepared by K. Apple.

earned less than \$8,000 (Table 1). Two-thirds of the respondents had hospital insurance. As Table 2 indicates, low income is associated with lack of hospital insurance, but the relationship is not strong.

TABLE 1
Family Income Distribution of Home Birth Parents

Income Bracket Dollars Per Year	Number of Respondents	Percentage
1,000 - 3,999	3	4.0
4,000 - 7,999	11	14.9
8,000 - 9,999	8	10.8
10,000 - 12,999	13	17.6
13,000 - 19,999	20	27.0
20,000 - 29,999	10	13.5
30,000 - 49,999	2	2.7
50,000 and over	5	6.8
Not ascertained	2	2.7
Total	74	100.0

TABLE 2
Parents' Income by Hospital Insurance

Income	Parents have hospital insurance				Total Percent
	Yes		No		
	Number	Percent	Number	Percent	
Less than \$8,000	5	35.7	9	64.3	100
\$8,000 - \$12,999	12	57.1	9	42.9	100
More than \$13,000	31	83.8	6	16.2	100
Not ascertained	2				

RACE

Respondents were essentially homogeneous in their racial background. One oriental and four black women were among

those interviewed. Hazell (1974, p. 9) viewed the absence of black women in the home birth movement in California in light of their broader aspirations.

Black people are beginning to be found in childbirth classes, but they are upwardly mobile and tend to opt for the "best" physician and hospital available. This tends to mean that they have the modal American birth, leaving responsibility for management to doctors, nurses and other hospital personnel.

One would expect this statement to be true for black women with higher incomes. Black families with low incomes, however, may well choose a home delivery for economic reasons. This study cannot provide evidence for this point since there were only four black women in the sample, none of whom had an income below \$8,000 per year.

In interpreting the racial and other social characteristics of the women in the sample, it should be remembered that the sampling conditions may have introduced a bias whereby people from minority, ethnic or lower socio-economic groups were underrepresented. For example, out-of-hospital births to unwed women could not be included in our sample for legal reasons, but the racial and educational distributions of this group are known. Of the 123 such births in Michigan, 65 were to black women and 58 were to white women. This stands in marked contrast to the racial distribution of the study population. Also, the unwed mothers were generally less educated than the planned home birth mothers. Fifty-two percent of the unwed women had not completed high school, compared to 10% of the study population. Of course, it is not known how many of the out-of-hospital births to the unwed mothers were planned; but even assuming that only a small percentage were planned home births, the social characteristics of the study population would have been significantly different had they been included.

RESIDENCE

The majority of the women in the sample (42) had spent most of their lives in an urban area and 52 had lived primarily

in Michigan. Nineteen women previously lived in other parts of the United States and three in foreign countries. At the time of the interview, respondents were distributed over 26 counties in Michigan, with the heaviest concentration in Oakland, Wayne, Ingham and Kent counties.

RELIGION

Almost one fourth (16) of the respondents said they had no religion. Over half identified with either Catholic or Protestant religions, or they simply indicated that they were non-denominational or Christian. The remainder were members of religious groups such as Jehovah's Witness, Christian Science, Divine Light Mission and Church of God. It is noteworthy that some of these religions reject certain forms of modern medical and health care.

EDUCATION

The home birth parents had generally achieved a fairly high level of education. The majority of the husbands had attended at least one to two years of college, and 46% of their wives also were college educated. The second largest group consisted of those who had completed high school. A small group, 10% of the mothers and 5% of the fathers, had not completed high school.

TABLE 3
Education of Home Birth Parents

Educational Level	Mother		Father	
	Number	Percent	Number	Percent
Some high school	8	10.8	4	5.4
High school completed	32	43.2	29	39.2
College and beyond	34	46.0	41	55.4
Total	74	100.0	74	100.0

AGE

Almost 79% of the respondents were in their twenties, 28% were between 30 and 34 years old, and the balance was either

18 or 19 (4.1%) or between 35 and 39 years old (4.1%). Thus, the overwhelming majority of mothers was in what is normally considered the optimal child bearing age of 20-34 years.

