ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3994 SHES HB 255 - HB 335

870

MAUREEN PILOT, Attorney

Maniilaq Association
Tribal Govt. Services Program
P.O. Box 256
Kotzebue, AK

Spoke on behalf of the eight IRA councils and three traditional councils of the region. "I would like to speak in support of HB 255, and we look forward, very much so, to working with the State of Alaska in negotiating and implemencing those agreements. Regarding the jurisdiction question, it is our opinion that this bill would neither add to or detract from any jurisdiction that tribal governments may or may not have in the State of Alaska. That issue is a matter of federal law and state legislation cannot alter it."

CHESTER BALLOT, Chairman, Kotzebue IRA Council

Native Village of Kotzebue
P.O. Box 256
Kotzebue, AK

Spoke in support of HB 255.

REBECCA CRAVER, Staff Attorney

Kawerak Native Association
P.O. Box 948
Nome, AK

Represents 20 IRA traditional councils and spoke in support of HB 255.

DEREK NELSON, Coordinator

Bristol Bay Native Association
Indian Child Welfare Program
Dillingham, AK

"The Association is in support of HB 255. The tribes right to exclusive jurisdiction in the nature of custody proceedings is paramount to the people's maintenance of their cultures. the loss of their young to a foreign culture , when in fact, the future of that culture rests within it's youth."

MIKE WALLERI, Village Government Specialist/Tribal Attorney

Tanana Chiefs Conference
201 First Avenue
Fairbanks, AK

"We greatly support this bill because the idea of having a working cooperative agreement with the State of Alaska for the benefit of Indian children and the maintenance and contact of those Indian children with their culture, extended families and villages. It seems to the Tanana Chiefs Conferencde that the technical problems of working out what the Indian Child Welfare Act means should not be an area for hostile litigation, but should be an area of cooperation between the villages and their agencies and the State. We support this and hope the bill is passed."

JULIAN ARGIL

Ketchikan Indian Corp.
P.O. Box 6820
Ketchikan, AK

"We support this proposed piece of legislation, HB 255 because it will enable the Ketchikan Indian Corp. to enter into a formal working arrangement with the State for the pruposes of implementing the Indian Child Welfare Act. We're interested in home funding and licensing foster homes for Native children, and supervising the licensed homes, as one of the services we provide. Under this legislation we would hope to be able to expand and coordinate services with the State."

DAVE GRAY

Central Council of Tlingit and Haida Tribes of Alaska
320 Willoughby Juno
Juneau, AK

"The Central Council supports the original legislation. The proposed committee substitute is more premissive, the Council indeed will support that as being laudatory."

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

BILL SHEFFIELD, GOVERNOR

604 BARNETTE ST., RM 228
FAIRBANKS, ALASKA 99701
PHONE: (907) 452-1568

March 30, 1983

Mike Walleri
Tanana Chiefs Conference
Building 201 - First Avenue
Fairbanks, Alaska 99701

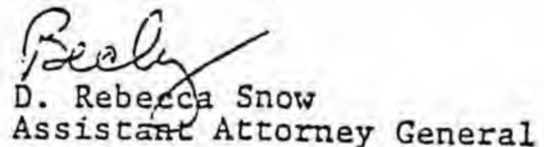
Dear Mike:

Many months ago you sent me a draft of a "109-Agreement" that you have been working on with the villages in your region. Jim Fox responded with some Division of Family and Youth Services' concerns. I have not responded previously because the Department of Law does not have a settled position on negotiation of Section 109 agreements.

At this point, in fact, we recognize that there has been no enabling legislation enacted by the State of Alaska which would authorize any State agency to enter into such an agreement with a village or an entity such as Tanana Chiefs Conference. Until such legislation is enacted setting the limits of any such authority, we feel that it would be impossible to enter into good faith negotiations on the substance of such an agreement. Thus, while I would suggest ordinarily that the proper process for arriving at such an agreement would be for a representative of the villages and/or Tanana Chiefs Conference to sit down with a representative of the Division of Family and Youth Services and a representative of the Department of Law, regretfully at this time I cannot offer to participate in such negotiations. Please be assured that should the necessary enabling legislation be enacted, we would be very willing to sit down with anyone designated by the villages to work on such an agreement.

Very truly yours,

NORMAN C. GORSUCH
ATTORNEY GENERAL

By: 
D. Rebecca Snow
Assistant Attorney General

DRS:bsw

cc: Ron Lorensen
Deputy Attorney General

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

HESS 4-29-86 1:43pm

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the origina' ·ecords of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

11/7/89
Date

02-519 (REV 8/78)

HB
335

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: HB 335

Sponsor: Koponen

Date referred to committee: 4/10/85

Synopsis completed:

Fiscal note:

Further referrals: none

CONTACTS:

H. Statistics for 1000 Births Managed by the Farm Midwives from (10-8-70 to 3-13-79)

Total Births	1000
Single mothers	131 (13%)
Non-Farm residents	468 (47%)
First-time mothers	434 (43%)
Doctor present at home birth, With midwife delivering	22 (2%)
Doctor deliveries at home, hospital, or Farm Maternity Clinic ("FMC")	51 (5.1%)
Delivered at home	925 (93%)
Delivered at FMC	32 (3%)
Delivered in the hospital, by doctor or midwife	43 (4%)
Vertex presentation	948 (95%)
Face-up position	16 (1.6%)
Breech presentation	32 (3%)
Face presentation	2
Transverse lie	1
Footling	1
C-sections	15 (1.5%)
Forceps deliveries	3 (.3%)
Induced deliveries	7 (.7%)
Death in utero (Pitocin IV)	4
Mild pre-eclampsia (snorted Pitocin at FMC)	1
Early rupture of membranes (snorted Pitocin at FMC)	2

Breeches	32 (3.2%)
Home	7
FMC	11
Hospital	14
by c-section	1
with anesthesia	2
without anesthesia	30
with episiotomy	16
without episiotomy	16
First-time mothers	17
Mothers over 30	6
External versions, breech to vertex	5
Premature (at least 4 weeks early)	27 (2.7%)
Home	16
Hospital	8
FMC	3
Reasons for doctor del. at home	9
Breech	4
Prolonged 2nd stage	2
Other[1]	3
Reasons for transfer to FMC	28
Breech	10
Suspected multiple gestation	5
Mild pre-eclampsia (induced labor)	1
Suspected premature	7
Premature rupture of membranes (induced labor)	1
Premature separation of placenta	1
Influenza	1
Mothers choice	1
For Video	1

Reasons for transfer to hospital	43
Transverse lie—2 mos. premature (c-section)	1
Marginal placenta previa (c-section)	1
Abruptio placenta (c-sec.)	2
Prolapsed cord (c-sec.)	1
Kidney infection (c-sec.)	1
Previous uterine surgery (c-sec.)	2
Cephalopelvic disproportion (c-sec.)	1
Lack of progress—influenza (c-sec.)	1
Repeat c-section	3
Previous c-section, delivered naturally by midwife	1
Fetal distress (c-sec.)[2]	2
Breech (term delivery)	10
Premature and breech	3
Premature (2 mos.)	2
Suspected premature	1
Suspected multiple gestation	1
Prolonged 2nd stage	2
Anencephalic baby	1
Parents' request	2
Other[3]	1
Fetal death in utero (induced labor)	4
Other complications of labor at home	5
Marginal placenta previa	1
Premature separation of placenta	3
Hematoma in birth canal	1
Maternal Mortality	0
Maternal Complications	63 (6%)
(7 ladies had 2 complications)	
Postpartum infection	31 (3.1%)
Hemorrhage	27
stopped with oxytocic (less than 500 cc)	21
needed transfusion (more than 500 cc)	6
Retained placenta	6
Subcutaneous pneumothorax	1
Inverted uterus	1
Severe tear	5
Prolapsed cervix	1
Treated at home	45
Treated at FMC	4
Treated at hospital	14
Complications of pregnancy	10
Pre-eclampsia	2 (.2%)
Polyhydramnios	3
Incompetent cervix (cerclage)	2
Prolapsed cervix	1
Down's Syndrome	1
Retro-bulbar optic neuritis	1
Meconium staining	45 (4.5%)
with complications	15
without complications	30

Total Perinatal Deaths[4]	15 (15 per 1000)
Stillbirths	7 (7 per 1000)
Deaths in utero	4 (4 per 1000)
toxemia	1
placental infarction	1
cord accidents	2
Deaths during labor	3 (3.0 per 1000)
anencephalic	1
prolapsed cord	1
premature separation of placenta	1
Neonatal deaths	8 (8 per 1000)
premature (10 weeks early)	1
RDS (premature)	2
Lethal congenital defects (1 anencephalic, 2 unknown but probable)	3
Cause unknown (1 month premature)	1
Crib death	1
Neonatal complications in living babies	17
RDS	7
Congenital abnormalities	6
supernumerary digits	1
Spina bifida	1
Polycystic kidney	2
Harelip	1
Phocomelia	1
1 ear	1
Birth injury (broken arm)	2
Hemolytic anemia (ABO incompatibility requiring transfusion)	1

Biggest baby		11 lb. 4 oz.
Smallest living baby		2 lb. 10½ oz.
Oldest mother		42 years
Youngest mother		16 years
Average weight		
boys		7 lb. 8 oz.
girls		7 lb. 4 oz.
Mothers' average weight gain		25 lb.
Average age of mothers		24.6 years
Average length of labor		
First-time mothers (for 316 births)		11 hr.
1st stage	for 111 births	10 hr. 12 min.
2nd stage		1 hr. 8 min.
3rd stage		18 min.
Second or later baby (for 380 births)		7 hr. 27 min.
1st stage	for 172 births	6 hr. 36 min.
2nd stage		21 min.
3rd stage		14 min.
Longest labor		72 hrs.
Shortest labor		1½ min.
No tear, no episiotomy		538 (54%)
Tear		264 (26%)
1°	166	
2°	94	
3°	4	
Episiotomy		199 (20%)
1°	120	
2°	70	
3°	9	
Apgar (recorded for 497 births)		
Apgar of 10/10		244 (49%)
Apgar of 10 after 5 min.		393 (79%)
Apgar of more than 6 at 1 min.		432 (87%)
Nursing mothers		99%
Ladies who had babies on Farm and left them		6
Postpartum depression		3

Births with anesthesia	1.6%
Births without anesthesia	98.4%
Births with continuous electronic fetal monitoring	.1%
Births without continuous electronic fetal monitoring	99.9%

1. One was our midwife at our Wisconsin Farm. There was no other midwife available. Two Mennonite ladies from the area were delivered at home by our doctor. Now they are delviered by our midwives.
2. This was a repeat c-section. Thd doctor was going to try vaginal delivery but the FHT dropped.
3. Normal term delivery by midwife. The doctor wanted it done in the hospital because of drugs he's given earlier to stop premature labor.
4. These include the 37 deliveries which the midwives considered high risk and which were delivered in the hospital. Many hospitals and clinics would not include in their statistics those cases which were transferred to another institution. Of the 926 babies delivered at home or in the Farm Maternity Clinic, there were 8 perinatal deaths, a rate of 8.6 per 1000 (1 stillbirth and 7 neonatal deaths, 3 of which were lethal congenital defects).

Here are some sample statistics for perinatal mortality from *Obstetrical and Gynecological Survey*, March 1977., Bronx Municipal Hospital Center, 1966: 36.3/1000; 1973: 21.7/1000. The Medical Center Hospital, Columbus, Georgia, 1970: 32/1000; 1972: 28/1000. Infant mortality in the State of Tennessee, 1977: 26/1000.

TO: BETTYE

FROM: SANDRA

RE: SB 239, MIDWIVES - THERE IS A Proposed <u>COMMITTEE SUBSTITUTE</u>

DATE: APRIL 2, 1985

INTRODUCED AT THE REQUEST OF THE ALASKA MIDWIVES ASSOCIATION.

<u>TELECONFERENCED TO ANCHORAGE AND FAIRBANKS, 1:30 - 2:15.</u>

URGENCY BECAUSE OF MEDICAL BOARD'S RECENT ADVICE TO THE COURT THAT MIDWIFERY IS THE PRACTICE OF MEDICINE, WHICH IS UNLAWFUL WITHOUT A LICENSE. (MUST BE UPHELD BY COURT TO BE VALID.)

<u>SB 239</u>:

1. DEFINES MIDWIFERY OUTSIDE OF THE MEDICAL PRACTICES ACT.
2. REQUIRES DEPT. HEALTH AND SOCIAL SERVICES TO DEVELOP REGULATIONS GOVERNING TRAINING AND EDUCATION.
   <u>COMMITTEE SUBSTITUTE</u> - REGS. GOVERNING <u>PRACTICE</u> AS WELL.

ALASKA ASSOCIATION OF MIDWIVES HAS DEVELOPED AN INTERNAL CERTIFICATION PROCEDURE. 6 MIDWIVES ARE CERTIFIED. PROBABLY 20 OTHERS PRACTICE. ESTIMATE THEY DELIVERED 300 BABIES IN THE STATE LAST YEAR.

THE MIDWIVES ORIGINALLY ASKED FOR A BOARD. WE ADVISED THEM OF THE ADMINISTRATION'S POSITION ON BOARDS. WE THEN TRIED OCCUPATIONAL LICENSING, WHICH WAS RELUCTANT BECAUSE THEY LACK EXPERTISE IN "MEDICAL" FIELDS. <u>NOW</u> THE MIDWIVES ARE CONCERNED ABOUT THE REGS. THAT DH&SS MIGHT DEVELOP (PARTICULARLY RELATIONSHIP WITH PHYSICIAN AND TRAINING REQUIREMENTS), AND BECAUSE OF THE GRASS ROOTS SUPPORT THEY'VE GENERATED, MAY WANT TO PUSH FOR A BOARD AGAIN.

WORD FROM THE MIDWIVES IS THAT THE STATE MEDICAL ASSOCIATION WILL NOT FORMALLY OPPOSE THE BILL.

MAY 8 1985

Midwives Association of Alaska

May 3, 1985

IMPORTANT MESSAGE TO ALL LEGISLATORS

CONCERNING SCS FOR H.B. 335

First of all, we would like to thank all of you for considering this matter carefully, and being responsive to the needs of the Alaskan people.

Apparently, there is some confusion over the matter of urgency--why are people writing in to say this bill must be passed this session to keep midwives from being illegal, and yet Rick Urion, Medical Lobbyist, is saying it is not the intention of the Medical Association to outlaw midwives? Let me clarify some points, because both positions are correct.

The Medical Review Board of Alaska did effectively outlaw midwifery, and all birth attendants other than Medical doctors,when they set down the opinion two months ago that "assisting healthy women in the natural delivery of their newborns" was the practice of medicine. At that time, I contacted a member of the Medical Review Board, Dr. Partnow, and he did say that it was not their express intent to outlaw midwives. Apparently, other members of the Medical Reveiw Board said the same thing, and Mr. Urion is relaying that message.

The point here, however, is not intent, but fact. Assistant Attorney General Kay Gowen has said it does outlaw midwifery. And because of wording, would outlaw even traditional native birth attendants.

In summary: this bill would allow for the safe and regulated practice of midwifery as a profession; it would allow continuation of traditional practices of midwifery in rural Alaska; and, as worded now, has the support of the Medical Association.

The reason for urgency in voting on this bill now is the fact that the Alaska Medical Reveiw Board did outlaw midwifery, albeit unintentionally. Now that the Medical Lobbyist and the Midwives have worked out a comprimise acceptable to all, please help us see this issue passed this session.

Sincerely,

Vicki Penwell, Director
P.O. Box 81242
Fairbanks, AK 99708

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 apprantice 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.

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, cerifled 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:
  - 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.)

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 lay 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 protenuria, 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 PRO[illegible]S: 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

encouragement and for assistance in preparing the manuscript.

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Perinatal and maternal mortality in a religious group avoiding obstetric care

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Atlanta, Georgia, and Indianapolis, Indiana

We investigated perinatal and maternal deaths occurring among women who were members of a religious group in Indiana; these women received no prenatal care and gave birth at home without trained attendants. Members of the religious group had a perinatal mortality rate three times higher and a maternal mortality rate about 100 times higher than the statewide rates. These findings suggest that, even in the United States, women who avoid obstetric care have a greatly increased risk of perinatal and maternal death. (AM J OBSTET GYNECOL 1984;150:826-31.)

