ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3214.84 HHESS HB 335

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James A. O. Smith
Signature of Camera Operator

7/25/89
Date

02-519 (REV 8/78)

HB

335

COMMITTEE REPORT

HOUSE

(7)

FURTHER:

3/29/85

Date: 1 April 1985

The Committee on HEALTH, EDUCATION AND SOCIAL SERVICES has had HB 335

"An Act relating to practice of midwifery; and providing for an effective date."

under consideration and recommends:

[X] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for ______ [ ] same title [ ] new title

and recommends ______

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note [ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the ______ Committee

MEMBERS SIGNING DO PASS

[signatures]

MEMBERS HAVING OTHER RECOMMENDATIONS:

[signature] (No-Rec)

[signature] (NO-REC)

[signature] No rec

[signature] (No Rec)

[signature] Co-ch

CHAIRMAN

[signature] Co-chm

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

COMMITTEE REPORT

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[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

CHAIRMAN

House

To: HESS Comm.

Reps. Gruenberg
Koponen
Taylor
Hanley
Hurley
Pettyjohn
Thompson

4/1/85 1 page

Testimony for meeting today at 4:30 p.m - please deliver

from: Vicki Penwell — FBKS.

4-1-85

Statement to be read at H.E.S.S. Committee hearing on H.B. 335 concerning the practice of midwifery.

The Midwives Association of Alaska, a self-regulating body, is in support of House Bill 335 which would clearly define midwifery in the state of Alaska. Members of our Association have received over 700 positive responses from consumers of midwifery care, coming from all the major cities and towns around the state. Several physicians have also given verbal support to a bill that would clearly define and legalize midwives, so as to prevent homebirths from going underground, a higher risk to mothers and infants.

Please understand that this bill does not address the question of physical setting for childbirth. The issue is whether women choosing alternative birth settings have the right to a qualified, legal attendant (a midwife). The World Health Organization, the International Confederation of Midwives, and the International Federation of Gynogology and Obstetrics have all defined the practice of midwifery as seperate from the practice of medicine, and have endorsed midwifery as a way to upgrade health care throughout the world. Alaska needs to take this same step.

Thank you very much for your careful consideration of this vital matter.

Respectfully submitted,

Vicki Penwell

Vicki Penwell, Registered Midwife
Director, Midwives Association of Alaska
P.O. Box 81242
Fairbanks, ALASKA 99708
479-6388 or 456-3719(w)

212 W 9th
Juneau. Ak.

Dear Judge Shortell: & The House Hus. Com.

I am a college-educated mother of two children. I took very seriously my responsibility for bringing children into the world and read many books on childbirth. This research taught me that it would be more dangerous to have my baby with medical intervention than at home with a midwife naturally. I read statistics that the rate for C-sections in US hospitals was 25% of all births when ten years earlier this rate had only been 2-3%. With a C-section I learned breastfeeding would be made more difficult as my body would have to recover from radical surgery.

MY first child, Kristen, was born in Louisiana, where there were only four midwives registered in the state. I lived in the city of New Orleans which had outlawed midwifery in the 1920's, the result of pressure from the medical community. So I had to look and hard for a midwife. I also had to go to her house for my delivery as she lived outside the city limits where practicing midwifery was legal. Although a hospital birth was covered by our medical insurance we chose to pay out of our pockets so as to have a completely natural birth. My resulting birthing experience was wonderful; the strongest, most loving experience of my life. I was fully awake, totally undrugged. I had the midwife's total attention for the last six hours of my labor, during the birth and six hours afterward as well as hours of her kind attention, during my pregnancy and during the postpartum period. I don't know how often you have gone to see a doctor in the last decade but if you have you can understand how important it is to have someone handling your delivery who has lots of time and attention for you.

By the time my son was born I had moved to Alaska. I immediately looked for a midwife and was referred to Bonnie Lang here in Juneau. She was equally attentive during my pregnancy and extremely calm, efficient and caring during my homebirth. Cody was born with a complication, the umbilibal cord wrapped around his head several times, and Bonnie immediately cut it so he could be born unobstructed. This time was another occasion for joy and I could immediatly attend to my son's needs and begin breastfeeding and begin the parental bonding which is so vital to a happy parent-child reletionship.

My children are now 8 and 5, extremely healthy, confident children. I can count on one hand the times that either has gotten sick during childhood. I think their way of being born, naturally, had more to do with this than anything else. Bonnie Lang has had extensive training as a lay midwife; she does not practice medicine. She helps women and families facilitate an extremely natural act.

I urge you to support midwivery in our state by ruling that natural childbirth is not the practice of medicine.

Most sincerely,

Doris Lynch

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

Dear Rep Halcro & Spuce and Senate
Authority urge your
support of HB 335 and
SB 229. Do value my
freedom of choice
and the freedom
of those who assist
me in my choices.

Thank you very much,

Bobbie H Waldron
P o Box 2833
Juneau Ak 99801
789-1688

ANNA DiTRAGlia
1015 WEE BURN
Juneau 586-2361

I fully suppor HB 335 and
Senate Bill 239 and
the mergence of the two-

I believe our children are
our most valuable resource
and where and how and
with whom they are
born should remain
within the hands of
parents!

Lizette Hoff

We are the parents of five children. The first child was born in a hospital. The doctor insisted I stay for two days, although I felt well enough to go home 12 hours after her birth. ~~The next three children~~ During the ~~within~~ following two weeks of the birth I had fevers that varied from 99° to 105° - it was discovered that two pieces of placenta had been left inside the womb. The next three children were born at a doctor's office and I went home within four to six hours of each birth. I felt better and the older children were happier and accepted the baby more readily, since they never "lost" me to the hospital or the new baby.

The last child we chose to have a midwife ~~and~~ in attendance. We made this choice for several reasons.

1- Cost - just one visit to a doctor during my pregnancy cost me nearly 25% of my total ~~$1100~~. I late midwife bill to think what full care plus hospital delivery would have cost us!

2- Information - I found the midwife gave me more information about pregnancy, vitamins and delivery than any of my previous doctors had.

3- Patience - my midwife was not on a tight schedule, so she waited for my body to prepare for the birth. She let me take all the time I needed instead of having me push too hard, too soon and giving me an episiotomy

I firmly believe that if doctor's cared more for their patients than for their own time schedule there wouldn't be so many episiotomies

4- Knowledge - We found our midwife very knowledgeable about all aspects of pregnancy and delivery. She knows her limitations and was willing to take us to the hospital if an emergency had arisen.

We had our last child at home and with all the other children there to see her born. They were all epited and stayed out of the way as then were asked to. They each felt like they were a part of the birth and I have seen a greater show of love from them to this baby as a result of that. They all think she is very special, which she is.

I urge you to pass this legislation, so midwives can continue to offer this marvelous care in Alaska.

We plan to have another child and after our previous experiences would not want to have the birth anywhere but at home, with a midwife in attendence.

P.O. Box 137
Juneau, Ak., 99802

March 27, 1985

Honorable Judge Brian Shortell
303 K Street
Anchorage, Alaska, 99501

Honorable Judge Shortell,

I am writing in regard to the recent decision of the medical review board making attendance at a natural child birth a practice of medicine. This decision carries many ramifications.

First of all, birthing is neither historically nor traditionally a medical procedure. Your compliance with the decision of the medical board would not prevent women from choosing and having home births. The decision would, however, prevent women choosing home birth from having a qualified attendant, i.e. a midwife, present at the home birth. This will not result in fewer home births, but will result in more home births without a qualified attendant. If a birthing complication should arise (as happens in less than 10% of all births) the unattended woman may not get help in time to save her child or herself. If a midwife practicing "underground" is present, that midwife would not be able to call an ambulance, or accompany the birthing woman to the hospital for fear of criminal charges. Futhermore, if emergency care is necessary, a private hospital would not be obligated to take as a patient a woman who had first opted for home birth. Although this may sound punative, there are documented cases of hospitals either refusing or treating as criminals women who opted for home birth and then went to the hospital in states where midwifery is not legal.

Senate Bill #239 and House Bill # 335 will clearly define midwifery and ensure that practicing midwives are licensed by the state and have the training necessary to attend natural child births and give quality care. I would urge you to study these bills carefully in considering the decision of the medical review board.

Finally, I and many other Alaskan women who have and will continue to have our children at home would like to have our births attended by midwives who give quality service and are able to charge for their skills without being criminals.

Thank you for your reconsideration of this issue.

Sincerely,

Jan Herbert Doyle

4/1/85

Remund
P.O. Box 8881
Port Alexander, Ak.
99836

We support Senate Bill 239 and House Bill 335, both dealing with the practice of midwifery in the State of Alaska.

Childbirth is a natural process that traditionally and historically has been excluded from the practice of medicine. Midwifery should not be ruled as practicing medicine. Healthy low risk mothers and parents should have the option of having a safe natural childbirth at home with the professional care of a midwife.

We have chosen a home birth for the birth of our first child because we feel more comfortable in our home. Our midwife determined that I am in good health and a low risk mother so odds are that we will have a safe natural birth in our home. We feel that if any complications do arise we can easily go to the hospital. We feel our odds are better at home to have a natural childbirth because we have heard from people and also have read statistics that show us that there is often too much unneeded intervention such as ultrasound diagnosis, internal fetal monitoring, excessive use of sedatives, pain relievers, and anesthetics, pitocin-induced labor, and the temptation to resort to delivery by cesarean section. Technology itself is not the problem, but the overuse of it is.

We feel that the ability to exercise labor inducing techniques of our choice in a home birth situation are important to us. Techniques such as walking, squatting, changing positions, nipple stimulation, eating and drinking throughout labor, or whatever makes the mother more comfortable and helps labor progress are freely used in a home situation. We have heard from friends and family that in a hospital situation these techniques are not as freely used or accepted.

Evidence has been mounting over the past decade that indicates the use of drugs during delivery, especially anesthetics and those that induce labor, have a dramatic negative impact on the health of the child. We do believe though, that hospitals have their place and that there are times when technology and intervention are necessary for the birth of a child.

We feel that this is a basic human rights issue, and that parents should have the choice or option to have their children at home with a trained midwife or in a hospital with their physician. We feel that we should always have the right to have the birth of our children at home, where we are in control of our environment, where the mother is surrounded by people who really care for her, and where she feels her own sense of power and control; where her body can relax and she can give birth naturally

Sincerely,

Jean & Marty Rommel

To: Alaska House of Representatives April 1, 1985

From: Thomas G. Kluberton
815 Dixon St.
Juneau, Alaska 99801

Subj: HB335, a bill regarding
the practice of midwifery

My sentiment toward HB335 is very strong in favor of passage.

I'll offer two points in testimony to that end. First, notice the attached article which addresses the evolution of hospitals and points out that only in relatively recent times have more people survived hospitals than perished therein. Second, my personal belief in the natural (not pathological) nature of birth.

Perhaps germain to the second point, my own experiences with the home birth of my two sons have reinforced my committment to the availability of choice in the setting of the birth of one's children.

Both sons are happy healthy children and I am secure in my belief that hospitalization for either birth would have been a waste of time, and an undue encumberance of limited hospital resources.

The boys mom is a registered nurse with a baccalureate degree, yet we engaged the services of lay-midwives for these births.