FACTORS INFLUENCING THE DECISION TO DELIVER AT HOME

PREVIOUS HOSPITAL DELIVERY

Most of the women (44) in the sample had delivered a child in a hospital prior to their home delivery in 1976. Because previous research had established negative reactions to the hospital as a major element in the attitudinal profile of couples who opt for a home birth (Hazell, 1974), it seemed important to ask the respondents of this study how they felt about their previous hospital deliveries. The women had much to say in response to this open-ended question. Their answers can be grouped into three broad categories: positive, tolerable and negative hospital experiences. The majority of women (26) fell in the latter category, while 10 women reported a tolerable and 7 a positive experience (1 not ascertained).

Why do so many women react negatively to their hospital experience? A loss of control, which has several facets, was the most frequently mentioned reason. To many, a loss of control meant not being able to participate in decisions concerning the conduct of their care. Some said it meant a loss of dignity and a failure to be recognized as an individual with unique needs and desires. Additionally, for some women loss of control meant an inability to actively participate in their own

delivery. More specific reference to loss of control included responses that they were given medication when they did not feel it was necessary; that they were "put down," as the respondents phrased it, for wanting to nurse; or that they were left unattended in labor. As can be seen from Table 4, resentment of the institutional atmosphere of the hospital is mentioned more frequently than resentment of physicians.

TABLE 4
Reason for Negative Feelings About Hospital Deliveries†
(Multiple Responses)

	Respondents Citing Reasons	
	Number	Percent
Loss of control due to hospital procedures	28	63.6
Separation from baby	24	54.5
Impersonal, non-supportive relationship with staff	20	45.5
Dehumanized, assembly-line hospital atmosphere	14	31.8
Separation from husband	8	18.2
Resentment of doctors	8	18.2
Hospitals are for the sick	8	18.2
Total number of respondents who had previous hospital delivery	44	

† Q: How did you feel about your hospital delivery?

Quotations from two women may give some of the flavor and detail of the concerns which were expressed:

I felt like I was a sick patient and treated as such. I didn't like the idea of taking the baby away at birth. Babies need the closeness of their mother. The people in the hospital were kind, but they were anti-nursing,* so I didn't receive encouragement when I needed it. The main thing that bothered me in the hospital was that their routines did not allow me to be in the positions during labor that I found comfortable. Instead of being able to lay on my side, I had

* Anti-nursing here means against breast feeding.

to lie on my back. They believed in Lamaze so they let my husband into the labor and delivery rooms. But I was very lonely and forced to lie on my back for 22 hours. My pregnancy and labor were normal so there was no reason for the restrictions.

They were giving the baby supplementary formulas and sugar water when I was trying to breast feed. Hospital personnel and doctors alike need to school themselves on nursing . . . and be able to help and advise the nursing mother. They kept me for two extra days. They did not respect my wishes as the mother of the child. They had rigid standard procedures. My bed was next to the nursery and instead of sleeping I lay awake listening to the baby cry. Instead of nursing on demand they brought the baby on their schedule.

What emerges from these answers is the fundamental conflict between the way the respondents view their role in the labor and delivery process and the view of the patient that is implicit in the organization of hospitals. These women feel strongly that they understand the birthing process and that they are often a better judge of how to proceed than the physician or the staff. In holding this view, they are not arguing that they are the experts and the hospital staff and physicians are not. However, they do view themselves in conflict with the procedures which they believe exist for the convenience of the staff or are anchored more in hospital tradition than in expert knowledge. Above all, the women want to be active participants in what they consider a very crucial experience in their lives, whereas the hospital staff insists upon passive submission. Most of the women walked away from a hospital delivery with a deep sense of deprivation, as if they had been robbed of something that they had reason to expect should be their own.

THE DECISION TO DELIVER AT HOME

How do women who have chosen to depart from the generally accepted norm of delivering in the hospital explain their decision?

Many of the themes that emerged in the women's replies were similar to those mentioned in connection with the discussion of previous hospital deliveries. Dissatisfaction with hospital procedures was most frequently listed. For example, respondents were critical of hospital nursery practices that separate the mother from her newborn. The argument that a hospital is an inappropriate place to deliver a baby because pregnancy is not a disease, and a distrust of doctors were also mentioned here. But the decision to have a home birth was not entirely based on a negative reaction toward hospitals. The women who planned home births did so with much appreciation for the emotional support of relatives and friends which exists in the home. Furthermore, they wanted to assume an active role in the birthing process. The importance of exercising control and an emphasis upon *natural* delivery figured prominently in the responses. For many women the home was viewed as the most natural place to deliver a child.