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Although interest in out-of-hospital childbirth without medical attention has increased,[1-3] little is known about risks that may be associated with childbirth in such a setting. In this study, we describe perinatal and maternal deaths occurring from 1975 to 1982 among members of the Faith Assembly, a religious group in

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northeastern Indiana whose members do not seek prenatal care and who give birth at home without trained attendants.

We obtained the following information on the Faith Assembly from conversations with local county officials and newspaper reporters. The Faith Assembly religious group has been active in northeastern Indiana since 1973. Most members reside in Kosciusko and Elkhart Counties. Some 2000 members, including children, attend weekly religious services. Nearly all members are white; they represent diverse socioeconomic strata. Many are married couples in their 20s or 30s who have children. Fertility among members appears higher than average for Indiana and the United States in general, although documentation is unavailable.

Faith Assembly tenets hold that members should not receive medical care for any health problems. Pregnant women, therefore, receive no prenatal care and give birth at home without obstetric assistance. Although it has been reported that "lay midwives" have attended some Faith Assembly births, these attendants are unlicensed and have no formal training in obstetrics.

Since the mid-1970s, county health authorities have become aware of 27 fetal, neonatal, or maternal deaths among Faith Assembly members. Local health personnel and articles published in a local newspaper alerted the Division of Maternal and Child Health of the Indiana State Board of Health to the possibility that Faith Assembly members might be at increased risk for perinatal and maternal mortality. To examine this possibility, the Indiana State Board of Health invited the Division of Reproductive Health, Centers for Disease Control, to assist in an investigation of perinatal and maternal deaths among members.

Because local officials reported that most Faith Assembly members in Indiana reside in Elkhart and Kosciusko Counties, we focused our investigation in these counties. The combined population of these two counties is 188,635; 96% of residents are white. The largest city, Elkhart, has 41,305 residents.[4]

Methods

We identified all reported perinatal and maternal deaths occurring from 1975 through 1982 among Faith Assembly members living in Indiana. These included deaths identified through newspaper articles and county health authorities.

The fetal death rate is defined as the number of fetal deaths ($\geq$20 weeks gestation) per 1000 live births; the neonatal mortality rate is defined as the number of neonatal deaths (infants dying $\leq$28 days after birth) per 1000 live births. The perinatal mortality rate is defined as the number of fetal deaths plus the number of neonatal deaths per 1000 live births plus fetal deaths, and the maternal mortality rate is defined as the number of maternal deaths (pregnancy-related deaths occurring during or up to 1 year after termination of pregnancy) per 100,000 live births.

Exact methods[5] were used to calculate statistical significance and 95% confidence intervals. If the 95% confidence interval does not include 1.0, the rate is significantly different from the referent rate ($p < 0.05$).

For each death, a county health department employee, police official, or funeral director directly involved in the case verified that the decedent had been a Faith Assembly member. To identify any additional cases, we met with the director of the Indiana Maternal Mortality Committee as well as coroners and public health nurses in Elkhart and Kosciusko Counties. In addition, we visited the Faith Assembly headquarters to try to obtain information on births and perinatal and maternal deaths and about membership in general. However, we were not provided with this information.

We estimated the number of live births among Faith Assembly members through birth records. We used the following criteria to define such births: The birth occurred outside a hospital, between January 1, 1975, and December 31, 1982; the birth attendant was not a physician; the mother resided in Elkhart County or Kosciusko County; and the mother received no or unspecified prenatal care. We recorded maternal age, race, marital status, and educational attainment for each live birth. We assumed, but could not verify, that no Faith Assembly members were delivered of infants in hospitals during this interval.

Using state vital records, we then reviewed Indiana perinatal and maternal deaths and live births for the years 1975 through 1982 and tabulated for each live birth the four maternal characteristics previously listed.

Table I. Selected characteristics of women with live births in Indiana, Faith Assembly and all women, 1975 through 1982

Characteristic	*Faith Assembly** *(n = 344)* *(%)*	*Indiana, statewide†* *(n = 83,347)* *(%)*
Age		
≤19 yr	3	18
20-34 yr	95	78
≥35 yr	2	4
Race		
White	98	89
Black and other	2	11
Educational attainment		
≤12 yr	53	75
>12 yr	47	25
Marital status		
Married	99	86
Unmarried	1	14

*Faith Assembly members residing in Elkhart County or Kosciusko County, 1975 through 1982.
†All Indiana residents, 1978.

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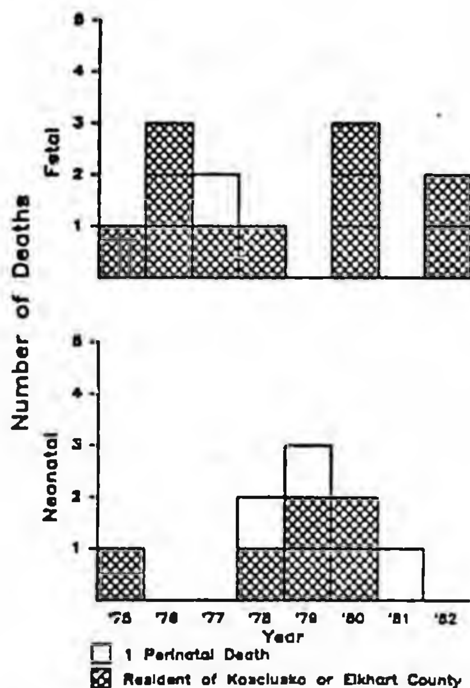

Fig. 1. Faith Assembly perinatal deaths, Indiana, 1975 through 1982.

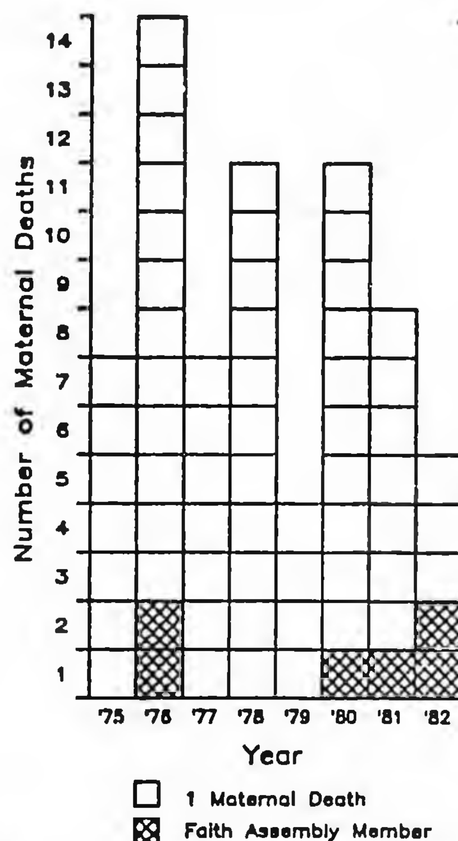

Fig. 2. Maternal deaths, Indiana residents, 1975 through 1982.

We also manually matched Elkhart County neonatal death certificates for 1975 through 1982 against live birth records for Faith Assembly members who were Elkhart County residents. We then reviewed fetal death certificates for Elkhart County for 1975 through 1982 in order to identify any additional fetal deaths occurring among mothers who received no prenatal care or for whom prenatal care was not specified.

Because the denominator data (births) we derived for Faith Assembly members were for residents of Elkhart and Kosciusko Counties only, we calculated perinatal and maternal mortality rate estimates only for members residing in these two counties. For the years 1975 through 1982, we calculated fetal, neonatal, perinatal, and maternal mortality rate estimates for Faith Assembly members residing in these counties and for the entire state, excluding members in these two counties.

Results

Live births. Using the criteria described previously, we identified 344 live births in Elkhart and Kosciusko Counties occurring among Faith Assembly members from 1975 through 1982. Birth certificates indicated that 291 of these mothers (85%) did not receive prenatal care; receipt of prenatal care was unspecified for the remaining 53 (15%).

Maternal characteristics. Compared with all Indiana women giving birth from 1975 through 1982, members of the Faith Assembly who lived in Elkhart County or Kosciusko County and who gave birth during this period were more likely to be age 20 to 34, white, and married and to have at least a high school education (Table I). More detailed information on maternal characteristics is available in a separate publication.[4]

Perinatal deaths. We identified 21 perinatal deaths occurring between 1975 and 1982 among residents of Indiana who were Faith Assembly members. Vital records listed 12 as fetal deaths and nine as neonatal deaths (Fig. 1). Of these 21 perinatal deaths, 11 fetal and six neonatal deaths occurred among members residing in Elkhart County or Kosciusko County.

Trauma or asphyxia at birth (often associated with umbilical cord problems) and respiratory problems accounted for most of these perinatal deaths. All neonatal deaths occurred within 6 days of birth, and most occurred within 1 day. Birth weights were recorded in 15 of the 21 perinatal deaths; 10 of these

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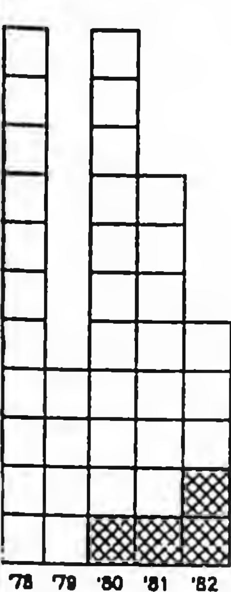

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Table II. Maternal deaths among Faith Assembly members, Indiana, 1975 through 1982

Year of death	*Maternal age*	*Time of death*	*Cause of death*
1976	37	2 days post partum	Hemorrhage/retained placenta
1976	23	Ante partum	Hemorrhage/placenta previa*
1980	37	1 mo post partum	Endometritis/sepsis*
1981	40	8 hr post partum	Peritonitis/ruptured appendix
1982	29	1 hr post partum	Hemorrhage/retained placenta*
1982	23	3 wk post partum	Postpartum hemorrhage†

*Resident of Kosciusko County or Elkhart County.

†Although decedent also had metastatic osteogenic sarcoma, this was not determined to be the cause of death.

Table III. Estimated perinatal and maternal death rates, Faith Assembly members* and Indiana statewide,† 1975 through 1982

	*Faith Assembly**	*Indiana†*	*Relative risk*	*95% Confidence intervals*
Total births	355	681,142	–	–
Live	344	675,072	–	–
Total perinatal deaths	17	12,141	–	–
Fetal	11	6,070	–	–
Neonatal	6	6,071	–	–
Total Maternal deaths	3	64	–	–
Mortality rates				
Perinatal‡	48	18	2.7§	1.6-4.2
Fetal‖	32	9	3.6§	1.8-6.3
Neonatal¶	17	9	1.9	0.71-4.2
Maternal#	872	9	92§	19-280

*Faith Assembly members residing in Elkhart County or Kosciusko County.

†Excludes Faith Assembly members residing in Elkhart County or Kosciusko County.

‡Perinatal deaths per 1000 live births plus fetal deaths.

§$p<0.001$.

‖Fetal deaths per 1000 live births.

¶Neonatal deaths per 1000 live births.

#Maternal deaths per 100,000 live births.

birth weights were ≥5 pounds. Autopsies were performed in four (19%) of these perinatal deaths; no congenital anomalies were noted. Birth-death record matching for Elkhart County residents did not identify any additional perinatal deaths among Faith Assembly members.

Maternal deaths. We identified six maternal deaths between 1975 and 1982 among residents of Indiana who were Faith Assembly members (Table II). Of these, three were members residing in Elkhart County or Kosciusko County. Hemorrhage accounted for four and infection for two of these deaths. All deaths occurred at home. Of the five postpartum deaths, all occurred within 1 month of delivery. One death occurred ante partum.

During the years 1975 through 1982, 61 other maternal deaths occurred among Indiana residents who were not known to be Faith Assembly members. Hence, about 9% of maternal deaths in Indiana during this period occurred among Faith Assembly members (Fig. 2).

The proportion of maternal deaths occurring in 1975 through 1982 and caused by hemorrhage or infection was higher for Faith Assembly members (100%) than for other Indiana residents (36%). Of the six Faith Assembly women who died of complications of pregnancy or delivery, three were age 35 or older; this contrasts with the 2% of births to Faith Assembly women in Kosciusko and Elkhart Counties that occurred among women 35 and older.

Perinatal mortality rates. For the years 1975 through 1982, the estimated perinatal mortality rate for Faith Assembly members residing in Elkhart County or Kosciusko County was 48 per 1000; for all other Indiana residents the perinatal mortality rate was 18. The estimated perinatal mortality rate for Faith Assembly members in these two counties, therefore, was almost three times higher (95% confidence limits, 1.6 to 4.2) than for Indiana statewide ($p < 0.001$). Estimated mortality rates for fetal and neonatal deaths were 32 and 17, respectively, for members; corresponding statewide rates were 9 and 9. The fetal death rate for Faith As-

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sembly members was significantly higher ($p < 0.001$) than for Indiana statewide, but the neonatal death rate for members was not significantly higher ($p > 0.1$) than for Indiana statewide (Table III).

Maternal mortality rates. For the years 1975 through 1982, the estimated maternal mortality rate for Faith Assembly members residing in Elkhart County or Kosciusko County was 872 per 100,000 live births; for all other Indiana residents the maternal mortality rate was 9 (Table III). Hence, the maternal mortality rate for Faith Assembly members in these two counties was 92 times higher (95% confidence limits, 19 to 280) than for the remainder of the state of Indiana ($p < 0.001$).

Comment

These estimated perinatal and maternal mortality rates for Faith Assembly members were about threefold and 100-fold higher, respectively, than statewide rates. Demographic characteristics of Faith Assembly members do not explain these higher mortality rates. Neonatal mortality is generally higher among adolescents, blacks, those with low educational attainment, and unmarried women.[7] Maternal mortality, likewise, is higher among women ≥35 years old, black women, and unmarried women.[8] Women belonging to the Faith Assembly were less likely to have these risk factors than other women in Indiana, yet their estimated neonatal and maternal mortality rates were higher than statewide rates.

Most neonatal deaths occur in low–birth weight infants. One half of neonatal deaths among infants of normal birth weight result from congenital anomalies.[9] Birth trauma or asphyxia in term infants, accordingly, should account for relatively few neonatal deaths; their occurrence suggests deficiencies in medical care. None of the five neonatal deaths that occurred among normal–birth weight infants of Faith Assembly members appeared to be related to congenital anomalies; at least two of these, however, resulted from birth trauma or asphyxia. This suggests that lack of medical care at delivery contributed to the high rate of perinatal mortality.

The perinatal and maternal mortality rates we calculated for members residing in Elkhart and Kosciusko Counties are probably substantial underestimates. For 53 infants, the birth certificate did not specify whether the mother received prenatal care. The mothers of many of these infants were probably not Faith Assembly members. Because we included in the denominator births that may not have been to Faith Assembly members, the denominator is probably an overestimate. To the extent that the denominator is too large, the calculated mortality rates are correspondingly low. Because birth-death record matching for Elkhart County did not identify any additional perinatal deaths, we did not perform record matching for Kosciusko County.

Faith Assembly members may have hidden perinatal deaths from local health authorities. For example, one of the fetal deaths was not initially reported to the county coroner, who became aware of it only after the fetus was exhumed from the family garden. If the practice of concealing perinatal deaths is more common among members than for the state of Indiana as a whole, the true difference in perinatal mortality rates for the Faith Assembly as compared with Indiana would be greater than our study indicates.

Because the Indiana Maternal Mortality Committee has performed active surveillance of maternal deaths since 1959,[10] our estimate of the maternal mortality rate for Faith Assembly members is probably more reliable than the perinatal mortality rate estimate. In addition, maternal deaths are rare and less likely to be overlooked than perinatal deaths.

There is little information about populations in the United States in which pregnant women avoid medical care. A study of home births in North Carolina from 1974 through 1976, however, found that planned home births without the attendance of a physician or trained midwife were associated with a neonatal mortality rate about eight times higher than the rate for planned home births with a trained attendant.[11] The maternal mortality rate for Faith Assembly members residing in Elkhart and Kosciusko Counties, however, is comparable with maternal mortality rates in developing countries where obstetric care is unavailable. For instance, the maternal mortality rate in Matlab *thana*, Bangladesh, from 1968 through 1970, was 570 deaths per 100,000 live births.[12] These findings suggest that when women, even in the United States, avoid obstetric care, they greatly increase the risks of perinatal and maternal death.