I am a computer consultant and at the time of both births and had ample insurance to cover the medical expenses.

The conviction here is CHOICE!
I do not want the medical profession mandating the surroundings and accompanyment of the most personal events of a person's life to be conducted in a cold sterile institution.

HOW MODERN HOSPITALS GOT THAT WAY

by Roslyn Lindheim

The very first requirement in a hospital is that it should do no harm. –Florence Nightingale

The adjectives used to describe hospitals include dehumanizing, depersonalizing, neutering, frightening, uncaring. I have never heard anyone describe a hospital as beautiful, peaceful, healing, warm, joyous.

This article is an attempt to capsulize 2000 years of hospital history into a few pages and pictures. It is the result of a series of talks on the architecture of hospitals given in an effort to understand why the image and the reality of the hospital are so far apart.

Many people are questioning the medical effectiveness of much of what is done in hospitals and point to the unnecessary surgery, the overuse of diagnostic facilities, the hazards of iatrogenesis (medically induced illness), and the astronomical costs – over 40 per cent of the U.S. health budget. Indeed a look at the modern hospital speaks not of human healing but of awe of technological progress, not of caring but of increase in the G.N.P., not of generating health but of saving jobs and institutions.

Despite this, the belief in hospitals is strong today. There is no awareness that until seventy years ago no one with any class or clout voluntarily went to a hospital. It was a place of disposal and death, not cure. It is only since the early part of the 20th century that once in a hospital one had better than a fifty-fifty chance of survival. But even with these new odds we know that our better health is due not to the medicine of hospitals but to better food and sanitation. The question is, where do we want to put our resources? How do we want to be cared for at birth, when sick, when old, and when dying?

Every day we read of more things that make us sick. Radiation in the air, poison in the water, food-anxiety, tension, frustration, loneliness, automobile accidents, asbestos, all producing sickness -- and every day on the next column we read of the crisis in medical care, the high costs, the lack of access. It's like firemen setting fires so they can use modern technology to effectively put them out.

The problem – the catch 22 – is trying to develop a rational approach to the design and operation of hospitals within the context of an irrational society. I thought that a sketch of the background, of the reasons and rationales that preceded this generation of hospitals might help us better grasp the issues of today.

A friend and colleague of Ivan Illich, Roslyn Lindheim is a Professor of Architecture at the University of California, Berkeley. Among her recent activities is setting her students loose in the South Oakland ghetto to find out what the people living there know of medical services available to them and how they find out. A major source is unused parking lots, where the locals hang out in their cars and gossip.
–SB

BEGINNI

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E ·· 428, Sausa

Alaska State Legislature
Pouch V, State Capital
Juneau, AK 99811

Dear Member,

I am writing to express my strong support for House Bill 335 & SB 239 which clearly defines midwifery, establishes licensing standards for midwives, and permits the practice to be a legal activity in the state of Alaska.

In recent years there has been a significant increase in the number of people who are choosing to have their babies at home. Reasons for this include the desire to experience birth in the comfort and intimacy of one's home as well as concerns about the safety of hospital birth. For my own part I can say that my wife and I plan to have our next baby at home, and the forgoing figure prominantly in our predisposition to do so.

The only conceivable objection to this legislation will come from those who may be concerned that home birth is not safe. This is a red herring if ever there was one. There is ample evidence to demonstrate that planned home births attended by licensed midwives are as safe or safer than hospital births. Consider the following:

1. A study in North Carolina from 1974 to 1976 examined 1,296 home deliveries. These births were classified by the researchers according to planning status (i.e. whether the fact that the birth took place at home was planned or unplanned), and whether or not attendants were present. The study found that among prenatally screened home births attended by licensed lay midwives, the neonatal mortality rate was only 4 per 1,000. For all hospital deliveries during the same time period there was a mortality rate of 12 per 1,000, and for low risk hospital deliveries a mortality rate of 7 per 1,000.

2. Lewis Mehl in a 1977 study used matched samples of over 1,000 planned homebirth women and planned hospital birth women, and found homebirths to be safer by a variety of measures for both mothers and babies.

3. Denmark, where a large proportion of births are at home and attended by midwives, has one of the lowest infant mortality rates of any nation. In contrast, the United States ranks 19th among industrialized nations in infant mortality.

These examples are illustrative of the fact that planned homebirth is safe when undertaken with a trained midwife in attendance. I would caution you to examine very carefully claims to the contrary, for inevitably they are based upon figures which fail to differentiate between planned and unplanned homebirths.

This legislation is desirable because it assures that midwives meet clear standards in order to be licensed. Establishing such standards will help guarantee that those midwives attending home births will be well-qualified. Indeed, the criteria used in the legislation is far more stringent than the minimum training a general practitioner must have with regard to labor and delivery in order to enter practice.

I strongly urge you to support Senate bill 239 & HB 335.

Sincerely,

David J. Ottoson

David J. Ottoson
212 West Ninth Street
Juneau, AK 99801

CONCERNING HOUSE BILL 335

I support this bill along with the Midwives Association of Alaska.

The basis of this legislation is the defining of midwifery--something that has been lacking in this state. Attending natural childbirth should not be construed as the practice of medicine. Traditionally and historically it has been treated separately. Midwives have for hundreds of years been helping women in childbirth. And women will continue to seek their care.

The difference is that today midwives have, for the most part, a much higher level of training and education. Most midwives today take great pains to acquire the education and skills they need and because there are still few schools for midwives, this takes a lot of self-determination and dedication.

A trained midwife is skilled in giving prenatal care, educating parents, giving nutritional advice and handling normal labor and delivery. She is able to recognize any deviation from normal and take appropriate steps to assure the safety of mother and baby. She will seek medical help when appropriate and in the absence of medical help, she is trained to deal with emergency situations.

The Midwives Association of Alaska has taken it upon themselves to regulate midwives in Alaska. The regulations define the scope of practice for midwives and provide additional safeguards for mother and baby. Even though these are now voluntary, most midwives feel they are appropriate and reasonable.

If this bill is passed (and even if it is not) the Midwives Association of Alaska will continue to regulate themselves to assure a high standard of care for our clients.

We ask for your support for this bill.

Thank you,

Kaye Kanne, Midwife
New Mexico License #84090-P

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 335

For "An Act relating to the practice of midwifery; and providing for an effective date.

This bill excludes the practice of midwifery from the practice of medicine or osteopathy and defines the practice of midwifery in Alaska. The definition is broad and does not limit the practice to the care of low risk or "normal" pregnancies and deliveries.

The practice of lay midwifery has been mostly unregulated in Alaska although the State Medical Board has apparently recently stated that if a fee is involved, lay midwifery would constitute the practice of medicine. The proportion of births attended by lay midwives is not known but is probably quite small. Over 95 percent of Alaska births occur in hospitals.

The development of alternatives to hospital births has become a subject of much discussion over the past 10-15 years. A number of women prefer birth to occur in the home in a non-medical atmosphere. Some others are concerned with costs of hospital care. In response to this, a relatively few physicians, some nurse-midwives, lay midwives and family members have become more frequently involved in home births. Also, in order to make birth a more "natural" event, many hospitals have established birthing rooms and free standing birth centers have become common. Alaska health facility licensing regulations allow for the establishment of such centers, and at one time two were in operation.

The role of the lay midwife is controversial. Many, if not most, physicians and nurse-midwives do not believe that the lay midwife is sufficiently trained to exercise adequate clinical judgment in the event of an unexpected misadventure in the course of pregnancy, labor, delivery or the immediate postpartum period. Proponents cite the right of the pregnant woman to decide on the type and location of her own care. Studies of the relative safety of home birth with various types of attendants abound but many are apparently not free of methodologic problems. Some relatively recent studies from North Carolina and Kentucky seem to indicate that planned home births (as opposed to precipitous delivery at home or to situations in which the woman cannot reach the hospital) are as safe or safer than hospital births. It should be pointed out, however, that no information is given regarding the degree to which home births or lay midwifery is regulated in these states.

POSITION PAPER/Department of Health & Social Services

The Department of Health and Social Services does not support HB 335 in its present form. If the Legislature wishes to authorize the practice of lay midwifery in the state, the Department believes that the administrative branch should be empowered to define education and training requirements as well as establish regulations governing the practice as it has done in most of the businesses and professions covered by Title 8 of the Alaska Statutes. Such regulations would be intended to ensure safety for mother and infant to the maximum extent possible and might cover requirements for medical screening, relationships with professional providers such as physicians and nurse-midwives, referrals, etc. An example of such regulations is attached.

Recommended by: _____

Robert I. Fraser, M.D.
Director
Division of Public Health

Date: _____

Approved by: John R. Pugh

John R. Pugh
Commissioner
Department of Health and Social Services

Date: 3/29/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: HB 335

Title: Practice of midwifery

Sponsor: Koponen

Requestor:

Date of Request: 3/28/85

FISCAL DETAIL

Agency Affected: Health & Social Serv.

Program Category Affected: Public Health

BRU, Program or Subprogram(s) Affected:
State Health Services

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 SUPPLIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS	0	0	0	0	0	0
800 MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

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

ANALYSIS: Attach a separate page if necessary

Prepared By: Robert I. Fraser, M.D. Phone: 465-3090

Division: Public Health Date:

Approved by Commissioner: John R. Pugh Date: 3/29/85 gcc

Agency: Department of Health & Social Services

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

7/1/84

January, 1985

To Whom it May Concern

Statement on the Regulations of Lay Midwives

The state of New Mexico updated its Regulations Governing the Practice of Lay Midwifery in 1980. With minor revisions in 1982, we have now had four years experience with registration and examination of lay midwives and regulation of lay midwifery practice under the new regulations.

The advantages of the regulation process are that it:

1. Establishes standards which insure basic competence for safe practice within the scope of practice outlined by the regulation.

    a. Allows would be practitioners/trainers to see what training is needed prior to practice.

    b. Allows would be consumers to make an informed choice based on capabilities and limitations of the registered practitioners.

2. Provides for monitoring of the management practices of lay midwives and the pregnancy outcomes of their clients.

3. Helps to identify areas of need for basic or continuing education of lay midwives.

4. Provides access to lay midwives via a registry generated mailing list to disseminate practice information/reporting, e.g. appropriate alternative medications for newborn eye prophylaxis, annual reports and to announce continuing education opportunities.

It should be kept in mind, however, that regulation does not make everyone work together in a cordial, collegial manner nor live happily ever after. Evaluation of complaints for possible disciplinary action is a difficult task at best, and regulations should provide for adequate legal authority, process and staffing to make as thorough an investigation of complaints as may be warranted.

Linda Lonsdale, C.N.M., M.P.H.
Maternal Health Section Head
P.O. Box 968
Santa Fe, New Mexico 87504-0968

HEALTH AND ENVIRONMENT DEPARTMENT
HEALTH SERVICES DIVISION
725 Saint Michael's Drive
Post Office Box 968
Santa Fe, New Mexico 87504-0968

HED-82-1 (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, certified nurse-midwife, or certified nurse practitioner specially qualified by the Board of Nursing.

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,

104.07. "Midwifery instructor" means a person as listed in section 602 who has a formal training and supervisory relationship with an apprentice lay midwife.