I felt the hospitals were unwilling to make changes that would permit the pregnant woman to have an active part in the labor and delivery. I felt that childbirth should be a natural process — not surgery.

Because of the previous hospital experience, I really wanted to be able to control the delivery in a normal relaxed atmosphere. I wasn't relaxed in the hospital.

I wanted to have my friends and family with me during the birth. I just feel more comfortable at home. . . . I believe in doing things the natural way. It was easier to deliver at home.

When asked why they decided to deliver their baby at home, 21 women mentioned economic factors. For example:

I've never considered any other way. I had seen a home delivery with a midwife and a doctor and I thought I would be more relaxed here. I didn't really have the money and I didn't want to pay \$2,000 unnecessarily. I'm healthy . . .

and didn't anticipate any complications. After I did some reading I found many more reasons. I wanted to keep the baby with me and breast feed; I didn't want to be hassled by the nurses about it. When I thought of the birth I envisioned the family being with me and a few friends — not making a big deal about it. I wanted my husband to be involved — as did he — and I didn't foresee the hospital agreeing to this.

My decision was a result of all the things I went through in the hospital. Also the financial part. With my last child the bill was \$1,500. I looked for quite a while to find a doctor who would deliver at home. I called all over . . . and they all acted like I was crazy. I had talked to somebody in the congregation who knew someone who had a doctor who did home deliveries. Finally I found a doctor when I was seven and a half months pregnant. Having a baby at home is natural. The other children accepted him. . . .

It is apparent from these answers that financial concerns were among many issues in the home birth decision. Their importance, as compared with the other factors, is difficult to establish. It should also be pointed out that a direct question about the importance of financial factors was not asked. Instead, there was an open-ended question about the general reasons for the home birth decision. This was done in order

TABLE 5

Parents' Income by Importance of Economic Reasons for Home Birth Decision

Income	Financial Factors Given for Home Birth Decision				Total Percent
	Yes		No		
	Number	Percent	Number	Percent	
Less than \$8,000	3	21.4	11	78.6	100
\$8,000 — \$12,999	6	28.6	15	71.4	100
More than \$13,000	12	32.4	25	67.6	100
Not ascertained	2				

to avoid suggesting answers. It may well be that some women chose not to mention economic issues even though they played a role in their decision. People may have been hesitant to mention financial reasons to a stranger. More important, women may have forgotten that economic reasons were an important component in this decision which they themselves have increasingly come to view in terms of either their criticism of the hospital or in terms of the importance of assuming active responsibility for the delivery.

In reflecting about the importance of economic factors in the decision to deliver at home, it is worthwhile to again refer to the incomes of the respondents. With more than half of the families earning over \$13,000 per year, it is difficult to

TABLE 6
Reasons for Home Delivery†
(Multiple Responses)

Reasons	Number	Percent
Dissatisfaction with hospital procedures and routines, and loss of control in hospital	49	66.2
Emphasis on comforts and emotional security in home	40	54.1
Desire to be close to and/or involve family and friends in birth process	39	52.7
Wanted natural birth, no drugs, no intervention	34	45.9
Control in the birth process (either loss of control in the hospital and/or positive control at home)	33	44.6
Desire to care for infant	28	37.8
Economic factors (e.g., no insurance)	21	28.4
Hospital is for sick people and/or concern over infection	19	25.7
Resentment towards or distrust of doctors	10	21.6
Total number of respondents	74	

† Q: Why did you decide to deliver at home?

explain the planned home birth phenomenon entirely in terms of poverty. Moreover, there is no statistically significant relationship between income and the reporting of financial reasons in the decision to deliver at home. That is to say, women in the higher income brackets are just as likely as those with lower incomes to mention economic factors. Therefore, it can be concluded that although the cost factor is certainly an element in the decision, it does not appear to be central to the decision to avoid a hospital.

THE DECISION-MAKING PROCESS

When did women decide to have a home birth and who participated in or tried to affect the decision? Thirty-seven women made the decision to deliver at home during the pregnancy which lead to the 1976 home birth; 33 decided at an earlier date, either before their first pregnancy (12), during a previous pregnancy (12), between the last and recent pregnancy (6) or during previous labor and delivery (3).

Given the emphasis which women placed on the role of family and friends, it is interesting to know who participated in the decision. In the majority of cases (65) the father was involved, but the woman generally suggested the idea first (44 instances). In 43 cases, others encouraged the home delivery — friends primarily (34), but also relatives (15), a physician or other health professional (6).