We wish to thank Dr. William A. Ragan, Dr. Michael E. Kafrissen, Dr. Robert A. Gunn, Ms. Jean Chaney, Ms. Gwen Rosssel, and Mr. Kenneth F. Schulz for their technical assistance.

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Effects of diuretics on plasma volume in pregnancies with long-term hypertension

Baha M. Sibai, M.D., F.A.C.O.G., Robert A. Grossman, M.D., and Hannah G. Grossman, M.D.
Memphis, Tennessee

The purpose of this randomized, prospective study was to investigate the effects of diuretics on plasma volume findings and perinatal outcome in pregnancies complicated by mild long-term hypertension. Twenty patients were in their first trimester and were receiving diuretics at time of entry to the study: Ten patients were allowed to continue their diuretic medication throughout pregnancy (diuretic group), whereas for the other 10 patients, diuretics were discontinued immediately. Plasma volume was serially measured throughout pregnancy with the use of the Evans blue dye–dilution technique. Initial plasma volume was similar in the two groups. However, in the diuretic group, subsequent plasma volume findings at various stages of gestation were markedly reduced when compared to respective plasma volume findings in the other group. In addition, plasma volume expansion was minimal in the diuretic group (mean increase of 18%), whereas it was normal in the other group (mean increase of 52%). Two patients in the diuretic group and one patient in the other group required other antihypertensive medication. There was no difference in perinatal outcome between the two groups. These results suggest that in hypertensive pregnancies, diuretics prevent normal plasma volume expansion without influencing perinatal outcome. (Am J Obstet Gynecol 1984;150:831-5.)

It is well documented that thiazide diuretics are the most frequently used drugs in treating nonpregnant patients with mild long-term hypertension.[1,2] However, the use of such drugs in patients with mild long-term hypertension during pregnancy is highly controversial.[3-8] Most of the available data in the literature describes the use of diuretics to treat preeclampsia and/or to prevent preeclampsia by treating excessive weight gain or edema during pregnancy.[9-11] In addition, there are no prospective controlled trials describing the use of diuretics alone to treat long-term hypertension during pregnancy.

From the Division of Maternal/Fetal Medicine, Department of Obstetrics and Gynecology, University of Tennessee College of Medicine.
Received for publication April 9, 1984; revised May 11, 1984; accepted May 25, 1984.
Reprint requests: Baha M. Sibai, M.D., F.A.C.O.G., University of Tennessee College of Medicine, Division of Maternal/Fetal Medicine, 853 Jefferson Ave., Memphis, TN 38163.

We previously reported that plasma volume determination is potentially useful in the clinical management of pregnancies complicated by long-term hypertension.[12-14] In the most recent report[13] we found that pregnant patients with long-term hypertension treated with diuretics have a marked reduction in plasma volume when compared to a well-matched group of patients not treated with similar medications. In addition, we reported that such patients demonstrated a rebound expansion in plasma volume when diuretics were discontinued. One drawback of that study was the fact that the control group was not receiving diuretics early in pregnancy and plasma volumes were not measured in patients continuing to receive diuretics throughout pregnancy.

The purpose of this prospective study is twofold: (1) to compare the plasma volume findings in patients with mild long-term hypertension receiving thiazide di-

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VRN
SB 239

DAVID T. WALKER
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(907) 586-3537

May 7, 1985

The Honorable Bettye Fahrenkamp
Chairman
Senate Health, Education and
Social Services Committee
Capitol, Room 125
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

On April 23 I wrote advising that the Alaska Nurses Association opposed Senate Bill 239, "An Act relating to the practice of midwifery" as the measure was presently drafted. I have enclosed a copy of a Resolution passed by Nurses Association's House of Delegates at its recent annual convention along with an official position paper of the Alaska Nurses Association opposing the practice of lay midwifery in Alaska. Would you please have these documents included in the committee files so that if Senate Bill 239 or the issue of midwifery comes before the committee the Association's position in this matter will be known?

Very truly yours,

David T. Walker

DTW/rnt
Enclosures
cc: Jacqueline Pflaum
Constance Trollan (without enclosures)
Members of Senate HESS Committee

No. 11 - 1985

ALASKA NURSES ASSOCIATION

RESOLUTION

Regarding

NURSE MIDWIVES

WHEREAS, the membership of the Alaska Nurses Association supports freedom of choice for families in the selection of competent health care professionals and in the location of birth, and

WHEREAS, the membership is aware that Alaskan families are currently seeking assistance from "lay midwives" as providers of intrapartum care in the home, and

WHEREAS, we recommend physicians be willing to provide emergency support for certified nurse midwives who are asked to provide home birthing services by the consumer, and

THEREFORE BE IT RESOLVED THAT the Alaska Nurses Association opposes "lay midwives" and supports certified nurse midwives practicing in alternative birthing sites with physician back-ups

BE IT FURTHER RESOLVED THAT the Alaska Nurses Association voting body affirmation be sent to the Alaska State Legislature.

Adopted by the House of Delegates
Alaska Nurses Association
12 April 1985

ALASKA NURSES ASSOCIATION

POSITION PAPER

ON

NURSE MIDWIVES/LAY MIDWIVES

DEFINITIONS

Nurse Midwife

As defined by the American College of Nurse Midwives (ACNM): A certified nurse midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse Midwives. Nurse midwifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically. This occurs within a health care system which provides for medical consultation, collaborative management, and referral and is in accord with the "Functions, Standards and Qualifications for Nurse Midwifery Practice" as defined by the ACNM.

The definition of the professional practice of nursing, recommended by the American Nurses' Association for the purpose of licensing legislation, is: the performance for compensation of any act in the observation, care, and counsel of the ill, injured or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social science.

Lay Midwife

One who, for compensation, gives advice concerning pregnancy and conducts deliveries without supervision for low risk women in excellent health; and cares for newborns and infants who are less than four weeks old; in this paragraph "cares for" means performing preventive measures, detecting abnormal conditions in mother and child, procuring medical help, and executing [illegible] any measures in the absence [illegible] help. (Proposed legislation)

EDUCATION

Nurse Midwife

Completion of two or four year college program (or three year diploma program)

R.N. Licensure

Completion of a one-two year nurse midwife program

Certification by the American College of Nurse Midwives

Certification by the State of Alaska as an Advanced Nurse Practitioner

Lay Midwife

High School completion or [illegible]

Current certification in CPR (cardiopulmonary resuscitation) of adults and newborns

Completion of didactic study and clinical experience

Qualifying exam

PRACTICE

Nurse Midwife

According to the American College of Nurse Midwives, comprehensive maternity care rendered by certified nurse midwives includes education and emotional support as well as management of physical care throughout the childbearing years which are necessary for improving and maintaining the health of American families. Hallmarks of care are meticulous screening throughout

the childbearing cycle; free sharing of information and decision making with clients; education about the events of pregnancy and birth, with an emphasis on nutritional guidance and the development of emotional supportive relationships with clients and their families. In addition, nurse midwives always function within the health care system in a team relationship with other health care providers and have medical consultation, collaboration, and referral in order that clients can have access to medical care when needed, at the earliest indication of complications. Nurse midwives are educated to recognize the symptoms of complications, to begin the appropriate interventions, and to summon medical assistance immediately when complications arise.

Lay Midwife

Lay midwives share collegial support, conduct deliveries without supervision and basically function outside of the health care system. A formalized collaborative relationship with health care providers does not exist for routine or emergency care and access to medical care may be limited. To be "lay" specifically means to be not part of or outside of a profession.

QUALITY ASSURANCE OF NURSE MIDWIVES

A major function of the American College of Nurse Midwives is to guarantee to the public high quality nurse midwifery care. The ACNMs Philosophy, Function, Standards and Qualifications guide the membership in their practice. The Core Competence and accreditation process of educational programs assist in quality nurse midwifery education. The National Certification Examination ensures to the public that a certified nurse midwife is a safe practitioner. Grievence and decertification procedures, research to document the practice and its outcomes, and guidelines for quality assurance and peer review are further assurances to the public of safe practice. Continuing education requirements provide the internal control to maintain competency and to meet the requirements, demands, and expectations of the society.

NURSE MIDWIFERY CONTRIBUTION TO U.S. PUBLIC POLICY GOALS

1. Increased Access.

   Nurse midwifery practice increases access to services in areas which have been traditionally underserved such as rural areas and inner cities.

2. Decreased Costs

   There are decreased costs for care. It takes less time and money to train a certified nurse midwife than a physician and because CNMs follow normal events and rely less on technology, further decreases in costs occur.

3. Consumer Preference

   Where CNM services are available, the consumer prefers these. Time intensiveness of care results in collaborative relationships with clients, fewer medical interventions, increased safety, and healthier outcomes.

OBSTACLES TO WIDER UTILIZATION OF CERTIFIED NURSE MIDWIVES

Consumer demand and federal support has quadrupled the number of certified nurse midwives in the last decade from 620 in 1970 to 2500 in 1982. Despite their outstanding record of reducing infant mortality and satisfying consumers, nurse midwives are still an underutilized health resource.

The obstacles to greater U.S. utilization of certified nurse midwives are restrictive state laws, lack of third party reimbursement practices, too few training programs and therefore a limited supply of CNMs. Physician resistance, however, is the most difficult problem. The resistance occurs despite the demand for nurse midwives by consumers, state governments and federal agencies; despite the record of improved health for mothers and babies; and despite increased cost effectiveness. The form which the resistance takes varies. It includes refusal of medical collaboration and permission or privileges for use of hospital facilities; placement of unjustifiable restrictions on nurse midwifery practices or settings, such as the home birth setting; refusal of third party payors to reimburse nurse midwives; harrassment of physicians who support nurse midwifery practice; request for unreasonable payments for liability insurance and misrepresentation of the nature of nurse midwifery practice to the public.

The Alaska Nurses Association opposes lay midwifery in the State of Alaska for the following reasons:

1. Creation of another bureaucracy and Board with administrative and fiscal impact on the State of Alaska are unnecessary when the certified nurse midwife in the most qualified professional already responsible for the care of normal mothers and babies throughout the maternity cycle.

2. Educational preparation of the lay midwife is outside of the nationally accredited educational and crediting institutions of higher learning. The lay midwife lacks adequate training to deal with medical emergencies arising with the mother and/or newborn.

3. Lay midwifery practice is outside of the health care system and formalized consultation, collaboration and referral - most particularly for emergencies - does not exist to protect the public.

The Alaska Nurses Association supports nurse midwifery in the State of Alaska. The Alaska State Legislature should concern itself with the fact that certified nurse midwives are an underutilized health resource and should help to promote this safe professional practice and overcome and remove the obstacles to wider utilization of CNMs to assure cost-effectiveness, quality maternity care, and patient safety and protection.

Would the State of Alaska be protecting Alaskan families by establishing another bureaucracy and profession just to assist with "home births" and by continuing the underutilization of the certified nurse midwife?

The public is demanding midwifery. Why not promote the most qualified professional to assist with births at home, at birthing centers or at the hospital? Consumers and Alaskan families would be the ultimate beneficiaries.

4/85

C. Tradler RN
Box 2907
Juneau, AK 99803
789-2374

ALASKA

Nurse-midwifery practice in Alaska is regulated under the Nurse Practice Act through Advanced Nurse Practitioner regulations. An Advanced Nurse Practitioner is defined as a "registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription of medical, therapeutic or corrective measures under regulations adopted by the Board."

In 1981, responsibility for promulgation of regulations for Advanced Nurse Practitioners was shifted from a joint responsibility of the Board of Medicine and the Board of Nursing to the sole responsibility of the Board of Nursing. Nurse-midwives are not specifically named in this statute or regulations, although they are named in the law mandating insurance company reimbursement of nurse-midwifery serviecs.

In order to practice nurse-midwifery in Alaska, one "must have satisfactorily completed a formal one academic year educational course of study which: (A) prepares registered nurses to perform an expanded role in the delivery of health care; (B) includes a combination of classroom instruction and a component of supervised clinical practice; and (C) awards a degree, diploma or certificate to persons who successfully complete the course of study." In addition, a nurse-midwife must be licensed as a registered nurse in Alaska, must have a certificate for specialty practice in nursing granted by a national certification body recognized by the Board of Nursing, and must earn 30 continuing education credits in her specialty area every two years in order to maintain her ability to practice.

The regulations currently require all Advanced Nurse Practitioners to give the Board of Nursing "documented evidence of an established collaborative arrangement with a physician, actively licensed in the state . . . whose usual scope of practice includes that practice area of the applicant and includes availability of direct communication, consultation and referral." This stipulation is, however, being reconsidered and ~~may have been revised or~~ was eliminated ~~by the end of 1983 or early~~ in 1984. As it now stands, the State Medical Board must approve the collaboration plan before the nurse practitioner can receive her certificate of authorization to practice. The nurse practitioner must notify the Board of Nursing if her collaboration relationship changes, and her authority to practice is suspended until she provides evidence of a new collaborative arrangement.

Alaska provides for the practice of Advanced Nurse Practitioners wishing to have preceptorships in that state by granting a preceptorship permit after approving the preceptorship arrangement drawn up by the student and her preceptor. Graduates who are waiting to take the next scheduled specialty board examination or who are awaiting results of that examination may practice on a temporary permit that is valid until the test results are received. Alaska also grants a four-month temporary permit to nurse practitioners whose certification from another state or jurisdiction is consistent with Alaska's requirements.

Advanced Nurse Practitioners may prescribe Class III, IV, and V controlled substances at the same level of prescribing authority held by their collaborating physicians. The Board of Nursing sends the Board of Pharmacy a list of Advanced Nurse Practitioners who have prescriptive authority. Prescriptions signed by Advanced Nurse Practitioners must include the physician's printed name and Drug Enforcement Administration number. The Board of Nursing also notifies the Board of Pharmacy if any change occurs in an Advanced Nurse Practitioner's prescriptive authority.

Alaska's Insurance Code mandates payment "in a reasonable amount" for care of women "during pregnancy, childbirth, and the period after childbirth" to Advanced Nurse Practitioners who are "certified to practice as a nurse-midwife" by the Board of Nursing. The insurance law further provides that if an insurance contract furnishes services "required of a physician in the care of women during pregnancy, childbirth, and the period after childbirth," the contract also must allow a nurse-midwife to provide those same services. The same bill that amended the private insurance code also implemented Medicaid reimbursement for certified nurse-midwives.

Are CNMs practicing in the jurisdiction: Yes

Authorizing law: Nurse Practice Act

Regulated by: Board of Nursing

Form of legal authorization to practice: Certificate of authorization to practice as an advanced nurse practitioner in the specialty area as a Certified Nurse-Midwife

Frequency of renewal of legal authorization: Every two years

CNM named in statute: No

CNM named in regulations: No

ACNM certification recognized: Yes, indirectly

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0091-2182/84/$03.00

RN license required: Yes

Written evidence of collaboration agreement required: Yes

Prescriptive authority: Yes

Can CNMs sign birth certificates: Not in institutions

Third-party reimbursement mandated: Yes

Medicaid reimbursement status: Regulations in place

Can graduate nurse-midwives practice before ACNM certification: Yes

CEUs required for CNM: Yes

CEUs required for RN: No

ADDRESS OF REGULATORY AGENCY

Board of Nursing
Centuary Plaza
142 East 3rd Avenue
Anchorage, AK 99501

ADDRESS OF MEDICAID OFFICE

Division of Public Assistance
Department of Health and Social Services
Pouch H-10
Juneau, AK 99811

ESSENTIAL LEGAL CITATIONS

Practice statute: Alaska Statutes, Sections 08.68.010 et seq.

Practice regulations: Alaska Administrative Code, Title 12, Section 44.010 et seq.

Prescriptive authority: Alaska Administrative Code, Title 12, Section 44.440

Private reimbursement statute: Alaska Statutes, Section 21.42.355

Medicaid regulations: In place, no citation

Birth center licensure: Alaska Administrative Code, Title 12, Section 7

Medical practice act: Alaska Statutes, Section 08.64.170 et seq.