104.08. "Physician" means a person licensed to practice medicine or osteopathy in the state in which he practices.

104.09. "Provisional lay midwife" means a person who has completed the provisional permit requirements of sections 600 and 601 and is in good standing on the registry of lay midwives maintained by the Division.

104.10. "Registered lay midwife" means a person who has completed all the requirements of sections 600 and 601, has successfully completed the examination process, and is in good standing on the registry of lay midwives maintained by the Division.

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

104.12. "Registration period" means the period from April 1 of any year through March 31 of the following year; registration or permits may be issued at any time but shall expire on March 31 of the following year.

104.13. "Supervision" means the coordination, direction and continued evaluation at first hand of the person in training and obtaining clinical experience as an apprentice lay midwife 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.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

HEALTH AND ENVIRONMENT DEPARTMENT
HEALTH SERVICES DIVISION
725 Saint Michael's Drive
Post Office Box 968
Santa Fe, New Mexico 87504-0968

HED-82-1 (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, certified nurse-midwife, or certified nurse practitioner specially qualified by the Board of Nursing.

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 87504-0968. Appeal of an adverse decision of the Division shall be consistent with the procedures and grounds for hearing in the Uniform Licensing Act, 61-1-1 thru 61-1-33 NMSA 1978 (1981 Repl.)

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 to obtain clinical experience under supervision of a physician, certified nurse-midwife, certified nurse practitioner specially qualified by the Board of Nursing, provisional 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, a certified nurse-midwife, or certified nurse practitioner specially qualified by the Board of Nursing.

104.07. "Midwifery instructor" means a person as listed in section 602 who has a formal training and supervisory relationship with an apprentice lay midwife.

104.08. "Physician" means a person licensed to practice medicine or osteopathy in the state in which he practices.

104.09. "Provisional lay midwife" means a person who has completed the provisional permit requirements of sections 600 and 601 and is in good standing on the registry of lay midwives maintained by the Division.

104.10. "Registered lay midwife" means a person who has completed all the requirements of sections 600 and 601, has successfully completed the examination process, and is in good standing on the registry of lay midwives maintained by the Division.

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

104.12. "Registration period" means the period from April 1 of any year through March 31 of the following year; registration or permits may be issued at any time but shall expire on March 31 of the following year.

104.13. "Supervision" means the coordination, direction and continued evaluation at first hand of the person in training and obtaining clinical experience as an apprentice lay midwife 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: No person shall hold himself 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. Violation of this provision is subject to prosecution or civil action as may be provided by law.

203. SCOPE OF PRACTICE OF EACH REGISTRATION LEVEL: A person may be registered as a lay midwife, a provisional lay midwife, or an apprentice lay midwife.

203.01. A registered lay midwife may provide any care or services allowed by these regulations.

203.02. A provisional lay midwife may provide any care or services allowed by these regulations for a period of two years with two renewals possible but not to exceed six years as defined in section 302.03.

203.03. An apprentice lay midwife may only provide care or services under the supervision of a licensed physician, certified nurse midwife, certified nurse practitioner specially qualified by the Board of Nursing, provisional or registered lay midwife.

REGISTRATION OF LAY MIDWIVES

300. TYPES OF PERMITS AND FEES: Upon application, meeting the requirements and payment of fees, a person subject to these regulations may be issued an apprentice permit, a provisional permit, or a registration permit, as applicable and in accord with these regulations.

301. APPRENTICE PERMIT: Upon application, an apprentice permit may be issued which authorizes the person to obtain the required clinical experience under the supervision of a licensed physician, certified nurse-midwife, certified nurse practitioner specially qualified by the Board of Nursing, provisional or registered lay midwife. The applicant must provide verification of apprentice/supervisor relationship from the person or persons supervising the applicant. The permit is valid only so long as the verified relationship(s) exist(s).

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 high school or its equivalent as determined by the Division;

302.02.02. Evidence of satisfactory completion of areas of study and required clinical experiences as cited for provisional permits in sections 600 and 601.

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

302.02.04. Evidence of current certification in cardio-pulmonary resuscitation of the adult and newborn.

302.03. A provisional permit may be renewed twice only for a total not to exceed six years.

303. REGISTERED LAY MIDWIFE PERMIT: Upon meeting the requirements of sections 600 through 601, a person may apply for a registered lay midwife permit and shall submit:

303.01. An application for the permit and to sit the next qualifying examination;

303.02. Evidence of completion of all the requirements of sections 600 and 601;

303.03. Evidence of current certification in cardio-pulmonary resuscitation of the adult and newborn.

303.04. Four recommendations, one each from a physician or certified nurse-midwife, a midwifery instructor, a consumer and a member of the community.

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 for a registered lay midwife permit and 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 PERMITS: Every lay midwife permit must be renewed every two years. An applicant for renewal shall submit to the Department:

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

307.02. Evidence of completion of sixteen (16) contact hours of continuing education as required by Section 603;

307.03. Evidence of current certification in cardiopulmonary resuscitation of the adult and newborn, and

307.04. Renewal fee as prescribed by the Division.

308. GRACE PERIOD: Delinquency in renewal of registration of 30 days or greater shall result in termination of registration.

309. INACTIVE STATUS Any lay midwife registered in New Mexico who is not practicing lay midwifery in New Mexico may be placed on inactive status by requesting such status in writing and filing an annual report. There is no fee for inactive status. Active status may be renewed by fulfilling the requirements of section 307. Any registered lay midwife who does not seek inactive status and allows her permit to expire must apply for a registered lay midwife permit as prescribed in section 303 and must pass the qualifying examination.

400. FEES: All initial applications 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 period or part thereof remaining.

400.01. Fee for change of registration status or renewal of registration shall be $25.00.

400.02. Fee for examination shall be $25.00 and is not included in change of status or registration fee.

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

500.01. Dereliction of any duty imposed by law;

500.02. Incompetence as determined by local midwifery standards;

500.03. Conviction of a felony;

500.04. Practicing while suffering from a contagious or infectious disease of public health importance;

500.05. Practicing under a false name or alias;

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

500.07. Obtaining any fee by fraud or misrepresentation;

500.08. Knowingly employing, supervising, or permitting directly or indirectly or permitting any person or persons not an apprentice, provisional or registered lay midwife 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," 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. Violating any of the provisions of these regulations.

EDUCATION

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

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

		Provisional Permit Requirements	Registered Permit Requirements
600.01.	Basic aseptic techniques	Required at application	Required at application
600.02.	Basic Observation skills	Required at application	Required at application
600.03.	Basic prenatal nutrition		Required at application
600.04.	Basic parent education for prepared childbirth		Required at application
600.05.	Provision of care during the antepartum, intrapartum, postpartum and newborn periods	Required at application	Required at application
600.06.	Management of birth and immediate care of the mother and the newborn	Required at application	Required at application

600.07.	Recognition of early signs of possible abnormalities	Required at application	Required at application
600.08.	Recognition and management of emergency situations	Required at application	Required at application
600.09.	Special requirements of home delivery		Required at application
600.10.	Information regarding the ethics, laws and regulations relating to the practice of midwifery in New Mexico	Required at application	Required at application

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

		Provisional Permit Requirements	Registered Permit Requirements
601.01.	Prenatal visits of at least 15 different women	60	100
601.02.	Labor observations and managements	20	40
601.03.	Delivery of newborn and placenta	10	20
601.04.	Newborn examinations	10	20
601.05.	Postpartum visits (home/office/hospital) to mother and baby within 36 hours of delivery	10	30

601.06.	Neonatal intensive care nursery observations at UNM Hospital or equivalent high risk nursery experience.	Card nursing + maybe appt.	Required at application
601.07.	High risk obstetric care observations at UNM Hospital Special OB Clinic or equivalent experience.		Required at application
601.08	Observation of one complete series of prepared childbirth classes	without your class and have Lamaze ACMI Cert.	One series of six meetings
601.09.	Observation of one complete breast feeding series.	Ver Breast Feeding	One series of four meetings

602. SUPERVISION OF CLINICAL EXPERIENCE: Apprentice lay midwives must obtain their clinical experience under the supervision of a physician, certified nurse midwife, certified nurse practitioner specially qualified by the Board of Nursing, provisional or registered lay midwife. This must be direct, present in the same room supervision. At least five of the experiences obtained in each of categories 601.01, 601.02, 601.03, 601.04 must be supervised by a physician, certified nurse-midwife, or registered lay midwife. Category 601.05 postpartum visits may be supervised by hospital nurses or public health nurses.

603. CONTINUING EDUCATION: Continuing education is required annually for renewal of registration.

603.01. In each registration period, sixteen contact hours of continuing education must be obtained. Suitable topics include midwifery management in the antepartum, intrapartum, postpartum and newborn periods; risk assessment, early recognition of potential problems; midwifery management of emergency situations; ethics, legal aspects of practice.

603.02. Continuing education may be obtained through organized courses, conferences, area midwives meetings or other mechanism as approved by the Division.

603.03. In any calendar year the Department may require specific topics for continuing education based upon any problem areas indicated by lay midwives' quarterly reports.

EXAMINATION

700. REQUIREMENTS OF EXAMINATION: Any person applying for a registered lay midwife permit must pass a qualifying examination administered under the auspices of the Division. The Division shall offer the examination at least twice a year.

701. FIELDS TESTED: The examination shall consist of two parts:

701.01. A written examination designed to test knowledge of theory regarding pregnancy and childbirth and to test clinical judgment in lay midwifery case management.

701.02. 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;

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;

702.01.06. Prenatal nutrition;

702.01.07. Patient teaching;

702.01.08. Special requirements of home delivery;

702.01.09. Risk factors in pregnancy;

702.01.10. Terminology used in the practice of midwifery;

702.01.11. Normal newborn characteristics and possible problems including anomalies;

702.01.12. Care of the newborn; and

702.01.13. Pertinent legislation and regulations for lay midwifery in New Mexico.

702.02. Case management judgment including:

702.02.01. Course and management of normal antepartum, intrapartum, postpartum, and newborn periods;

702.02.02. Early recognition of abnormalities in the antepartum, intrapartum, postpartum, and newborn periods, their significance and possible sequelae if untreated;

702.02.03. Recognition and management of emergency situations.

703. SCOPE OF PRACTICAL EXAMINATION: The practical examination shall cover basic management skills:

703.01. Obtaining a complete client history;

703.02. Performing a client examination including:

703.02.01. Temperature, pulse, respiration

703.02.02. Blood pressure.

703.02.03. Fundal height

703.02.04. Abdominal palpation for uterine muscle tone or tenderness

703.02.05. Leopold's maneuvers to determine fetal lie, presentation, position

703.02.06. Fetal heart tones;

703.02.07. Vaginal examination to determine location, condition of the cervix;

703.02.08. Edema

703.03. Interpreting the historical and physical findings; describing their significance, and any needed follow up.

DUTIES AND RESPONSIBILITIES

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

801. MEDICAL EVALUATION: The lay midwife must require that the patient have a physical examination by a physician and be found to be essentially normal or low risk at that time before a lay midwife assumes her care.