Although encouragement from others was forthcoming, efforts to discourage the woman from delivering at home were even more frequent. Sixty women, or 81%, said efforts had been made to discourage them from having a home birth. A variety of specific concerns were expressed in the attempt to discourage women — fear of complications during birth, concerns over the safety of the mother or the child — indicating that some of the relatives, friends or health professionals with whom the respondent was in contact considered the risks of a home birth to be extensive.

Most of the women (59) knew someone who had had a home delivery and 15 had attended a home delivery other than their own. As can be seen from the following quote, knowing someone who had delivered at home can be an important element in the decision making process.

One reason for our home birth was that we didn't have insurance and hospitals are expensive. After we talked to a woman who had two babies at home . . . she recommended a couple of books and reading the books we decided to have the baby at home. My mother had 14 children at home and no complications. Knowing that helped me to decide.

The experience of an older relative who delivered at a time when home births were still common and the experience of contemporaries who chose a home birth more recently seem important in influencing women in their decision. This finding stands in contrast to Hazell's (1974) observation in one California study in which members only occasionally knew others who had a home birth.

TABLE 7
Who Discouraged Home Delivery† (Multiple Responses)

Who Discouraged Home Delivery	Respondents Who Cited Sources of Discouragement	
	Number	Percent
One or more members of mother's family	26	43.3
Friends	23	38.3
Physician	21	35.0
One or more members of father's family	18	30.0
Everyone	12	20.0
Nurses or other hospital personnel	6	10.0
Total number of respondents who received discouragement	60	

† Q: Did anyone discourage you from having a home delivery?

RISKS

How do women who have delivered at home view the question of risks? As can be seen from Table 8, the attitudes of the women in the sample can be distributed along a continuum. At one end of this continuum are those women who

state definitely that there are risks in home deliveries (16); at the other extreme are those who state that there are fewer risks in delivering at home than in the hospital (18). In between these extremes are those respondents who are of the opinion that there are risks if (a) the woman has not received prenatal care or (b) during prenatal care, the pregnancy is diagnosed as problematic. Others state that the decision to deliver at home has to be based on individual circumstances or that there are no special risks unique to a home birth. On the whole, most women do not feel that there are major risks attached to delivering at home, especially if proper steps have been taken to ascertain potential problems through prenatal care. These answers are not surprising. If women perceived major risks, one would not expect them to make a decision in favor of a home confinement. Moreover, by definition, only those who successfully completed a home birth were surveyed. Women who planned a home delivery but had to go to a hospital because of major complications during labor or delivery are not included in the sample. One would expect women who had complications to be less sanguine about the risks involved in a home birth. Perception of risks was not related to level of education.

TABLE 8
Perception of Risk

Perception of Risk	Number of Respondents	Percent
There are risks in home deliveries	16	21.6
Yes, there are risks if pregnancy is diagnosed as problematic or if no prenatal care	15	20.3
Decision has to be based on individual circumstances	8	10.8
No special risks unique to home deliveries	17	23.0
Fewer risks at home than in the hospital	18	24.3
Total	74	100.0

In summary then, there were four major reasons that led to the decision to deliver at home: a strongly negative orientation toward a hospital, a commitment to an active role in the birthing process, a desire for emotional support from relatives and friends, and economic reasons. Not one, but several of these concerns influenced the decision of each woman. The husband played a major role in the decision, and many respondents knew of others who had elected a home delivery. Although relatives, friends and occasionally health professionals cited the perceived risks of home births in attempts to discourage respondents from their decision, most of the respondents did not view risks in the same light.

These results capture the major concerns of the women who decided not to deliver in a hospital. Being survey results, they cannot portray the depth and full flavor of the women's concerns. One of the respondents provided a copy of the letter which she wrote to her newborn baby. She describes the circumstances of her birth, touching upon many of the themes which have been discussed.

LETTER TO SASHA

Dear Sasha, little strong baby, you've made it past one week of life. Your first critical week, and it looks like you'll be around for a while.

As ten o'clock came around tonight, I recalled last Thursday when contractions of my uterus told me you were going to be born soon. The contractions had begun at about two in the afternoon, weak and sporadic at first, then growing in rhythm and intensity, slowly, progressively. All the while I tried to ignore them—No, I'm not ready yet, this can't be the real thing, it's too soon, I haven't gained enough weight yet, it'll be too small. And on and on like that all afternoon and evening while I did laundry and typed on some work I had brought home.