Birth certificates: Alaska Statutes, Section 18.50.160

APPENDIX II
Functions, Standards, and Qualifications

FUNCTIONS FOR THE PRACTICE OF NURSE-MIDWIFERY

The Nurse-Midwife:

1. Assumes the responsibility for management of care of the essentially healthy woman and newborn throughout the childbearing process.
2. Assumes responsibility for the management of care of the essentially healthy woman as related to her gynecologic and interconceptional needs.
3. Develops with the woman a plan of care appropriate for her total health care needs, recognizing the unique role of the family in this process.
4. Provides to clients individual and/or group counseling and teaching appropriate to their needs.
5. Collaborates with the physician in the management of care of medically complicated women.
6. Collaborates with other health professionals in the delivery and evaluation of health care.
7. Conducts an ongoing assessment of own professional abilities and functions.
8. Assumes responsibility for maintaining currency and safety in professional practice.
9. Utilizes Guidelines for Evaluation of Nurse-Midwifery Procedural Functions in development and evaluation of practice.
10. Promotes and assists the education of nurse-midwifery students.
11. Assists with the education of other health care personnel.
12. Practices according to the philosophy and official policies of the American College of Nurse-Midwives.

STANDARDS FOR THE PRACTICE OF NURSE-MIDWIFERY

Nurse-Midwifery Practice:

1. Fosters the delivery of safe and satisfying care to women.
2. Upholds the right to self-determination of consumers within the boundaries of safe care.
3. Endeavors to provide comprehensive health care to women including continuity of care, emotional and social support, and health education.
4. Encompasses the provision of care during the childbearing years recognizing that this is a family experience and encourages the active involvement of family members in this care.
5. Stimulates community awareness of and responsiveness to the need for quality family-centered care, recognizing variations in family patterns.
6. Includes the provision of interconceptional and gynecological services to women who request preventive health care.
7. Recognizes the client's health and growth as developmental processes occurring throughout the life cycle.
8. Occurs interdependently within a health care delivery system.
9. Demonstrates a safe mechanism for physician consultation, collaboration and referral within an alliance agreement which includes mutually approved protocols.
10. Requires continuing professional growth and development which includes an ongoing process of evaluation as defined by the American College of Nurse-Midwives.

QUALIFICATIONS FOR THE PRACTICE OF NURSE-MIDWIFERY

1. Certification by the American College of Nurse-Midwives.
2. Compliance with legal requirements of the jurisdiction in which nurse-midwifery practice will occur.

Revised and Approved April 1983

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APPENDIX III
JOINT STATEMENT OF PRACTICE RELATIONSHIPS BETWEEN OBSTETRICIAN/GYNECOLOGISTS AND CERITIFIED NURSE-MIDWIVES*

It is critical that obstetrician/gynecologists and certified nurse-midwives have a clear understanding of their individual, collaborative and interdependent responsibilities. As agreed upon in previous Joint Statements by the American College of Nurse-Midwives, the American College of Obstetricians and Gynecologists, and the Nurses Association of the American College of Obstetricians and Gynecologists, the maternity care team should be directed by a qualified obstetrician/gynecologist. The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives believe that the appropriate practice of the certified nurse-midwife includes the participation and involvement of the obstetrician/gynecologist as mutually agreed upon in written medical guidelines/protocols. The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives also believe that the obstetrician/gynecologist should be responsive to the desire of certified nurse-midwives for the participation and involvement of the obstetrician/gynecologist. The following principles represent a joint statement of the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives and are recommended for consideration in all practice relationships and agreements.

1. Clinical practice relationship between the obstetrician/gynecologist and the certified nurse-midwife should provide for:
   a. mutually agreed upon written medical guidelines/protocols for clinical practice which define the individual and shared responsibilities of the certified nurse-midwife and the obstetrician/gynecologist in the delivery of health care services;
   b. mutually agreed upon written medical guidelines/protocols for ongoing communication which provid[illegible] for and define appropriate consultation between the obstetrician/gynecologist and the certified nurse-midwife;
   c. informed consent about the involvement of the obstetrician/gynecologist, certified nurse-midwife, and other health care providers in the services offered;
   d. periodic and joint evaluation of services rendered, eg, chart review, case review, patient evaluation, review of outcome statistics; and
   e. periodic and joint review and updating of the written medical guidelines/protocols.
2. Quality of care is enhanced by the interdependent practice of the obstetrician/gynecologist and the certified nurse-midwife working in a relationship of mutual respect, trust, and professional responsibility. This does not necessarily imply the physical presence of the physician when care is being given by the certified nurse-midwife.
3. Administrative relationships, including employment agreements, reimbursement mechanisms, and corporate structures, should be mutually agreed upon by the participating parties.
4. Access to practice within the hospital setting for the obstetrician/gynecologist and the certified nurse-midwife who have a practice relationship in concurrence with these principles is strongly urged by the respective professional organizations.

The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives strongly urge the implementation of these principles in all practice relationships between obstetrician/gynecologists and certified nurse-midwives, and consider the preceding an ideal model of practice.

The American College of Nurse-Midwives
The American College of Obstetricians and Gynecologists
November 1, 1982

* This statement supersedes previous Joint statements of Maternity Care by the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, and the Nurses Association of the American College of Obstetricians and Gynecologists dated 1971 and 1975.

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see p. 6, sec. 6 midwives

Offered: 5/7/85
Referred: Rules

Original sponsors: Koponen, Adams,
Clocksin, et al

1 IN THE HOUSE BY THE FINANCE COMMITTEE

2 SENATE CS FOR HOUSE BILL NO. 335 (Finance)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to practice of midwifery; and pro-
7 viding for an effective date."

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

9 * Section 1. AS 08.64.370 is amended to read:

10 Sec. 08.64.370. PERSONS NOT AFFECTED. This chapter does not
11 apply to

12 (1) officers in the regular medical service of the armed
13 services of the United States or the United States Public Health
14 Service while in the discharge of their official duties;

15 (2) a physician or osteopath, who is not a resident of this
16 state, who is asked by a physician or osteopath licensed in this state
17 to help in the diagnosis or treatment of a case;

18 (3) the practice of the religious tenets of a church;

19 (4) [REPEALED

20 (5)] a person while serving as a student, intern, resident
21 physician, or fellow at a hospital, clinic, or medical facility in the
22 state;

23 <u>(5)</u> [(6)] a physician in the regular medical service of
24 the United States Public Health Service or the armed services of the
25 United States volunteering services without pay or other remuneration
26 to a hospital, clinic, medical office, or other medical facility in
27 the state<u>;</u>

28 <u>(6) a person who is registered as a lay midwife by the</u>
29 <u>Department of Health and Social Services under AS 18.05.040 or who is</u>

1 excluded from registration under AS 18.05.057 while engaged in the practice of lay midwifery whether or not the person accepts compensation for those services.

4 * Sec. 2. AS 08.64.380 is amended by adding a new paragraph to read:

5 (10) "practice of lay midwifery" has the meaning given in AS 18.05.070.

7 * Sec. 3. AS 18.05.040(a) is amended to read:

8 (a) The commissioner shall adopt [, REPEAL AND AMEND RULES AND] regulations consistent with existing law for

10 (1) the definition, reporting and control of diseases of public health significance;

12 (2) [REPEALED

13 (3) REPEALED

14 (4)] cooperation with local boards of health and health officers;

16 (3) [(5)] protection and promotion of the public health and prevention of disability and mortality;

18 [(6) REPEALED]

19 (4) [(7)] the transportation of dead bodies;

20 [(8) REPEALED

21 (9) REPEALED

22 (10) REPEALED

23 (11) REPEALED

24 (12) REPEALED]

25 (5) [(13)] carrying out the purposes of this chapter;

26 (6) [(14)] the conduct of its business and for carrying out the provisions of laws of the United States and the state relating to public health;

29 (7) [(15)] establishing the divisions and local offices

1 and advisory groups necessary or considered expedient to carry out or
2 assist in carrying out a duty or power assigned to it;
3 [(16) REPEALED]
4 (8' [(17)] the voluntary certification of laboratories to
5 perform diagnostic, quality control, or enforcement analyses or exami-
6 nations based on recognized or tentative standards of performance
7 relating to analysis and examination of food to include seafood, milk,
8 water, and specimens from human beings submitted by licensed physi-
9 cians and nurses for analysis;
10 (9) [(18)] the regulation of quality and purity of commer-
11 cially compressed oxygen sold for human respiration;
12 (10) [(19)] the notification of engagement or release of a
13 physician assistant by persons under AS 08.64.170(b);
14 (11) the registration of lay midwives who meet the require-
15 ments adopted by the department for education, training, and disci-
16 pline of persons engaged in the practice of lay midwifery.
17 * Sec. 4. AS 18.05 is amended by adding new sections to read:
18 Sec. 18.05.056. PRACTICE OF LAY MIDWIFERY. (a) Except as
19 provided in (d) of this section, a lay midwife may not attend the
20 delivery of a woman unless the woman's pregnancy is determined to be
21 low risk.
22 (b) A lay midwife shall
23 (1) inform an expectant mother and the father, if the
24 father is participating in prenatal care or delivery, of the risks of
25 home birth;
26 (2) comply with the requirements of AS 18.15.150 concerning
27 taking of blood samples, AS 18.15.200 concerning screening for phenyl-
28 ketonuria (PKU), AS 18.50.160 concerning birth registration, AS 18.-
29 50.230 concerning registration of deaths, AS 18.50.240 concerning

1 fetal death registration, and regulations adopted by the Department of
2 Health and Social Services concerning prophylactic treatment of the
3 eyes of newborn infants; and
4 (3) accept full legal responsibility for the midwife's acts
5 and omissions.
6 (c) If a lay midwife seeks to consult with or refer a patient to
7 a licensed physician, the responsibility of the physician for the
8 patient does not begin until the patient is physically within the
9 physician's care.
10 (d) Unless a physician is not available to attend a delivery, a
11 lay midwife may not knowingly deliver a woman who
12 (1) has had a previous caesarean delivery or other uterine
13 surgery;
14 (2) has a history of thrombophlebitis or pulmonary em-
15 bolism;
16 (3) has diabetes, hypertension, Rh disease with positive
17 titer, active tuberculosis, active syphilis, active gonorrhea, epilep-
18 sy, heart disease, or kidney disease;
19 (4) contracts genital herpes simplex in the first trimester
20 or has active genital herpes in the last two weeks of pregnancy;
21 (5) has severe psychiatric illness;
22 (6) is addicted to narcotics or other drugs;
23 (7) has multiple gestation;
24 (8) has a fetus of less than 37 weeks gestation at the
25 onset of labor;
26 (9) has a gestation of more than 42-1/2 weeks by dates and
27 examination;
28 (10) has a fetus in any presentation other than vertex at
29 the onset of labor;

1 (11) is a primigravida with an unengaged fetal head in
2 active labor, or any woman who has rupture of membranes with unengaged
3 fetal head, with or without labor;
4 (12) has a fetus with suspected or diagnosed congenital
5 anomalies that may require immediate medical intervention;
6 (13) has pre-eclampsia or eclampsia;
7 (14) has bleeding with evidence of placenta previa.
8 Sec. 18.05.057. EXCLUSION FROM REGULATION. (a) A person may
9 practice lay midwifery without registration if the person does not
10 accept compensation for those services.
11 (b) Notwithstanding other provisions of this chapter, a person
12 who is practicing lay midwifery on the effective date of this Act may
13 continue to practice and to receive compensation for services without
14 registration if the person's cultural traditions have included, for at
15 least two generations, the attendance of lay midwives at births, and
16 if the person has attended at least 10 births.
17 (c) A person whose cultural traditions have included, for at
18 least two generations, the attendance of lay midwives at births, may
19 accept compensation for the practice of lay midwifery without regis-
20 tration if the person has assisted another who is excluded from
21 registration under this section or a registered lay midwife,
22 physician, nurse midwife, or public health nurse in at least 10
23 births.
24 * Sec. 5. AS 18.05.070 is amended by adding a new paragraph to read:
25 (3) "practice of lay midwifery" means, in accordance with
26 AS 18.05.056 and regulations adopted by the Department of Health and
27 Social Services, the performance of the following for compensation:
28 giving education and advice concerning pregnancy; supervising, caring
29 for, and advising women during pregnancy, labor, and the postpartum

1 period; conducting deliveries without supervision; and caring for
2 neonates; in this paragraph "caring for" means performing preventive
3 measures, detecting abnormal conditions in mother and child, procuring
4 medical help, and executing emergency measures in the absence of
5 medical help.

6 * Sec. 6. LAY MIDWIVES WORKING GROUP. (a) There is established in the
7 Department of Health and Social Services a lay midwives working group
8 composed of three lay midwives holding certificates from the Midwives
9 Association of Alaska, one representative of the department, and one physi-
10 cian or nurse midwife licensed in this state. The commissioner shall
11 appoint the members of the working group. The working group shall develop
12 regulations for the commissioner to propose under AS 18.05.040 for the
13 registration, training and education requirements, and disciplinary mea-
14 sures for lay midwives.

15 (b) The department shall report to the legislature by the 10th day of
16 the Second Session of the Fourteenth Legislature concerning the regulations
17 proposed by the working group. The department may not adopt the regula-
18 tions until after they are presented to the legislature.

19 (c) Members of the working group are not entitled to receive compen-
20 sation for their services or travel and per diem under AS 39.20.180.

21 * Sec. 7. Notwithstanding AS 08.64, a lay midwife practicing in this
22 state on the effective date of this Act who is not registered by the De-
23 partment of Health and Social Services may continue to practice until the
24 department adopts regulations under AS 18.05.040 for the practice of lay
25 midwifery and completes any review of the midwife's credentials required by
26 the regulations. The midwife shall cooperate with the department in the
27 review.

28 * Sec. 8. Section 6 of this Act is repealed on the day after the de-
29 partment completes the adoption of regulations for

1 (1) training, education, and experience requirements for lay
2 midwives;
3 (2) standards for the practice of lay midwifery; and
4 (3) discipline of persons practicing lay midwifery.
5 * Sec. 9. This Act takes effect immediately in accordance with AS 01.-
6 10.070(c).

Alaska State Legislature

adopted by HESS Committee but not full body

BETTYE FAHRENKAMP, Chairman
ARLISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
PAUL FISCHER
EDNA ARMSTRONG-DE VRIES

POUCH V
STATE CAPITAL
JUNEAU, ALASKA 99811
(907) 465-3834
(907) 465-3835

Senate

Committee on
Health, Education and Social Services

LETTER OF INTENT
FOR
SCS CS HB 335 (HESS)

SCS CS HB 335 (HESS) provides for establishment of a working group, appointed by the Department of Health and Social Services, to develop regulations governing the education, training, standards of practice, and discipline of persons engaged in the practice of lay midwifery.

It is the intent of the Legislature that working group members be appointed and the first meeting of the group held within 30 days of the effective date of this act. Further, to keep costs of the working group to a minimum, it is intended that meetings will be held over the state teleconference network.

HB 335am

"House Health, Education & Social Services Committee

LETTER OF INTENT TO ACCOMPANY HB 335am

(Practice of Midwifery)

April 9, 1985

It is the intent of the House of Representatives that HB 335am be a first step toward licensing lay midwives. The bill is being passed as an emergency measure because of the possibility that lay midwifery may soon be outlawed by the courts.

The House Health, Education and Social Services Committee will immediately introduce and hold hearings on legislation to license lay midwives and provide adequate consumer protection.

The House further hopes the Senate will consider these issues of licensure and adequate consumer protection for mothers and infants when it holds hearings on this bill.

/s/ Niilo Koponen (Co-Chairman) /s/ Max Gruenberg (Co-Chairman)"

Representative Marrou objected.

The question being: "Shall the letter of intent on HB 335am be approved?" The roll was taken with the following result:

HB 335AM INTENT

Yeas:	24	Boucher, Clocksin, Cotten, Davis, Duncan, Frank, Goll, Gruenberg, Grussendorf, Hurley, Jenkins, Koponen, Larson, Martin, Miller,M.M., Miller,M.W., Navarre, Phillips, Pourchot, Ringstad, Shultz, Sund, Taylor, Thompson
Nays:	12	Adams, Binkley, Fuller, Furnace, Hanley, Herrmann, Marrou, Pearce, Pettyjohn, Rieger, Uehling, Wallis
Excused:	3	Cato, Collins, Szymanski
Absent:	1	Pignalberi

And so, the letter of intent was adopted.