802. REQUIRED TESTS: Initial physician examination shall include clinical pelvimetry and the following laboratory tests — VDRL, GC screen, blood group and Rh, hematocrit or hemoglobin, rubella titer and urinalysis. Hematocrit or hemoglobin 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 in her records evidence of the physician visits.

806. ADVANCE PREPARATION FOR NEED: The 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 by the client for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.

807. INFORMED CONSENT: The 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.

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. HOME VISIT: For home births, the lay midwife will make a home visit 3-5 weeks prior to the EDC to assess the physical environment, to ascertain whether 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 lay midwife must remain with the mother and infant for at least two hours postpartum, or until the mother's condition is stable and the infant's condition is stable, whichever is longer. Maternal stability is evidenced by normal blood pressure, pulse, respirations, fundus firm and lochia normal. Infant stability is evidenced by established respirations, normal temperature, and strong sucking.

811. HOSPITALIZATION: The lay midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and 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 lay midwife must recommend that any infant delivered by the midwife 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 lay midwife shall make postpartum 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.

814. RH BLOOD FACTOR: In case of an unsensitized Rh negative mother, the lay midwife shall:

814.01. Obtain a sample of cord blood from the placenta and arrange for testing within 24 hours of the birth.

814.02. Be certain that the mother receives Rh immunoglobin as indicated within 72 hours of delivery.

815. PREVENTION OF INFANT BLINDNESS: Within one hour of birth, the lay midwife shall administer two drops of 1% solution of silver nitrate or other agent 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 lay midwife must complete a birth certificate and file it with the local registrar within ten days of the birth.

817. SANITATION: The lay midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.

818. RECORDS: The lay midwife shall maintain records of each patient on standard obstetric forms or other forms approved by the Division. Inactive records shall be maintained no less than ten years. All records are subject to review by the Division.

819. ANTEPARTUM: The lay midwife shall obtain medical consultation or refer for medical 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, persistant 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.

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 rupture of membranes prior to 37 weeks gestation.

819.10. Has marked 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.

820. INTRAPARTUM: The lay midwife shall obtain medical consultation or refer for medical 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 persistent or recurrent 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 of hospital is greater than 1 hour).

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 1 hour).

820.13. Does not deliver the placenta within 1 hour if there is no bleeding and the fundus is firm (or 30 minutes, if distance to hospital is greater than 1 hour).

820.14. Has a partially separated placenta with bleeding or with a blood pressure below 100 systolic or with a pulse rate over 100 beats per minutes or who is weak and dizzy.

820.15. Bleeds more than 1000 cc (4 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 lay midwife shall obtain medical consultation or refer for medical care any woman who during the postpartum period:

821.01. Has a third or fourth degree laceration.

821.02. Has uterine atony.

821.03. Bleeds in an amount greater than normal lochial flow.

821.04. Does not void within 6 hours of birth.

821.05. Develops a fever greater than 100 4/5°F. or 38°C on any 2 of the first 10 days postpartum excluding the first 24 hours.

821.06. Develops foul smelling lochia.

822. NEWBORN PROBLEMS: The lay midwife shall obtain medical consultation or refer for medical 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. Develops jaundice within 48 hours of birth.

822.07. Has an abnormal cry.

822.08. Weighs less than 5½ pounds or 2500 grams or weighs more than 9 pounds or 4100 grams.

822.09. Shows signs of prematurity, dysmaturity or postmaturity.

822.10. Has meconium staining.

822.11. Does not urinate or pass meconium in the first 12 hours after birth.

822.12. Is lethargic or does not feed well.

822.13. Has edema.

822.14. Appears weak or flaccid, has abnormal facies or appears not to be normal in any other respect.

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

900. UNAPPROVED PRACTICE: In accord with section 201 which states that the lay midwife may provide care to low risk patients determined by physician evaluation to be prospectively normal for pregnancy and childbirth, the 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 hemmorrhage with previous deliveries.

900.03. Has a history of thrombophlebitis or pulmonary embolism.

900.04. Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, hepatitis, heart disease or kidney disease.

900.05. Contracts genital herpes simplex in the first trimester or has active genital herpes in the last four weeks of pregnancy.

900.06. Has a contracted pelvis.

900.07. Has severe psychiatric illness or a history of severe psychiatric illness in the 6 month period prior to pregnancy.

900.08. Is addicted to narcotics or other drugs.

900.09. Ingests more than 2 ounces of alcohol or 24 ounces of beer a day on a regular basis or participates in binge drinking.

900.10. Smokes 20 cigarettes or more, per day, and is not likely to cease in pregnancy.

900.11. Has a multiple gestation.

900.12. Has a fetus of less than 37 weeks gestation at the onset of labor.

900.13. Has a gestation beyond 42 weeks by dates and examination.

900.14. Has a fetus in any presentation other than vertex at the onset of labor.

900.15. Is a primigravida with an unengaged fetal head in active labor, or any woman who has rupture of membranes with unengaged fetal head, with or without labor.

900.16. Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention.

900.17. Has preeclampsia.

900.18. Has a parity greater than 5.

901. EXAMINATION IN LABOR: The 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 lay midwife will not perform routinely any operative procedure other than: artificial rupture of membranes at the introitus; clamping and cutting the umbilical cord; repair of first or second degree perineal lacerations or repair of episiotomy, if done.

903. MEDICATIONS: The lay midwife will not administer any restricted drugs or medications except when specifically ordered to do so by a physician or when administering medication in accordance with Regulations Governing the Prevention of Infant Blindness.

904. ARTIFICIAL MEANS: The lay midwife will not use any artificial, forcible or mechanical means to assist the birth.

905. CORRECTION OF PRESENTATION: The lay midwife will not attempt to correct fetal presentations by external or internal version.

EMERGENCY MEASURES

1000. EMERGENCY MEASURES: The following measures are permissible in an emergency situation:

1000.01. Cardio-pulmonary resuscitation.

1000.02. Episiotomy

1000.03. Intramuscular administration of pitocin for the control of postpartum hemorrhage in accord with a prescription or a standing order from a physician.

1000.04. Screw maneuver of Woods.

1001. REPORTS: When any of the measures listed in section 1000 are utilized, a special report must be filed within 10 days with the Division describing in detail the emergency situation, the measure taken, and the outcome.

SUPERVISION BY DIVISION

1100. ADVISORY BOARD: The Division shall appoint a Lay Midwifery Advisory Board which will assist in the development, practice and problems of lay midwifery, and will assist Division staff in the development of examinations (written and clinical). The Lay Midwifery Advisory Board will be composed of five (5) members:

1100.01. One physician who must be active in perinatal care;

1100.02. One certified nurse midwife;

1100.03. Two registered lay midwives;

1100.04. One member at large.

The Lay Midwifery Advisory Board will meet at least annually to evaluate the practice of lay midwifery as reflected in the annual reports and conduct other relevant business.

1101. QUARTERLY REPORTS: The 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.

1102. MORTALITY: IMMEDIATE REPORTING: In addition to reports required for birth and death registration, the lay midwife must report within 48 hours to the Health Services Division any fetal, neonatal or maternal mortality in patients for whom she has cared.

1103. FORMS SUPPLIED: The Division will send to each lay midwife an ample supply of quarterly report forms.

1104. STATISTICS: The Division will compile annual lay midwifery statistics and make them available to lay midwives and other interested groups or persons.

1105. PREVENTION OF INFANT BLINDNESS: The Division will provide necessary supplies for prophylactic treatment of infant eyes as required by these regulations.

1106. REPEALER: These regulations supersede the Regulations Governing the Practice of Midwifery adopted by the State Board of Public Health, May 4, 1944, and No. HED-80-3 (HSD) filed on February 5, 1980, and No. HED-80-3A (HSD) filed on March 12, 1980.

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: HB 335

Title: Relating to the practice of Midwifery

Sponsor: (Various Representatives)

Requestor:

Date of Request:

FISCAL DETAIL

Agency Affected: Commerce & Economic Dev.

Program Category Affected: Consumer Protection

BRU, Program or Subprogram(s) Affected: Occupational Licensing

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE		0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS:

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

ANALYSIS: Attach a separate page if necessary

Prepared By: Jennifer Strickler, Management Analyst Phone: 465-2144

Division: Occupational Licensing Date: 4-1-85

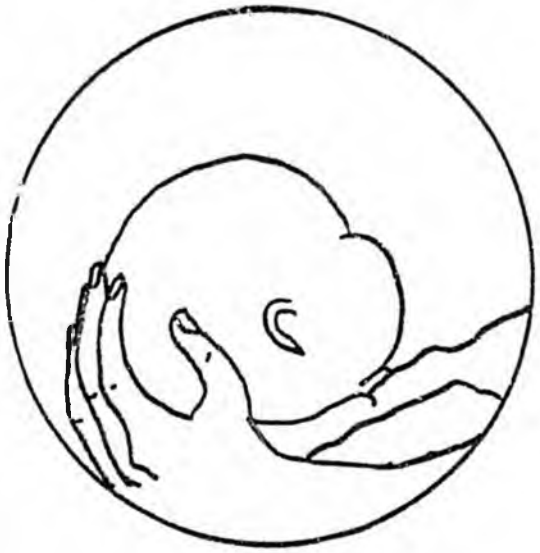
Approved by Commissioner: Loren H. Lounsbury Date: 4/1/85

Agency: Commerce and Economic Development

Distribution (by Agency preparing fiscal note):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

7/1/84



Midwives Association of Alaska

OUT OF HOSPITAL BIRTHS IN ALASKA

1984

Currently in Alaska the Vital Statistic Offices have discontinued compiling statistics concerning the place of birth. We have no means of detailing how many births occur out of the hospital or whether they are attended by a physician, trained midwife, family member or friend.

Midwives recognized by the Midwives Association of Alaska have reported approximately three hundred births attended by one or more midwives during 1983. In addition we estimate that this many or more have occured in alternative settings, being attended by midwives outside of our Association, family members or friends.

Midwives Association of Alaska

REGULATIONS GOVERNING THE PRACTICE OF MIDWIFERY

1. **DEFINITION:** The Midwives association of Alaska accepts the International definition of a midwife which has been accepted by the Council of the International Confederation of Midwives (I.C.M.), the International Federation of Gynaecology and Obstetrics (F.I.G.O.) and by the World Health Organization (W.H.O.). The International Definition is:

> A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country (state) in which it is located,* has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during their pregnancy, labor and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical help, and the execution of emergency measures in the absence of medical help. She has an important task in counseling and education— not only for patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or any other service.//

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

   - Prenatal supervision and counselling
   - Preparation for childbirth
   - 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.

3. **REQUIREMENTS OF REGISTRATION:** No person shall hold her/himself out as a certified midwife under the Midwives Association of Alaska unless currently registered as a midwife under these regulations.

4. **SCOPE OF PRACTICE OF EACH REGISTRATION LEVEL:** A person may be certified as a Registered midwife, a provisional midwife, or an apprentice midwife.

   - A registered midwife may provide any care or service allowed by these regulations.
   - A provisional midwife may provide any care or services allowed by these regulations for a period of two years with two renewals possible, not to exceed six years.
   - An apprentice midwife may only provide care or services under the supervision of a licensed physician, certified nurse midwife, or registered midwife.