But you kept coming, getting more and more ready to be born whether or not I was ready. I was scared, too, would everything be okay, please, I need more time to think things over, get ready in my head.

But the body is ready even if the mind is not quite. By ten o'clock, after visiting with your then uncle-to-be, and my roommate, and getting some calm and quiet around here, I flipped into being relaxed. Mellow and relaxed—like I can't be anywhere but at home. The fear left as the time went on.

You were born in your home, Sasha, an unusual thing the year you were born for women to even consider. Can't imagine except in a nightmarish way how things will be when and if you even decide to have a child. But in 1976, hospitals, along with much of everything are pretty messed up. Things are backwards—health is sickness, peace is war, honesty is lies, love is hurt. But hospitals are particularly messed up, and I didn't want to bring a child into the world in a cold, sterile, germ-infested, profit-oriented, impersonal, inhumane place that a hospital is.

Being pregnant with you was one of the most beautiful and weird experiences I have had, and to bring it to a climax in a hospital, drugged and intimidated and frightened and at the mercy of the medical profession was too much for me to handle. That's why I decided to give birth to you at home. I hope that it's a commonplace practice by the time you can read this, that women get control of their heads and their bodies to know that they can do it. That giving birth is/can be a warm, personal, intense experience to share with people you love rather than to endure or escape from—or be "quick and painless, easy and efficient," like the doctor tried to tell me.

Well, by ten o'clock my midwives had come and visited and made some preparations and timed some of my contractions, which were now five minutes apart and a full minute long—strong and regular. I thought I was in the early stage of labor and it had all really just begun until the midwife did a vaginal exam and told me I was six centimeters dilated (about four more to go) and that she could feel your head and the hair on it. I burst into tears when she said that—tears of joy, happiness, fear, excitement, everything at once. She said you'd be born in a few hours!

I began to make some phone calls between my contractions to people I wanted to share the news with or ask to come. My friend and your aunt, who was excited and nervous at first but calmed down and watched and helped. My mother, who was also very nervous and frightened by what was happening. She didn't agree with my decision to birth you at home but

didn't come down on me or try to scare me out of it. "It's your decision," she said, "you know what's best for yourself." I hope I can be that way with you some day.

Your father had come back from a meeting which I had talked him into going to earlier, to give the contractions and me time and space to get our rhythm together.

Your birth here was about the most beautiful thing I could have imagined, if I had been able to imagine it, which I hadn't. The house was warm and filled with people and concern and support and love for both of us. Most of my labor was done in a comfortable big chair in the living room, talking and drinking tea between times, making phone calls and feeling better and better about your coming. When the contractions became more intense, we moved into the bedroom which had been made ready with extra sheets, a plastic sheet a few days earlier and last minute preparations by our friends which I wasn't much aware of. I changed into an old yellow nightgown and my sister helped me change my socks—didn't like the short blue socks I'd been wearing all day, so I changed to beige knee socks, a concession to vanity. By the time your birth came, the nightgown had been shed and I wasn't even aware of the socks.

The room was filled with people who came in and out during the next few hours. They watched and breathed with me, encouraging my efforts and telling me what a good job I was doing. I wasn't aware of the goodness of what I was doing just that I was doing what my body was telling me needed to be done. Breathing and relaxing and panting and relaxing and nothing else was on my mind.

It all happened much quicker than I thought it would. The contractions had become more and more intense but I was staying with them. Then, all of a sudden my body did something very different—it really took over for the final big pushes. Felt like I was going to take a huge crap whether I liked it or not and you would explode into the world. Then the harder work began. I could feel those pushes so clearly, could help them along by holding my breath and concentrating on pushing down until I would feel some burning and let up, relaxing my muscles in the pelvic floor and waiting for the next contractions to come. Those pushes had brought your head out and during the relaxing it would slip back in. There were a lot of cheers from everyone watching when your head

came out and sighs when it went back in. But it kept coming further and further with each one, and after six or seven of those heavy contractions, I felt that your head was almost all out.

I couldn't see your head emerging like everyone else could. I was feeling all the sensations, concentrating fully on what I was doing. Such a beautiful cheerful sigh filled the room when your head was completely out! You were born with a cowl over your head—I'm told that's a sign of psychic power.