HB 335am was referred to the Chief Clerk for engrossment.

HB 335am

HB 335AM AM3

Yeas:	30	Adams, Binkley, Boucher, Clocksin, Cotten, Davis, Duncan, Frank, Fuller, Goll, Gruenberg, Grussendorf, Herrmann, Hurley, Jenkins, Larson, Martin, Miller,M.M., Miller,M.W., Navarre, Pearce, Phillips, Pignalberi, Pourchot, Ringstad, Sund, Taylor, Thompson, Uehling, Wallis
Nays:	7	Furnace, Hanley, Koponen, Marrou, Pettyjohn, Rieger, Shultz
Excused:	3	Cato, Collins, Szymanski
Absent:	0	

And so, Amendment No. 3 was adopted.

The question to be reconsidered: "Shall HB 335am pass the House?" The roll was taken with the following result:

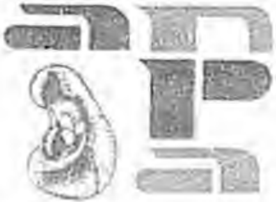
HB 335AM RECONSIDERATION

Yeas:	31	Adams, Binkley, Boucher, Clocksin, Davis, Duncan, Frank, Fuller, Furnace, Goll, Gruenberg, Grussendorf, Herrmann, Hurley, Jenkins, Koponen, Larson, Marrou, Martin, Miller,M.M., Miller,M.W., Pearce, Pettyjohn, Pourchot, Ringstad, Shultz, Sund, Taylor, Thompson, Uehling, Wallis
Nays:	6	Cotten, Hanley, Navarre, Phillips, Pignalberi, Rieger
Excused:	3	Cato, Collins, Szymanski
Absent:	0	

And so, HB 335am passed the House on reconsideration.

Representative Clocksin moved and asked unanimous consent that the roll call on the passage of the bill be considered the roll call on the effective date clauses. There being no objection, it was so ordered.

Representative Clocksin moved and asked unanimous consent that the following letter of intent on HB 335am be approved:



APR 8 1985

Alaska Neonatal / Perinatal Associates

April 3, 1985

Senator Bettye Fahrenkamp, Chair
Senate Health, Education and Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 239
Lay Midwivery

From: Dr. Jack Jacob, Clinical Director, Alaska Newborn Care Project
Dr. Edward C. Alderete, Clinical Director, Newborn Care Special Care Nursery, Providence Hospital
Dr. Harry Harrison, Clinical Director, Newborn Intensive Care Unit, Humana Hospital
Dr. Roy F. Davis

We are opposed to Senate Bill 239 on Lay Midwivery for the following reasons:

1) The bill legitimizes the practice of lay midwivery. As the bill exists there are no standards of care for the practice. Our experience in practicing newborn intensive care in Alaska in the last five years we have seen numerous cases each year of catrastrophies that have occured from lay midwivery births. Lay midwives that have testified about their good results in Alaska during their practiced midwivery have not said that the reason for the good results is that whenever they have a catastrophy they send the mother to the hospital at the last minute to deliver. What should be counted as their catastrophic result ends up being counted as a medical catastrophic result. We feel that such legislation needs to establish the same high standards of care that exist for the practice of medicine.

2) Legislation does address issues of supportive services that are needed for the practice of lay midwivery. Approximately 40% of births that occur that have an unexpected problem that arises late in delivery. Thus there needs to be an emergency

services backup available during the midwivery or home birth so that expert emergency care can be available at the time of delivery without interfering with the normal birth process. At the present time the emergency medical services in the Anchorage area are stressed to their limits. Furthermore, the bush communities aren't adequately able to cope with medical emergency since distances in Alaska are great. The committee has heard that there are European countries where midwivery births are done and have a low mortality rate. This is indeed true. However, what has not been said is that these European countries are small, highly urban, and the medical system is highly socialized unlike that that exists in the United States. Such countries have emergency ambulances available during home deliveries. Therefore unless Alaska is willing to make that added committment one is likely to see bad outcomes. We feel that if the Senate is going to be responsible for the passage for such a bill it also needs to be responsible for making the system safe for both mother and unborn child.

3) This legislation will lead to added costs for handicapped children's services for the state of Alaska. Dr. Jack Jacob in practicing newborn medicine in the past five years in Alaska knows of several cases that cost the state of Alaska $10,000 or more a year in handicapped children's funds. We feel that the legislature needs to be aware of these added costs.

4) The legislature needs to consider the rights of the unborn child to the best available care. Our society has numerous examples of cases where the rights of the child supercedes the rights of the parents. We feel that we as medical specialists of newborn infants can be and are spokesmen for the unborn child. It is clear that delivering without highly trained personnel being present is jeopardizing the unborn infant.

5) The Alaska Newborn Care Project has as its goal the improvement of mortality and morbidity of pregnant mothers and newborn infants. The Alaska Newborn Care Project opposes this legislation as being not consistent with the welfare of newborn infants or pregnant mothers in the state of Alaska.

6) We would like to make it clear that we do not oppose home births but rather if home births are done we feel that it needs to have adequate support services to lead to a successful and positive outcome not only for the parents but also the unborn child.

No.24 - 1983

ALASKA NURSES ASSOCIATION

RESOLUTION

APR 8 1985

Regarding

NURSE MIDWIVES

WHEREAS, The membership of the Alaska Nurses Association supports freedom of choice for families in the selction of competent health care professionals and in the location of birth, and

WHEREAS, The membership is aware that Alaskan families are currently seeking assistance from untrained "midwives" as providers of intrapartum care in the home, and

THEREFORE BE IT RESOLVED THAT the Alaska Nurses Assocation does not support the delivery of intrapartum care in the home by non-nurse midwives.

Adopted by House of Delegates
Alaska Nurses Association
18 March 1983

Copies to:
Alaska State Legislature

DRAFT - TO BE VOTED ON 4/12/85 or 4/13/85

ALASKA NURSES ASSOCIATION

R E S O L U T I O N

Regarding

LAY MIDWIVES

WHEREAS, The membership of the Alaska Nurses Association supports freedom of choice for families in the selection of competent health care professionals and in the location of birth, and

WHEREAS, The membership is aware that Alaskan families are currently seeking assistance from untrained "midwives" as providers of intrapartum care in the home, and

WHEREAS, The Alaska Nurses Association believes that "lay midwives" should have specific education with certification; standards and licensure, such as is required of "certified nurse midwives", and

WHEREAS, Currently there is not a system required for a relationship with physicians or hospitals in the event of emergency need for professional care and hospitalization, and

THEREFORE BE IT RESOLVED THAT the Alaska Nurses Association does not support home deliveries by non-licensed "lay midwives" without certification and without emergency medical back-up systems.

Copies to:
Alaska State Legislature

Fairbanks Clinic

1867 Airport Road • Fairbanks, Alaska 99701-4096 • (907) 452-1761

November 25, 1985

David Maguire, M.D.
President,
Alaska State Medical Association
4107 Laurel Street
Anchorage, AK 99504

Dear David:

I have been asked by Dr. Mary Wing, President of the Fairbanks Medical Association, to respond to the suggested content for Midwife Regulations.

On Page 1, under the title of "Medical Consultation", - It is suggested that consultation be limited only to physicians whose scope of practice includes obstetrics or pediatrics, and not middle level practitioners, as is currently proposed. Next, on Page 15, under the section entitled "Required Medical Visit", - It is suggested that the required general medical examination be limited to a physician whose practice includes obstetrics and not alternately to a certified Nurse/Midwife or advanced Nurse/Practitioner. Next, on Page 18, under "Antepartum Medical Consultation", - It is suggested that the title be changed to "Antepartum Medical Referral" and that all those patients who have one or more conditions listed, be referred for medical care by a physician licensed to practice obstetrics in Alaska. Moreover, on Page 19, under the section "Intrapartum Medical Consultation", - It is suggested that the title be changed to "Intrapartum Medical Referral", so that the conditions listed constitute a basis for referral for medical care to a physician licensed to practice obstetrics. And finally, if it is at all possible, given the current fear of malpractice litigation and inability to obtain affordable malpractice coverage, it is suggested that physicians accepting patients, initially seen by a Lay Midwife, be granted immunity from liability, since that person would be acting as a "good samaritan". Perhaps the "good samaritan" statute which now exists in Alaska could be expanded to include physicians who accept patients under emergency conditions.

Thank you for your attention to the above. I will be happy to answer any further questions that you may have regarding the proposed Registered Midwife Regulations. I feel the above changes are necessary to ensure quality obstetrical and neonatal care and at the same time, protect the vested interests of all parties concerned.

Sincerely yours,

Marshall

Marshall F. Goldberg, M.D.
Obstetrician/Gynecologist
MFG/rh

cc: Mary Wing, M.D.

a division of DENALI MEDICAL SERVICES A Professional Corporation

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY
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POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
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May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

HESS 4-16-85 1:38 pm

BILL SHEFFIELD
GOVERNOR

SB 239

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

April 2, 1985

Ms. Vicki Penwell, Director
Midwives Association of
Alaska
P.O. Box 81242
College, AK 99708

Dear Ms. Penwell:

Thank you for your recent communication to me regarding your proposal for State licensure of midwives.

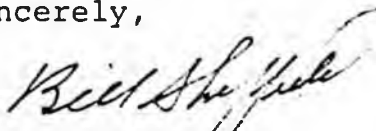
While you certainly make a number of excellent points in your letter, please understand that there are a number of proposals and bills currently being discussed that would increase the State's involvement in the licensing and regulation of occupations and professions. We are looking at these critically to ascertain actual public need, administrative considerations, and cost to the State. Another area we are looking at is the proliferation of boards, commissions, and advisory committees over the past decade. I encourage you to explore options that achieve licensure, certification, or registration without the creation of a new board or committee.

Our State government is substantially involved in occupational licensing. One out of every five Alaskans is licensed by the State to practice professions or trades through the Division of Occupational Licensing in the Department of Commerce and Economic Development. Many other professions, such as teaching and law enforcement, are licensed through other State departments. It has become very costly to administer all these licensing programs with very little of the expense being borne by the licensees themselves.

We will continue to look at this issue with one eye on declining State oil revenues and with one eye on adequate protection for the public from untrained and unscrupulous professional practitioners.

We will monitor the progress of Senator Fahrenkamp's bill related to the licensure of midwives.

Sincerely,



Bill Sheffield
Governor

cc: Senator Bettye Fahrenkamp
Representative Niilo Koponen
Representative Max Gruenberg

Commissioner John R. Pugh
Department of Health and
Social Services

Commissioner Loren Lounsbury
Department of Commerce and
Economic Development

Midwives Association of Alaska

Vicki Penwell, Director
P.O.Box 81242
College, Alaska 99708
479-6388

March 7, 1985

Dear Govenor Bill Sheffield,

I am writing to ask your consideration in a matter of utmost importance that affects a large number of Alaskan citizens.

Enclosed you will find a letter that was recently sent to Senator Fahrenkamp, Chairman of the Health, Education and Social Services Committee. A similar letter was also sent to Niilo Koponen, Chairman of the House H.E.S.S. Committee. Both Senator Fahrenkamp and Representative Koponen feel this issue has a great deal of merit, and their offices are currently working on introducing a bill that would define and regulate the practice of midwifery in Alaska.

The problem is this: While we realize you have stated you want no new boards set up this year, there seems to be no way to obtain licensing for midwives without an advisory board. We feel that the licensing of midwives is an immediate need in this state. With a large bush population and many rural residents, there is an increasing need and demand for midwifery services by the people. Besides the obvious geographical distance between many Alaskans and a hospital setting, for many consumers of obstetrical health care there exists a philosophical distance as well. In other words people will continue to seek out of hospital settings for childbirth whether or not a trained birth attendant is available.

Midwives offer much more than just the delivery of a child, however. Regardless of where the child is born, it has been proven that quality prenatal care (such as that received from a trained midwife) is a primary factor in good outcomes. It has been suggested that if the state had a program for licensing and training midwives, the village health aides could obtain such training, and could offer ongoing quality prenatal care and instruction to the rural native population. This group suffers a very high infant mortality rate at the present time.

As it stands now, midwives in urban areas who can afford it are going to great time and expence to obtain training and licensing from other states, while rural health aides and midwives are receiving little or no ongoing training. However, the number of citizens choosing a midwife's care is increasing dramatically. We anticipate close to 1,000 individuals will seek the services of a midwife in 1985 alone.

Govenor Sheffield, we are not polititions or professional lobbyists. We are only concerned about the Maternal/Child health care system in our state, and about the legal protection for the trained midwives who are meeting their needs.

We are requesting regulation through the Department of Public Health, and licensing through Occupational Licensing, with an advisory committee or board to review applications, and inforce regulations. We feel that in a short time the fees from applications would cover the cost of this board, and that even now the cost would be minimal.

While we realize this request is a little out of the ordinary, since it so directly would affect life and the quality of live for many Alaskans, we hope you will consider it carefully. Thousands of our citizens and future citizens could benefit.

A representative from the Midwives Association of Alaska, Bonnie Lang of Juneau, will be contacting you soon to discuss this further and answer any questions you may have.

Thank you so much for your time and help in this matter.

Sincerely,

Vicki Penwell

Enclosures: Copy of letter to Senator Fahrenkamp
Midwives Association of Alaska Regulations

POSITION PAPER/Department of Health & Social Services

superseded

POSITION PAPER

SENATE BILL NO. 239

For "An Act relating to the practice of midwifery."

This bill defines and authorizes the practice of lay midwifery in Alaska and obliges the Commissioner of the Department of Health and Social Services to adopt regulations setting standards for the education and training of persons engaged in the practice of midwifery.

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 SB 239 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 not only to define education and training requirements but also to 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: [signature]
Robert I. Fraser, M.D.
Director
Division of Public Health

Date: 3/26/85

Approved by: John R. Pugh
John R. Pugh
Commissioner
Department of Health and
Social Services

Date: 3/26/85

Dean Tirador 3030

David Spence 3100

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB 239
Title: Practice of midwifery

Sponsor: Fahrenkamp by request
Requestor:
Date of Request: 3/20/85

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)

OPERATING	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	5.0	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	5.0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
GENERAL FUND	0	5.0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	5.0	0	0	0	0

POSITIONS:

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
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

$5.0 is requested for a professional services contract to research and develop educational and training standards.

Prepared By: Robert I. Fraser, M.D. RIF/DB   Phone: 465-3090
Division: Public Health   Date:

Approved by Commissioner: John R. Pugh [signature]   Date: 3/26/85 JCC
Agency: Department of Health & Social Services

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor

from: Rick Urion – Alaska State Medical Ass'n

Section 1. AS 08.64.370 is amended by adding a new section to read:

(7) lay midwives who, for compensation, attend homebirths for low risk women in excellent health.

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

CHAPTER 61. Lay Midwives

Sec. 08.61.010. Legislative findings. The legislature finds that:

1) childbirth has carried a high mortality rate throughout history
2) midwives have attended births for centuries
3) through education and research the medical profession has been instrumental in reducing the maternal and infant death rate
4) although there are known risks to homebirthing, there are a number of residents who desire this type of experience
5) lay midwives have operated unregulated in the state for years
6) there is a legitimate and compelling governmental interest to allow them to continue to operate and to keep statistical data that will be beneficial prior to further regulations.

Sec. 08.61.020. Registration. Lay midwives shall register with the Division of Occupational Licensing.

Sec. 08.61.030. Duties. A lay midwife shall:

1) inform expectant mother ~~and father~~ and/or father of the possible risks of ~~home~~ child birth

2) comply with the requirements of
AS 18.50.160 (birth registration),
AS 18.50.230 (death registration),
AS 18.50.240 (fetal death registration),
AS 18.15.150 (taking of blood sample),
AS 18.15.200 (screening for phenylketonuria PKU), and
7 AAC 27.111 (eye drops)

[margin note: [illegible] registration [illegible] home births]

3) accept full legal responsibility for actions, acts, and omissions. If a lay midwife seeks consultation from and/or referral to a licensed physician, the responsibility of that physician ~~until the patient is physically in the care of~~ does not begin until the patient is physically within their care.