5. **FEES:** Upon application, a $25.00 application fee is required. An additional fee of $25.00 is required at the time the applicant applies to sit the exam, and each time the status is changed.

*According to the ICM Constitution this may be a state or country's professional organization.

A person who is provisionally certified is required to do the following:

- Submit monthly reports to the Regional Director for their area
- Attend and participate in chart review with other midwives in their area if available
- Insure that each woman in her care have two prenatal visits; one in the first trimester and one at 36-40 weeks; with a physician, naturopath, osteopath.

8. **REGISTERED MIDWIFE PERMIT:** Any person who presents satisfactory evidence of education, training and experience shall upon application and examination be issued a registered permit. Such person shall submit:

- Evidence of completion of high school or its equivalent
- Evidence of current certification in cardio-pulmonary resusitation of the adult and newborn (CPR)
- Evidence of satisfactory completion of the areas of study (as detailed under the provisional section.)
- Evidence of the following clinical experience: according to regs
  - 100 Prenatal visits
  - 10 Labor and Delivery observations
  - 40 Labor managements
  - 20 Delivery of the newborn and placenta
  - 30 Newborn examinations
  - 30 Postpartum visits (home/office/hospital) of the newborn and mother

  (The total of births attended must be equal to or greater than 50. Delivery of the newborn and placenta can also count as managements as long as the applicant managed the ENTIRE labor. Labor and delivery observations remain separate and should precede any managements or deliveries.)

☆ EXAM

SUPERVISION OF CLINICAL EXPERIENCE: At least five (5) of all the areas of clinical experience must be done under direct in the room supervision of physician, certified nurse midwife or registered midwife. The supervision shall be documented by a letter of supervision that shall include:

- Dates of delivery and/or supervision
- Setting
- Relationship between supervisor and applicant
- Detailed description of the applicants performance and competency in the areas supervised
- Signature of supervisor and their title

EVIDENCE OF EXPERIENCE: Written evidence must be submitted whenever experience is cited, whether birth observations, labor managements or deliveries. Written evidence shall include:

- Name, address and phone number of parents
- Date of birth
- Location of birth
- Baby's sex and weight
- Who managed labor
- Who delivered newborn and placenta

- A copy of the applicant's own personal Informed Choice form that they will make available to clients in their care.
- Evidence of 16 contact hours spent learning or observing in a medical or hospital setting, such as the intensive care neonatal nursery or regular newborn nursery, high risk O.B. clinic, woman's health care clinic, physicians office or labor and delivery ward. (This requirement may be waived if applicant shows satisfactory proof of having been unable to obtain the experience.)
- An application for the permit to sit the next qualifying examination
- Upon meeting all the requirements to be registered, the applicant must then pass the qualifying exam with a score of 80%. (See Exam)

9. **FOREIGN EXPERIENCE:** Applicants for registration as a midwife who lack required clinical experience in Alaska, but who have equivalent experience from another jurisdiction, may apply for a registered midwife permit and to sit the qualifying examination after submitting evidence of experience and of all other requirements.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

Midwives Association of Alaska

REGULATIONS GOVERNING THE PRACTICE OF MIDWIFERY

1. **DEFINITION:** The Midwives association of Alaska accepts the International definition of a midwife which has been accepted by the Council of the International Confederation of Midwives (I.C.M.), the International Federation of Gynaecology and Obstetrics (F.I.G.O.) and by the World Health Organization (W.H.O.). The International Definition is:

> A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country (state) in which it is located,* has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during their pregnancy, labor and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical help, and the execution of emergency measures in the absence of medical help. She has an important task in counseling and education— not only for patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or any other service.

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

   - Prenatal supervision and counselling
   - Preparation for childbirth
   - 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.

3. **REQUIREMENTS OF REGISTRATION:** No person shall hold her/himself out as a certified midwife under the Midwives Association of Alaska unless currently registered as a midwife under these regulations.

4. **SCOPE OF PRACTICE OF EACH REGISTRATION LEVEL:** A person may be certified as a Registered midwife, a provisional midwife, or an apprentice midwife.

   - A registered midwife may provide any care or service allowed by these regulations.
   - A provisional midwife may provide any care or services allowed by these regulations for a period of two years with two renewals possible, not to exceed six years.
   - An apprentice midwife may only provide care or services under supervision of a licensed physician, certified nurse midwife, or registered midwife.

5. **FEES:** Upon application, a $25.00 application fee is required. An additional fee of $25.00 is required at the time the applicant applies to sit the exam, and each time the status is changed.

*According to the ICM Constitution this may be a state or country's professional organization.

6. **APPRENTICE PERMIT:** Upon application an apprentice permit may be issued to any person who presents the following:

- Evidence of completion of high school or its equivalent.
- A letter (or letters) of supervision from a licensed physician, certified nurse midwife or registered midwife, stating that they will provide direct in the room supervision of at least 30 prenatals, 10 labor managements, 10 deliveries of the newborn and placenta, 10 newborn exams and 10 postpartum exams.

7. **PROVISIONAL REGISTRATION PERMIT:** Any person who presents satisfactory evidence of education, training and experience shall, upon application and examination be issued a provisional permit. Such person shall submit:

- Evidence of completion of high school or its equivalent.
- Evidence of current certification in cardio-pulmonary resusitation of the adult and newborn (CPR).
- A copy of the applicant's own personal Informed Choice form that they will make available to clients in their care.
- Evidence of satisfactory completion of the following areas of study:
  - Basic aseptic techniques
  - Basic observational skills
  - Basic prenatal nutrition
  - Basic parent education for prepared childbirth
  - Provision of care during the antepartum period
  - Provision of care during the intrapartum period
  - Provision of care during the postpartum period
  - Provision of care during the newborn period
  - Management of birth and immediate care of the newborn and mother
  - Recognition of early signs of possible abnormalties
  - Recognition and management of emergency situations
  - Special requirements of home delivery
  - Information regarding the ethics, laws and regulations relating to the safe practice of midwifery in Alaska

- In each afore mentioned category the applicant shall cite approved training sources. If self-instructed, it is necessary to cite dates of study, textbooks used and names and addresses of any teachers or workshop leaders. For each category, applicant shall write a brief summary of learning, methods or course of study and learning objectives obtained. A standard COURSE OF STUDY APPLICATION form will be provided.
- Evidence of the following clinical experience:
  - 30 Prenatal visits
  - 10 Labor and delivery observations
  - 10 Labor managements
  - 10 Delivery of newborn and placenta
  - 10 Newborn examinations
  - 10 Postpartum visits (home/office/hospital) to mother and newborn within 36 hours of delivery

  (The total of births attended must be equal to or greater than 20. Delivery of newborn and placenta can also count as managements as long as the applicant also managed the ENTIRE labor. Labor and delivery observations remain separate and should precede any managements or deliveries.)

- SUPERVISION OF CLINICAL EXPERIENCE: Apprentice midwives must obtain their clinical experience under the supervision of a physician, certified nurse midwife, or registered midwife; at least five (5) of the experiences obtained in each of the categories must be direct, in the room supervision by a physician, cerified nurse midwife or registered midwife, and shall be documented by a letter of supervision. The letter of supervision shall include:
  - Date of delivery and/or supervision
  - Setting
  - Relationship between supervisor and applicant
  - Detailed description of the applicants performance and competency in the area(s) of supervision
  - Signature and title of supervisor

Upon meeting all the above requirements for provisional registration the applicant must apply and sit the provisional qualifying exam, passing with a score of 80% or greater. (See Exam)

A person who is provisionally certified is required to do the following:

- Submit monthly reports to the Regional Director for their area
- Attend and participate in chart review with other midwives in their area if available
- Insure that each woman in her care have two prenatal visits; one in the first trimester and one at 36-40 weeks; with a physician, naturopath, osteopath.

8. **REGISTERED MIDWIFE PERMIT:** Any person who presents satisfactory evidence of education, training and experience shall upon application and examination be issued a registered permit. Such person shall submit:

- Evidence of completion of high school or its equivalent
- Evidence of current certification in cardio-pulmonary resusitation of the adult and newborn (CPR)
- Evidence of satisfactory completion of the areas of study (as detailed under the provisional section)
- Evidence of the following clinical experience: according to regs
  - 100 Prenatal visits
  - 10 Labor and Delivery observations
  - 40 Labor managements
  - 20 Delivery of the newborn and placenta
  - 30 Newborn examinations
  - 30 Postpartum visits (home/office/hospital) of the newborn and mother

  (The total of births attended must be equal to or greater than 50. Delivery of the newborn and placenta can also count as managements as long as the applicant managed the ENTIRE labor. Labor and delivery observations remain separate and should precede any managements or deliveries.)

X EXAM

SUPERVISION OF CLINICAL EXPERIENCE: At least five (5) of all the areas of clinical experience must be done under direct in the room supervision of physician, certified nurse midwife or registered midwife. The supervision shall be documented by a letter of supervision that shall include:

- Dates of delivery and/or supervision
- Setting
- Relationship between supervisor and applicant
- Detailed description of the applicants performance and competency in the areas supervised
- Signature of supervisor and their title

EVIDENCE OF EXPERIENCE: Written evidence must be submitted whenever experience is cited, whether birth observations, labor managements or deliveries. Written evidence shall include:

- Name, address and phone number of parents
- Date of birth
- Location of birth
- Baby's sex and weight
- Who managed labor
- Who delivered newborn and placenta

- A copy of the applicant's own personal Informed Choice form that they will make available to clients in their care.
- Evidence of 16 contact hours spent learning or observing in a medical or hospital setting, such as the intensive care neonatal nursery or regular newborn nursery, high risk O.B. clinic, woman's health care clinic, physicians office or labor and delivery ward. (This requirement may be waived if applicant shows satisfactory proof of having been unable to obtain the experience.)
- An application for the permit to sit the next qualifying examination
- Upon meeting all the requirements to be registered, the applicant must then pass the qualifying exam with a score of 80%. (See Exam)

9. **FOREIGN EXPERIENCE:** Applicants for registration as a midwife who lack required clinical experience in Alaska, but who have equivalent experience from another jurisdiction, may apply for a registered midwife permit and to sit the qualifying examination after submitting evidence of experience and of all other requirements.

10. RENEWAL OF PERMITS: Every midwife permit must be renewed every two years. An applicant for renewal shall submitt:

- A renewal application
- Evidence of completion of 16 contact hours of continuing education. This may be obtained through organized courses, conferences, area midwives meetings, workshops or inservices.
- Evidence of current certification in cardio pulmonary resuscitation of the adult and newborn (CPR)
- Renewal fee of $25.00

11. EXAMINATIONS

REQUIREMENTS OF EXAMINATIONS: Any person applying for a provisional or registered permit must pass a qualifying exam for that status. This examination shall be offered at least twice a year.