The next contraction brought out your arm and then the rest of your body. My friend said your hand and arm came out and up like a gesture of greeting. I looked down between my legs, opening my eyes at last, and saw your little head looking all around and your eyes, I swear, checking out the new world you'd come into.

You went through a struggle coming and staying in this world the first week of your life. You were so tiny we didn't know if you would survive. Even considered taking you to a hospital where they would have put you in an incubator and probably fed you artificial milk and kept you away from me until you had gained a few pounds. I almost did it, as much as I didn't want you or me on the inside of a hospital. But I wanted you to survive, Sasha, and I would have done whatever was necessary. Decided to keep you at home, do all we could for you here, before taking that big step and turning you over to a hospital. We incubated you in the bedroom. I fed you every two hours whether you wanted it or not, kept a record of all that went in your body and came out, weighed you constantly, held you and gave you every encouragement I could, day and night for almost a week. And you thrived, Sasha, grew bigger and stronger and more alive each day.

You are now almost two weeks old and weigh over five pounds and have a habit of sleeping most of the day and staying awake most of the night, a habit you picked up from your mother. Your baby uterine skin is almost all peeled away, you're growing eyelashes and your lung capacity has increased. You cry much louder than a few days ago. And you let out little squeaks and smiles and giant burps. You seem peaceful and contented most of the time (not so sure about myself these days but that has more to do with me than you.) You give me much joy just looking at your peaceful sleeping face and know-

ing that my milk and my care are keeping you alive and well. You have a lot of growing to do, Sasha, and I'm looking forward to us growing and learning and loving together.

Your Mother.

OBSTETRICAL HISTORY, PREPARATION FOR HOME BIRTH AND CARE DURING LABOR AND DELIVERY

The "Letter to Sasha" illustrates a dramatic rejection of hospitals. In deciding to nurse their premature infant at home, Sasha's family was assuming a tremendous responsibility. Though this is an extreme example, its spirit is not atypical of that expressed by many of the respondents whose decision to deliver at home was often based on negative hospital experiences. But did all the women take on the responsibility of a home birth with the same diligence as Sasha's mother? Critics of the home birth movement frequently state that those delivering out-of-hospital are unaware of the risks they are taking. Would some of these women have been considered high risk cases because of serious complications during a previous pregnancy and delivery? In order to assess this item, the women who participated in the study were asked about their obstetrical background.

Prior to the home birth in 1976, 14 of the 74 women interviewed had experienced an interrupted pregnancy; 10 had an involuntary abortion (miscarriage), 4 a voluntary abortion. No woman reported having more than one miscarriage or abortion. Since only women with three consecutive spontaneous abortions are considered habitual aborters, medical

opinion would not consider them at greater risk than other women. In the case of the voluntary abortions, information about the month of the pregnancy in which the abortion was performed is not available and, therefore, the risk factor cannot accurately be judged. If the women had had their voluntary abortions in the second trimester, they may have been at greater risk in their 1976 pregnancy than other women.

For 19 women, the 1976 home birth was their first delivery. Of the 55 women who had previous deliveries, 28 had one child, 15 had two children, 7 had three children, 3 women had four children, and 2 women had five children. As Table 9 indicates, 36 of the 55 mothers who had children before 1976 had not experienced any complications during their previous pregnancies or deliveries. However, 10 women did report complications during a prenatal period. These include two cases of toxemia, one ectopic pregnancy and one instance where problems resulted from obesity. Others described minor problems such as spotting, morning sickness and colds. Ten had complications during their labor and delivery: breech presentation (2), face or posterior presentation (3), blue baby (1), vomiting and delayed delivery of the placenta (4). Two women reported complications during both the prenatal period and delivery. While several of the complications listed are potentially serious at the time they occur, most would not necessarily redevelop in a subsequent pregnancy.

TABLE 9

Previous Pregnancies: Problems During Prenatal Period by Problems During Labor and Delivery

Problems During Prenatal Period	Problems During Labor and Delivery		Total
	Yes	No	
Yes	2	8	10
No	8	36	44
Not ascertained			1
No previous pregnancy			19
Total	10	44	74

Judging from their histories, most of the women in the sample who had given birth before 1976 do not appear to have been at greater risk than the general population. The exceptions to this are the respondent who cited obesity as a complication and the two grand multiparas. The 19 primiparas, of course, did not have an obstetrical history which could contribute to judging risk factors.