[margin note: Vicki — good]

Sec. 08.61.040 Prohibited Practice. A lay midwife shall not knowingly deliver at homebirth a woman who:

1) Has had a previous cesarean delivery or other known uterine surgery
2) Has a history of thrombophlebitis or pulmonary embolism
3) Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, heart disease or kidney disease
4) Contracts genital herpes simplex in the first trimester or has active genital herpes in the last two weeks of pregnancy
5) Has severe psychiatric illness
6) 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~~
7) Has multiple gestation
8) Has a fetus of less than 37 weeks gestation at the onset of labor
9) Has a gestation beyond 42½ weeks by dates and examination
10) Has a fetus in any presentation other than vertex at the onset of labor
11) 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
12) Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention
13) Has pre-eclampsia or eclampsia
14) Has a parity greater than 5
15) Has bleeding with evidence of placenta previa

[margin note: Vicki — shouldn't be in law. As research changes these may not be risks.]

Sec. 08.61.050. Penalty. A person who violates this chapter is guilty of a class A misdemeanor.

Sec. 08.61.060. Definitions.

(1) lay midwife means one who, for compensation, gives advice concerning pregnancy and conducts deliveries without supervision for low risk women in excellent health; and cares for newborns and infants who are less than four weeks old; in this paragraph "cares for" means performing preventive measures, detecting abnormal conditions in mother and child, procuring medical help, and executing emergency measures in the absence of medical help.

prefer Fahrenkamp's original bill

Crowd supports midwife bills

By JOHN CREED
Staff Writer

More than 150 people—all shapes, sizes and political persuasions—assembled at the local Legislative Information Office Tuesday evening for the weekly Interior delegation's teleconference. The meeting saw nearly universal support for two midwifery bills before the Legislature.

"My wife and I are both college-educated, church-going, redneck, patriotic, conservative and productive members of society," said Gary Wells, who works at Fairbanks Memorial Hospital. "We are not wild-eyed hippies living in a teepee out in the woods trying to get back to nature. Yet, there are those who would make us criminals because we have chosen to have our child at home."

The state medical board ruled a month ago that "assisting healthy women in the natural delivery of their newborns at home" is the practice of medicine, which prompted two Fairbanksan-sponsored midwifery bills, one by Sen. Bettye Fahrenkamp and one by Rep. Niilo Koponen, both Democrats. Both bills put natural, at-home childbirth outside the practice of medicine to prevent midwives from being outlawed.

About 30 people had time to testify in the hour-long teleconference. All but six addressed midwifery. House Bill 335 passed the house Tuesday, and a vote on HB 335 in the Senate was expected today.

"Child birth is big business," said local resident Bradley Snow. "Asking medical boards to rule on whether midwifery is practicing medicine is like asking the crocodile who should be allowed to swim in the river. The conflict of interest is overwhelming."

"That is a cheap shot," local obstetrician Marshall Goldberg, who did not attend the teleconference, said this morning. "It's like saying just because we gain financially that the well-being of mothers and babies is of no concern to us. My motivation is not financial. I'm not competing with midwives. There's too much of a gap in our knowledge and skills and experience to even consider them competition."

The Fairbanks Memorial Hospital, which delivers some 1,500 babies a year, has no official position on the midwifery issue, according to spokesperson Ann Spinks.

Barbara Maynard, an advanced nurse practitioner and family nurse midwife who testified against the bill, said she did not oppose midwifery, rather the lack of licensing of lay midwives in Alaska.

Koponen explained that his bill was amended Tuesday to insure midwifery licensure within one year, adding that a licensure bill was drafted in committee Tuesday.

"I'm a conservative Republican and loyal supporter of our President," said Ann Tewson, a registered nurse and mother of five born-at-home children. "With the help and skill of a midwife, homebirth is a safe and wonderful alternative to hospital birth. Birth is not a disease or sickness."

Two local chiropractors—Guru Singh Khalsa and Bill Tewson—spoke in support of the bill. No physicians or other medical professionals opposing the bill testified.

Tewson said modern medicine treats childbirth as a disease.

"More than 95 percent of births to healthy women can and should be done outside the hospital," he said, adding that the medical establishment's "scare tactics" haven't diminished people's desire for home births and alternative health care.

saying legislators have received much input and cooperation from medical professionals on this issue.

"I'm a conservative Republican and I wholeheartedly support this bill," said Sen. Jack Coghill (R-Nenana).

But local resident Doug Deraadt questioned the position of Sen. Don Bennett, who did not attend the teleconference. Deraadt said Bennett is part owner of the Fairbanks Clinic where many obstetricians practice, and might therefore might have a conflict of interest and vote against the bill.

Bennett owns no interest in the Fairbanks Clinic, according to his legislative aide, Dick Robinett.

"He's (Bennett) not taking a public position on the midwifery bill," Robinett said. "He wants to see what the Senate HESS committee ultimately comes out with."

John Anderson said he had children born both in the hospital and at home with a midwife.

CROWD AT HEARING— The Fairbanks Legislative Information Office Tuesday evening overflowed with adults, infants and children. Local legislators listened to an overwhelming majority of testimony in favor of two midwifery bills currently before the Legislature. *(Photo by Todd Paris)*

Ekstedt unofficially new Nenana mayor

Correspondent's report

NENANA—Unofficial election results show Jim Ekstedt gaining enough votes to be Nenana's new mayor.

However, results of the special election won't be final until questioned and absentee ballots are counted, Barbara Carson, head election judge, said Tuesday night.

Ekstedt received 85 votes, or 40.8 percent; Joe Cooper received 76 votes or 36.5 percent; Bob Knight received 33 votes or 15.8 percent and Wayne Hooker received 11 votes, or 5.3 percent.

Three write-in votes, all for Acting Mayor Jim Coghill, were also cast, Carson said, for a total of 208 votes.

Questioned ballots numbered 36 and there are also some absentee ballots still to be counted, she said.

If neither Ekstedt nor Cooper, his closest contender, receives 40 percent of the vote in the final tally, a run-off election will be required.

Ekstedt is in his second year as a Nenana resident and is manager of the Nenana Ice Classic. He actively campaigned for the mayor's position, saying it was time for change in Nenana.

Jack Coghill had been mayor for most of the past 20 years, but resigned in January after being elected to the state Senate.

Carson said that a charter amendment was approved by voters Tuesday. The amendment says that elected officials are not allowed to hold paid municipal jobs. The unofficial vote on that was 159-38, Carson said.

School board OKs ten new policies

By SUSAN FISHER
Staff Writer

Ten new policies received Fairbanks school board final approval Tuesday, with one member voting against two policies covering library book and material selections. Another covering challenges to materials was tabled, 4-2.

Seven policies deal with selection of materials, library books, films, textbooks and other materials, and challenges to selected materials and disposal of outdated materials. Four others, all passed unanimously, cover employee leaves of absence.

Tuesday's meeting was dominated by the policy considerations, and marked by brief debate over three of them.

... committee of administrators, teachers, librarians, parents and students reviewing library and media materials. The new policy identifies that committee as responsible for selection.

Redden said he had no objection to the criteria for selection, but he objected that this policy does not put the final responsibility on the superintendent. He also disagreed with stating in policy that the district embraces the objectives of the American Library Association's Library Bill of Rights, the Student's Right to Read and the School Library Bill of Rights.

Those two policies passed on 5-1 votes after Redden unsuccessfully attempted amendments. Absent Tuesday was H.O. Williams.

House vote for midwives draws mixed reactions

By JOHN CREED
Staff Writer

Reaction was mixed following the 30-3 vote in the state House Monday on a bill that would allow midwives to continue practicing in Alaska.

"It's only the very first battle won in a long fight," said Fairbanksan Vicki Penwell, president of the Midwives Association of Alaska. "But this is not just a liberal issue, nor a poor woman's issue. Many conservative Republicans also want the right to have their babies at home."

Fairbanks obstetrician Marshall Goldberg called the House vote "an irresponsible act."

"It was pressured by various lay groups appealing to the emotionalism of freedom of choice," he said. "The fetus is not being allowed to choose the safest place to be born. I think women should be discouraged from having their babies at home."

Eileen Montano, chairman of the state's nursing board, called the vote "terrible news" because it gives lay midwives "a little bit more credibility."

Goldberg said the infant death rate in Alaska in 1950—when most babies were born at home—was 37.6. In 1982 it dropped to 11.1, when most babies were born in hospital.

Penwell said hospitals are not necessarily "the safest place for healthy women to have babies. A lot of studies show just the opposite." She said the United States—where most babies are born in hospitals—ranks only 15th among industrialized countries in infant mortality.

"That's nothing to be proud of," Penwell said. "The industrialized countries that rank in the top ten utilize midwives almost exclusively, such as Sweden, Norway, Switzerland, and Holland."

The bill passed from lack of sufficient input "from the professional community," Goldberg said. "It (a pro-midwifery law) would make childbirth in the home environment an acceptable alternative."

Penwell said seven of 10 births in Great Britain are attended by midwives.

The state's medical board testified in Anchorage Superior Court last month that "assisting healthy women in the natural delivery of their newborns at home" constitutes the practice of medicine, prompting two midwifery bills in the Legislature.

"I'm personally outraged that the state medical board should tell women where they are to have their babies, especially in the Bush," said Robert Rowan, an Anchorage family physician. "I'm embarrassed by my colleagues who would dare to call pregnancy a disease."

Rowan said the years-long struggle of midwives and naturopathic doctors for state licensure "is no different from the American Medical Association's (AMA) past harassment of chiropractors, who are now an acceptable alternative." He added that the medical board's decision "could make criminals" out of Native traditional doctors and midwives such as Della Keats of Kotzebue.

"People are thirsty for alternatives to drugs and getting cut open," Rowen said, adding that Alaska's decline in infant deaths over the past few decades is more due to better nutrition, prenatal care and disease control, and not increased hospital births.

The medical community says it opposes home births and lay midwifery because of the safety factor.

"When delivering a child at home by unskilled personnel," Montano said, "society bears the costs of future medical care. The qualifications of lay midwives is so limited."

But Penwell, who said she's delivered more than 150 babies, said the term "lay" midwives implies she's untrained.

"In the past two years in Alaska, members of the Midwives Association of Alaska, who are recognized by the International Federation of Midwives, have delivered more than 600 drug-free babies," said Penwell, who holds a midwifery license issued by the state of New Mexico. "Association members in Alaska have a flawless record. What hasn't come out yet is that midwives are in fact skilled, highly trained people. We're definitely in support of skilled, well-trained midwives in Alaska."

Anchorage physician Tom Center, head of the Anchorage Medical Association, said this morning he's "adamantly opposed" to both midwife bills. He called "the unsupervised practice of home births by non-licensed midwives an extraordinarily dangerous method of bringing children into the world."

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APR 25 1985

APR 2 - 1985

April 23, 1985

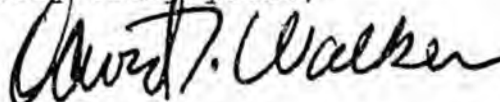
The Honorable Bettye M. Fahrenkamp
Chairman
Senate Health, Education and Social
Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

I am the registered lobbyist for the Alaska Nurses Association. The Association opposes SB 239, "An Act relating to the practice of midwifery" as that measure is presently drafted. I realize that the Committee passed out HB 335 relating to the same subject and that at the present time no hearings are scheduled for SB 239. If that situation changes and the Committee desires to act on SB 239, I would appreciate it very much if you would have your staff notify me of the hearing schedule, so that the Association will be able to appear and present testimony.

Please do not hesitate to contact me if you have a question about the Association's position regarding SB 239 or any other matter.

Very truly yours,



David T. Walker

DTW/rnt
cc: Jacqueline Pflaum, R.N.
Constance Trollan, R.N.
Georgann Beckwitt, Certified Nurse Midwife (State of Alaska - Advanced Nurse Practitioner)
Members of Senate HESS Committee

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE CS FOR HOUSE BILL NO. 335 (HESS)

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

This bill separates the practice of lay midwifery from the practice of medicine for those midwives who meet requirements for training set by the Department of Health and Social Services, empowers the Department to regulate the education, training, standards of practice and discipline of persons practicing lay midwifery and establishes a working group to formulate regulations. It also provides that proposed regulations must be reviewed by the legislature prior to adoption. Until regulations are adopted, lay midwives may continue to practice. The bill does not provide for certification or licensure. Final HESS CS. provides for registration.

The practice of lay midwifery has been unregulated in the state. In a recent court action, the State Medical Board has stated that it considers lay midwifery to be the practice of medicine. The Court has not yet ruled on the case in question which primarily concerns a naturopath and the scope of the anticipated ruling is unknown. The possibility exists that lay midwifery will be declared illegal.

Lay midwifery is a controversial topic. Many, if not most, physicians and nurse-midwives disapprove of the practice contending that home birth is not a safe practice at least for an unpredictable proportion of births and that lay midwives are insufficiently trained to exercise adequate clinical judgement or intervention in the case of unanticipated problems. Advocates of home births assert that childbirth is a natural event and that the family has the right to determine the location of the birth and the type of birth attendant. There are numerous published studies of the outcomes of home births and births attended by lay midwives but most suffer from methodological problems including small numbers of events examined and a lack of controls. 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 in general. However, no information is given regarding the degree to which home birth or lay midwifery is regulated in these states.

The number of home births attended by lay midwives in Alaska is unknown to the Department although estimates of perhaps 300 have been made. The number of persons actively practicing lay midwifery is also unknown but is thought to be between 15 and 20. There have been no published studies of outcomes of home births in the state.

Regulation of lay midwifery is likely to be difficult given the strong support and equally strong opposition which has been voiced at recent hearings on the topic. If, for example, statute or regulation required that every expectant mother be examined and screened for home birth by a physician, lay midwives in some areas of the state would be effectively

barred from practice since physician involvement may be difficult to secure because of professional convictions and liability concerns. There will be some costs associated with regulation since the state will be obligated to investigate complaints from a number of sources or face liability questions of its own.

The lay midwives working group established by Section 5 of the bill would perhaps provide a forum through which some of these problems could be worked out.

Recommended by: [signature]
Robert I. Fraser, M.D.
Director
Division of Public Health

Date: 4/15/85

Approved by: [signature]
John R. Pugh
Commissioner
Department of Health and Social Services

Date: 4-16-85

POSITION PAPER/Department of Health & Social Services

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No. SCSHB 335(HESS)
Title: Relating to practice of midwifery
Sponsor: Senate HESS
Requestor:
Date of Request: 4-12-85

FISCAL DETAIL
Agency Affected: Health & Social Services
Program Category Affected: Public Health
BRU, Program or Subprogram(s) Affected: State Health Services

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	9.5	8.3	8.7	9.0	9.4
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	9.5	8.3	8.7	9.0	9.4
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
GENERAL FUND	0	9.5	8.3	8.7	9.0	9.4
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	9.5	8.3	8.7	9.0	9.4

POSITIONS:

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
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

See attached sheet

Prepared By: Robert I. Fraser, M.D. RIF/DB
Phone: 465-3090
Division: Public Health
Date:

Approved by Commissioner: John R. Pugh [signature]
Date: 4-16-85 JCC
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget

CALCULATIONS

FY 1985: No special costs will be incurred during the remainder of the current fiscal year.

FY 1986: $8,500 are allowed for a consultant from a state allowing the practice of lay midwifery to work with the lay midwives working group in formulating regulations, including setting up examination procedures, etc. $1,000 are provided for advertising public hearings on regulations, printing and distribution of about 300 copies of draft regulations, costs of teleconferenced public hearings, etc. It is assumed that regulations will not be in force until late in the fiscal year.

FY 1987: It is assumed that costs will be incurred mostly in relation to complaints. $8,344 are provided for a contract complaint investigator to look into six complaints per year, allowing five days per investigation at $250 per day plus one trip to Fairbanks and one to Juneau with travel costs and per diem for those trips. The Division of Public Health will provide necessary secretarial services.

FY 1988-
1990: 1987 costs are inflated at a 4% annual rate.