SCOPE OF WRITTEN EXAMINATION: The exam shall consist of two parts, a written examination designed to test knowledge of theory regarding pregnancy and childbirth, and a written case management judgement examination to test clinical judgement in midwifery case management. The written exam shall cover theory regarding pregnancy and childbirth including but not limited to the following areas:

- Anatomy and physiology of the female reproductive system, in both pregnant and non-pregnant states
- Normal growth and development of fetus and placenta
- Normal progress of pregnancy, labor and delivery
- Comfort measures in the antepartum, intrapartum and postpartum periods
- Significance of laboratory studies in pregnancy and the neonatal periods
- Prenatal nutrition
- Patient teaching
- Special requirements of home delivery
- Risk factors in pregnancy
- Terminology used in the practice of midwifery
- Normal newborn characteristics and possible problems including anomalies
- Care of the newborn
- Pertinent legislation and regulations for midwifery in Alaska

The case management judgements shall cover but not be limited to:

- Course and management of normal antepartum, intrapartum, postpartum and newborn periods
- Early recognition of abnormalities in the antepartum, intrapartum, postpartum and the newborn periods, their significance and possible sequela if untreated
- Recognition and management of emergency situations

12. DUTIES AND RESPONSIBILITIES:

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

MEDICAL EVALUATION: It is recommended that the midwife require her clients have a physical examination by a physician, naturopath, osteopath or certified nurse midwife and to be found to be essentially normal or low risk at that time.

REQUIRED TEST: Initial physician examination shall include clinical pelvimetry and the following laboratory tests: VDRL, GC screen, blood group and RH, hematocrit and hemoglobin, rubella titer and urinalysis. The hematocrit or hemoglobin must be rechecked at 28 and 36 weeks gestation.

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.

RECORDS: The midwife shall maintain in her records evidence of the physician visits, charting of all prenatal visits, charting of labor and delivery and charting of postpartum and newborn visits and exams.

ADVANCE PREPARATION FOR NEED: The midwife, prior to the onset of labor must have:

- Arrangements made for transport of mother and/or infant to a hospital
- Agreement by the client for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.

INFORMED CONSENT: The midwife must inform any woman seeking home birth of possible risks of home birth and must obtain written informed consent of the woman for home birth prior to the onset of labor.

COMMUNITY RESOURCES: The midwife must be familiar with community resources for pregnant women such as prenatal classes, WIC program, La Leche League, and Well Baby clinics.

HOME VISIT: For home births, the midwife will make a home visit 3 to 5 weeks prior to the EDC to assess the physical environment, to ascertain whether the woman has all necessary supplies, to prepare the family for the birth, and to instruct the family to correct problems or deficiencies.

NORMAL DELIVERY: The midwife must remain with the mother and infant for at least 3 hours postpartum, or until the mother's condition is stable and the infant's condition is stable, whichever is longer. Maternal stability is evidenced by normal blood pressure, pulse, respirations, fundus firm, lochia normal and bladder empty. Infant stability is evidenced by established respirations, normal temperature, and strong sucking.

HOSPITALIZATION: The midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and verbal report to the physician assuming care. If possible, she should remain with the mother and/or infant to ascertain outcome.

PHYSICIAN EVALUATION OF NEWBORN: The midwife must recommend that any infant delivered by the midwife be evaluated by a physician within 3 days of age, or sooner when it becomes apparent that the newborn needs medical attention.

POSTPARTUM VISITS: The midwife shall make postpartum visits to evaluate the condition of mother and infant at least twice— once within 24 hours of birth and once on the third or fourth day. Additional visits shall be made as indicated.

RH BLOOD FACTOR: In case of unsensitized Rh negative mother, the midwife shall:

- Obtain a sample of cord blood from the placenta and arrange for testing within 24 hours of the birth.
- Be certain that the mother receives Rh immuniglobin as indicated within 72 hours of delivery
- Prenatally, be certain that mother receives a minimum of two antibody screens

PREVENTION OF INFANT BLINDNESS: Within 2 hours of birth, the midwife shall administer two drops of 1% solution of silver nitrate or other agent of equal potency and harmlessness (Ilotycin Erythromycin opthalmic ointment may be used) into the eyes of the infant in accordance with the laws in the state of Alaska, or obtain a signed waiver from the parents.

BIRTH REGISTRATION: The midwife must complete a birth cerificate and file it with the local registrar within ten days of the birth.

SANITATION: The midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.

ANTEPARTUM: The midwife shall obtain medical consultation or refer for medical care any woman who during the antepartum period:

- Develops Blood pressure of 140/90 or an increase of 30m Hg systolic or 15 mm Hg diastolic over her normal blood pressure
- Develops 2 + or greater pitting edema of the face and hands
- Develops severe, persistent headaches, epigastric pain or visual disturbances
- Does not gain 14 pounds by 30 weeks gestation or at least 4 pounds a month in the last trimester or gains more than 12 pounds in one month in any trimester
- Develops glucosuria or proteinuria, more than one episode of 1 + or greater
- Has symptoms of urinary tract infection, i.e: rise in temperature, kidney or flank pain, urinary frequency or dysuria
- Has vaginal bleeding before onset of labor
- Has rupture of membranes prior to 37 weeks gestation
- Has marked decrease in or cessation of fetal movement
- Has inappropriate gestational size
- Has demonstrated anemia by blood test (hematocrit less than 30, hemoglobin less than 10.5)
- Has fever of 100.4° F. or 38° C. for 24 hours
- Has effacement and/or dilatation of cervix prior to 36 weeks gestation
- Is found to be Rh negative, to insure access to antibody titers and Rhogam
- Has severe protruding varicose veins or extremities or vulva

INTRAPARTUM: The midwife shall obtain medical consultation or refer for medical care any woman who during the intrapartum period:

- 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
- Develops severe headache, epigastric pain or visual disturbance
- Develops proteinuria, 1 + or greater
- Develops a fever over 100° F. or 38° C.
- Develops respiratory distress
- Has persistant or recurrent fetal heart tones below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular or showing late or variable decelerations
- Has ruptured membranes prior to delivery
- Has bleeding prior to delivery
- Has meconium stained fluid (other than very light)
- Does not progress in effacement dilation or station after 2 hours in active labor (after 4 cm), or about 1 hour if distance to hospital is greater than 1 hour away
- Does not show continued progress to delivery after 2 hours of second stage labor, or 1 hour if distance to hospital is greater than one hour away
- Does not deliver the placenta within one hour if there is no bleeding and the fundus is firm, or 30 minutes if distance to hospital is greater than 1 hour away
- Has partially separated placenta with bleeding or with a blood pressure below 90 systolic or with a Pulse rate over 110 beats per minute or who is weak or dizzy
- Bleeds more than 1000 cc (4 cups) with or after the delivery of the placenta
- Has retained placental fragments or membranes
- Desires medical consultation or transfer

POSTPARTUM: The midwife shall obtain medical consultation or refer for medical care any woman who during the postpartum period:

- Has third or fouth degree laceration
- Has uterine atony
- Bleeds in an amount greater than normal lochial flow
- Does not void within 6 hours of birth
- Develops a fever greater than 100.4° F. or 38° C. on any 2 of the first 10 days postpartum, excluding the first 24 hours
- Develops foul smelling lochia
- Develops a hematoma

NEWBORN PROBLEMS: The midwife shall obtain medical consultation or refer for medical care any infant who:

- Has an apgar score of 7 or less at 5 minutes
- Has any obvious anomaly
- Develops grunting respirations, retractions or cyanosis
- Has cardiac irregularities
- Has a pale, cyanotic or grey color
- Develops jaundice within 24 hours of birth
- Has an abnormal cry
- Weighs less than 5 pounds or weighs more than 10 pounds
- Shows signs of complications due to prematurity, dysmaturity or postmaturity
- Has meconium staining greater than very light
- Does not urinate or pass meconium in the first 24 hours after birth
- Is lethargic, or does not feed well
- Has edema
- Has required resuscitation or CPR
- Appears weak or flaccid, or appears not to be normal in any other respect

UNAPPROVED PRACTICE: In accord with the philosophies of the Midwives Assocition of Alaska, which states that homebirth should only be for low risk women in excellent health, the midwife shall not knowingly accept responsibility for the prenatal or intrapartum care of a woman who falls into any of the following categories. However, the Midwives Association of Alaska also recognizes the right of the pregnant woman/couple to choose their birth place and have a skilled attendant present, even though it may not be the safest choice physically. (See High Risk Waiver)

The midwife shall not deliver at home any of the following without a signed copy of the Midwives Association of Alaska High Risk Waiver being submitted to the review board by 37 weeks gestation (or as soon as it is discovered and discussed with the parents).

- Has had a previous cesarean delivery or other known uterine surgery
- Has a history of thrombophlebitis or pulmonary embolism
- Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, heart disease or kidney disease
- Contracts genital herpes simplex in the first trimester or has active genital herpes in the last two weeks of pregnancy
- Has a contracted pelvis

- Has severe psychiatric illness
- Is addicted to narcotics or other drugs
- Ingests more than 2 ounces of alcohol or 24 ounces of beer a day on a regular basis or participates in binge drinking
- Smokes 20 cigarettes or more, per day, and is not likely to cease in pregnancy
- Has multiple gestation
- Has a fetus of less than 37 weeks gestation at the onset of labor
- Has a gestation beyond 42½ weeks by dates and examination
- Has a fetus in any presentation other than vertex at the onset of labor
- Is a primigravida with an unengaged fetal head in active labor, or any woman who has rupture of membranes with unengaged fetal head, with or without labor
- Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention
- Has pre-eclampsia or eclampsia
- Has a parity greater than 5
- Has bleeding with evidence of placenta previa

EXAMINATION IN LABOR: The 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.

EMERGENCY MEASURES: The following measures are permissive in an emergency situation:

- ~~Cardio-pulmonary resuscitation~~
- Episiotomy
- Intramuscular administration of pitocin or methegine for the control of postpartum hemorrhage
- ~~Screw maneuver of Woods~~
- ~~Oxygen therapy for mother or infant~~

HIGH RISK WAIVER: Whenever the midwife accepts a woman for care who is outside the limits of low risk, the midwife must do the following:

- Explain fully all risks involved to the woman/couple, and provide appropriate reading materials on the subject(s),.
- Obtain a signed High Risk Waiver and submit it with the birth report at the quarters end
- Recommend visit with her physician, chart the visit and document his or her advise and recommendations for the birth, being fully aware of the woman's birth plans

REPORTS: The midwife shall submit reports each quarter (each month for provisional midwives) on standard forms provided. A special form must be filed whenever an emergency measure is used.

13. **REGIONAL DIRECTORS:** There will be regional directors appointed as needed to coordinate area chart reviews, supervise apprentice and provisional midwives, and to administer the examination twice yearly. The regional directors will be appointed by vote of the general membership of The Midwives Association of Alaska at their annual meeting

14. **STATISTICS:** The Midwives Association of Alaska will compile annual midwifery statistics and make them available to midwives and other interested groups or persons

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: HB 335

Title: Relating to the practice of Midwifery

Sponsor: (Various Representatives)

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TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
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REVENUE		0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND		0	0	0	0	0
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TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS:

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ANALYSIS: Attach a separate page if necessary

Prepared By: Jennifer Strickler, Management Analyst Phone: 465-2144

Division: Occupational Licensing Date: 4-1-85

Approved by Commissioner: Loren H. Lounsbury Date: 4/1/85

Agency: Commerce and Economic Development

Distribution (by Agency preparing fiscal note):

Legislative Finance
Legislative Sponsor
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4-1-85

Statement to be read at H.E.S.S. Committee hearing on H.B. 335 concerning the practice of midwifery.