PREPARATION FOR THE HOME BIRTH

There were several dimensions to the preparation of planned home births on the part of the parents. Preparation may have included any one or a combination of the following: prenatal care, reading, childbirth preparation classes, special instruction for home birth, physical preparation of the environment and preparation for possible complications.

Prenatal Care

Prenatal care is essential if certain complications of pregnancy are to be recognized and appropriately managed. Sixty-eight women in our sample recognized the need for prenatal care, although the type varied. Most women sought care from medical physicians; several others from osteopathic physicians; and three women reported care from either a chiropractor, a midwife or a Christian Science practitioner. As Table 10 indicates, care from a medical physician was supplemented with care from an osteopathic physician or midwife in six instances.

The American College of Obstetricians and Gynecologists has established guidelines for prenatal care.

A normal patient should generally be seen at least every four weeks for the first 28 weeks of pregnancy, every two weeks until the 36th week, and weekly thereafter. Weight, blood pressure, urinalysis, height of fundus, abdominal findings on palpation and character and location of fetal heart tones should be determined at each visit.*

* From "Standards for Obstetric-Gynecologic Services", Committee on Professional Standards of the American College of Obstetricians and Gynecologists, 1973-1974, p. 36.

TABLE 10
Prenatal Care Provider by Month Care Began

Prenatal Care Provider	Month Care Began			Total
	1st-3rd	4th-6th	7th-9th	
M.D.	38	12	2	52
D.O.	3	2	—	5
M.D. and D.O.	1	1	1	3
M.D. and midwife	3	—	—	3
Chiropractor	1	—	—	1
Midwife	—	1	—	1
Christian Science practitioner	—	—	1	1
Not ascertained	1	1	—	2
Total who received prenatal care	47	17	4	68
No prenatal care				6
Total				74

Almost 60% of the women (44) who received prenatal care had 10 or more visits and, hence, compare quite favorably with the ACOG standards. On the other hand, 22 respondents (32.4%) reported having fewer than 10 visits. Obviously, this constitutes limited prenatal care.

Table 11 shows the number of prenatal visits the women had relative to the month of pregnancy in which they began receiving care. While there is some relationship between a high number of visits and early prenatal care, there are also a few women who started prenatal care early but had very few visits. These women may have encountered resistance from health care providers when they discussed their plans for a home birth, or possibly they may have had other negative reactions to the health care system that influenced their decision not to return. Emrey's (1973, p. 2) discussion of why there is inadequate prenatal care for women who plan a home birth in California may provide insights into what is happening in Michigan as well.

Another difficulty experienced by many families seeking home births is the reluctance or refusal of established medical care systems, such as clinics or private physicians, to accept or continue them for prenatal care if their wishes for

home birth become known. Some wishing to approach delivery with as much knowledge and assurance of their risk status as possible choose to hide their delivery plans. Others, attempting to be honest, find themselves terminated from care or subjected to considerable hostility and insensitivity. Many physicians, on the other hand, fear medicolegal implications if they are called in to salvage a failed home labor or birth. In this situation, the physician may have difficulty establishing effective communications with the family and providing the needed care in an acceptable manner, which reinforces his reluctance to deal at all with families seeking such alternatives. Frequently they face a family with whom they have not developed a trust relationship and who may present considerable fear or hostility toward the traditional medical establishment. Often, there has been too long a delay in obtaining hospital care, no adequate history or prenatal data is available, medical or surgical intervention may be needed. The fear of such an occurrence may have prompted the choice for home birth in the first place.

TABLE 11
Number of Prenatal Visits by Month Care Began

Month Care Began	Number of Visits					Not Ascertain- ed	Total
	Under 5	5-9	10-14	15-19	20 & over		
1st	-	2	7	4	-	1	14
2nd	1	5	8	4	4	1	23
3rd	-	4	4	1	-	1	10
4th	1	4	2	-	-	-	7
5th	2	1	4	-	-	1	8
6th	-	1	1	-	-	-	2
7th	1	-	-	-	-	-	1
8th	1	-	-	-	-	-	1
9th	1	-	-	-	-	-	1
Unknown	-	-	-	-	-	1	1
	-	-	-	-	-	-	-
Total who received prenatal care	7	17	26	9	4	5	68
No prenatal care							6
Total							74