Alaska should not legitimize practice of lay midwifery

Guest opinion

The Daily News-Miner welcomes guest opinions on a variety of topics from readers who have some expertise in a particular subject matter. Contact editorial page editor Sue Mattson at 456-6661 to discuss a specific idea.

By DR. MARSHALL GOLDBERG

Pending in the Senate Finance Committee is a bill (HB 335) which would recognize lay midwifery as outside the practice of medicine and provide for its regulation under the Department of Health and Social Services. As someone who has earned American board certification in obstetrics and gynecology, general preventive medicine and public health and who has spent his entire professional career promoting the well-being of mothers and their newborn children, I am adamantly opposed to any bills that would legitimize the ancient craft of lay midwifery. In explaining my position, I will address the myths being promoted by lay midwives and their home birth advocates.

Myth 1. "Lay midwives are skilled and highly trained."

According to the regulations of the Midwives Association of Alaska, to become a midwife, one needs a high school diploma (or its equivalent), a basic CPR course, an apprenticeship of unspecified length, and the delivery of 20 babies. There is no recognized school of lay midwifery in the U.S. and therefore no standard to training. Board-certified obstetricians, in contrast, present themselves to the public with a college degree, a medical degree, four years of formalized postgraduate training and at least two years of independent experience in obstetrics.

Myth 2. "Lay midwifery has traditionally been outside the practice of medicine."

One has only to look at the late 19th and early 20th centuries to see why the public demanded better care than their midwives delivered. Maternal and infant mortality and morbidity were at an all-time high and the quality of care rendered by lay midwives was extremely variable. There was no scientifically based information on pregnancy and childbirth until midwifery gave rise to the medical science of obstetrics. Likewise, there was no scientific foundation for the treatment of infant and childhood diseases until pediatrics became a recognized part of medicine. The scientific achievements of these specialty areas of medicine rapidly eclipsed the myths, superstitions and nostrums that characterized lay midwifery at the turn of the century.

Although claiming not to practice medicine, the lay midwives of today administer prescription drugs to the mother and newborn. When and how did they acquire specific medical knowledge of drug action, dosage and side effects? They also perform operations such as episiotomies. When and how did they acquire the knowledge of pelvic anatomy and the specialized surgical skill necessary to accomplish these procedures? Those of us who practice medicine needed extensive formal training before we could successfully and safely accomplish these tasks.

Myth 3. "Lay midwives need no outside supervision."

Because of their abbreviated training and limited skills, it is difficult to imagine any lay midwife qualified to practice without provisional medical supervision. Other paramedical groups, such as state-licensed physician's assistants and advanced nurse practitioners, work either under strict physician-guided protocols or in association with a responsible physician. Why are lay midwives unique in this regard, especially when they are assuming the weighty burden of preventing mishaps to pregnant women and their offspring?

Myth 4. "Lay midwives are responsible professionals."

The nature of obstetrical practice is such that one can never have a perfect record. Lay midwives carry no malpractice insurance, even in states where they are fully registered and licensed. Consequently, there is presently no mechanism for compensating their clients should a serious problem arise as a result of negligence or incompetence. However, independent, unsupervised practitioners, who profess to have the same expertise as M.D.'s in performing particular medical tasks are subject to the same standard of care that would apply to a physician performing those tasks. Persons seeking the services of a lay midwife should recognize this fact because it is their only source of legal redress should an adverse outcome occur.

Myth 5. "Lay midwives are needed to fill the gap in qualified birth attendants for those couples seeking home birth."

The state currently has 30 certified nurse-midwives who are duly licensed and able to attend deliveries in a home or hospital setting. Certified nurse-midwives are graduates of a baccalaureate program in nursing, have at least one year of experience in a hospital labor and delivery suite, and spend one or two years in a formalized midwifery program, usually with in a medical school. As a result, they are far better qualified and trained than lay midwives to handle normal obstetrics and newborn care and to recognize potential disasters. The fact that most certified nurse-midwives prefer the hospital setting merely reflects their more extensive experience and their preparedness to react to emergencies with the best medical technology available.

Myth 6. "If lay midwives are outlawed, then women will be forced to deliver their babies at home unattended."

Women electing to deliver at home will be no more forced to deliver at home than they were forced to become pregnant in the first place. Couples electing home birth, despite its additional risk, still have the option of seeking the care of certified nurse midwife or physician.

Myth 7. "Opposing House Bill 335 would outlaw home births and prevent lay midwives from attending them."

Nowhere in this bill is a specific reference to the setting for birth. In addition, there are no laws which presently prevent an unlicensed practitioner from attending a home birth, except when payment for that service is expected.

Myth 8. "Pregnancy is not a disease."

If one looked at the sum total of physical and psychological changes that take place during pregnancy, which are not normally found in the non-pregnant state, one would have to conclude that pregnancy presents a temporary disease-like state which is capable of causing sudden loss of life or severe disability in a mother or newborn infant. In this country for over 50 years, pregnancy and childbirth have been recognized as medical conditions. This view has compelled society to examine the needs of pregnant women and provide them with the resources for obtaining adequate prenatal care, good nutrition, and a well trained hospital birth attendant. Recognizing pregnancy as a temporary disability, moreover, has qualified working pregnant women for worker's compensation and has guaranteed them job security following maternity leave. If indeed the traditional view of pregnancy and childbirth had persisted, it is doubtful that these special maternity considerations would have occurred.

Myth 9. "Childbirth is a natural process and medical intervention is not needed."

Death, dying and disease are all natural processes. Our society already expends a great deal of its resources to prevent, minimize or delay these effects. Making childbirth an exception would only undermine the well-being of pregnant women and their offspring.

Myth 10. "The home is a safer alternative to the hospital."

There are no "no risk" pregnancies. Even when "low-risk" pregnant women are carefully screened by physicians, 12 to 15 percent will need to be transferred from the home to the hospital under emergency conditions. In 2 percent of all deliveries, there is a sudden, unexpected and serious threat to the mother or her unborn child which necessitates immediate medical attention. If home birth were really as safe as lay midwives would have the public believe, there would rarely be a need for a hospital transfer.

Regardless of the birth setting, delivery remains risky for the fetus. During the birth process and the first 24 hours of life, the risk of death is the highest that humans experience until the age of 55. Overall, a mother-to-be or her fetus can expect at least one complication (although not necessarily serious) about 50 percent of the time.

Myth 11. "The medical establishment is still not doing an adequate job."

At the turn of the century, approximately one mother in 100 died from a complication of pregnancy or childbirth. With modern obstetric care that number is presently eight per 100,000 live births, making death as a result of pregancy or childbirth a very rare phenomenon. In 1930, 65 infants per 1,000 live births died within the first year of life; with modern pediatric care, the number is now less than 11 per 1,000. Apart from these markedly improved outcomes, many of today's hospital births are family centered and take place in home-like atmospheres, thereby making the hospital childbirth experience more emotionally satisfying for childbearing women and their families.

Given the myths of lay midwifery and the accomplishments of the medical establishment, I am surprised that Alaska lawmakers would respond so promptly and favorably to a group of marginally trained, self-proclaimed professionals. The state has a vested interest in promoting the welfare and well-being of all its citizens, especially those not yet born. The mothers of yesterday, all too familiar with the hazards of childbirth, wanted a safe birthing experience. The mothers of today have that option. We who responded to that need now wish to remind those who have forgotten the past that we are condemned to repeat our mistakes if we proceed along our present course. For all of the above reasons, I am opposed to any legislation that would legitimize lay midwifery, and I urge all of those who share this view to join me in expressing that opposition to members of the House and Senate.

Marshall F. Goldberg, M.D., M.P.H., is a Fairbanks physician

Time-honored profession, midwifery, must be encouraged

By VICKI PENWELL, R.M.

Currently in the state of Alaska, there is a strong push by the medical profession to outlaw and annihilate the time-honored profession of midwifery. A recent Medical Review Board opinion stated that "assisting healthy women in the natural delivery of their infants at home" constituted the practice of medicine. The Medical Review Board decision did not come about because of any charge or complaint against a midwife.

Pending in the Legislature is HB 35 that would define and regulate the practice, making midwifery clearly legal and setting high standards of training and practice. While public opinion in favor has been overwhelming (legislators are saying they have never seen such positive input on any subject) a small but vocal percentage of Alaskan doctors are adamantly and venomously opposed.

There were many factors that attributed to the drop in infant and maternal mortality around the turn of this century. Understanding aseptic technique was a major factor. (Deaths were never higher than when women first began going to hospitals in the early 1900s and doctors would examine them with blood on their hands from another patient or corpse). Other factors were better nutrition, better living conditions, and fewer children in a family.

About this time, the medical profession, only recently interested in obstetrics, waged a high smear campaign to discredit midwives as "ignorant, dirty, superstitious grannies." Many of the midwives during this period were European immigrants, who had gone through much the same training as a doctor in their native countries, and were highly respected professionals back home. However, because of language and cultural barriers, midwives in America were not able to unite and successfully fight off this unprovoked attack. In areas of the deep South and in poor rural areas, midwives continued to practice, and it is significant, if not sad, to note that as long as midwives only assisted poor women who had no money to pay a doctor, they went unopposed.

In the past 20 years, the demand for midwives in this country has been steadily increasing, this time cutting across all social and economic lines and now the opposition is heard.

Not all physicians agree with opposition to midwifery, however. Current studies have shown outcomes as good and better than physician-attended hospital births. Dr. Robert Mendleson, M.D., says that "Modern Medicine invents a crisis out of a normal situation. By treating childbirth as a disease, the obstetrician makes his intervention indispensable." He goes on to say that 95 percent of births proceed entirely without complication and should occur in a home setting.

In 1977, Dr. Lewis Mehl, M.D., did the only truly matched study to date comparing home with hospital births. He matched two groups of 1,046 women each, for race, age, parity, education, socio-economic status, and risk factors. None of the home birth group were attended by board- certified obstetricians and none of the hospital group were attended by midwives. His findings were:

For the hospital group: 3.7 times more babies required resuscitation, respiratory distress was 17 times higher, six times more fetal distress, four times higher infection rate, 2.5 times more meconium aspiration pneumonia, five times more maternal high blood pressure, eight times more shoulder dystocia, three times more maternal hemorrhage. In every area, complications were much worse for the hospital group.

Guest opinion

The Daily News-Miner welcomes guest opinions on a variety of topics from readers who have some expertise in a particular subject matter. Contact editorial page editor Sue Mattson at 456-6661 to discuss a specific idea.

Dr. David Stewart, president of the National Association of Parents and Professionals for Safe Alternatives in Childbirth, states that "other studies have yielded similar results. The conclusion that we draw is that hospitals pose hazards to mothers and babies that are unique to the hospital."

All of the findings used to argue the danger involved in out-of-hospital births are no more than raw statistics and data collected by Public Health departments; they are not carefully modeled studies such as those done by Dr. Mehl. When doctors quote a study that claims hospital births are five times safer, they are using a study done by the Health Department in 11 states that clumped all out-of-hospital births together: Premature births before viable age, accidental births while in transit to the hospital, unplanned home deliveries, and planned home deliveries with no attendant and no prenatal care at all.

The Farm, a community of families in Tennessee, has carefully compiled statistics of over 1,000 births attended at home by midwives. The perinatal outcomes are excellent, more than three times less than that of the state of Tennessee, and as much as four times less than several other medical centers around the country.

Midwives do not use drugs or surgery in the course of normal pregnancy, labor, and delivery. (The definition of the practice of medicine has commonly been "drugs and surgery"). If it seems likely that a mother or her baby would benefit from either of these, she is taken to a hospital. Use of drugs or surgery place a mother and baby in a high-risk category and she should be under a doctor's care. Midwives who assist at home deliveries in Alaska follow a standard of care which recognizes potential problems. Transfers to a medical facility are rarely emergencies. For example, the standard of care requires consult or transfer for a women who does not show appropriate weight gain or uterine growth, or when the baby is presenting other than head first. A transfer rate of 10 to 12 percent is realistic, in view of the fact that midwives' first concern is for safety, and not for "homebirth at any cost." A significant factor here is that 88 to 90 percent of women who seek midwifery care deliver with no drugs and no surgical intervention at all. Compare this with the local hospital statistics of drug use in 90 percent of all birth, and surgical procedures in almost 100 percent of vaginal deliveries (amniotomy—artifically breaking the bag of water, and episiotomy—cutting the vagina) and 20 percent cesarean deliveries (major abdominal surgery) to extract the baby.

From these local statistics it is easy to see that childbirth is, in the majority of cases, able to occur safely outside of a hospital, and without medical intervention. The fact that most doctors use surgery and drugs on practically every woman in their care does not mean that it is necessary, or in fact desirable.

VICKI PENWELL
Registered Midwife

It has been stated that regardless of setting, delivery is risky to the baby. How much more so for an infant whose small system is already compromised by drugs and interventions used on his mother during labor? The American Academy of Pediatrics has stated that no drug has been proven safe for the unborn baby. Dr. Caldreyo-Barcia, president of the International Federation of Obstetritions and Gynecologists, published a study that proved artificially breaking the bag of water produced a significant adverse effect on the unborn baby.

In June 1984, Dr. Philipson, et al., in an article published in the American Journal of Obstetrics and Gynecology, found that even a simple seemingly harmless local anesthetic right before birth has dangerous effects on the baby (commonly used lidocaine, given prior to episiotomy, goes into the baby's bloodstream in less than 1 minute).

Yet all of these are common practices during childbirth in a hospital.

I find it interesting to note that when a doctor is faced with the issue of lay midwifery, he often cites the "medical model" training of certified nurse-midwives as ideal. However, there have been certified nurse-midwives in this community as well as other places in Alaska who have been restricted in their practice or not allowed to work at all because no doctor would back them, even for hospital births. CNMs rarely attend home deliveries because, not being an independant practice, they need physician approval for their very existence. It is obvious to me that many if not most physicians in Alaska are merely giving lip service to the desire to work with midwives, and really wish we could all be wiped off the face of the earth.

With the exception of two doctors in Homer, I know of no physicians in this state willing to attend out-of-hospital births. In fact the trend throughout Alaska is for doctors to deny care of any kind to pregnant women expressing a desire not to be hospitalized for childbirth. For a Fairbanks doctor to say that a woman who wants a homebirth has the option of seeking care from a CNM or physician is misleading and completely false. That option does not exist.

The Midwives Association of Alaska is a professional, self-regulating organization, which offers a two-year training program that incorporates coursework (teaching modules that use obstetrical textbooks as the base) with a clinical apprenticeship or preceptorship. This apprenticeship or preceptorship may be with a physician, certified nurse-midwife or registered midwife. If physicians are concerned about what midwives may or may not know, it is their option to help train them, as is the case in New Mexico, where Taos Holy Cross Hospital and individual OBs and pediatricians supervise midwives doing prenatals, labor managements and deliveries, and newborn exams.

Midwives are also taught emergency measures, and carry emergency equipment with them to out of hospital deliveries.

The midwifery standard of care espouses the following principles: individualized prenatal care; special attention to nutrition; family centered, natural childbirth; home or birth center delivery; immediate family-infant bonding; and early and extended breast feeding.

Nobody wants to go backwards to the days in which many babies and sometimes mothers died in childbirth.

Midwifery of today is moving forward, looking to work as equal members of the health care team to lower our astonishingly high infant death rate in this country. There is room for both doctor and midwife, especially in Alaska, where medical help is not readily available or financially feasible to all citizens. Midwives have proven themselves to be a safe alternative for healthy women. Now it is a freedom of choice issue. It would be discrimination of the worst kind to deny Alaskan women the right of attendance in childbirth if they will not or cannot be hospitalized.

Public Opinion Messages on this matter can be sent to members of the House and Senate free of charge, through the Legislative Information Office. I urge all who believe people should have freedom to choose safe alternatives in childbirth to voice their opinons now.

Vicki Penwell, R.M., is director of the Midwives Association of Alaska. Licensed by the state of New Mexico and a member of the International Confederation of Midwives, she currently practices in Fairbanks.

SB 239

Editorial

Midwives Are Superior To Doctors in Birthing

The Farthest North Press Club over the years has heard many guests supporting various side. of an issue but so far as we are concerned the guest last Friday came close to being the most convincing to appear before the group in the past 20 years.

The guest was Vicki Penwell, president of the Midwives Association of Alaska, and operator of a Midwife Clinic here.

Armed with mountains of statistics and results of studies, she convinced this editor at least that trained, experienced midwives were not only safer in assisting healthy mothers to give birth at home in comparison with births in the institutional setting of hospitals, but she also convinced this editor that having the assistance of a midwife was superior in many other ways.

She pointed out that the United States— where most babie are born in hospitals—ranks 15th among the industrialized countries in infant mortality. Countries such as Norway, Sweden, Switzerland, and Holland, which are in the top ten, she said, almost exclusively use midwives. In fact, she said that in the countries of the world other than the U.S. and Canada, the only two countries that have tried to ban midwifery, that 97 per cent of the babies are born utilizing midwives.

Penwell was making the presentation because of a threatened ban on lay midwifery in Alaska brought about by a State Medical Board ruling that anyone who assists a woman in child birth is illegally practicing medicine without a license. The ruling has been cited in an Anchorage Superior Court case in which an Anchorage naturopath is [illegible] charged with practicing medicine without a license.

If the Medical Board's ruling is upheld, such could have a very devastating effect in Alaska, not only in making midwifery illegal, but also affecting many other categories of people who assist women in childbirth in some way— people such as ambulance emergency personnel, physician assistants, and the like.

The medical community in opposing midwifery cites a study made in 11 states supposedly showing that births in hospitals are 5 times safer than non-hospital births. That study, however, is misleading because it includes births such as in taxi-cabs, on hospital front lawns, unattended births, and so on. When only the cases involving assistance by trained, experienced midwives are isolated, the statistics show these births are safer with midwives than are hospital births, in which drug use and surgery are commonplace.

But so far as we are concerned, one of the big factors in births is the psychological effects on the mother, father, and child. As pointed out by Ms. Penswell, if one takes away a newly born calf from a cow for just a half hour, the cow will now own? the calf and give it milk. The bonding of the mother and child is very important.

Midwives encourage fathers to participate in births and consequently there is closer bonding. Mothers utilizing midwives hold their babies immediately. Studies have shown that in cases where there is bonding, the parents are more frank with their offspring and the incidence of child abuse later is significantly lowered. This is an important factor when one considered the rising incidence of child abuse in Alaska.

In the hospital institutional setting, the father is often excluded, the child is whisked away to nurseries, and there is little or no bonding.

While we had not given the subject of child birth much thought previously and had not considered the pros and cons of midwife assisted births vs. hospital births, now that we have we believe that the former is superior to the latter. Perhaps it is time to begin encouraging the former, discouraging the latter.

We wonder it the medical community is trying to ban midwifery because of greed. Hospitals charge on the average about $7,000 per birth. Midwives charge about one fourth of that while performing for a more valued service.

Active DOT Construction Projects

The State Department Transportation and Public Fac ties have 53 active constructi projects totaling $116,471,0C

They are:

80-Mile Steese Maintenan Facility, $757,000, completi date, March 15, 1985.

Airport Road & Richardsc Highway Beacon, $21,000, cor pletion date, May 1, 198

Airport Way Signals Channel, $1,556,000 , compl tion date, June 1, 1985.

Alaska Highway-Yerric COnstruction/Robertson, $7,838,000.

Alaska Highway—Milepo: 1256-1253, $3,260,000, con pletion date, May 25, 198:

Ballaine Road Bike Tra: Repair, $131,000.

Barrow Airport Improve ments, $1,021,000, completio October 30, 1985.

Dalton Resurfacing & Bridge Repair, $4,090,000, com pletion date August 30, 1985

Deadhorse Parallel Taxiway $3,027,000, completion dat June 19, 1985.

Denali—Fish Creek Bridge, 165,000, completion date, July 15, 1985.

Denali—McLaren River Bridge, $1,395,000, completion date, July 1, 1986.

E. College Road-Marietta Steese, $1,885,000, completion date July 14, 1986.

Eagle Land & Roadway Improvement, $991,000, completion date, October 31, 1985.

Ernestine Maintenance Shop $452,000, completion date, March 15, 1985.

FAI CAT II Generator, $205,000, completion dat March 15, 1985.

FAI CFR Building Re...

Support Local Hire Come Out to Sat... Jay Rally

MEMORANDUM:

file SB 239

FROM: Marshall F. Goldberg, M.D. MFG

DATE: April 19, 1985

RE: Proposed Amendments to House Bill No. 335

1. Amend title of the Bill to read as follows: "An Act Relating to Practice of Lay Midwifery and Providing for an Effective Date"

   RATIONALE:

   Lay Midwives should be distinguished from certified nurse-midwives who are already licensed and practicing in the state. I believe, since the term lay midwifery is used throughout the text of the Bill, that it is entirely appropriate to re-title the Bill referring specifically to lay midwifery.

2. Amend Section 4, AS 18.05.070 (3), by adding: "Caring for" does not include the administration of prescription medications and the performance of surgical procedures such as episiotomies and the repair of genital lacerations, which presently constitute the practice of medicine.

   RATIONALE:

   Adding this amendment clearly distinguishes the practice of lay midwifery from the practice of medicine and protects the public from less knowledgeable and skilled practitioners. This is especially important because lay midwives will be totally unsupervised by other obstetric practitioners possessing greater knowledge, skill and experience.

3. Amend section 7, paragraph (b), by adding the following: A licensed physician shall not be compelled by law to accept any patient referred by a lay midwife, ~~regardless of the patient's condition~~.

   RATIONALE:

   Since the preceeding sentence states that the physician's responsibility does not begin until the patient is physically within his or her care, it places the physician at greater medicolegal risk because he or she does not have the necessary rapport or prior knowledge of the patient's condition to render effective care, especially under emergency conditions. Without this exclusionary statement, physicians will find themselves increasingly at greater risk for malpractice litigation. In addition, because compensation awards to plaintiffs can cost millions of dollars, physicians will either pay higher malpractice premiums, which will then be passed along to their patients via higher fees, or reduce, if not give up, obstetrical practice. Given its limited health care resources at this time, Alaska can afford neither set of circumstances.

RE: Proposed Amendments to House Bill No. 335

DATE: April 19, 1985

4. Amend section 7 (c), by deleting, "Unless the lay midwife obtains a high risk waiver", leaving, "A lay midwife practicing under Section 6 of this act may not deliver a woman who..." and deleting section 7 (d), (1), (2) & (3) in its entirety.

RATIONALE:

Any woman having a home birth is already placing herself and her unborn child at greater risk for an obstetrical mishap which could lead to loss of life and/or disability. Lay midwives, because of their marginal training and skill, should be duty bound as well as legally required to except only low risk patients. Having high risk patients deliver at home by a lay midwife places the mother and her unborn child in triple jeopardy. The mere fact that lay midwives would accept these patients is troubling, to say the least, since it implies that they are not truly cognizant of their limitations.

1/8/85 Sandra

Vicki Penwell, President, Midwives Association
H 479-6388
W 456-3719

Alaska doesn't have licensing for midwives; association wants it to be established in Dept. H&SS. Regulation will ensure a particular standard of care and provide consumer protection.

Want to be legally recognized by defining "midwifery" in the statute (she's sending the international definition of midwifery which has been accepted by the World Health Organization and others).

Also want the Dept. to keep the records/vital statistics on out-of-hospital births.

The state organization has established a certification procedure based on the American College of Nurse-Midwives certification. Involves experience (certain number of prenatal visit exams, deliveries, post-partum exams, etc.), education (2-year written program with apprenticeship/preceptorship; involves 13 areas of study such as prenatal care, management of complications, etc.), clinical experience supervised by licensed midwife or physician, and 16 hours in a medical learning situation (like a hospital).

New Mexico (where Vicki is licensed) has three tiers of licensing (apprentice, provisional, and full) to accommodate "granny" midwives.

So far ~~Alaska~~ the Association has certified 6 midwives, a small percentage of those practicing. Estimate that 9% of births in Anchorage are performed by midwives; 6% in Fairbanks.

V. Fischer introduced similar legislation 2 years ago - died in committee. It outlined regulations, essentially, which Vicki thinks was the problem. Start by getting legal regulation (per definition in statute).

Important to <u>not</u> make <u>where</u> people give birth the issue.

SENDING PACKET OF INFO. WOULD LIKE TO COME TO JUNEAU AND MEET WITH BETTYE TO DISCUSS. TOLD HER I'D CALL HER ONCE I'D REVIEWED INFORMATION.

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

7TH FLOOR FRONTIER BLDG.
3601 C STREET, SUITE 722
ANCHORAGE, ALASKA 99503
PHONE: (907) 561-2878

April 4, 1985

ALASKA BOARD OF NURSING

Position on Senate Bill 239 and House Bill 335

The Alaska Board of Nursing has taken a position in opposition to Senate Bill 239 and House Bill 335 "An Act relating to the practice of midwifery". The Board believes the proposed legislation falls short of any intent to protect the public.

While the Board of Nursing recognizes a parent's freedom of choice in birthing alternatives, it also recognizes the State's responsibility to protect the rights of the child being born. In so recognizing the State's responsibility, the Board supports utilization of competent safe practitioners.

The Board of Nursing currently has responsibility for authorizing the practice of certified nurse midwives. These practitioners are registered nurses with additional education and certification gained through nationally recognized programs. Among the functions of the nurse midwife are management of care of the essentially healthy woman and newborn throughout the childbearing process. In provision of these services, the nurse midwife collaborates with physicians and other health professionals.

The lay midwives lack the education and training to practice safely. In particular, there is no recognized standardized accredited education in Alaska for the lay midwife. Most lay midwives are not adequately trained to deal with medical emergencies arising with the mother and newborn child.

Any legislation relating to the practice of midwifery should specify that it pertains to lay midwifery to avoid confusion with the certified nurse midwife. We have seen in the recent past, confusion on the part of some consumers between the practice of the lay midwife and the certified nurse midwife.

In summary, the proposed legislation is a start in regulating the practice of lay midwifery. However, it does not go far enough to protect the public health and welfare.

MEMORANDUM State of Alaska

APR 8 1985

TO: Members Senate Health, Education & Social Services Committee

DATE: April 4, 1985

FILE NO:

TELEPHONE NO:

FROM: Alaska Board of Nursing
Eileen Montano, Chair
Effie Graham
Constance Bertholf
Alice Soloman
Keith Wise
Barbara Carberry
Linda Todd
Gail McGuill, Executive Secretary

SUBJECT:

Please find attached the Board of Nursing position on SB 239 "An Act relating to the practice of midwifery."

Should you have questions about our position, do not hesitate to contact us. Thank you for your consideration of our position in this health related matter.

Alaska State Legislature

BETTYE FAHRENKAMP, Chairman
ARLISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
PAUL FISCHER
EDNA ARMSTRONG-DE VRIES

POUCH V
STATE CAPITAL
JUNEAU ALASKA 99811
(907) 465-3834
(907) 465-3835

Senate
Committee on
Health, Education and Social Services

MEMORANDUM

TO: Members, Senate Committee on Health, Education and Social Services

FROM: Committee Staff

RE: Committee Meeting, April 2, 1985

DATE: March 29, 1985

On Tuesday, April 2, at 1:30 pm in the Beltz Room, the Senate Committee on Health, Education and Social Services will hear the following bills:

SB 239, Practice of Midwifery

SB 239 would define the practice of midwifery outside of the state medical practices act, and require the Department of Health and Social Services to develop regulations setting standards for the education and training of lay midwives. Neither current state statute or regulation addresses midwifery. Six lay midwives in the state are currently certified under procedures established by the Midwives Association of Alaska.

A recent decision by the state medical board has deemed midwifery the practice of medicine. If upheld in court, the ruling would effectively outlaw the practice of lay midwifery in Alaska.

A draft committee substitute, clarifying the Department's authority to regulate the practice of midwifery, is attached. This portion of the hearing will be teleconferenced to Anchorage and Fairbanks, from 1:30-2:15 pm.

5/86

file SB 259

#5

ALASKA NURSES ASSOCIATION

R E S O L U T I O N

Regarding

LAY-MIDWIFERY REGULATIONS

Whereas, the State of Alaska has proposed regulations (7AAC16.010) for defining and outlining the registration, training and scope of practice of the lay-midwife, and

Whereas, the Department of Health and Social Services has been placed as the regulating body for the State of Alaska in overseeing the implementation of these regulations without providing funds for the process, and

Whereas, a number of allowed skills are included which we feel are not appropriate for lay-midwifery such as tracheal intubation, intramuscular medication administration, intravenous administration of Lactated Ringers solution, metabolic screening of the newborn, and

Whereas, the method of education is a strictly apprenticeship training with no method of assuring good clinical competency by either instructor or student, and

Whereas, the health care of the pregnant and delivering woman and her newborn are of social and community concern and

In As Much As nurses are a part of the community and directly involved in all health care outcomes involving maternal/child health

Therefore, Be It Resolved That The Alaska Nurses Association stands opposed to 7ACC16.010 as written and requests reconsideration of the regulations.

To be copied to: Office of the Governor
Mr. John Pugh, Commissioner, DHSS
Mr. David Bruce, DHSS
All Representatives and senators

COMMITTEE REPORT
SENATE

FURTHER:

4/?/85

Date 4-?-85

Mr. President

The Committee on HESS considered HB 335 on

practic of midwifery; etc

and (a majority of the committee) (the committee) reports it back with the following recommendations:

[X] do pass

[ ] do pass with attached amendment(s)

[/] replace with/or adopt CS for HB 335 ...
[ ] new title
[x] same title and recommends Do Pass

[/] and attached a "LETTER OF INTENT" [ ] NEW FISCAL NOTE

[ ] reports it back without recommendation

[ ] recommends referral to ______ Committee

MEMBERS SIGNING DO PASS	MEMBERS HAVING OTHER RECOMMENDATIONS
[signature]	
[signature]	
[signature]	

[signature]
Chairman

[signature]
Chairman recommendation

4/3/85 Anch Daily News

legislature

Opinions split sharply on regulation of midwives

By ROBB FULCHER
United Press International

JUNEAU — Alaskans in Anchorage, Fairbanks and Juneau were sharply divided Tuesday on the issue of whether the state should regulate lay midwives.

People in the three cities made their views known at a legislative hearing broadcast statewide by teleconference, which was held to discuss a bill by Sen. Bettye Fahrenkamp, R-Fairbanks, which would set state regulations for midwives.

Nurse midwives currently are permitted to assist in childbirth under a physician's suprvision.

Many of those opposing the bill told the Senate Health, Education and Social Services Committee that "legalizing" the practice of lay midwives delivering babies unsupervised would put women and children in danger.

People speaking in favor of the bill said that it would assure greater safety in increasingly popular in-home births by setting standards for a previously unregulated field.

There is no statute outlawing midwifery in Alaska.

But a state board recently ruled that assisting in the delivery of a baby for a fee is a medical practice, so a years-old push to set standards for the business has been hurried along in the forms of the Fahrenkamp bill and a similar bill introduced in the House.

Fahrenkamp's bill would describe midwifery as a "social service," not as a medical service.

"There is a growing percentage of women in Alaska who are either fiancially, geographically or emotionally unable to give birth in a hospital setting. They benefit greatly from a midwife's care," said Vicki Penwell, director of the Midwives Association of Alaska.

"This bill would clearly define midwifery and would assure quality, legal care for women who are unable for any reason to be hospitalized for birth," Penwell said.

Thomas Senter, president of the Anchorage Medical Society, told the committee that passage of Fahrenkamp's bill would result in danger to mothers and babies.

"It would legalize the unsupervised practice of home delivery which is a risky business at best, and place the infants at risk who are truly in harm's way, just by coming into the world," Senter said.

"I believe that when a child comes into this world he deserves the best medical care available. In Alaska in 1985, the very best medical care available involves hospital care or birthing rooms in the hospital," Senter said.

Kasey Wilbur told the committee that her three children were all delivered by midwives.

new bills

The Associated Press

JUNEAU — Here is a list of bills and resolutions introduced Tuesday, the 79th day of the first session of the 14th Alaska Legislature.

SENATE:

[illegible] Would add Kuskokwim Ice Classic to state's games of chance category: Introduced by Sen. John Sack[illegible]

[illegible] Tuesday.

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May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

HESS 4-16-85 1:38 pm