The Midwives Association of Alaska, a self-regulating body, is in support of House Bill 335 which would clearly define midwifery in the state of Alaska.Members of our Association have received over 700 positive responses from consumers of midwifery care, coming from all the major cities and towns around the state. Several physicians have also given verbal support to a bill that would clearly define and legalize midwives, so as to prevent homebirths from going underground, a higher risk to mothers and infants.

Please understand that this bill does not address the question of physical setting for childbirth. The issue is whether women choosing alternative birth settings have the right to a qualified, legal attendant (a midwife). The World Health Organization, the International Confederation of Midwives, and the International Federation of Gynogology and Obstetrics have all defined the practice of midwifery as seperate from the practice of medicine, and have endorsed midwifery as a way to upgrade health care throughout the world. Alaska needs to take this same step.

Thank you very much for your careful consideration of this vital matter.

Respectfully submitted,

Vicki Penwell

Vicki Penwell,Registered Midwife
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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

PATTON D. PETTIJOHN, N.D. VIKKI SOLBERG, ELLEN WICKETT, and LINDA ACTON,

Plaintiffs,

vs.

STATE OF ALASKA, RICHARD LYON, COMMISSIONER OF THE DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT; HARRY D. TREAGER, DIRECTOR OF THE DIVISION OF OCCUPATIONAL LICENSING, THE ALASKA STATE MEDICAL BOARD,

Defendants.

PATTON D. PETTIJOHN, N.D.,

Appellant,

vs.

THE STATE OF ALASKA, DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT and THE STATE MEDICAL BOARD,

Appellees.

THE STATE OF ALASKA, DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT and THE STATE MEDICAL BOARD,

Plaintiffs,

vs.

PATTON D. PETTIJOHN, N.D.,

Defendant.

No. 3AN-84-160 (Consolidated) Civil

ANSWERS OF ALASKA STATE MEDICAL BOARD TO QUESTIONS TO BE CONSIDERED ON REMAND BY THE STATE MEDICAL BOARD TO CLARIFY AND SUPPLEMENT ITS SEPTEMBER 20, 1984 FINAL DECISION AND ORDER REGARDING PATTON D. PETTIJOHN

Please answer each of the following questions as fully as possible. References to the transcript of the hearing (TR), to your Order, and to Patton Pettijohn's Amended Answer,

indicate some, but not all, places in the record where the subjects are discussed.

COUNT I
OF THE AMENDED TEMPORARY
CEASE AND DESIST ORDER

1. Patton Pettijohn performed nutritional analysis for Cheryl Jones (See Paragraph 23 at p. 12 of your Order and Stipulated Finding of Fact, Paragraph 26, below.) Was this the practice of medicine, in violation of AS 08.64.170?

No, but the testimony of Pettijohn that Jones complained of vaginitis confuses this question. See answer to 2 and 3 below.

COUNT II

2. Did Patton Pettijohn treat Cheryl Jones for vaginitis? (See TR. 174-181.) If yes, was this the practice of medicine in violation of AS 08.64.170 as alleged?

The Board cannot answer this question because it is unclear from the transcript whether there was any "treatment" of a pathologic condition. Cheryl Jones requested a nutritional analysis which was provided. She also had symptoms of vaginitis. It is unclear from the transcript whether Pettijohn prescribed the dietary changes as part of the "treatment" of that condition.

3. It is uncontested that Patton Pettijohn recommended dietary changes to Cheryl Jones and sold vitamins to her. (See TR. 174-181, unnumbered Paragraph 5 at page 2 of your Order, numbered Paragraph 23 at p. 12 of your Order, Paragraph 5 of Pettijohn's amended answer, and Stipulated Finding of Fact, Paragraph 26, below.) Was this the practice of medicine in violation of AS 08.64.170?

The Board cannot answer this question because it is unclear from the transcript whether there was any "treatment" of a pathologic condition. Cheryl Jones requested a nutritional analysis which was provided. She also had symptoms of vaginitis. It is unclear from the transcript whether Pettijohn prescribed the dietary changes as part of the "treatment" of that condition.

COUNT IV

4. In Paragraph 24, at p. 12, of your Order, you found that:

> Pettijohn . . . "treated" Drew Holt by counseling him and advising him how to care for his shoulder including immobilization, use of diathermy and ultrasound, remedial exercises and physical therapy.

Did Patton Pettijohn thereby practice medicine and violate AS 08.64.170? (See TR. 181-184 and the fifth paragraph at page 2 of the Order.)

Yes. Pettijohn recommended treatment to correct a pathologic condition - bursitis.

COUNT VI

5. It is uncontested that Patton Pettijohn provided routine care and conducted routine examinations of Teresa Keklak (Sandone) during her pregnancy. (See TR. 355-372, and Stipulated Finding of Fact, Paragraph 29, below.) In so doing, did Patton Pettijohn violate AS 08.64.170?

Yes, because this treatment involves a prior diagnosis of the possibility of abnormality. The ability to recognize abnormality and the recommendation of an appropriate treatment is part of a continuous act of diagnosis.

COUNT VII

6. It is uncontested that Patton Pettijohn assisted in the natural delivery of Ms. Teresa Keklak's (Sandone's) infant. It is also uncontested that Pettijohn performed an episiotomy during the delivery, and repaired that episiotomy. (See TR. 355-372, Paragraph 20 of Pettijohn's Amended Answer and Paragraph 34 at pp. 15-16 of the Order.) Did Patton Pettijohn violate AS 08.64.170?

Yes. Episiotomy is clearly performed to prevent or correct a potential or actual pathologic condition.

COUNT VIII

7. It is uncontested that Patton Pettijohn performed the acts described in Paragraph 23 of the Amended Temporary Cease and Desist Order. In so doing, did Patton Pettijohn violate AS 08.64.170?

The Board is unable to answer this question because it is not specified how Pettijohn assisted. There are many levels of assistance, from standing by to active, hands-on care.

8. It is uncontested that Ms. Penny Armstrong's infant was delivered without an episiotomy, that Patton Pettijohn assisted in that delivery, and that he sutured a small perineal laceration. (See TR. 326-354, esp. p. 350 and Stipulated Finding of Fact, Paragraph 31 below.) Did Patton Pettijohn violate AS 08.64.170?

Yes. Suturing implies that a pathologic condition was identified (diagnosed) and corrected.

COUNT IX

9. In Paragraphs 18, 19, and 20 of the Order, you found that:

> 18. Pettijohn . . . is listed in the Yellow Pages under Naturopathic Physicians and refers to himself that way on all business cards. (PDP 17, S-5.)
>
> 19. Further, there was no evidence presented by the State either by inference or from testimony that Pettijohn presents himself to the public as anything but a naturopathic physician. All patients testified explicitly that they were well aware Pettijohn was a naturopath and that this was the reason why they chose to seek his services.
>
> 20. The State presented no evidence that Pettijohn at any time uses the word "physician" without the prefix "naturopathic."

Did Patton Pettijohn violate AS 08.64.170?

Yes. The Board is concerned about use of the term "physician" in the title. Use of the term "naturopath" is unobjectionable. or "naturopathic doctor".

COUNT X

10. Count X of the amended temporary cease and desist Order alleges that Patton Pettijohn "as a general course of practice" violated AS 08.64.170 by various actions. During the administrative hearing, Pettijohn admitted that he has been trained in, and/or that his practice includes, each of the acts described below. Which of the following acts, <u>if performed by Patton D. Pettijohn as part of his naturopathic practice</u>, would constitute the practice of medicine under AS 08.64, and thus require a medical license? Please know that, among other things, [redacted] ent than those generally used by licensed M.D.'s and O.D.'s are engaged in the practice of medicine; [redacted] d whether offering health enhancement and disease prevention advice and services involving non-controlled substances is the practice of medicine.

10.1 The drawing of blood for the purpose of diagnostic testing. TR. 27, 433, 667.

Yes. Diagnostic testing is included in the practice of medicine.

10.2 The administration of diagnostic tests, including blood chemistry test; CBC; urinalysis; hormone level test; viral, bacterial, and fungal cultures; antibody titer.

Yes. See 10(1)

10.3 The interpretation of test results after return from a laboratory. TR. 38, 662, 86.

Yes. See 10(1)

10.4 Use of injection technique. TR. 82-83, 399-400, 433-434.

Yes.

10.5 Taking a pap smear. TR. 86.

Yes.

10.6 Hair analysis, for purpose of diagnosing heavy metal poisoning. TR. 61, 391, 695-697.

Yes.

10.7 Hair analysis, for purpose of early diagnosis of nutritional deficiencies. TR. 61, 391.

No, unless the diagnosis of a nutritional deficiency is itself evidence of a disease or pathologic condition.

10.8 Determining human pregnancy.

No. Unless the pregnancy is diagnosed by methods such as ultrasound or pelvic examination.

10.9 Administering and/or interpreting any of the diagnostic tests listed above for the purpose of conducting a so-called "well exam" (that is, an exam which screens for problems not yet recognized or complained of by the patient).

Yes, because part of conducting a well exam is to exclude the possibility of health problems. Wellness is the absence of disease. Diagnosis of wellness implies that the absence of a pathologic condition is recognized.

10.10 Conducting routine gynecological exams of women who have no gynecological complaints. TR. 88-89.

Yes. If for the purpose of identifying abnormalities.

10.11 Conducting routine gynecological exams of women who do have gynecological complaints. TR. 88, 89.

Yes.

10.12 Physical examination of a pregnant woman for the purpose of determing whether a woman or fetus will be exposed to unacceptably high risk in the course of home delivery. TR. 26-32, 185 - 188, 269, 286-287; See also Paragraph 25 of the Order.

Yes. This would include diagnosing the appearance of abnormality and deciding on treatment.

10.13 Administration of and interpretation of diagnostic tests for the purpose of determining whether a woman or fetus will be exposed to unacceptably high risk in the course of home delivery. TR. 26-32, 269 - 274, 287, 686-689; See also Paragraph 25 of the Order.

Yes. See answer to 10(12).

10.14 Observation of and monitoring of active labor. TR. 33-34, 481-482, 475, 477-478, 479-483.

Yes. See answer to 10(12).

10.15 Rupture of membranes after active labor has begun, when the membranes have not broken. TR. 35-36, 395-396, 684-685.

Yes. Rupturing the membrane requires a diagnosis that this is necessary and the ability to recognize and treat complications, if any which may follow.

10.16 Use of topical antiseptics associated with childbirth, such as iodine, neosporin, and erythromycin opthalmic ointment. TR. 79.

No. Regulation 7 AAC 12.416 permits the use of erythromycin ophthalmic ointment for gynecocal prophylaxis in the newborn and the other substances are non-prescription drugs. Iodine is an antiseptic, neosporin and erythromycin are antibiotics.

10.17 Performing an emergency episiotomy as indicated by signs of fetal distress. TR. 34-35.

Yes. This implies recognition and treatment of a pathologic condition.

10.18 Suturing an episiotomy. TR. 39.

Yes. This implies recognition and treatment of a pathologic condition.

10.19 Repair of perineal laceration following childbirth. TR. 39.

Yes. This implies recognition and treatment of a pathologic condition.

10.20 Cutting the umbilical cord following natural delivery.

No. However cutting of the umbilical cord occasionally has to be cone before the baby is completely delivered in order to prevent a problem delivery.

10.21 It is uncontested that the infants of Karen Redstone, Terry Lynn, and Ellen Wickett were delivered without any episiotomy or suturing, and that Patton Pettijohn assisted in those deliveries. TR. 229-240 (esp. p. 240), 241-258 (esp. p. 250), and 283-295 (esp. p. 288); Stipulated Finding of Fact, Paragraph 33 below. It is also uncontested that Ms. Penny Armstrong's infant was delivered without an episiotomy, but that a small perineal laceration was sutured (See question No. 8 above). TR. 326-354 (esp. p. 350); Stipulated Finding of Fact,

Paragraph 31, below.. It is also uncontested that the delivery of Ms. Teresa Keklak's (Sandone's) infant required an episiotomy, which was performed and repaired by Patton Pettijohn (See question No. 6 above). TR. 355-372; Paragraph 20 of Pettijohns's Amended Answer; Paragraph 34 of pp. 15-16 of the Order; and Stipulated Finding of Fact, Paragraph 30, below. Did Patton Pettijohn violate AS 08.64.170 in any of these instances? If yes, in which instances?

a. Redstone, Lynn, Wickett - The Board cannot answer the question because they do not know how Pettijohn "assisted" them.
b. Armstrong - yes.
c. Keklak (Sandone) - yes.

10.22 Assisting healthy women in the natural delivery of their newborns at home without using any of the substances or doing any of the acts described in questions 10.15, 10.16, 10.17, 10.18, 10.19, 10.20, and 10.21. TR. 117, 152, 165-166, 190-191, 371, 446, 468.

Yes. This would include diagnosing the appearance of abnormality and deciding on treatment. A licensed physician or qualified health worker is expected to recognize events or conditions that can endanger life and limb and to take corrective or preventive measures.

10.23 Physical examination of neonate and performance of PKU test. TR. 36.

Yes. This implies recognition of a pathologic condition.

10.24 Performing a circumcision. TR. 39, 256.

Yes. The law specifically exempts persons which do so under religious tenents and by implication, precludes all others. See A.S. 08.64.370(3).

10.25 Removal of warts by freezing or by cauterization. TR. 40.

Yes.

10.26 Removal of foreign matter from the superficial tissue of the extremities and the scalp. TR. 41.

No. In this particular case and based on the transcript testimony of the procedures involved.

10.27 Suturing or other repair of superficial tissue of the extremities or the scalp after removal of foreign matter. TR. 41.

Yes.

10.28 Removal of sebaceous cysts. TR. 42-43.

Yes. This includes diagnosis of a pathologic condition & intervention.

10.29 Use of medicinal diathermy. TR. 46-48.

Yes. Requires the ability to diagnosis and treat.

10.30 Use of therapeutic ultrasound to increase circulation. TR. 49-51.

Yes. This requires the ability to diagnose a pathologic condition and decide on treatment.

10.31 Use of ultrasound to stimulate acupuncture points. TR. 50-51, 52-54.

Yes. This requires the ability to diagnose a pathologic condition and decide on treatment.

10.32 Practice of Chinese acupuncture. TR. 51-52, 421.

Yes. The practice of acupuncture is regulated by statute. See A.S. 08.64.170 and A.S. 08.64.380.

10.33 Therapeutic use of sine and galvanic current. TR. 53, 219-221, 224.

Yes. When this treatment is done by others, it is done under the prescription of a physician.

10.34 Manipulation of bony structures. TR. 57, 276, 420.

This example is unclear. Depending on the situation, it could be chiropractic (which is regulated by statute), massage or the practice of medicine if diagnosis of a pathologic condition is involved.

10.35 Manipulation of soft tissue. TR. 52, 420.

This example is unclear. Depending on the situation, it could be chiropractic (which is regulated by statute), massage or the practice of medicine if diagnosis of a pathologic condition is involved.

10.36 Analysis of diet for the purpose of isolating the quantity of specific vitamins and other nutrients which are ingested over a period of time. TR. 59, 414-419, 446.

No.

10.37 Use of nutritional therapy to enhance or improve the health of people who are already healthy. TR. 166-167, 169-170, 428-429.

No.

10.38 Making dietary recommendations to a healthy person, following a nutritional analysis, for the purpose of preventing illness or disease. TR. 59-60, 446-451.

No.

10.39 Making dietary recommendations, following a dietary analysis, for the purpose of alleviating or curing an illness or disease. TR. 59-60, 414-419.

Yes. This implies diagnosis and treatment of an illness.

10.40 Clinical application of nutritional research. TR. 116, 427-428, 614, 618-619.

This question is vague, and its meaning unclear from the transcript.

10.41 Treatment of premenstrual syndrome with special diet, and with increase in specific nutritional substances. TR. 63-64, 392, 438-440, 615, 670-674.

Yes.

10.42 Treatment of hypertension with nutritional analysis and with special diet. TR. 64-65, 161, 303-305.

Yes.

10.43 Treatment of arthritis by removing certain substances from the diet, and adding others. TR. 65-66, 68, 69, 101-102, 394, 677-679.

Yes.

10.44 Treatment of chronic prostatitis with diet and homeopathic remedies. TR. 245-247.

Yes.

10.45 Recommending a low-caffeine diet for women with fibro-cystic disease. TR. 431.

Yes, because it has been preceded by a diagnosis of a pathologic condition.

10.46 Prescription of low-calorie diet to obese persons, and/or dispensing nutritional supplements to such people. TR. 387, 461.

No, unless the supplements are prescribed for pathologic conditions or unless the weight reduction is urgent to alleviate problems of hypertension, heart failure, diabetes, etc.

10.47 Prescription of chromium for hypoglycemia, hyperinsulinism or diabetes. TR. 68, 400.

Yes.

10.48 Treatment of chronic infection and decreased resistance to disease with a raw gland extract of thymus. TR. 70.

Yes.

10.49 Therapeutic use of dessicated thyroid. TR. 71.

Yes.

10.50 Emergency use of epinephrin for treatment of anaphlactic shock. TR. 72.

Yes.

10.51 Prescription of homeopathic substances. TR. 74-76, 313, 389, 423-426, 619, 680-681.

Yes, because according to the testimony this is done in the context of treating illness.

10.52 Use of botanical extracts such as hydrastis, rauwolfia, etc. TR. 76-79, 619-620, 698-701, 705.

Yes, because according to the testimony this is done in the context of treating illness.

10.53 Treatment of vaginal infections with a hydrastis douche. TR. 79-80.

Yes.

10.54 Use of pancreatin and bromelain to improve digestion. TR. 80-81.

No. Unless used to treat a pathologic condition, for example, chronic pancreatitis, cystic fibrosis, etc.

10.55 Treatment of strep throat with homeopathic belladonna, and/or vitamin C therapy, and/or removal from the diet of refined carbohydrates, and/or the prescription of natural penicillin. TR. 98-100, 244, 403-404, 596, 620-621, 690-691. Please answer specifically.

Yes.

10.56 Recommending the use of Vitamin E to discourage formation of post-operative adhesions, or for other therapeutic purposes. TR. 261, 393-394, 674-677.

No.

10.57 Selling vitamins and nutritional supplements to patients. TR. 221, 223-224.

No.

10.58 The treatment of arthritis with the following methods: recommended changes to diet, the administration of calcium, magnesium, vitamin D.

Yes.

10.59 A large percentage of Pettijohn's practice relates to individuals with no known health problems and no health complaints, who nonetheless wish to be advised on whether and how they could be better nourished, more fit, and generally preserve good health and lead an even healthier life. Assume such a person consults Pettijohn. May Pettijohn advise the individual about good health and nutrition generally?

Yes.

May Pettijohn conduct and/or interpret laboratory tests to determine a specific individual's dietary profile and needs?

Yes, to the extent that the assumption as stated is that the person is healthy and there is no part of the interpretation of the test which would diagnose illness.

May Pettijohn conduct a physical examination to determine how the individual could enhance his/her health?

Yes.

May Pettijohn take and interpret food questionnaires to determine how the individual could enhance or preserve his/her good health?

Yes.

10.60 Assume Pettijohn believes all persons -- no matter how healthy -- benefit from taking a noncontrolled nutritional substance X, such as nutritional fibre, for example. May he prescribe, administer, or recommend nutritional fibre?

The Board is unable to answer this question because it would depend on the particular substance and its potential for harm. In the example, the recommendation of nutritional fibre would be unobjectionable.

In the alternative, assume that Pettijohn believes, based on his diagnosis of the specific individual, that, although not all healthy persons necessarily benefit from additional amounts of nutritional fibre, this individual would. Assume the individual has no clinically measurable shortage of that substance nor any malady s[illegible]ng from a shortage of that substance. May Pettijohn prescr[illegible] administer, or recommend nutritional fibre based on his diagnosis and his belief regarding the importance of that substance for this individual?

In the example, the recommendation of nutritional fibre would be unobjectionable.

ADMINISTRATIVE INTERPRETATION
OF AS 08.64.170

11. Does AS 08.64.170 prohibit all persons who are not licensed under Title 08, and who are not working with or upon the prescription or referral of a person so licensed, from administering to healthy pregnant women and assisting them in the natural delivery of their infants, for a fee?

Yes, because the underlying assumption is that there has been a prior determination that there is no abnormality or health risk which includes the ability of the practitioner to diagnose. Because problems may occur very quickly, the assumption of "health" and a "natural delivery" assume facts which are apparent only after the act is completed.

12. Does AS 08.64.170 prohibit all persons who are not licensed under Title 08, and who are not working with or upon the prescription or referral of a person so licensed, from prescribing vitamins, minerals, and other nutritional supplements to healthy people who are seeking to prevent disease or to enhance or preserve their health for a fee?

No. Assuming that the person selling the substance was not diagnosing a problem, complaint, or illness and is not prescribing a treatment.

13. Does AS 08.64.170 prohibit all persons who are not licensed under Title 08, and who are not working with or

upon the prescription or referral of a person so licensed, from prescribing vitamins, minerals, and other nutritional supplements for the purpose of treating ailments or physical disorders for a fee?

Yes.

14. Does AS 08.64.170 prohibit all persons who are not licensed under Title 08, and who are not working with or upon the prescription or referral of a person so licensed from diagnosing a human ailment, illness, or physical malady, for a fee?

Yes.

15. Does AS 08.64.170 prohibit all persons who are not licensed under Title 08, and who are not working with or upon the prescription or referral of a person so licensed, from diagnosing or treating all human "conditions," including alcoholism, obesity, addiction to cigarettes or drugs, hearing disorders, speech disorders, and muscular pain, for a fee? (See TR. 457-463, 591-593, and Paragraph 3, p. 19 of the Order.)

No, unless the problem includes the prescription of medications, drugs, or surgery.

SIMILARITIES AND DIFFERENCES BETWEEN NATUROPATHIC AND ALLOPATHIC MEDICINE

The following questions are relevant to Patton Pettijohn's assertion that naturopathy is a distinct profession from the practice of "allopathic medicine" (i.e. conventional medical practice and theory). Please answer these questions based on the record of the hearing: