1982

DEPARTMENT OF HUMAN RESOURCES

MIDWIFERY STUDY COMMITTEE

REPORT AND RECOMMENDATIONS TO THE SECRETARY OF THE DEPARTMENT OF HUMAN RESOURCES

Executive Summary

As a result of extensive review of the literature, selective review of legal precedent in this and other states, and extensive debate among its members, the Midwifery Study Committee recommends that a Board of Midwifery be established to regulate the profession of midwifery in North Carolina as further defined in Section VI of this report. As a second choice, the committee considered the alternative that the regulatory authority be granted to the Joint Subcommittee of the Boards of Medicine and Nursing, also as further defined in Section VI of this report.

TABLE OF CONTENTS

I. Introduction

On January 19, 1982, the Midwifery Study Committee met for the first time. Established as an advisory committee to Dr. Morrow, in order to comply with H.B. 695, the committee's purpose was to study the safety and efficacy of out-of-hospital births and to examine the state's role in licensing or otherwise permitting the activities of birth attendants functioning in the non-hospital setting. It was agreed at the first meeting that the following functions would be included in the committee's work: review of the literature, review of other states statutes regarding midwifery, and collection of information regarding deliveries by midwives permitted under H.B. 695. In order to complete the work as expeditiously as possible, subcommittees were formed. They were directed to meet, proceed with the identified tasks and report back to each full committee meeting.

The full Midwifery Study Committee met seven times between January and October, 1982, while the subcommittees met numerous times during this same period. The subcommittees met to accomplish the following purposes:

1. Literature Review Subcommittee - To include a literature review nationally and internationally which addresses the issues involved in out-of-hospital deliveries. (See Section III)

2. Data Collection Subcommittee - To collect and review data on out-of-hospital deliveries in order to study the safety and efficacy of such deliveries; consider data in North Carolina by midwives permitted under H.B. 695 and data outside of North Carolina. (See Section IV)

3. Model Legislation Subcommittee - To draft a bill which would be based on the study committee's recommendations to the Secretary of the Department of Human Resources. (See Sections V & VI)
   Areas to be addressed include:
   (a) North Carolina definition of midwife
   (b) Role of state government in licensing or issuing permits for the practice of midwifery
   (c) Resolution of the current dual system for obtaining permission to practice as a C.N.M. in North Carolina
   (d) Delegation of responsibility for the regulation and supervision of midwifery in North Carolina (if midwifery is to be recognized as a profession in this state).

II. Midwifery Study Committee

Members	Representing
1. Chair: Earl G. Trevathan, M.D.	Commission for Health Services
2. Louis T. Kermon, M.D.	N. C. Board of Medical Examiners
3. Lois Simmons-Isler, F.N.P.	N. C. Board of Nursing
4. Linda May, C.N.M.	N. C. Chapter of the American College of Nurse-Midwives
5. Dan Domizio, P.A. (replacement August 1982: Arnie Katz)	Lay Midwifery
6. Frederick C. Heaton, M.D.	Obstetrics
7. Mary Edith Rogers, Health Director	Public Health
8. Linda Glenn, C.N.M.	N. C. Nurse's Association
9. Robert G. Brame, M.D.	N. C. Medical Society
10. Jane Helwig	Citizen
11. Barbara Parker	Citizen
12. Ann Woodward	Citizen

Subcommittee Membership

A. Data Collection Subcommittee - Jane Helwig, Chair; Ann Woodward, Chris Heaton

B. Literature Review Subcommittee - Ann Woodward, Chair; Chris Heaton, Barbara Parker

C. Model Legislation Subcommittee - Dan Domizio, Chair; Lois Simmons-Isler, Mary Edith Rogers, Linda May, Linda Glenn, Louis Kermon, Robert Brame

Division of Health Services Staff

1. Debbie Stanford, C.N.M.
2. Martha W. Ballard, M.N., R.N.C.
3. Elizabeth Berryhill, C.N.M.
4. Richard Nugent, M.D.

III. Literature Review

Published literature in the U.S. since 1970 on the medical outcomes of home and out-of-hospital births was reviewed. The conclusions to be drawn from this review include the following:

1. There are no definitive studies comparing the relative safety of hospital births with planned out-of-hospital births.

2. There is no credible evidence that intended, attended, out-of-hospital births with adequate prenatal care pose statistically significant health or safety risks to either mother or infant.

3. There are no studies to indicate a relationship between medical outcome of mother or infant and the formal educational qualifications of the attendant in cases of intended, attended, out-of-hospital births with adequate prenatal care.

(Please see attached report prepared by Ann Woodward, M.P.H., September 1, 1982)

HOME AND OUT-OF-HOSPITAL BIRTHS:
STATUS OF EVALUATION EFFORTS

A review of the literature shows that little scientific data available in North America supports the strongly held opinions of both advocates and opponents of home births (Adamson). A description of evaluation of the medical outcomes of home and out-of-hospital births since 1970 is complicated by several factors.

I. Definition of setting

A. State birth statistics traditionally are classified as occurring in-hospital and out-of-hospital (Burnett). In 1979, only 12 of 48 state health departments were able to link newborn mortality with place of birth (Pearse).

B. The government statistics, published by the National Center for Health Statistics, summarize hospital, clinic or institutions as "hospital births", while office, residence, street address, enroute or born on arrival are "out-of-hospital". Thus figures for free-standing birth centers are tabulated in national reports as "in hospital" (Stewart).

II. Definition of planned and unplanned

A. Inclusion of unintended home births with the home birth statistics is a frequent source of error. Unintended home births are not professionally attended, and are more likely to be premature. Thus, the apparent risk of home delivery may be artifically high (Shy, Select Panel).

B. Home birth statistics have not included a category for planned births. It could be assumed that planning would ensure prenatal screening, preparation and identification of attendant. Planning status has impact on the outcome of a birth. The relative risk of unplanned home deliveries was 20 times more than that of planned home deliveries (Burnett).

III. Vital statistics

To date, out-of-hospital birth data has been obtained from birth certificates (Burnett, Shy, McCartha). In some studies, birth certificates were cross-tabulated with records of neonatal deaths (Burnett, Shy). There are confounding factors that may be a potential source of bias.

A. Underreporting of home births has been estimated to be as much as 5% in some areas and higher in other areas. And, while home births may be registered with the Health Department, specific records are not kept on the outcome of births (Stewart).

B. Underreporting of neonatal deaths. A Georgia study attempted to identify the maternal and infant characteristics associated with highest risk of death. The researchers found procedural errors in the processing of birth and death certificates and failure to register some infant deaths at all (McCarthy). The effect of underreporting of neonatal deaths on attempts to evaluate safety of hospital and out-of-hospital births is important to note.

C. Reported home births with undesirable outcomes. Home births with problems are often reported since these are the ones that come into contact with the medical system. If a significant number of home births are unreported, a disproportionate number with unfavorable outcome will be registered (Stewart).

D. Risk screening. There is no source of information in the birth statistics that indicates whether an out-of-hospital birth was high or low risk on the basis of prenatal screening. Women who are screened and defined as high-risk usually deliver in the hospital.

IV. Characteristics of the population

The highly selected nature of the population being studied makes the data scientifically unreliable (Adamson).

A. Self-selection (positive) A home birth population that is self-selected is usually middle-class, adequately nourished, receives prenatal care, screening and preparation, chooses an attendant, values breastfeeding and is a relative low risk (Hazell).

B. Selection (negative). There is another part of the home birth population that do not have other alternatives available, receive little or no prenatal care or screening, are undernourished and at high risk (Adamson). Some may reject medical care and refuse to go to the hospital for religious reasons (Pearse).

V. Attendants

A. Professionals or other persons may attend a birth. These include physicians, nurse-midwives, nurses, lay-midwives, and such others as fathers and naturopaths. It is apparent that training varies and that care given the clients would vary substantially (Institute of Medicine).

VI. Other factors

A. Two important considerations to women, as consumers of maternity care, are not evaluated in the studies and statistics on out-of-hospital births. First, the women's perceptions of medical risk sometimes do not conform to mainstream obstetric doctrine. Second, women's birth strategies are based on evaluations of social risks and benefits associated with maternity care alternatives in addition to perceptions of safety (McClain).

The following pages are brief outlines of the major statistical studies on the medical outcomes of out-of-hospital births in the United States published since 1975.

"Health Department Data Shows Dangers of Home Births"

ACOG News Release, ACOG Headquarters,

Chicago, Illinois, January 4, 1978

objectives: information on stillbirths

strategy: survey

definitions: none

population: unclear, data from 11 state health departments that had available statistics

controls: none

data collection: The American College of Obstetrics and Gynecology asked for information from every state health department. Eleven provided statistics relating fetal and newborn mortality with place of delivery

analysis: not stated

results/
conclusions: "Babies born at home have a risk of dying two to five times greater than those born in hospital"

remarks: There are no definitions for "place of birth", "fetal and newborn mortality", the population represented by these statistics, the type of attendants at these out-of-hospital births, whether the births were attended or the planning status.

Burnett, Claude A., James A. Jones, Judith Rooks, Chong Hwa Chen, Carl W.Tyler, C. Arden Miller: "Home Delivery and Neonatal Mortality in North Carolina," JAMA, 224:24, p. 2741-2745 December 1980.

objectives: analysis of neonatal mortality in North Carolina during 1974 through 1976 with attention given to places and circumstances that characterized out-of-hospital deliveries

strategy: uncontrolled, observational study with retrospective classification

definition: planned home birth: all home deliveries attended by a lay midwife
unplanned home births: home deliveries of infants weighing 2000 gr. or less and not attended by a lay midwife
measure of risk: neonatal death rates

population: home deliveries as recorded on birth certificates obtained through North Carolina vital statistics 1974-76, N=1296

sampling: all births as described in the population above

control: none

data collection: (1) computer linkage of birth and neonatal death records, coded by place of birth as "home"
(2) unclassified home deliveries were subsequently defined as (a) precipitate (b) intended (c) failure to plan for health care (d) unknown, by questionnaire sent to health department of mother's place of residence
(3) field work by health department staff was utilized when no record on circumstances of birth was available.

analysis: statistical

results/
conclusions: Home deliveries, without regard to planning status, had a neonatal mortality rate of 30/1000. Analysis of planning status revealed that planned home deliveries had neonatal mortality rate of 6/1000, while that of unplanned deliveries was 120/1000.

Outcome of delivery varied importantly with place and circumstances of delivery. In-hospital and out-of-hospital classification does not adequately group births by risks of neonatal mortality. Deliveries at home ranged from lowest to highest risk of neonatal mortality depending on planning, prenatal screening, and attendant.

remarks: Home delivery practices in North Carolina are not necessarily representative of other states; there might be possible errors in classification in the true place and circumstances of birth; underreporting of home births and neonatal deaths may have occurred.

"Home Birth in Salt Lake County, Utah"

Cameron, Joyce, Eileen Sharon Chase, and Sallie O'Neal, American Journal of Public Health, 69:7, July, 1979, p. 716-717.

objectives: need for information about people who choose to give birth at home

strategy: retrospective

definition: home deliveries were judged planned or unplanned by attendant and place of delivery

population: 62 women in 1972 and 105 women in 1975 who had a planned home delivery

sampling: of the 167 who had planned home delivery, 29 were eliminated from the sample "because the attendant was a paramedic or an obstetrician known not to participate in the births", or because the delivery was enroute to the hospital

controls: none

data collection: birth certificate data of home births was compared with Utah vital statistics for 1973 and 1970 records from census tracts in which the women resided
-three indices of prenatal care were obtained from the birth certificates: month prenatal care began, number of prenatal visits, blood and serology tests

an attempt was made to interview the entire home birth population
57 (34%) could not be located, 16 (10%) were known to have moved, 83 of 94 remaining agreed to be interviewed

results/
conculsions: Women were similar to 1973 Utah childbirth population in age, race, marital and socioeconomic status, years of education. Homebirth was not restricted to the poor of Salt Lake County.

Cameron, (cont.)

TABLE 1—Comparison of Age, Race, Marital Status and Education in the Home Birth Group and the State of Utah

	Salt Lake County Home Birth Group		State of Utah[1]	
	1972 N=62	1975 N=105	1973	1975
Median Maternal Age (Years)	26	25	25	25
Race (Per cent White)	100	98	97	97
Marital Status (Per cent Out-of-Wedlock)	1.6	3.8	4.3	4.2
Education (Per cent with high school or above)	83[2]	85[3]	83	85.4

1) 1973, 1975 Utah Vital Statistics Report
2) N=61
3) N=103

remarks: This study did not group out-of-hospital deliveries by planning status. A large percentage of the home birth population was not interviewed.

Dingley, Erma F.: "Birthplace and Attendants: Oregon's Alternative Experience, 1977," Women & Health, Vol. 4(3) Fall 1979.

objectives: analysis of birth certificates in Oregon during 1977 to compare hospital vs. out-of-hospital births on variables of attendant, parental education levels, age of mother, birth weight, number of prenatal visits, and neonatal/infant deaths

strategy: uncontrolled, observational study

definition: measure of risk: neonatal and infant death rates

population: deliveries as recorded on birth certificates in Oregon for the year 1977, N=38,448

sampling: all births in population above

control: none

data collection: Oregon birth certificates contain information about place of birth (home, other residential address, clinic, hospital); classification of attendant (licensed: MD, ND, DC, DO, CNM, RN; unlicensed: lay midwife, father, mother, other relative, friend, helper, etc.); mother's and father's highest educational level achieved; age of mother and live birth order; birth weight; number of prenatal visits. Neonatal and infant death rates were obtained by matching infant/full-term fetal death reports with birth certificates.

analysis: various crosstabulations of the above variables

results: Out-of-hospital births in Oregon in 1977 increased 56% over 1976, with a large increase in the number of births taking place in clinics. Non-licensed attendants predominated, at more than a 3-to-1 ratio. Out-of-hospital delivery parents show a higher educational level, and out-of-hospital births are less likely to be first births. For out-of-hospital births attended by a licensed attendant, the number of prenatal visits was the same as that for hospital births; it was less for those attended by unlicensed attendants. Neonatal death rates were 3.4 per 1000 live births for the out-of-hospital births and 7.8 for all live births; infant death rates were 10.1 for out-of-hospital births and 12.1 for all births. (U.S. estimates for 1977: 9.8 for neonatal deaths, 14.0 for infant deaths)

remarks: This study did not group out-of-hospital deliveries by planning status. The author notes that it is legal for anyone to attend a delivery in the State of Oregon insofar as medications are not administered and an episiotomy is not performed by a lay midwife; she also states that the quality of birth certificate data is high in Oregon, due to an established training and follow-up system. For these two reasons, it could be assumed that Oregon reporting of out-of-hospital births is more complete than in states where the legal issues are cloudy.

"Outcomes of Elective Home Births: A Series of 1,146 Cases"

Mehl, Lewis E., Gail H. Peterson, Michael Whitt and Warren E. Hawes: Journal of Reproductive Medicine, 19:5, November, 1977, p. 281-290

objectives:	provide data on medical outcomes of a series of elective home births
strategy:	retrospective
definitions:	home birth: those deliveries attended by personnel from five home delivery services
population:	home births from five delivery services in northern California
sampling:	Point Reyes physician group represented 40.4% of sample, Mill Valley physician group 11.2%; Bereley physician group 7.6%; Santa Cruz County midwives 30.8%; Sonoma County midwife 10.0%
controls:	none
data collection:	medical record review to find rate of complications
analysis:	statistical
conclusions:	perinatal mortality rate is significantly lower (95% confidence interval) than the 20.3% for the state of California in 1973. Complication rates are lower than expected. Evidence suggests that home delivery is a safe alternative for medically screened healthy women.
remarks:	This is a self-selected healthy group of women, screened for obvious problems and complications occurring pregnancy, so the data is not comparable to state statistics. The study suffers from not having a hospital comparison population.

Mehl, Lewis E., "Research on Alternatives in Childbirth: What Can It Tell Us about Hospital Practice?" in 21st Century Obstetrics Now, Vol. I. NAPSAC: Chapel Hill, NC., 1977., p. 186-195.

objectives: to answer questions regarding safety of home environment compared to hospital environment

strategy: retrospective

definitions: home delivery: those women planning to deliver at home immediately prior to labor, rupture of membranes, or emergent complication. All cases transferred to hospital during or after labor meeting these criteria were included.

population: unclear as to home delivery population except for definition above

hospital population was from two hospitals in Madison, Wisconsin

sampling: 1,046 women planning a home delivery were randomly matched with

controls: 1,046 planned hospital deliveries, for mother's age, risk factors, gestational length, parity, education, and socioeconomic factors. Most couples in both groups had taken childbirth classes

analysis: statistical

conclusions: A complicating variable differentiated between the two groups -- the difference in obstetrical philosophy and practice between the home birth practitioners and the hospital practitioners. Home attendants were non-interventionist in contradistinction to hospital practice. Other differences between groups might include nutritional status (although same SES) and motivation to learn material in childbirth classes.

other findings:
-mean birth weight not significantly different between two groups
-greater incidence of fetal distress in hospital group (may be an artifact of EFM)
-mortality statistics, rate of neurologically abnormal infants, and fetal hypoxia not significantly different between two groups
-Apgar scores higher in home group
-incidence of birth injury higher in hospital group as was use of oxytocin to stimulate or induce labor and the use of forceps
-incidence of maternal infection was the same in both groups
-neonatal infection was higher in hospital

The author concluded that "it was not clear that the additional medical and obstetrical procedures rendered in the hospital resulted in improved outcome over the home delivered group"

remarks: This is the only study with a matched population

Shy, Kirkwood K., Floyd Frost, Jean Ullom, "Out-of-Hospital Delivery in Washington State, 1975 to 1977," American Journal of Obstetrics and Gynecology, Vol. 137, No. 5 July 1, 1980, p. 547-552.

objectives: to investigate the association between selected demographic variables and alternative out-of-hospital deliveries, which had increased to 2.4% of births in 1977

strategy: descriptive study

definitions:
home birth: a delivery occurring in mother's residence as stated on birth certificate
non-residence home: personal residence, not that of mother
birth center: place of delivery not affiliated with a hospital that was site of five or more births
other: out-of-hospital births that did not occur in home or birth center, including births enroute
attendant: naturopath and midwife, only if licensed as such by State of Washington

population: deliveries in Washington State, 1975-77

sampling: all births, 1975-77

controls: none

data collection: out-of-hospital: birth certificates coded for place of birth (note that this study does not differentiate between planned and unplanned out-of-hospital births)

hospital: Washington State birth certificate computer tapes

variables: maternal age and race, parity, birth attendant, month of pregnancy at onset of prenatal care, number of prenatal visits, birth weight

infant deaths: from a linked file of birth and death certificates

maternal transfers: a review of hospital log book for main referral hospital. This would be a crude count of intended out-of-hospital births that took place in a referral hospital.

infant transfers: a review of NICU log books at two hospitals

analysis: crosstabulations on variables; chi-square statistic used for comparison of proportions and trends; mortality rates were compared by calculating relative risks, standardized for birth weight

results/
conclusions: The authors note some sources of bias:

-High-risk pregnancies may be selectively excluded from birth centers and intended home births. This selection acts strongly to increase the apparent risk of a hospital delivery as compared to an out-of-hospital delivery.

-Infant deaths have been underreported in certain settings and the data intimate that this also may have occurred in the home delivery population.

-Mothers who select an out-of-hospital delivery may be similar to other users of natural childbirth, who are of high socio-economic and educational status. The standard comparison group of hospital patients is not appropriate and this comparison group would result in a relative risk that underestimates the true infant mortality risk for out-of-hospital delivery.

-Since unattended home births are not professionally attended and since they are more likely to be premature, inclusion of these unintended home births in a general home delivery group increases the apparent risk of home delivery.

The authors concluded by saying, "A superior approach would be to prospectively classify pregnancies by the intended rather than the actual site of delivery. Birth center deliveries and intended home deliveries must be analyzed separately. A comparable low-risk hospital control group should be sought and the pregnancy risk status for all study groups should be ascertained antepartum and prior to labor. Lastly, objective outcome measures in addition to infant mortality are necessary. Mortality does not measure more subtle adverse outcomes. Thus we believe that behavioral measures of infant health should also be used. Indices of maternal health and pregnancy complications are also necessary."

RECOMMENDATIONS FOR FUTURE STUDIES

The Institute of Medicine of the National Academy of Sciences has published the "Proposal for Assessing Alternative Birth Settings", (Institute of Medicine). Having reviewed related research, the investigators listed the following topics for future research:

- What data are available from experience in the United States and abroad that can be used to assess different settings, with respect to health and disease, measures of personal and emotional satisfaction and relative costs?

- What kinds of additional data are needed to help make the personal and societal decisions involved?

- How can these data be used to develop an algorithm to help make the most rational decisions in each individual case?

- What indexes of health status for mother and child should be studied to make comparisons?

- What are the criteria and standards of care appropriate to each alternative birth setting, e.g., for personnel, training, referral?

- What are the areas in which reporting requirements should be developed to enable the relative merits and quality of settings and particular centers to be evaluated?

- If it appears that a variety of settings should be provided, how can a proper proportion among them be maintained, within anticipated limits of personnel and resources?

- What modifications, if any, should be undertaken in existing professional and allied educational programs to make maintenance of such settings possible?

- What effects may be anticipated on capital-investment institutions of various kinds?

- What measures, in the various categories cited, might best be used to evaluate future studies?

- How can these measures be refined to apply to the physical and mental health of both mother and child to cost-benefit ratios, and to relative costs to those paying for the care?

- How can prospective studies be designed to provide secure answers to the questions posed?

- How may randomized trials be organized?

- What other alternatives might yield truly comparable groups?

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IV. Data Collection

Many issues arose as to the legislative intent of H.B. 695 regarding the charge "to undertake a study".

The committee concluded that given the time constraints, a prospective, well-designed study with numbers sufficient to make the study statistically significant, was impossible. Therefore, it was agreed that the collection of data on births attended by midwives permitted under H.B. 695 and the review of literature, studies and other state's statutes would constitute the only realistic study that could be done.

Each midwife permitted under H.B. 695 (i.e. C.N.M.'s and granny midwives) was asked to complete a data form, designed and provided by the committee, for each client who indicated a desire for a home birth and delivered between December 1, 1981 and December 1, 1982. A copy of this form and a sample client consent for the release of information follow; the aggregate of the data collected is to appear in the appendix after December 1982.

DEPARTMENT OF HUMAN RESOURCES

DIVISION OF HEALTH SERVICES

Midwifery Study Committee

Data Collection on Home Births by Permitted Midwives

Purpose - To collect the following information for each client who indicates a desire for home birth for review by the Midwifery Study Committee in order to comply with ratified House Bill 695.

Method - The following information should be obtained from midwives currently permitted and performing home births in North Carolina.

1. Maternal Characteristics: (Please complete all items below)
   (A) Age _____
   (B) Marital Status _____
   (C) Race _____
   (D) Highest grade completed _____
   (E) Gravida _____
   (F) Parity _____
   (G) Number of years since last live birth _____
   If less than 2 years, number of months _____
   (H) Risk Status _____
   Describe:

2. Clients screened out of home birth program at initial visit:
   (A) Give weeks gestation when client became ineligible for home birth program
   _____(wks.)
   (B) Reason for advising hospital birth (check all that apply)
   ___ Previous history of uterine surgery, including Caesarean Section
   ___ Cardiovascular - pulmonary disease
   ___ Diabetes
   ___ Problems with previous pregnancies
   Describe:
   ___ RH sensitization
   ___ Drug or alcohol abuse
   ___ Nutritional problems
   ___ Contraindications on initial physical exam
   Describe:
   ___ Home further from hospital than practitioner advises
   ___ Emotional factors
   ___ Other
   Describe:

3. Clients dropping out of home birth program (check reason below)
   ___ Spontaneous abortion
   ___ weeks gestation
   ___ Moved from area
   ___ Decided on hospital delivery for personal reasons
   ___ Other
   Describe:

4. Clients initially accepted for home birth program but became ineligible during antepartum period:
   (A) Give weeks gestation when became ineligible _____

(B) Reason for ineligibility (check all that apply)

___ Anemia
___ Placenta previa
___ Abruptio placenta
___ Hypertension
___ Ruptured membranes with no labor
___ Non-vertex presentation
___ Premature labor
___ Post maturity by dates
___ Multiple gestation
___ Pre-eclampsia
___ Diabetes
___ Herpes progenitalis
___ Suspected fetal growth retardation
___ Emotional factors
___ Non-compliance with practitioner's guidelines
___ Other
Describe:

5. Prenatal characteristics: (complete all items)
   (A) Weeks gestation at initial prenatal visit ..... _____
   (B) Weight gain ..... _____
   (C) Last hematocrit ..... _____
   (D) Number of prenatal visits ..... _____
   (E) Type of provider giving prenatal care ..... _____

6. Labor and Delivery Characteristics: (complete all items)
   (A) Length of gestation ..... _____
   (B) Length of first stage ..... _____
   (C) Length of second stage (minutes) ..... _____
   (D) Length of third stage (minutes) ..... _____
   (E) Presentation ..... _____
   (F) Episiotomy - yes___ no ___; (Give degree) ..... _____
   (G) Laceration requiring repair - yes ___ no ___; (Give degree). _____
   (H) Type of attendant (M.D., C.N.M., permitted lay midwife, other - specify) _____
   (I) Place of delivery (hospital, home, other - specify) ..... _____
   (J) Delivery type (check one)
   ___ spontaneous vaginal delivery
   ___ low forceps
   ___ mid forceps
   ___ Caesarean Section
   (K) Use of oxytocin: (check any that apply)
   ___ first and second stage labor
   ___ third stage labor
   (L) Specify any other medications used _____

7. Clients transferred to the hospital during labor:
   (A) Give time (in minutes) from decision to transfer to arrival at hospital _____
   (B) Hematocrit at discharge _____
   (C) Reason for transfer (check all that apply):
   ___ Elevated maternal temperature or evidence of infection
   ___ Dystocia first stage
   ___ Dystocia second stage
   ___ Hypertension

___ Hypotension
___ Meconium staining
___ Fetal distress
  Describe:
___ Cord prolapse
___ Client request
___ Other
  Describe:

8. Clients transferred to the hospital postpartum:
   (A) Give reason for the transfer (check all that apply)
   ___ Retained placenta
   ___ Excessive bleeding
   ___ Irregular vital signs
   ___ Maternal infection
   ___ Other
   Describe:

9. Infant characteristics:
   (A) Birth weight ..... _____
   (B) Apgar scores, /and 5 minutes ..... _____
   (C) Feeding method - breast or bottle... _____
   (D) Resuscitation ..... _____

10. Neonatal complications requiring hospitalization during First Week: (check all that apply)
   ___ Birth weight less than 2500 grams
   ___ Prematurity (less than 37 weeks gestation by Dubowitz exam or estimated gestational age)
   ___ Respiratory Distress Syndrome
   ___ Congenital anomalies
   ___ Birth injury or asphyxia
   Describe:
   ___ Jaundice
   ___ Other
   Describe:

11. Optional Comments:

Midwifery Study Committee

- SAMPLE -

Client Consent for the Release of Information

I hereby give permission to _____ to release
(permitted midwife)
information contained in my medical records which pertains to my pregnancy and the birth of my child. I understand that this information will only be released to the Midwifery Study Committee for the purpose of data collection and review. The Midwifery Study Committee was established by the Secretary of the Department of Human Resources in order to comply with Ratified H.B. 695 of the 1981 session. I understand that my personal privacy will be rigorously protected by the committee.

_____
(Signature of Mother)

_____
(Date)

V. Review of State Statutes

Information was gathered regarding the legal status of midwifery in other states. The sources of this information were in the form of: state statutes; a computer search by the Clearinghouse on Licensure, Enforcement and Regulation: The Council of State Governments; The University of Washington's report, Midwifery Outside the Nursing Profession: The Current Debate in Washington; and published articles.

The statutes were reviewed in accordance with the following categories:

1 Midwife definitions

2. Scope of practice; settings for deliveries

3. Regulatory Board
   a. Composition
   b. Authority
      1. Scope
      2. Source

4. Credentialling Process
   a. Professional Midwife/CNM
   b. Educational Program
   c. Competencies/testing

5. Recertification Process (continuing education)

6. Fees - applications and renewals operating expenses of the board

7. Status of the statute (proposed/passed)

The following chart is a summary of five state statutes which represent those reviewed.

	WASHINGTON	RHODE ISLAND	CALIFORNIA	ILLINOIS	UTAH
1. Midwife Definition	Rendering medical aid to a woman during AP-IP-PP for a fee; does not include CNM's and RN's certified under a different statute.	includes CNM's and persons completing programs equivalent to ACNM approved programs, which are approved by State Health Director	includes CNM's and non nurse-midwives	".....obstetrical management and care of a woman and her infant during AP-IP-PP periods of normal childbirth...."	Includes CNM's only
2. Scope of Practice	-location not addressed -can obtain & administer drugs, including oxytocics, local anesthetics, neonatal opthalmics.	-provides AP-IP-PP & newborn care in continual collaboration with M.D. with all complications being referred to M.D. & a system for emergencies including transport established.	-OB management during AP-IP-PP for normal childbirth with consultation with M.D. for complications -Doesn't include assistance with mechanical means -Drugs to be used will be decided by the council -charges must be in accordance with medical	When complications or abnormal signs appear, a M.D. must be consulted and be physically present. -may administer drugs pursuant to the protocols developed by the Dept. -authority to admit & practice in a health facility with M.D. consent and supervision -home setting implied only.	care & management of normal newborns & women AP-IP-PP, incl. gyn. services -midwife may or may not receive compensation or profit. -CNM standards of practice -evidence of back-up M.D., though not required to be present -tasks noted in rules & regulations to incl. Hx, PE, lab, manage & evaluate, drugs as noted in joint CNM/MD protocol, episiotomy & repair, anesthesia -no "in" or "out of" hospital statements -"This act shall in no way or at anytime.... limit or change...the right of a mother...to delivery...where, when, how and with whom they choose regardless of certification."

	WASHINGTON	RHODE ISLAND	CALIFORNIA	ILLINOIS	UTAH
(Con't) 3. Regulatory Board	-Advisory committee (1 M.D., 1 OB, 1CNM, 3 midwives licensed under this, 1 citizen) - appointed by Director make recommendations to the Director of licensing on issues including con. ed., re-examination, peer review,... -Director takes applications, issues licenses, accredites programs, develops standards for educational prog., dev. or approves licensure exam., considers credentials of other programs (esp. foreign) -Develops form which explains to consumer the qualifications of a licensed midwife.	-Advisory Council within Division of Professional Regulation in Dept. of Health - Composition: 2 M.D.'s, 2 midwives (1CNM), 1 consumer Appointed by Director of Health Advises Director on recommendations regarding practices -Director responsible for: maintaining register of midwives, conducting exams, staffing Council, etc.	-Midwifery examining committee given authority to make rules & regulations to guarantee quality care, standards of practice, & availability of alternate maternity care services (specific standards cited in the statute) -Committee appointed by governor, includes: 2 OB's, 1 Pediatrician 2CNM's, 2 midwives, 1 midwife educator, 3 citizens. (staggered terms) -Comm. prepares, administers & approves exams -Approves education program.	-Midwifery examining Committee in the Dept. of Registration and Education. Composed of: 1 MD, knowledgeable of home birth practices, 1Pediatrician, 1 CNM, 1 lay midwife, 1 educator for midwife, 1 citizen -make rules &regulations -Committee reports to Director of Dept. who: adopts standards, criteria for certificates for schools/training, qualification & exam. of applicants for certification -Dept. had administrative duties including: healthy & safety, cont. educat., defining relationship with MD, drugs & other practice issues. Collects fees, gives exam.	"Committee of Certified Nurse-Midwifery" a part of the Dept. of Registration Composition: 2 CNM's licensed under this act, one in active practice, 1 citizen (no health or board activities). Term 3 yrs., appointed by Governor -Adopt & revise rules & regulations; recomment programs for approval to the Dept.; recommend licensing of applicants.
4. Credentialling Process	-graduate of accreditted midwifery prog. (approved by Director); 21 yrs. old -Educational prog. must incl. 3 yrs. training incl. basic nursing skills unless a RN/LPN, then 2 yrs. training -Statute specified courses required, extent of clinical experience of prog. -Training shall be in any setting but must include low & high risk preg. -Licensing exam required at end of training.	-required to pass exams on subjects determined by Council -license may be given without exam if already licensed in another state -foreign trained midwives must take refresher course & pass exam.	-Written or oral exam required -Diadactic educat. 1 yr if RN, 18 mos. if not plus Apprenticeship with MD or Midwife for 1 yr. if RN, 2 yrs. if not statute specifies the components of the apprenticeship. -must complete an approved midwifery program (courses cited in the law).	-Completion of approved program (list subjects) which includes an apprenticeship. -Apprenticeship exam -Certification exam No specific distinction between CNM & other midwife.	(A) Passed CNM Prog., approved passed exam approved by committee other statements in statute re: exception to exam (b) foreign trained midwives must take refresher course & pass ACNM exam (c) Educational programs recommended for approval by comm. -temporary permits for new graduates x 6 mos.
5. Recertification/Renewal Process	Along with a license renewal fee, must submit annually a written plan to include methods for consultation, emergency transfer, & transport	-Must have practiced within past 2 yrs. or completed a refresher course in order to renew license.	-Must apply and pay fee annually	--	Renewal every 2 yrs. No educational requirements

(Con't)	WASHINGTON	RHODE ISLAND	CALIFORNIA	ILLINOIS	UTAH
6. Fees	-Director establishes the fee commensurate with costs incurred by the government to administer the laws - shall be from $15 to $35	-Unspecified	-Application fee for program approval $100 -registration fee, apprentice midwife $10 -midwife applicant $25 -Apprentice exam $50 -Certification exam $100 -Annual renewal fee $150	Program applic. $100 once approved (initial) $500 annual $200 Reg. fee, appren.$10 Application midwife $25 Exam fee, apprent. $50 midwife $100 Initial Certified fee $50 Annual renewal Cert.$150 Members of committee are reimbursed for exp.	Fees required which are sufficient to pay expenses of committee, but not exceed same.
7. Status	-passed April 1981	-adopted spring 1978	-Senate bill which was introduced as of Fall 1981, had not passed yet	Presented 1979, 1980 current status unknown	Adopted August 1980

VI. Recommendations for Model Legislation

Members of the Midwifery Study Committee were able to openly and thoroughly discuss the multiple, complicated issues revolving around the practice and regulation of midwifery in North Carolina. Various approaches to model legislation for North Carolina were explored, their advantages and disadvantages being weighed against one another. Although it was the committee's intent and desire to make one unanimous recommendation, it became clear that this was not possible. The majority of the committee recommend that a Board of Midwifery be established by the legislature to regulate the practice of midwifery in North Carolina. Specific components of this regulation and characteristics of such a board are addressed in the attached Model B (page 28). The members of the committee who voted for this model are as follows:

Lois Simmons-Isler. F.N.P.
Linda May. C.N.M.
Arnie Katz
Mary Edith Rogers
Linda Glenn, C.N.M.
Jane Helwig
Barbara Parker
Anne Woodward

Robert Brame, M.D. and Louis Kermon, M.D. were opposed to certain components of this model and, therefore, have submitted their rationales for not voting for it (page 31). Chris Heaton, M.D. did not vote for a Midwifery Board as proposed in Model B (vote obtained by mail).

Two other models (A and C) were considered by the committee and rejected. These appear in the appendix (pages 38 and 41).

At the final meeting of the Midwifery Study Committee, Dr. Levine met with the Committee and gave feedback from Dr. Morrow regarding the committee's draft report. In response to Dr. Morrow's concerns, the committee developed an alternative model which charges the Joint Subcommittee of the Board of Medicine and Nursing to regulate the practice of midwifery and includes the establishment of a Midwifery Advisory Committee. The specific components of this regulation are addressed in the attached model (Model D page 32). The members of the committee who voted for this model are as follows:

Earl Trevathan
Lois Simmons-Isler
Linda May
Robert Brame
Chris Heaton*
Mary Edith Rogers
Linda Glenn
Jane Helwig
Barbara Parker
Anne Woodward

*Dr. Heaton prefers that statement C-5 of Model D end after the work Nurse-Midwife and that statement C-9 be deleted.

DHR Midwifery Study Committee's Recommendation for Model Legislation

BOARD OF MIDWIFERY (Model B)

MODEL: Board of Midwifery

Secretary of State
↓
Board of Midwifery

A. Preamble: An act to protect the safety and health of pregnant and recently delivered women and their newborns, and to allow greater choice of birth attendants and delivery settings to residents of North Carolina.

B. Definitions:
"Midwife means a person who offers his/her services for hire in attending women and infants during the course of prenatal, intrapartum, post partum, interconceptual and newborn periods; and whose scope of practice is consistent with the items listed in the definition of "midwifery" herein.

"Midwifery" means the practice of maternal and newborn care, the scope of which includes the following:

1. Initial and subsequent prenatal Care
   a. Historical and physical assessment
   b. obtaining and assessing the results of routine laboratory tests by guidelines established by the Board of Midwifery
   c. supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medicines
   d. giving client education

2. Intrapartum Care
   a. attending women in uncomplicated labor
   b. assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation
   c. performing amniotomy
   d. administering local anesthesia
   e. performing episiotomy and repair
   f. repairing first and second degree laceration of the perineum associated with childbirth

3. Postpartum Care
   a. management of the normal third stage of labor
   b. administration of pitocin after delivery of the infant when indicated
   c. six weeks postpartum evaluation exam and initiation of family planning method

4. Newborn Care
   a. routine assistance of the newborn to establish respiration and maintain thermal stability
   b. routine physical assessment including APGAR scoring
   c. vitamin K administration
   d. eye prophylaxis for ophthalmia neonatorum

This scope of practice occurs within a health care system which provides for consultation, collaborative management and referral with physician(s) licensed to practice medicine in North Carolina. The standard of supervision by physician is described in the following "Joint Statement of Practice Relationships Between Obstetrician/Gynecologists and Certified Nurse-Midwives."

JOINT STATEMENT OF PRACTICE RELATIONSHIPS
BETWEEN OBSTETRICIAN/GYNECOLOGISTS AND CERTIFIED NURSE-MIDWIVES
Developed July 30, 1982
Adopted November 1, 1982

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 statement by ACNM, the ACOG and the Nursing Association of ACOG, the Maternity Care Team should be directed by a qualified Obstetrician/Gynecologist. The ACOG and ACNM believe that the appropriate practice of the CNM includes the participation and involvement of the obstetrician/gynecologist as mutually agreed upon in written medical guidelines protocols. The ACOG and ACNM also believe that the obstetrician/gynecologist should be responsive to the desire of CNM's for the participation and involvement of the obstetrician/gynecologist. The following principles represent a joint statement of the ACOG and ACNM and are recommended for consideration in all practice relationships and agreements.

1. Clinical practice relationships 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 provide 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, e.g., 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.

*This statement supercedes previous Joint Statements on Maternity Care by ACOG, ACNM and NAACOG dated 1971 and 1975.

C. Regulation:

1. A Board of Midwifery will be established to regulate the practice of midwifery in North Carolina.

2. The board shall be composed of nine members as follows:
   a. 4 midwives licensed to practice in North Carolina
      - at least 2 of whom are certified nurse-midwives
      - at least one of whom are appointed by the N.C. Board of Nursing
   b. 3 physicians licensed to practice in North Carolina
      - a board certified obstetrician who has had working experience with midwives
      - a family practice physician who includes obstetrics in his/her active practice
      - a physician from the Board of Medical Examiners
   c. two consumers of midwifery services

3. The authority to promulgate rules for midwifery practice and to issue or revoke approval for individuals to practice midwifery is granted to the North Carolina Board of Midwifery.

4. The Board of Midwifery (BM) shall develop and promulgate rules for midwifery practice and associated medical acts.

5. The BM shall adopt the education and experience standards of the American College of Nurse-Midwives or an equivalent standard for midwives who are not nurses for individuals to be approved for practice under this legislation.

6. The BM shall approve for midwifery practice those applicants who meet these standards even though some of those applicants may not be nurses.

7. The BM shall not "unduly restrict"* the privilege of properly qualified midwives to practice their profession in North Carolina, nor shall it act to limit the site of delivery to the inhospital setting except in cases of documented increased risk to the fetus.

8. The Department of State shall establish a systematic and ongoing evaluation of the safety and efficacy of childbirth in hospital and non-hospital settings.

9. This act shall in no way or at anytime abridge, limit or change in any way the right of a mother and/or father to deliver their baby where, when, how and with whom they choose, regardless of certification.

*While there may be some sensible limitations to the numbers of midwives a physician may supervise and the geographic area which a midwife may cover these policies should not be used in an unduly restrictive way so as to prevent midwifery practice.

EAST CAROLINA UNIVERSITY
SCHOOL OF MEDICINE
GREENVILLE, NORTH CAROLINA 27834

DEPARTMENT OF
OBSTETRICS and GYNECOLOGY

Telephone (919)
757-4610

September 1, 1982

Ms. Debbie Stanford
Division of Health Services
P.O. Box 2091
Raleigh, NC 27602-2091

Dear Ms. Stanford:

Dr. Kermon and I wish to express our disagreement with certain activities of the Midwifery Study Committee as follows:

1. We do not endorse the recommendation that nurse midwives be permitted to practice independently. On the contrary, we believe that the nurse midwife can carry out the medical practice acts involved only under the direct supervision of a physician.
2. We do not endorse the recommendation that nurse midwives be regulated by a separate board which is able to grant privileges for medical practice acts. We believe that prerogative rests solely with the North Carolina Board of Medical Examiners. Obviously, this question arises only because of the recommendation that nurse midwives practice independently, an issue which I addressed in number one above.
3. We concur that there is no definitive study comparing outcomes of in-hospital and out-of-hospital births, but we disagree adamantly and unequivocally with the recommendation made by the committee which suggests that there is ample evidence that out-of-hospital births and attendence at birth by unskilled persons "poses no significant health or safety risks to either mother or infant." We believe at the least that that conclusion is an unwarranted one based on any evidence we know, and is an inappropriate liberty taken by the committee with the facts as we know them.

I hope this records for you the major points about which we disagree.

Respectfully submitted,

R. G. Brame

R. G. Brame, M.D.
North Carolina Medical Society

Louis T. Kermon

Louis T. Kermon, M.D.
North Carolina Board of Medical Examiners

RGB/mch/d10-16

DHR Midwifery Study Committee's Alternative
Recommendation for Model Legislation

JOINT SUBCOMMITTEE ALTERNATIVE (MODEL D)

MODEL: Joint Subcommittee of the Board of Medical Examiners and Board of Nursing
↓
Midwifery Advisory Committee

A. Preamble: An act to protect the safety and health of pregnant and recently delivered women and their newborns, and to allow greater choice of birth attendants and delivery settings to residents of North Carolina.

B. Definitions:
"Midwife" means a person who offers his/her services for hire in attending women and infants during the course of prenatal, intrapartum, post partum, interconceptual and newborn periods; and whose scope of practice is consistent with the items listed in the definition of "midwifery" herein.

"Midwifery" means the practice of maternal and newborn care, the scope of which includes the following:

1. Initial and subsequent prenatal care
   a. historical and physical assessment
   b. obtaining and assessing the results of routine laboratory tests by guidelines established by the Department of Human Resources
   c. supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medicines
   d. giving client education

2. Intrapartum Care
   a. attending women in uncomplicated labor
   b. assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation
   c. performing amniotomy
   d. administering local anesthesia
   e. performing episiotomy and repair
   f. repairing first and second degree laceration of the perineum associated with childbirth

3. Postpartum Care
   a. management of the normal third stage of labor
   b. administration of pitocin after delivery of the infant when indicated
   c. six weeks postpartum evaluation exam and initiation of family planning method

4. Newborn Care
   a. routine assistance of the newborn to establish respiration and maintain thermal stability
   b. routine physical assessment including APGAR scoring
   c. vitamin K administration
   d. eye prophylaxis for ophthalmia neonatorum

This scope of practice occurs within a health care system which provides for consultation, collaborative management and referral with physician(s) licensed to practice medicine in North Carolina. The standard of supervision by physician is described in the following "Joint Statement of Practice Relationships Between Obstetrician/Gynecologists and Certified Nurse-Midwives."

JOINT STATEMENT OF PRACTICE RELATIONSHIPS
BETWEEN OBSTETRICIAN/GYNECOLOGISTS AND CERTIFIED NURSE-MIDWIVES
Developed July 30, 1982
Adopted November 1, 1982

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 statement by ACNM, the ACOG and the Nursing Association of ACOG, the Maternity Care Team should be directed by a qualified Obstetrician/Gynecologist. The ACOG and ACNM believe that the appropriate practice of the CNM includes the participation and involvement of the obstetrician/gynecologist as mutually agreed upon in written medical guidelines protocols. The ACOG and ACNM also believe that the obstetrician/gynecologist should be responsive to the desire of CNM's for the participation and involvement of the obstetrician/gynecologist. The following principles represent a joint statement of the ACOG and ACNM and are recommended for consideration in all practice relationships and agreements.

1. Clinical practice relationships 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 provide 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, e.g., 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.

*This statement supercedes previous Joint Statements on Maternity Care by ACOG, ACNM and NAACOG dated 1971 and 1975.

C. Regulation:

1. The authority to promulgate rules for midwifery practice and to issue or revoke approval for individuals to practice midwifery is granted to the Joint Subcommittee of the Board of Medical Examiners and the Board of Nursing. The Joint Subcommittee's decision regarding the practice of midwifery and associated medical acts shall be autonomous.

2. The Joint Subcommittee shall develop and promulgate rules for midwifery practice and associated medical acts.

3. The DHR shall appoint members of the Midwifery Advisory Committee, to be composed of nine members as follows:
   a. 4 midwives licensed to practice in North Carolina
      - at least 2 of whom are certified nurse-midwives
      - at least one of whom are appointed by the N. C. Board of Nursing
   b. 3 physicians licensed to practice in North Carolina
      - a board certified obstetrician who has had working experience with midwives
      - a family practice physician who includes obstetrics in his/her active practice
      - a physician from the Board of Medical Examiners
   c. two consumers of midwifery services

4. The Midwifery Advisory Committee shall make recommendations to the Joint Subcommittee regarding aspects of midwifery practice.

5. The Joint Subcommittee shall adopt the education and experience standards of the American College of Nurse Midwives or an equivalent standard for midwives who are not nurses for individuals to be approved for practice under this legislation.

6. The Joint Subcommittee shall approve for midwifery practice those applicants who meet these standards even though some of those applicants may not be nurses.

7. The Joint Subcommittee shall not "unduly restrict"* the privilege of properly qualified midwives to practice their profession in N. C., nor shall it act to limit the site of delivery to the in-hospital setting except in cases of documented increased risk to the fetus.

8. The Department of Human Resources shall establish a systematic and ongoing evaluation of the safety and efficacy of childbirth in hospital and non-hospital settings.

9. This act shall in no way or at anytime abridge, limit or change in any way the right of a mother and/or father to deliver their baby where, when, how and with whom they choose, regardless of certification.

*While there may be some sensible limitations to the numbers of midwives a physician may supervise and the geographic area which a midwife may cover these policies should not be used in an unduly restrictive way so as to prevent midwifery practice.

A P P E N D I X

VII. Appendix

DIVISION OF HEALTH SERVICES
P.O. Box 2091
Raleigh, N.C. 27602-2091

Ronald H. Levine, M.D., M.P.H.
STATE HEALTH DIRECTOR

May 28, 1982

Joyce Reynolds, M.D.
N. C. Board of Medical Examiners
222 N. Person Street
Raleigh, NC

Dear Dr. Reynolds:

The Midwifery Study Committee, which was established by H.B. 695, has reached a point in its deliberations that we need the opinion of the Board of Medical Examiners regarding midwifery acts that are considered not to be medical acts. An opinion of the Board will bear on the definition of midwifery and the manner in which midwifery is regulated.

The Study Committee has agreed that the following should be included in the definition of midwifery acts. This will include the performance of:

I. Initial and Subsequent Prenatal Care
   A. historical and physical assessment
   B. obtaining and assessing results of routine laboratory studies
   C. supervising the use of prenatal vitamins with folic acid, iron, non-prescription medicines
   D. client education
II. Intrapartum Care
   A. Attending the conduct of normal labor in stage I and II
   B. spontaneous vaginal delivery of a vertex term (37 wks. - 42 wks.) infant
   C. amniotomy (if engaged, vertex presentation, at least 4 cms. dilatation, in active labor)
   D. administering local anesthesia
   E. episiotomy and repair
   F. repair of first and second degree lacerations associated with childbirth
III. Post Partum Care
   A. management of normal third stage labor
   B. the administration of pitocin when indicated
IV. Newborn
   A. Routine care including a physical assessment
   B. Vit. K administration
   C. eye prophylaxis for opthalmia neonatorum

Clarification by the Board of Medical Examiners of that group of acts which constitutes midwifery will aid the committee's thinking about larger issues such as physician supervision, credentials for midwives and the nature of a regulatory body.

Dr. Kermon, a member of the Board of Medical Examiners, also serves on the midwifery committee and has agreed to review this issue with the board. Our committee requests that Linda May and Linda Glenn, its Certified Nurse-Midwife members, also

be present when the board reviews this matter.

Our committee has been asked to present its draft of proposed legislation to the Department of Human Resources by October 1982, and we still have a major phase of committee work to accomplish once we receive your response. For these reasons, we urge you to place this on your June 14 agenda so that our work may proceed in a timely matter.

Thank you for your consideration.

Yours truly,

Earl Trevathan, M.D.
Chair, Midwifery Study Committee

ET:fm

cc: Dr. Sarah Morrow
Dr. Ronald Levine
Dr. Louis Kermon

JOYCE H. REYNOLDS, M.D., PRESIDENT
WINSTON-SALEM, N. C.

BRUCE B. BLACKMON, M.D., SECRETARY
BUIES CREEK

BRYANT D. PARIS, JR.
EXECUTIVE SECRETARY
SUITE 214, 222 NORTH PERSON ST.
RALEIGH, N. C. 27601
TELEPHONE 833-5321

BOARD OF MEDICAL EXAMINERS
OF THE
STATE OF NORTH CAROLINA

June 23, 1982

Earl Trevathan, M.D., Chairman
Midwifery Study Committee
Division of Health Services
Post Office Box 2091
Raleigh, North Carolina 27602

Dear Dr. Trevathan:

This will acknowledge receipt of your letter of May 28, 1982, which was considered by the Board of Medical Examiners at its recent meeting.

After reviewing the list of proposed midwifery acts included in this letter, it is the opinion of the Board that all items listed, with the exception of "client education," constitute medical acts.

Sincerely,

Bryant D. Paris, Jr.

Bryant D. Paris, Jr., Executive Secretary
NORTH CAROLINA BOARD OF MEDICAL EXAMINERS

BDPjr:sl

Model Considered and Rejected by Midwifery Study Committee

BOARD OF MEDICAL EXAMINERS (Model A)

MODEL: Board of Medical Examiners (BME)

Secretary of State
↓
Board of Medical Examiners
↓
Midwifery Advisory Committee

A. Preamble: An act to protect the safety and health of pregnant and recently delivered women and their newborns, and to allow greater choice of birth attendants and delivery settings to residents of North Carolina.

B. Definitions:
"Midwife means a person who offers his/her services for hire in attending women and infants during the course of prenatal, intrapartum, post partum, interconceptual and newborn periods; and whose scope of practice is consistent with the items listed in the definition of "midwifery" herein.

"Midwifery" means the practice of maternal and newborn care, the scope of which includes the following:

1. Initial and subsequent prenatal Care
   a. historical and physical assessment
   b. obtaining and assessing the results of routine laboratory tests by guidelines established by the Board of Medical Examiners
   c. supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medicines
   d. giving client education

2. Intrapartum Care
   a. attending women in uncomplicated labor
   b. assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation
   c. performing amniotomy
   d. administering local anesthesia
   e. performing episiotomy and repair
   f. repairing first and second degree laceration of the perineum associated with childbirth

3. Postpartum Care
   a. management of the normal third stage of labor
   b. administration of pitocin after delivery of the infant when indicated
   c. six weeks postpartum evaluation exam and initiation of family planning method

4. Newborn Care
   a. routine assistance of the newborn to establish respiration and maintain thermal stability
   b. routine physical assessment including APGAR scoring
   c. vitamin K administration
   d. eye prophylaxis for ophthalmia neonatorum

"Supervision" means

1. the midwife establishes written guidelines for his or her practice which are reviewed and approved by his or her supervising physician(s) and which include:
   a. screening procedures for complications of the maternity and newborn course, and
   b. standing orders for commonly used drugs;

2. the midwife will apply for approval to practice in conjunction with his or her supervising physician(s); and

3. the midwife will document continuing medical supervision at the time of application for renewal of approval.

C. Regulation:

1. The authority to promulgate rules for midwifery practice and to issue or revoke approval for individuals to practice midwifery is granted to the N.C. Board of Medical Examiners (BME)

2. The BME shall develop and promulgate rules for midwifery practice

3. To assist in the development of rules, the BME shall establish a subcommittee on midwifery

4. The subcommittee shall be composed of nine members as follows:
   a. 4 midwives licensed to practice in North Carolina
      - at least 2 of whom are certified nurse-midwives
      - at least one of whom are appointed by the N.C. Board of Nursing
   b. 3 physicians licensed to practice in North Carolina
      - a board certified obstetrician who has had working experience with midwives
      - a family practice physician who includes obstetrics in his/her active practice
      - a physician from the Board of Medical Examiners
   c. two consumers of midwifery services

5. The subcommittee shall, regarding aspects of midwifery practice involving medical acts and medical supervision, develop proposed rules and recommend approval of applicants for adoption by the BME

6. The subcommittee shall, regarding aspects of midwifery practice not involving medical acts or medical supervision, promulgate rules on its own authority

7. The BME shall adopt the education and experience standards of the American College of Nurse Midwives or an equivalent standard for midwives who are not nurses, for individuals to be approved for practice under this legislation

8. The BME shall approve for midwifery practice those applicants who meet these standards even though some of those applicants may not be nurses

9. The BME shall require midwives to practice under the supervision of a physician who is licensed to practice medicine in North Carolina and includes obstetrics in his active practice

Revised 8/25/82

10. The BME Shall not "unduly restrict"* the privilege of properly qualified midwives to practice their profession in North Carolina, nor shall it act to limit the site of delivery to the inhospital setting except in cases of documented increased risk to the fetus

11. The Department of State shall establish a systematic and ongoing evaluation of the safety and efficacy of childbirth in hospital and non-hospital settings

12. Providers of gratuitous or emergency obstetric services shall not be liable for prosecution for practicing midwifery without a permit/license.

*While there may be some sensible limitations to the numbers of midwives a physician may supervise and the geographic area which a midwife may cover these policies should not be used in an unduly restrictive way so as to prevent midwifery practice.

Model Considered and rejected by Midwifery Study Committee

DEPARTMENT OF HUMAN RESOURCES (Model C)

MODEL: Department of Human Resources
↓
Midwifery Advisory Board

A. Preamble: An act to protect the safety and health of pregnant and recently delivered women and their newborns, and to allow greater choice of birth attendants and delivery settings to residents of North Carolina.

B. Definitions:
"Midwife means a person who offers his/her services for hire in attending women and infants during the course of prenatal, intrapartum, post partum, interconceptual and newborn periods; and whose scope of practice is consistent with the items listed in the definition of "midwifery" herein.

"Midwifery" means the practice of maternal and newborn care, the scope of which includes the following:

1. Initial and subsequent prenatal Care
   a. Historical and physical assessment
   b. obtaining and assessing the results of routine laboratory tests by guidelines established by the Department of Human Resources
   c. supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medicines
   d. giving client education

2. Intrapartum Care
   a. attending women in uncomplicated labor
   b. assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation
   c. performing amniotomy
   d. administering local anesthesia
   e. performing episiotomy and repair
   f. repairing first and second degree laceration of the perineum associated with childbirth

3. Postpartum Care
   a. management of the normal third stage of labor
   b. administration of pitocin after delivery of the infant when indicated
   c. six weeks postpartum evaluation exam and initiation of family planning method

4. Newborn Care
   a. routine assistance of the newborn to establish respiration and maintain thermal stability
   b. routine physical assessment including APGAR scoring
   c. vitamin K administration
   d. eye prophylaxis for ophthalmia neonatorum

This scope of practice occurs within a health care system which provides for consultation, collaborative management and referral with physician(s) licensed to practice medicine in North Carolina.

C. Regulation:

1. The authority to promulgate rules for midwifery practice and to issue to revoke approval for individuals to practice midwifery is granted to the Secretary of the Department of Human Resources.(DHR)

2. The DHR shall develop and promulgate rules for midwifery practice and associated medical acts.

3. The DHR shall establish a Midwifery Advisory Board, to be composed of nine members as follows:
   a. 4 midwives licensed to practice in North Carolina
      - at least 2 of whom are certified nurse-midwives
      - at least one of whom are appointed by the N.C. Board of Nursing
   b. 3 physicians licensed to practice in North Carolina
      - a board certified obstetrician who has had working experience with midwives
      - a family practice physician who includes obstetrics in his/her active practice
      - a physician from the Board of Medical Examiners
   c. two consumers of midwifery services

4. The Midwifery Advisory Board shall, regarding aspects of midwifery practice, associated medical acts, and medical supervision, develop proposed rules and recommend approval of applicants for adoption by the Secretary of the DHR.

5. The DHR shall adopt the education and experience standards of the American College of Nurse Midwives or an equivalent standard for midwives who are not nurses for individuals to be approved for practice under this legislation.

6. The DHR shall approve for midwifery practice those applicants who meet these standards even though some of those applicants may not be nurses.

7. The DHR shall not "unduly restrict"* the privilege of properly qualified midwives to practice their profession in N.C., nor shall it act to limit the site of delivery to the inhospital setting except in cases of documented increased risk to the fetus.

8. The Department of Human Resources shall establish a systematic and ongoing evaluation of the safety and efficacy of childbirth in hospital and non-hospital settings.

9. Providers of gratuitous or emergency obstetric services shall not be liable for prosecution for practicing midwifery without a permit/license.

*While there may be some sensible limitations to the numbers of midwives a physician may supervise and the geographic area which a midwife may cover these policies should not be used in an unduly restrictive way so as to prevent midwifery practice.

MINUTES

DATE: January 19, 1982

TOPIC: Minutes from Midwifery Study Committee, Initial Meeting

PRESENT: Members

Dr. Earl G. Trevathan
Mr. Bryant Paris (Representing Dr. Joyce Reynolds)
Ms. Lois Simmons-Isler
Ms. Linda May
Mr. Dan Domizio
Dr. Frederick Heaton
Ms. Mary Edith Rogers
Ms. Linda Glenn
Dr. Robert G. Brame
Ms. Jane Helwig
Ms. Barbara Parker
Ms. Anne R. Woodward

DHS Staff

Dr. Ronald H. Levine
Dr. Jimmie L. Rhyne
Dr. Richard Nugent
Ms. Marty Ballard, MCH Nursing Consultant
Ms. Elizabeth Berryhill, MCH Nursing Consultant
Ms. Debbie Stanford, MCH Nursing Consultant

Other

Mr. Svea Oster
Mr. Arnie Katz

Dr. Earl Trevathan, Chairperson, convened the Midwifery Study Committee. Dr. Sarah T. Morrow provided introductory remarks and expressed appreciation to members for serving on this important committee. Members were given the opportunity to introduce themselves. Dr. Ronald H. Levine discussed midwifery events in North Carolina and the related involvement of the Division of Health Services. Also he discussed legislative debate leading to acceptance of H. B. 695.

DISCUSSION: Purpose and Function of the Committee

1. The purpose of the Midwifery Study Committee was discussed. In accordance to H.B. 695, the committee will make recommendations regarding the "safety and efficacy of out-of-hospital delivery, including an examination of the State's role in licensing or otherwise permitting the activities of birth attendants functioning in the non hospital setting." The Secretary will report findings to the 1983 session of the General Assembly.

Discussion centered around several areas relating to functions of the Committee:

a. review of the literature - Some members have already reviewed the literature rather extensively. It was mentioned that in the presence of good and bad studies relating to this area, there is a need to collect objective information in the most reliable fashion. Several persons indicated interest in this area.

b. collection of information - In considering other state's role in the licensing, etc., the committee will need information for review. Copies of the Washington State report, Midwifery Outside the Nursing Profession: The Current Debate in Washington, will be obtained for members. A search on this subject from a national clearinghouse will be initiated pending further information from Linda Glenn.

c. information regarding deliveries by permitted C.N.M.'s. - It was discussed that the committee may want to recommend that detailed information be collected on the out-of-hospital births which are to be attended by permitted C.N.M.'s. According to Linda May, the N.C. Chapter of the American College of Nurse Midwives had discussed this and that C.N.M.'s would provide information as determined by the Committee. The Chatham Family Birth Center's obstetrical record and consent for home birth was shared with the committee. On initial review, the consensus was that detailed information could be gathered if such a record was used. More time is needed for a more comprehensive review. It was discussed that detailed information may need to be collected but a standard patient record may not be needed.

A question was raised regarding whether significant information could be obtained for the 1983 Legislative report due to the small number of anticipated out-of-hospital deliveries by permitted C.N.M.'s. Discussion also centered around whether other kinds of information should be collected such as psychological factors, etc. used in determining candidacy for out-of-hospital deliveries in addition to standardized medical risk factors. It appeared that there were very few centers using such an approach and no standardized tool for psychological factors may yet be available. Linda Glenn has had an interest in this area and will continue to look for available information. Members voiced differing opinions regarding the charges of the Committee as it related to financial aspects. It is recognized that economics is an important issue. Analysis of reasons, including financial aspects, for choosing out-of-hospital delivery is an area which might be addressed by the Legislature. Dr. Morrow also mentioned economic issues in her introductory remarks. It was reported in the practice by the Chatham Family Birth Center that home births were not cost effective when compared to a delivery in their Birth Center. As economic conditions worsen, more women are expected to be medically indigent compounding the problem of cost and access to care.

2. Legislative Intent - Dr. Brame asked for clarification regarding the intent of House Bill 695.

Chris Hoke, the DHS lawyer, discussed H.B. 695. Section 1. requires the Department of Human Resources to study the safety and efficacy of non-hospital births. Section 2. provides for the DHR to issue permits only to certified nurse midwives. It is not uncommon to interpret a subsequent section of a law in the context of the prior section. On this basis it could be inferred that the second section allows issuance of permits to CNM's for the purpose of out-of-hospital delivery. Dr. Brame was concerned with this interpretation indicating that some members of the Medical Society felt that permits should be issued to CNM's only for the purpose of the study.

Dr. Levine stated the current legislation was a compromise among different approaches. H.B. 695 was re-written considerably and the C.N.M. aspect was added at a later date.

Dan Domizio expressed his opinion that H.B. 695 was enabling legislation for the C.N.M. with a permit to respond to the demand for out-of-hospital delivery and outlawing midwifery with no other recourse would increase the underground midwifery movement.

The Committee felt that inferring the legislative intent from this law was not straightforward. The committee was reminded by Dr. Levine that recommendations regarding the resolution of this problem could be made by them and that Dr. Morrow would report findings of this Study to the General Assembly.

3. Committee Functions - Discussion centered around how the work of the Committee could be completed as expeditiously as possible. The consensus was that sub-committees could be designed to work on assignments which would be reported to the overall committee for action. Three subcommittees were formulated to cover the following areas: 1) Data collection, 2) Review of the Literature and 3. Model Legislation. Members submitted their preferences to Dr. Trevathan. The consensus was that sub-committees would meet as needed between regular committee meetings.

Dan Domizio asked the committee to address non-nurse midwifery. Even if a sub-committee defines midwifery, it will be important for the whole committee to discuss this. Consideration regarding non-nurse midwifery should impinge on any model legislation or recommendations made by this committee.

It was suggested that the committee consider a retreat style meeting. The consensus was that the committee should consider this at a latter date when the amount of work needed to be accomplished would demand the intensive effort of a one to two day retreat.

4. N.C. Home Births - For information, a map showing the 306 "home births" by county as designated by birth certificates was shared with the group. It was pointed out that these included both planned and unplanned home births.

5. Approval to Practice for C.N.M.'s - H.B. 695 results in a dual system regarding approval to practice for C.N.M.'s. H.B. 695 allows DHR to provide a permit to do midwifery. The Joint Sub-committee of the N.C. Board of Medical Examiners and Board of Nursing gives approval "to perform medical acts." C.N.M.'s in N.C. have practiced under the latter for several years. It was also pointed out that "midwifery" is excluded as a medical Act in the N.C. Medical Practice Act. These areas may need to be further addressed as work of the committee proceeds.

6. Public Forums - The Committee briefly discussed public forums. The Committee felt that the decision regarding public forums should be delayed until aspects of the study and model legislation were more clearly developed.

7. Next Meeting is scheduled for March 24, 1982 from 1-4:30 p.m. in the Norton Board Room of the Cooper Building.

Minutes Submitted By

Martha W. Ballard

Martha W. Ballard

MINUTES

MIDWIFERY STUDY COMMITTEE

March 23, 1982

Members Present: Earl Trevathan, Barbara Parker, Linda Glenn, Mary Edith Rogers, Robert Brame, Louis Kermon, Dan Domizio, Linda May, Lois Simmons-Isler, Ann Woodward, Jane Helwig, Chris Heaton.

Others Present: Pamela Scudder, Dick Nugent, Debbie Stanford, Chris Hoke, Jimmie Rhyne, Arnie Katz, Betty Berryhill, Charles Rothwell, Ronald Levine, Bryant Paris, Marty Ballard.

Dr. Trevathan opened the meeting by welcoming the members and quests. Dr. Louis Kermon was recognized as a member of this committee replacing Dr. Reynolds. The minutes were approved for the last meeting.

Reports were given from committees:

1. Data Collection - Jane Helwig reported that the literature has been reviewed and a bibliography has been compiled. There are no good prospective studies which show definitive outcomes when many important variables are considered such as type of attendant, training status, planned or unplanned out-of-hospital delivery and risk status. There have been about ten home births thus far deliverd by permitted C.N.M.'s. The numbers are very small and it was suggested that it would be difficult to extract significant statistical data. After much discussion regarding conducting a study of out-of-hospital deliveries by permitted midwives, it was suggested the Data Collection Committee decide what type of information is needed and develop a tool to obtain information.

Dan Domizio voiced concern that the study was limited to permitted C.N.M.'s that this not be politically used to exclude non-nurse attendants. Dr. Trevathan asked that the committee proceed with the above assignment.

Survey

Charles Rothwell met with the committee and discussed the possibility of conducting a study or survey. A possible audience for a survey might be those women who had delivered in the last year. Some simple questions relating to midwifery could be asked. The cost of such a survey would be large because of size since the number of women who gave birth in 1981 aged 18 - 35yrs. with no infant deaths; married; had babies who weighed 5 lbs. 8 oz. or above would be 60,600 women. A 5% random sample could be completed for an estimated cost of $1500. One might expect a 65% response from such a study. An official cover letter would help in improving responses.

A telephone study from families was discussed as a possibility. In an existing survey of 1100 people, it was pointed out that many would not be of child bearing age and may not be the target audience for obtaining midwifery opinions. The decision on survey was tabled at this time.

2. Review of Literature - A summary of the review of the literature was previously sent to members and discussed today. The members reviewing the literature will be happy to share articles which they have collected. The committee felt some studies were biased. The question was raised as what we could learn from the studies even though some had faults. The committee rejected news releases and some articles with no corresponding

data to examine. The subcommittee asked members to share studies which they may have. Other suggestions would also be helpful.

3. Model Legislation - During three previous meetings this subcommittee has discussed the international definition of midwives and the variety of laws from other states in defining midwifery. It was felt the entire committee should decide on the definition of midwifery. Regulating the practice of midwifery has varied. Some have boards which regulate practice and all have different requirements. The resolution of dual permits has not yet been fully addressed. There is some consensus that the State should not be licensing "untrained" persons. The Midwifery Study Committee was asked for consensus on definition. Dr. Levine suggested midwifery in North Carolina be defined first and then define midwife with education and qualifications to perform midwifery. The definition of nurse midwifery practice has been nationally defined by the American College of Nurse Midwives. Dan discussed the fact of whether a midwife would have to have the same skills for in hospital practice as opposed to out-of-hospital practice. Will we eliminate people from practicing midwifery if they have to utilize a certain standard? After much discussion, the following definitions relating to midwifery were formulated:

Midwife - A person who practices midwifery

Midwifery - Midwifery is defined in the State of North Carolina as the practice of attending women for hire during antepartum, intrapartum, postpartum, interconceptional care as well as newborn care.

The following qualifications were suggested:

No one shall practice midwifery without successful completion of a midwifery program approved by the American College of Nurse Midwives or an equivalent program approved by the board.

Chris Hoke suggested having in the statutes the standards and qualifications for practicing midwifery. Another alternative would be to give the authority to a committee or some other regulatory agency to promulgate rules for the statutes. Chris suggested that experts on the committee define the practice and qualifications to do the acts and this should be put in statutes.

Some discussion centered around having a board. It was pointed out that if a board was created, some things such as approval of curriculum, etc. could be handled via this approach.

After further discussion, the following motion was made by Linda May and seconded by Linda Glenn. The Subcommittee on Model Legislation is asked to develop recommendations for Dr. Morrow which address the following issues:

1. The identification of a single regulatory authority to govern the practice of midwifery.

2. The development of guidelines pertaining to:
   (a) The composition of the authoritative body.
   (b) The nature of regulation it may articulate.

The above motion was unanimously accepted.

In conclusion, Dr. Trevathan opened the floor for comments about the committee. In general, the comments were positive in how the committee is functioning and the progress made in the initial stages.

Next two meetings - May 26, 1 P.M.
August 25, 1 P.M.

Submitted by

Martha W. Ballard
MCH Nursing Consultant

MINUTES

MIDWIFERY STUDY COMMITTEE

May 26, 1982

Members Present: Dan Domizio, Earl Trevathan, Jane Helwig, Linda May, Chris Heaton, Barbara Parker, Mary Edith Rogers, R.G. Brame, Ann Woodward, Linda Glenn, Louis Kermon.

Others Present: Marty Ballard, Debbie Stanford, Arnie Katz, Elizabeth Weil, Dick Nugent, Karen Long, Sandy Moulton, Ellen Kendall, Chris Hoke, Svea Oster, Nicola Vaugerus, Jimmie Rhyne, Diane Machado, Linda Watkins, Bryant Paris, Jr., Elizabeth Pifer.

Dr. Trevathan welcomed members and guests. The minutes of the last meeting were approved.

Subcommittee Reports:

1. Review of Literature: No new report from this subcommittee. Materials from a National Clearinghouse from selected states have been received and was given to the Model Legislation Subcommittee.

2. Data Collection: A copy of the draft of the tool used to collect information on out-of-hospital deliveries was discussed. A concern was raised about protection of privacy in reports submitted. The DHS attorney said a consent for release would be needed with the type of information to be released and to whom the information would be accessible. The staff will develop a sample consent which could be used. The data collection tool will be completed by attendant midwife. Dr. Nugent suggested certain modifications which were included in a revised version. A suggestion was made to include an "other" category which could elicit feelings about the birth from the parent(s) and attendant. The motion was approved and seconded that this report be accepted with the above modifications which were suggested. It was also suggested that this report be completed by permitted C.N.M.'s and other permitted midwives.

3. Model Legislation Subcommittee: Dr. Kermon asked that a correction be made in the May 12 minutes of this Subcommittee regarding a statement he made. The corrected statement is, "Dr. Kermon responded that any service outside that of delivery of a child would be performing a medical act or treatment of illness and those acts would be subject to the Board of Medical Examiners approval." The entire minutes of the last meeting of this subcommittee were reviewed. Dan Domizio reported the members of this subcommittee would like the whole committee to consider some of their options/issues. The following options/ issues were discussed:

a. Should a representative group from the Midwifery Study Committee meet with the Board of Medical Examiners (BME)? Is the definition of midwifery developed by this committee compatible with the BME? It was recognized that when the scope of the practice of midwifery is expanded into the diagnosis and treatment area, the BME has regulatory authority. A common list of procedures associated with midwifery (see attached) was developed. It was proposed that this list be discussed with BME in relation to midwifery and/or medical acts. BME will meet in June. If it is not possible for a representative group to meet with BME regarding the list of midwifery acts, Dr. Kermon will present the list of midwifery acts and get suggestions/technical assistance from the board. Earlier in the meeting suggestions regarding composition of representative group included Linda Glenn, Linda May, Dan Domizio and Louis Kermon. Chris Heaton volunteered to be available if possible to come to BME meeting on short notice.

b. Should there be one board for midwifery? Pros and cons were discussed with no clear concensus. A handout was distributed which contained a draft consisting of three models of boards and responsibilities of such boards, which were derived from ideas explored by the Model Legislation Subcommittee. A suggested "Models for Authority to Regulate Midwifery" was handed out by Dan Domizio.

4. Discussion regarding other "possibilities" which need further exploration:

a. Could DHR be responsible to Midwifery acts and BME through Joint Subcommittee continue to be responsible for medical acts (current system)? (Dan Domizio)

b. After discussion or input from BME, we should re-define midwifery and select a model. (Earl Trevathan)

c. Would an autonomous board for midwifery jeopardize the progress of midwifery in North Carolina? (Chris Heaton)

d. What is difference in "supervision" by physician and "back-up" physician? (several) Chris Hoke responded that supervision calls for more activity - "it includes monitoring, keeping in touch", and means more than being available for referrals. Back-up is difficult to define but could be defined in statute. Back-up in the sense of being available to take referral doesn't mean very much.

e. Model C of draft "Models for Authority to Regulate Midwifery" is approximation of what we already have. It does not reduce the present regulations. Should there be a board or reduction in number of authorities regulating midwifery? (Linda May) Should DHR be the permitting authority - Model A? (Dan Domizio) Clause regarding "not liable for prosecution for practicing midwifery" in #1 regarding providers of gratuitous or emergency obstetric service was a concern. (Dan Domizio) This needs further consideration. Violation of Statute 130 should be considered. Definition of "practice" usually means doing more than once, having necessary equipment and being for hire. (Chris Hoke)

Next Meetings - June 23, 1 P.M., Administration Building, Conference Room #301
July 14, 1 P.M., 6th floor Board Room, Cooper Building
August 25, 1 P.M., 6th floor Board Room, Cooper Building

Submitted by

Martha W. Ballard
MCH Nursing Consultant

MIDWIFERY ACTS

Antepartal Care - initial and continuing antepartal care of the uncomplicated gravida -
includes vitamins/minerals and any non-prescriptive medication acceptable for use during pregnancy -
routine laboratory tests -
physical examination, including pelvic exams -

Intrapartal Care - attends the conduct of normal labor including 1,2,3 and 4th stages -
spontaneous vaginal delivery of vertex infant (37-42 weeks) -
uncomplicated episiotomy and repair (1^{o} and 2^{o}) -
repair of laceration (1^{o} and 2^{o}) following childbirth with local anesthesia (xyolocaine) -
amniotomy in the presence of engaged vertex and at least 4 cm. dilated in active labor -

Postpartal Care - Care of the normal mother and newborn in early postpartal period.
prophylastic eye medication for infant (N.gonorrhoeae) -
*pitocin, intramuscular injection -
*oxytocin, intramuscular injection -
*intravenous -

*Midwifery acts if indicated in emergency situations

Draft- Distributed at May 26, 1982 meeting by Dan Domizio

Models for Authority to Regulate Midwifery

1) All models described do not include gratuitous services, or those provided in emergencies. Legislation should specifically decriminalize these activities. For example: "providers of gratuitous or emergency obstetric services shall not be liable for prosecution for practicing midwifery without a permit/license."

2) Model A would have the currently existing formula:

   Midwives would be permitted by DHR to practice midwifery. The law could be written to include any or all parts of midwifery practice. DHR might/might not (depending upon the degree of autonomy we give it) be able to include "medical acts commonly attendant to the practice of midwifery." There could be two permits issued: one for "midwifery", one for "practitioner acts", or a single permit with one or two scopes of practice specified.

   DHR could hold on to this permitting authority until such time as another mechanism proved more useful. This model allows for future flexibility but might require that some authority be taken away from the NCBME through legislation.

3) Model B - the same formula as above basicially except that, instead of DHR granting permits/licences, a "Regulatory Authority" would be established.

   The same questions concerning authority come up and would be answered by our committee and then by the legislature in the writing of the "final copy" of the new law.

   The advantage of having a separate authority for midwifery is offset by the fact that this method would cost more money to implement and sustain. The N.C. Legislature is unlikely to accept this alternative unless the midwifery authority is truly autonomous.

4) Model C - is an approximation of what we currently have:

   Nurses are licensed by the Board of Nursing.

   Nurse practitioners are permitted by the BME.

   CNM's are permitted by DHR.

   A Regulatory Authority which permits for midwifery, but not the "attendant medical acts" is what we are positing here. Nurse midwives would still have to have permits for those acts granted by the NCBME.

   Though we would have a "Midwifery Authority" here, it is unlikely that the NC Legislature would find it justifiable to spend money on a new authority that was not able to do <u>all</u> that was required in the regulation of Midwifery Practice by nurse midwives.

MINUTES

MIDWIFERY STUDY COMMITTEE

June 23, 1982

Members Present: Earl Trevathan, Jane Helwig, Linda May, Dan Domizio, Barbara Parker, Linda Glenn, Ann Woodward, Bob Brame

Others Present: Debbie Stanford, Betty Berryhill, Jimmie Rhyne, Marty Ballard, Chris Hoke, Sandy Moulton, Maureen Darcey, Art Mines, Elizabeth Dyer, Barbara Overman, Svea Oster,

Dr. Trevathan opened the meeting. There were no additions or corrections to the last meeting. Dr. Trevathan read letter from Bryant Paris, Executive Secretary Board of Medical Examiners, in reply to the May 28 letter sent to Dr. Reynolds from Dr. Trevathan regarding midwifery acts. According to Mr. Paris's letter, the opinion of the Board of Medical Examiners was that all acts listed in the letter were medical acts as they required medical judgement, with the exception of client education. It appears that the current Board of Medical Examiners interprets that acts done by granny midwives in this state are not medical acts as these midwives are baby catchers only. The group discussed the board's actions and decided to proceed. Linda May suggested the following additions to the list of midwifery acts (which were listed in the letter to Dr. Reynolds): I.B. add ....within guidelines of normalcy, III. add "c. six weeks postpartum evaluation exam and contraceptive advice".

Chris Hoke reminded the group of a suggestion made in one of the subcommittees that there might be two forms of certification - one for lay midwives and one for nurse-midwives who do what lay midwives do plus additional acts.

Linda May asked who would determine competency of the acts. Parents-to-be determine who they want, not what competence level the person has. Several members expressed an interest in having a statement in the proposed statute - similiar to the one in the Utah statute which states "This act shall in no way or at anytime .... limit or change... the right of a mother...to deliver...where, when, how and with whom they choose". There followed a lengthy discussion of how much preparation of skills the birth attendant needs in order to be competent and safe.

Dr. Brame stated that it may not be the prerogative of the state to stop any person from choosing to deliver out of hospital, but it is well within the purview of the state to have standards of practice if you go public for hire.

Dr. Trevathan - Who meets these skills?

Dr. Brame - I know CNM's meet these skills. In some other countries, there are midwives who meet these skills and have appropriate education.

There followed discussion about others, such as PA's, who might also have those skills and competencies.

Dr. Trevathan suggested the group address the issue of a credentially or regulatory body.

Jane Helwig expressed concern that the models presented thus far include only one consumer with three physicians and three midwives. Dan Domizio agreed. There was

discussion over the appropriate number of members for such a board. Dan reminded the committee that Mary Edith Rogers had previously requested that one person on the board represent public health. Several members expressed an interest in specifying that one of the members have a public health approach - by a degree in public health or experience in the area. Linda Glenn expressed opposition to the creation of a Board whose composition included more non midwives than midwives. It was stated that other boards are composed of consumers and the professionals whose practice is being regulated - with those professionals being in the majority. Linda May voiced an interest in a 5/2/2 ratio (5 midwives, 2 physicians, 2 consumers). There followed a lengthy discussion over the political practicalities of getting a board of various compositions and numbers of representatives passed through the legislature. It was generally agreed that the physicians should represent the specialities of obstetrical and family practice, and if a third physician is added, this should be a neonatologist. The ratio of 4 midwives/3 physicians /2 consumers was also mentioned as an option for consideration. Linda Glenn suggested that it be specified that the consumer be a consumer of maternity services and preferably midwifery services. The committee agreed. Some discussion took place regarding the feasibility of specifying that the physicians have had prior or current experience with midwives.

Dr. Brame asked the committee if they would be willing to submit a statement to Dr. Morrow requesting that the Board be comprised of physicians, midwives and consumers, and not specify numbers since this could be worked out in the lobbying process with the legislature. Linda Glenn made the following motion: "I move that the composition of the Board be made up of midwives licensed to practice in North Carolina, physicians with prior experience with midwifery, and consumers of midwifery and maternity care and be called the Board of Midwifery - that board to have a total number of nine." The motion was seconded and passed. Linda May told the committee that she had shared the committee's list of midwifery acts (see minutes of May 26, 1982 or letter to Dr. Reynolds from Dr. Trevathan, May 28, 1982) with at least 5 obstetricians and believed that many obstetricians in the state could support this list. A motion was made by Ann Woodward that the list of midwifery scope of practice acts, as listed in the May 28, 1982 letter to Dr. Reynolds, be accepted with the following additions/delections:

I.B. add " within normalcy guidelines established by the Midwifery Board"
II. C. delete the phrase "if engaged, vertex presentation, at least 4 cms. dilatation, in active labor"
III. add "c. six weeks postpartum, evaluation, exam and contraceptive advice"

The motion was seconded by Linda Glenn and passed unanimously.

Dr. Brame asked that the committee discuss the question of the responsibilities of the supervision of midwifery practice. The issue is one of independent practice or supervision. There was discussion over the extent and type of physician supervision or back-up and the political problems involved in requiring a physician to have in writing that (s)he is the supervising physician. It was suggested that the parents and the midwife could agree who would be back-up for those midwifery acts. It was also stated that one option was for the Board of Midwifery to approve midwifery acts and that approval for medical acts would be requested through the Board of Medical Examiners. This, however, would create the need for C.N.M.'s to obtain approval from 2 boards if their scope of practice is beyond those acts agreed on as midwifery. Another option was for the board of midwifery to approve all acts performed by midwives. Dr. Trevathan requested that the committee look at the definitions of midwife and midwifery, as previously agreed upon (see minutes of March 23, 1982 or attached) and the scope of midwifery practice as agreed upon today in considering the midwife's relationship to a physician.

After discussion, a motion was made to add the following statement to the section in the statute dealing with scope of practice and to include this statement after the list of midwifery scope of practice acts: "This scope of practice occurs within a health care system which provides for consultation, collaborative management, and referral with physician(s) licensed to practice medicine in the state of North Carolina."

The motion was seconded and passed.

Dr. Brame abstained from voting on this motion.

Dr. Trevathan and Dan Domizio raised the issue of consumer concerns regarding the committee's intent of collecting data on home births and its use of this data once collected. Dr. Trevathan said that the committee has received letters of concern from several consumers regarding this issue and that he appreciated their comments. Several members of the committee expressed the opinion that the statute says that a study should be done, but there were various viewpoints expressed on defining "a study". Since a prospective, well designed study with numbers sufficient to make the study statistically significant is not possible, is not the collection of data - retrospectively on births attended by midwives under this law plus the review of literature/studies/ statutes an adequate "study"?

Jane Helwig told the committee that some consumers were worried about the interpretations of the data since often times there are different interpretations by "experts" on the variations of normal labor patterns. Linda Glenn and Debbie Stanford agreed and elaborated some on this, particularly, the differences in midwifery care vs. obstetrical care in some instances. There was some discussion over the use of this data - giving a report to Dr. Morrow, interpretations of the data by Division of Health Services staff, comparing the data to comparable hospital data,...etc.

Debbie Stanford reminded the committee that it was appropriate for them to decide the type of data collected, who interprets it, what it is to be used for and if it is to be collected at all, or, that they can delegate these functions to the staff of DHR.

It was agreed that the committee would think about this issue over the next month and resolve it at the next meeting.

The meeting was adjourned.

Submitted by,

Betty Berryhill/sr
Debbie Stanford/sr

Betty Berryhill
Debbie Stanford

MINUTES

MIDWIFERY STUDY COMMITTEE

July 14, 1982

Members Present: Earl Trevathan, Jane Helwig, Robert Brame, Barbara Parker, Dan Domizio, Linda Glenn, Louis Kermon, Frederick Heaton

Others Present: Debbie Stanford, Marty Ballard, Betty Berryhill, Jimmie Rhyne, Sandy Moulton, Karen Long, Chris Hoke, Dick Nugent, Arnie Katz

Dr. Trevathan opened the meeting. The minutes of the last meeting were approved with the exception of one sentence from page one, first paragraph which was restated as: "According to Debbie Stanford, Dr. Kermon said it appears that the current Board of Medical Examiners interprets that acts done by granny midwives in this State are not medical acts as these midwives are baby catchers only."

1. Data Collection - Jane Helwig reviewed the concerns of some consumers regarding confidentiality of data collected from home births attended by permitted midwives. A second concern is due to the small number; statistically significant correlations relating to safety and efficacy of home births could not be drawn or the information may not be used appropriately. Much discussion followed and Linda Glenn suggested the report could be done on an aggregate basis. An example of aggregate date compiled was shared with the group. The following motion was made by Dan Domizio:
MOTION - The current data collection activities and data be confined to use by this committee and the current data activities collected on an individual basis be continued with safeguards made relating to privacy. This motion passed unanimously. Chris Heaton suggested that the committee state that the number of births about which information is being collected and the length of time for the study is too small to collect meaningful data and that a good study be designed in the future.

2. Midwifery Board/Type of Report to Be Submitted - The action regarding the Midwifery Board from last meeting was reviewed. Linda Glenn recognized that there may be division or conflict within the committee regarding responsibilities and authority of this board. Would this lead to a majority and minority report rather than a single basic report? Dr. Trevathan asked if there was a common ground which we could unite rather than report the past majority and minority report of the former Midwifery Committee. Sandy Moulton, DHR Attorney, stated that sooner or later the Department may have to decide upon some issues and rather than a general vague report, the committee should try to resolve issues as much as possible and should be specific. Dr. Brame recognized that there may be some unresolvable differences. Should we agree to disagree or on each issue provide voting record of committee members and allow rationale(s) or reason(s) for not voting affirmatively to be included in the report? Dr. Brame identified issues such as medical practice act, lack of medical supervision not included in present terminology in scope of practice, and who issues privileges as areas of concern and possible areas of disagreement. Sandy Moulton agreed to discuss the type of format with Dr. Morrow and she will share this with Dr. Trevathan. Dr. Trevathan will be glad to discuss this with Dr. Morrow if needed. Overall, it was suggested that if the report expressed ideas and opinions of the group with rationales allowed to be expressed, the report would be adequate.

Responsibilities of the Board - The responsibilities as outlined in the May 12 minutes from the Model Legislation Subcommittee were reviewed and slight revisions made as follows:
1. Establish education and other credentialing criteria - Determine competence of midwife.
2. Process applications
3. Establish rules for practice
4. Monitor/enforce midwifery practice
5. Issue/revoke/repeal licenses for the practice of midwifery and associated medical acts.
6. Fees - The wording and process for fee collection should be left to Sandy Moulton.

MOTION - The Midwifery Study Committee should accept the above as responsibilities of the Midwifery Board:

yes - 4 (Helwig, Parker, Glenn, Domizio)
no - 2 (Brame, Kermon)
Abstain - 1 (Heaton)

The motion carried.

Credentialing - The credentialing process was discussed. Should this be the process used by A.C.N.M. or approved by A.C.N.M. or should the Midwifery Board establish credentials which would be acceptable? It was discussed that the A.C.N.M. is looking at a credentialing process for non-nurse midwives and may in the future develop certain criteria and standards for this practice, although this has not yet been resolved and differences of opinions exist within the College. Some discussion followed about other states who have incorporated credential processes.

Other points of discussion centered around the Midwifery Board:
Do we need to be more specific about the Board and equivaleny requirement? (L. Glenn)
Requirements to practice midwifery in N. C. should be same as those requirements determined by A.C.N.M. If not, there will be loss of support from Medical Society. (C. Heaton)
The credentialing process should not lock out people who are non-nurses (D. Domizio)
Consumers want options; would rather have a cumbersome option rather than no option at all. (B. Parker) After much discussion the following motion was made by Barbara Parker:
MOTION - The education credentialing process should be the one approved by A.C.N.M. or by equivalent standards accepted by the Midwifery Board.

yes - 4 (Domizio, Helwig, Parker, Glenn)
no - 1 (Heaton)
abstain - 2 (Brame, Kermon)

After additional discussion regarding certification and other requirements, Dr. Brame made the following motion:
MOTION - The Midwifery Board will determine criteria for certification, renewal and continuing competency.

yes - 5 (Brame, Domizio, Helwig, Glenn, Heaton, Parker)
no - 0
abstain - (Kermon)

Dr. Trevathan suggested that at the next meeting on August 25, 1982, the committee would be looking at a suggested format for the report which would include aspects already completed and to go back to those items recognized as asteriked indicating areas of differences. (example: supervision, composition responsibilities and authority of Midwifery Board.)

At the end of the meeting, Dan Domizio announced his resignation from the committee as he has accepted a position in Central America where he will be working with a health care system utilizing traditional birth attendants. Dan announced he will leave his address with Dr. Trevathan. Also, Dan announced that Arnie Katz is expected to replace him on this committee. Dr. Trevathan acknowledged Dan's major contribution to the work of this committee and the admirable way he has respresented lay midwifery.

Submitted by,

Marty Ballard

Martha W. Ballard

Committee Recommendations as of July 14, 1982

1. Midwife Definition

   (A) Midwife - A person who practices midwifery
   (B) Midwifery - Midwifery is defined in the State of North Carolina as the practice of attending women for hire during antepartum, intrapartum, postpartum, interconceptual care as well as newborn care.

2. Scope of Practice

   Midwifery Scope of Practice shall include the performance of:

   I. Initial and Subsequent Prenatal Care
      A. historical and physical assessment
      B. obtaining and assessing results of routine laboratory studies within normalcy guidelines established by the Midwifery Board
      C. supervising the use of prenatal vitamins with folic acid, iron, non-prescription medicines
      D. client education
   II. Intrapartum Care
      A. attending the conduct of normal labor in stage I and II
      B. spontaneous vaginal delivery of a vertex term (37 wks. - 42 wks.) infant
      C. amniotomy
      D. administering local anesthesia
      E. episiotomy and repair
      F. repair of first and second degree lacerations associated with childbirth
   III. Post Partum Care
      A. management of normal third stage labor
      B. the administration of pitocin when indicated
      C. six weeks postpartum evaluation, exam and contraceptive advice
   IV. Newborn
      A. routine care including a physical assessment
      B. vit. K administration
      C. eye prophylaxis for opthalmia neonatorum

*This scope of practice occurs within a health care system which provides for consultation, collaborative management, and referral with physician(s) licensed to practice medicine in the state of North Carolina.

*Comments: ___ out of the 12 members of the committee did not agree to this statement since it does not specifically state physician supervision. Some members of the committee were reluctant to have "supervision" used because of the political problems involved in requiring a physician to have in writing that (s)he is the supervising physician for a midwife who does home births.

3. Regulatory Board

   *The establishment of a North Carolina Board of Midwifery to be composed of nine members representing:

   -midwives licensed to practice in North Carolina
   -physicians with prior experience with midwifery
   -consumers of midwifery and maternity care

*Comments:
The committee cannot agree on the ratio of representatives to this board. ____ members believe that the Board of Medical Examiners should control the board because they view midwifery acts as medical acts. ___ members believe that midwives should control the representation since all other professions with boards are also represented in the majority as they are the most knowledgeable about the profession. The majority of members felt a 5/2/2 or 4/3/2 ratio would be preferable (5 or 4 midwives, 2 or 3 physicians and 2 consumers). ___ members of the committee believe that this board should be a regulatory board.

4. Responsibilities of the Board

(A) Establish education and other credentialing criteria in order to determine competence of the midwife
(B) Process applications
(C) Establish rules for practice
(D) Monitor/enforce midwifery practice
*(E) Issue/revoke/repeal licenses for the practice of midwifery and associated medical acts.
(F) Fees ____(wording to be left to Sandy Moulton)

*Comments:
The committee cannot agree on whether the board should regulate midwifery acts only or if the board can also give permission to the qualified midwife to perform selected medical acts, thus preventing the C.N.M. from having to apply to the Board of Medical Examiners also for approval of those acts.

5. Credentialing Process

*(A) The education credentialing process should be the one approved by the American College of Nurse-Midwives or by equivalent standards accepted by the Midwifery Board.

*Comments:
__ Members believe that this should be restricted to only those approved by ACNM.

(B) The Midwifery Board will determine criteria for certification, renewal and continuing competency.

6. Future Studies / Evaluation Component

It is further recommended that N.C. undertake a well designed, controlled, long term prospective study of home births in N.C. by qualified attendants. This study should conform to the following format/criteria:

7. Suggestion made and agreed upon but not voted on

Inclusion of a statement in the proposed bill which would be similiar to the following statement that appears in the Utah Statute - "This act shall in no way or at anytime...limit or change... the right of a mother...to deliver ...where, when, how and with whom they choose", or include this in the intent of the statute.

MINUTES

MIDWIFERY STUDY COMMITTEE

August 25, 1982

Members Present: Earl Trevathan, Arnie Katz, Linda May, Jane Helwig, R. G. Brame, Linda Glenn, Barbara Parker, Ann Woodward, Mary Edith Rogers, Lois Simmons Isler, Louis Kermon.

Others Present: Svea Oster, Nicola Varysnus, Barbara Conger, Sandy Moulton, Debbie Stanford, Dick Nugent, Pam Scudder, Marty Ballard.

Dr. Trevathan called the meeting to order and welcomed guests. Arnie Katz was welcomed to the Midwifery Study Committee as a replacement for Dan Domizio. The minutes were approved as written.

1. Literature Review Committee - A typed statement regarding the review of the literature which would preface the report from this committee was distributed and discussed. There was consensus regarding Statement #1. Dr. Brame expressed concern about Statement #2 as the first statement negates additional statements. Statement #2 was restated as: There is no credible evidence that intended, attended out-of-hospital births with adequate prenatal care pose significant health or safety risks to mother or infant. The last statement was discussed and was restated as #3: There are no studies to indicate a relationship between medical outcome of mother or infant and the formal educational qualifications of the attendant in cases of intended, attended, out-of-hospital births with adequate prenatal care. A motion was made to adopt the revised introductory statements for the ensuing report from this committee. (yes - 8 remaining members present; no - 1 Brame; abstain - 1 May). The Literature Review Committee requested Dr. Heaton's voter/comment on this as he was not present during the draft of the introductory remarks or for the discussion today.

2. Format of Report to Dr. Morrow - Dr. Trevathan reported meeting with Dr. Morrow regarding the work of the committee and format of report to the Secretary of D.H.R. Dr. Trevathan expressed his opinion that after meeting with Dr. Morrow, the Midwifery Study Committee was on the right track in dealing with the issues and Dr. Morrow was very interested and was open to suggestions. Debbie Stanford suggested the following format for the report:

I. Review of the Literature
II. Chart Regarding Recent Statutes (Examples from States using different approaches)
III. Data Collection Report
IV. Copy of Minutes (Midwifery Study Committee and Subcommittees)
V. Recommendations for Model Legislation

A motion was made that this format be chosen. (yes - 10 all of the members present; no - 0; abstain - 0).

3. Staff Proposals - Debbie Stanford introduced the three models which were developed by DHS staff and were identified as the following:

A. Board of Medical Examiners
B. Board of Midwifery
C. Department of Human Resources
(models attached with minutes)

A lengthy discussion followed regarding the models. The following points were emphasized:

1. Another model might be addressed such as Tennessee where lay midwives are not regulated. - Katz

2. The models complicate the issues being discussed. Although there is some disagreement, there is a significant amount of agreement of previously resolved. - Brame; the models were very helpful in looking at the issues. - May

3. There is agreement on all except the basic premise (supervision and approval). Plan A contains physician supervision and direct approval by Board of Medical Examiners and is acceptable. - Kermon

4. Plan A is more restrictive than current mechanism for approval. - Glenn

5. Plan B is preferable. - May

6. Plan B is illegal at present time. - Kermon

7. Board of Medical Examiners has looked at midwifery too narrowly. - Helwig

8. There should be provision for P.A.'s or non-nurse midwives to practice. - Katz

9. If a new board was not an option, would committee proceed differently? - Trevathan

10. Antonomous boards are expensive. Will funds be set aside by Legislature? It may be helpful to suggest options. - Moulton

11. If the legislature is not responsive to a Midwifery Board, could the Joint Subcommittee of the Board of Medical Examiners and Board of Nursing be autonomous? Nurse-Midwives would like to be included in decisions relating to the practice of nurse midwifery. - Glenn - May

12. There is no consumer representation on Joint-Subcommittee. - Helwig

13. How do all models meet need for out-of-hospital births? It is important to insure lay midwifery representation on Midwifery Board. There should be physicians, nurse-midwives, and non-nurse midwife and consumer representation whose practice experience includes out-of-hospital births. - Katz

14. Feels midwifery board would be representative. - Rogers

15. Several members voiced concerns about statement #9 at the end of Board of Midwifery Model (Model B). " 9. Providers of gratuitous or emergency obstetric services shall not be liable for prosecution for practicing midwifery without a permit/license." A concern expressed was that even though there were no charges, someone without midwifery skills might represent self as a midwife and could endanger the safety of consumers of such service. - Glenn

16. In the absence of Chris Heaton, a letter from him was received which stated his recommendation to limit the credentialing to nurse-midwives. - Glenn

Motion: A motion was made to add the following statement to Plan B (Board of Midwifery):

10. This act shall in no way or at anytime abridge, limit or change in any way the right of a mother and/or father to deliver their baby where, when, how and with whom they choose, regardless of certification.

yes - (6) Simmons-Isler, Katz, Glenn, Helwig, Parker, Woodward
no - (2) Brame, Kermon
abstain - (2) Rogers, May
The motion carried. (Note: Statement #9 was not changed.)

Motion: A motion was made to adopt the amended Plan B (Board of Midwifery) as the Model chosen by the Midwifery Study Committee.

yes - (8) Glenn, Helwig, Katz, May, Parker, Rogers, Simmons-Isler, Woodward
no - (2) Brame, Kermon
abstain (no) (Note: Chris Heaton's vote obtained after this meeting by mail .)

Dr. Trevathan asked Dr. Brame and Dr. Kermon to prepare a minority statement to accompany this vote.

It was suggested by Linda May that alternatives to Plan B be considered. Dr. Brame made a motion to submit all models (A,B,C) as an attachment to today's minutes.
yes - 10; no - 0; abstain - 0

4. Public Forums - Arnie Katz suggested the group discuss the need for public forums. The consensus of the group was that public forums were held previously and the need for future public forums should be decided by the Department of Human Resources or the Legislature.

5. Information being collected from permitted midwives - It was decided to extend the time period for the collection of this information through November, 1982.

6. Next Meeting - October 19, 1982 at 2:00 p.m. in the Norton Board Room, 6th Floor of the Cooper Building. Dr. Morrow and Dr. Levine will be invited to attend this session. The format and draft of the Midwifery Study Committee Report will be distributed and circulated. Hopefully, this will be our last meeting if our task can be completed. Dr. Trevathan expressed his thanks to committee members who have worked so hard to accomplish the task set forth for the committee.

Submitted by,

Martha W. Ballard

MINUTES

MIDWIFERY STUDY COMMITTEE

October 19, 1982

Members Present: Earl Trevathan, Linda May, Barbara Parker, R. G. Brame, Arnie Katz, Frederick Heaton, Mary Edith Rogers, Ann Woodward, Lois Simmons-Isler, Jane Helwig, Linda Glenn.

Others Present: Verna Barefoot, Sandy Moulton, Pamela Scudder, Tom Adams, Svea Oster, Nicola Varysnus, Debbie Stanford, Richard Nugent, Jimmie Rhyne, Faye McLamb, Betty Berryhill, Marty Ballard, Ronald Levine

Dr. Trevathan opened the meeting and greeted members and guests.

1. Minutes - The minutes of the last meeting which were included in the draft report of the Midwifery Study Committee were approved with the exception of adding the word "statistically" to the following sentence found in statement two of the Review of Literatur Committee's report: "There is no credible evidence that intended, attended out-of-hospital births with adequate prenatal care pose statistically significant health or safety risks to mother or infant."

2. Acknowledgement of Midwifery Study Committee by Dr. Morrow - Dr. Levine met with the Committee to discuss Dr. Morrow's responses and impressions to the draft report. Dr. Levine mentioned that Dr. Morrow had many positive remarks and expressed appreciation to the Committee for their hard work. Due to time restraints, discussion was limited to four main areas of concern.

a. Concern: The Board of Midwifery shall adopt the education and experience standards of the American College of Nurse-Midwives or an equivalent standard for midwives who are not nurses for individuals to be approved for practice under this legislation. Dr. Morrow would like the sentence to stop after American College of Nurse-Midwives as there are current developments in the college to include regulatory standards for midwives who are non-nurses.

   Midwifery Study Committee Discussion: Committees of the College have been examining this issue for some time. Representatives from the College are also working with the Alliance of Midwives who are developing standards and criteria for education and competence for midwives. It is not known when these will be available or if the standards will be developed by the College or through representation with the Alliance of Midwives. The general consensus of the group was that the equivalent clause should remain due to the unsure time framework for the development and approval of standards.

   The intent of the equivalency clause by the Midwifery Study Committee was to demand a high standard comparable to the existing A.C.N.M. standards for nurse-midwives.

b. Concern: "Providers of gratuitous or emergency obstetric services shall not be liable for prosecution for practicing midwifery without a permit/license." Dr. Morrow feels there is an inappropriate distinction in protection of mothers and babies if providers of gratuitous midwifery services are not subject to regulations regarding preparation and standards of practice. The statement concerning providers of emergency services is appropriate.

   Discussion: After much debate, a motion to retain this statement as is was defeated. Note: yes - 4, no - 5; abstain - 0.

The statement concerning "Providers of gratuitous or emergency obstetric services --- " will be removed from the Midwifery Study Report.

c. Concern: Under the definition of midwifery as related to the scope of practice statement, there is concern that midwifery acts should be carried out under the supervision of physician licensed to practice medicine in North Carolina.

Discussion: After discussion regarding physician supervision, a concensus was made to accept the definition of supervision as is being formulated by the American College of Nurse-Midwives. (see page 2 of Joint Subcommittee Alternative for statement)

d. Concern: The Board of Midwifery model recommended by the committee calls for another Board to be developed. Dr. Morrow feels that in the current economic climate, this recommendation may not be well received by the legislature. A better approach might be to use existing practice boards or agencies and recommend enabling legislation to deal with existing restraints or barriers. A concern was also expressed about recommending only one model.

Discussion: The Midwifery Study Committee discussed at length a possible alternative to the three models which were previously examined. Several issues were voiced:

1. The Board of Medical Examiners has been reluctant to consider "out-of-hospital" delivery sites for certified nurse-midwives. If this model was chosen, clear cut language would be needed in statute in order that practice site would not be unduly restricted.
2. The Joint Subcommittee at the present time has no provisions for those who are not registered nurses.
3. The Joint Subcommittee at the present time is not autonomous in that the Board of Medical Examiners may make final decisions and overrule the Joint Subcommittee.
4. The Joint Subcommittee does not have consumer representation.
5. Midwives need to have authority over the practice of professional midwifery. The current Joint Subcommittee does not have midwifery or obstetrical expertise.

3. Conclusion: Activities of the Midwifery Study Committee

a. After lengthy debate, the following motion was made: Motion - The Midwifery Study Committee will submit the Report of the Midwifery Study Committee as it presently exists and also will submit alternatives which address Dr. Morrow's concerns provided by feedback.

yes - all members present except Dr. Brame
no - Dr. Brame
abstain - 0

b. An alternative to accompany Report of the Midwifery Study Committee was developed and is enclosed. This alternative was developed after discussion of some of Dr. Morrow's concerns. The Midwifery Study Committee asked that this document be typed and mailed to members with the minutes to allow members to read the final document and take action on this by mail if at all possible. (see attached Model: Joint Subcommittee Alternative (Model D).

Changes which appear in the Joint Subcommittee Model and which differ from DHR Model which were voted on or approved include:

(1) autonomy by the Joint Subcommittee regarding decisions in midwifery matters.
(2) deletion of statement #9 on page 27, "Providers of gratuitous or emergency services ..."
(3) addition of statement #10 on page 27, included. "This act shall in no way or at anytime abridge, limit or change in any way the right of a mother and/or father to deliver their baby where, when, how and with whom they choose, regardless of certification."

vote: yes - 8; no - 2; abstain - 0.

(4) addition of standard of physician supervision by adding the current "Joint Statement of Practice Relationships Between Obstetrician/Gynecologists and Certified Nurse-Midwives."* which was approved by A.C.N.M. and ACOG.

(5) addition of interconceptual care was added to the definition of midwife

c. The Midwifery Study Committee agreed to have the staff compile the aggregate data from births attended by permitted Certified Nurse Midwives and permitted lay midwives. This information will be added to the Report of the Midwifery Study Committee.

d. The Midwifery Study Committee agreed to "leave as is" the summary page on review of the literature.

e. A motion was made by Jane Helwig to commend Dr. Trevathan for his outstanding leadership in the way he has directed the Midwifery Study Committee and for the excellent manner he has used in conducting the meetings and working with the members. All unanimously approved this motion!

Submitted by,

Marty Ballard

Martha W. Ballard

*approved October, 1982 by ACOG and ACNM

MINUTES

MIDWIFERY MODEL LEGISLATION SUBCOMMITTEE

February 17, 1982

Present: Dan Domizio, Lois Isler, Linda Glenn, Louis Kermon, Mary Edith Rogers, Ann Woodward, Linda May, Debbie Stanford, Svea Oster.

Members welcomed Dr. Kermon to the committee, he will replace Dr. Reynolds as the representative for the Board of Medical Examiners.

It was decided that this subcommittee will meet again March 3rd at 1:00 p.m. at Duke. It was suggested that the subcommittee also consider meeting at 11:00 a.m. on March 24, prior to the complete committee meeting. Dan reviewed how the subcommittees were divided up - which was according to individual preference. Dan suggested that the group express their feelings about the issues involved with this committee in order to foster their ability to work together since this will affect the outcome.

Linda Glenn expressed ambivalent feelings and wanted an exploration of educational routes that non-nurse midwives may take. With the increased demand for midwives, what can be done to insure provision of services and training for non-nurse midwives?

Linda May said that the education of non-nurse midwives was not economically feasible. It is more feasible to train nurses as midwives, as Britain has learned. Discussion followed re: the advantages of being educated in nursing and midwifery.

According to Linda Glenn there are 23 Schools of Nurse-Midwifery in the U.S. and 6 or 7 Schools of midwifery (non-nurse).

Mary Edith Rogers shared her views as a health director - that 1/3 of the people in her county cannot afford private obstetrical services. Some of these are not economically eligible for health department care but yet are not able to pay the private rate.

Some discussion re: the margin in safety between midwives and nurse-midwives.

National surveys predict an excess in obstetricians by 1990.

Dr. Kermon expressed the view that the medical profession, including the Board of Medical Examiners, does not approve of home deliveries. He wanted the group to focus on the delineation between nurse-midwifery home births vs. non-nurse midwifery home births.

Linda May pointed out that the group should be looking at out of hospital deliveries, not just in the home.

Dr. Kermon and Lois Isler clarified that the Board of Medical Examiners approves nurses to perform medical acts and the Division of Health Services grants approval for midwifery. According to them, the legislature changed the regulations of the Board of Medical Examiners by not specifying where a midwife may practice and as a result, the Joint Subcommittee does not require a statement from a C.N.M. that (s)he must confine deliveries to the hospital. (as was done prior to H.B.695)

Discussion centered around the rights or non-rights of consumers to access all types of care. Some views expressed as to whether or not the consumer is informed or knowledgeable enough to make such choices.

Dan reviewed his involvement with home births outside of the U.S. and his awareness of the interest in N.C. He asked the group to consider what body of knowledge would be required of a non-nurse midwife.

Several expressed the belief that the needs must be defined further in order to decide what type of legislation is best. Discussion of a survey in N.C. to identify the numbers of people interested in home birth or out of hospital birth as an option. The group was interested in surveying all areas of the state - urban vs. rural, public vs. private, etc. Debbie will check into how the state can assist in a survey and will explore the possibility of involving a student in the School of Public Health. Ann agreed to talk to the Data Collection Subcommittee. Ann will send all members a copy of a paper she did on home births.

Discussion followed regarding the definition of midwife. The possibilities of a role description include:

1. lay midwife as a delivery technician
2. lay midwife providing AP-IP-PP care
3. Certified Nurse-Midwife (in hospital only)
4. C.N.M. (all settings)

Some discussion of the trend of physicians doing home deliveries (outside of N.C.) and the willingness of physicians in N.C. to provide back up for home births.

Discussion regarding the use of the international definition of a midwife for use in N.C. The group agreed to look at the laws in other states to see how they've resolved this issue, and use their experiences to guide this group in setting up model legislation for N.C. The group was reminded that professional groups are usually accountable to a board who addresses the following: qualifications to practice, education and training, certification, supervision, etc.

As this is a diversified group, any legislation written should encompass all aspects and views of this group. (Dan)

Meeting adjourned.

This subcommittee will meet again March 3, 1:00 p.m., here at Duke.

MINUTES

MIDWIFERY MODEL LEGISLATION SUBCOMMITTEE

March 3, 1982

Present: Dan Domizio, Louis Kermon, Lois Isler, Linda May, Linda Glenn, Robert Brame, Ann Woodward, Debbie Stanford, Svea Oster.

A brief review of the last meeting took place in order to acquaint Dr. Brame with the issues that had been raised.

There was discussion over a possible statewide survey which would attempt to identify the needs of citizens for out-of-hospital births and the types of birth attendants. Debbie informed the group that she and Dr. Nugent would be meeting with Charles Rothwell at the State Center for Health Statistics (SCHS) to explore the feasibility and validity of such a survey. Mr. Rothwell will be invited to the meeting on March 24 to share his ideas. There was much discussion about what a survey would accomplish; primarily the intent would be to gather more data which the committee could use in formulating model legislation.

Questions raised: Can you get meaningful results from this type of survey of consumers who may not understand the difference in various levels of midwives, etc? What "type" of midwife would serve the "paying population" vs. the "poor population"? If midwifery or home births is an option for providing low cost care, how would this be received by the health department client? Who would financially support these midwives?

Discussion followed re: Supply-demand issue of this option. Demand has been established by the existence of H.B. 695 and the committee's task is to set up the guidelines and the mechanism for which this demand can be responded to safely. (Dr. Brame)

Discussion of whether or not the legislation should deal with the definition of a non-nurse midwife, should protocols be addressed in the statute or delegated to a board.

Review of legislation in other states reveals the following:

South Carolina has established "Standards of Practice for Midwifery in S. C." which requires a state exam, list required courses, establishes a lay midwifery licensing board, requires an apprenticeship, etc.

Copies of midwifery legislation for other states which are available to the committee include New Jersey, Rhode Island, Illinois, California, Washington, Arizona, New Mexico.

It was suggested by Linda Glenn that this subcommittee consider the following for North Carolina.

1. Use the international Definition of a midwife (with possibly some alterations) for N.C.'s definition.
2. Legislate the establishment of a midwifery council or board.
3. That the practice of midwifery be allowed in North Carolina and that rules and regulations be set up for all types of midwives who are accountable to the board/ council. (Council to be composed of CNM's, professional midwive(s), obstetrician(s) who work with CNM's, consumer(s)).

Dr. Brame expressed the need to review the definition before offering any further comments about it.

It was agreed that Dan, Debbie and interested others would summarize the various state's legislation and make this available to the Subcommittee before the next meeting.

Issues to look at when reviewing legislation in other states:

1. Midwife definitions
2. Scope of practice (s)
   settings
3. Regulatory Board
   (a) Composition
   (b) Authority
      1. scope
      2. source
4. Credentialling Process
   (a) Professional Midwife/CNM
   (b) Educational Program
   (c) Competencies/testing
5. Recert. Process (cont. ed.)
6. Fees - applications and renewals
   operating expenses of the board
7. Status of the statute (proposed/passed)

Ann Woodward has reviewed the statistics which have been published (See excerpt from Ann's paper which was mailed to you along with notification of the March 24th meeting). The data collection subcommittee has only looked at articles, not legislation.

Dan encouraged the group to write recommended legislation which accommodates most all viewpoints so as to prevent discord later. He asked the group how they felt that this could be done, especially with the medical profession. Some discussion followed.

Meeting adjourned.

This subcommittee will reconvene on March 24th from 11:00 a.m. to 1:00 p.m. in the Board Room of the Cooper Building (immediately prior to the committee meeting).

Plan to have lunch with the group. (Either bring your own or we will call for a take out order).

MINUTES

MIDWIFERY MODEL LEGISLATION SUBCOMMITTEE

March 24, 1982

Present: Dan Domizio, Louis Kermon, Lois Isler, Linda May, Linda Glenn, Robert Brame, Mary Edith Rogers, Ann Woodward, Earl Trevathan, Debbie Stanford, Marty Ballard.

The meeting began with a discussion about the pros and cons of distributing a survey. Ann Woodward plans to make a presentation about this at the committee meeting in the afternoon. She and Debbie Stanford met with Charles Rothwell to discuss what the State Center for Health Statistics could provide in terms of a survey; Charles will attend the meeting in the afternoon to discuss this. According to Dan, a survey may be needed to document what we think we know about the demand. Linda May felt that results of the survey may be used by the legislature to take action. Dan questioned whether the legislature will accept our recommendations without a document/survey. Linda Glenn felt that the Survey idea is complex and that most consumers need more education re: midwifery. Dr. Brame felt that the legislature has responded to a need but doesn't know the extent of the demand or what the survey results would mean. There was general agreement about the lack of a clear need for hard data, in the form of a survey. Discussion deferred until after the afternoon's presentations. It was agreed that unless members are convinced otherwise, the subcommittee will not pursue the survey.

Several members of the subcommittee had reviewed midwifery statutes in other states; this review was not a comprehensive review in that only those states which dealt with midwifery in the law were reviewed. Dan surmised his review of the statutes as follows:

Each law designated a regulatory body composed of practitioners and non-practitioners with staggered terms. A common theme is that the "board" makes decisions and is accountable to a state agency or person. Some boards were advisory only. All of the laws were very specific about the scope of practice.

Debbie briefly reviewed the statutes from Washington, Rhode Island, California and New Jersey.

Debbie and Dan will compile this review and distribute it to all members.

Discussion followed regarding the need for the committee to decide on a definition of midwife and midwifery practice. It was generally felt that the subcommittee could not proceed further until the entire committee agreed on the definitions. It was suggested that the International Definition of Midwife be used as a starting point.

There was some discussion regarding the definition as including C.N.M.'s and trained professional midwives, and whether the definition could accommodate other types of birth attendants/midwives who might limit their practice to a specific setting.

Meeting adjourned.

MINUTES

MIDWIFERY MODEL LEGISLATION SUBCOMMITTEE

April 21, 1982

Members present: Dan Domizio, Linda May, Linda Glenn, Mary Edith Rogers, Louis Kermon, Lois Isler.

Others present: Debbie Stanford, Chris Hoke, Sandy Moulton, Bryant Paris, Svea Oster, Ms. King and (2 participants in the Duke P.A. Program).

Debbie reviewed the tasks for the next two subcommittee meetings, which were delegated to this subcommittee as a result of the last full committee meeting. A chart of five state midwifery statutes was prepared and shared with members of the subcommittee; the chart categorizes midwifery statutes according to:

1. midwife definition
2. scope of practice
3. regulatory board
4. credentialling process
5. recertification/renewal process
6. fees
7. current status

Dan asked Chris Hoke, J.D. and Sandy Moulton, J.D. what they thought Dr. Morrow wanted from the committee in terms of final recommendations - a majority report only or alternative recommendations. Sandy gave her opinion that Dr. Morrow would prefer one majority report in order to assist her in formulating her recommendations to the legislature.

The subcommittee agreed to look at the process of writing the draft legislation considering the alternative definitions of a midwife (i.e. CNM and Non-CNM). The group discussed the composition of a regulatory board. Dr. Kermon expressed his opinion that nurse-midwives perform medical acts that are not midwifery (ex. treating urinary tract infections) and that the Board of Medical Examiners would have to continue regulating these acts. The attorneys were asked their legal opinions as to whether this would have to continue if a midwifery board was established. The legal opinions of Chris and Sandy were that the legislature could define midwifery as they so choose and could include certain medical acts in the statute/definition which would not have to involve the Board of Medical Examiners.

The group discussed alternative types of regulatory boards keeping in mind the "ideal" according to certain constituencies as well as the political realities involved.

The following models were developed for consideration:

#1 Model: (with 2 types of board composition)
Department of Human Resources
↓
Midwifery Advisory Board - - Board could be composed 2 ways:
(A) CNM'S x 8
Obstetricians who work with CNM's x 2
Pediatricians who work with CNM's x 2
Consumers x 2
Or,
(B) CNM'S x 4
Midwives x 4
Obstetricians x 2
Pediatricians x 2
Consumers x 2

In this model, the Secretary of DHR would appoint the members of the Midwifery Advisory Board, who would advise the Secretary on issues (to be decided on at next meeting) regarding midwifery.

#2 Model: (with 2 types of board composition)

Secretary of State

Board of Nursing	Board of Medical Examiners	Board of Nurse-Midwifery.....	composition: CNM's x 3 Obstetrician x 1 Pediatrician x 1 Board of Medical Examiners member x 1 Consumer x 1

OR

Secretary of State

Board of Nursing	Board of Medical Examiners	Board of Nurse-Midwifery	composition: CNM's x 3 Board of Medical Examiners x 3 Consumer x 1

#3 Model:

Secretary of State

Board of Nursing	Board of Medical Examiners	Board of Midwifery.....	composition: CNM's x 2 Midwives x 2 Obstetricians x 1 Pediatricians x 1 Board of Medical Examiners x 1 Consumer x 1

Discussion occurred between Dr. Kermon and other members regarding how the board could be composed of physicians who would represent the Board of Medical Examiners and, therefore, satisfy the Board of Medical Examiners that they have authority over non-obstetrically related medical acts.

The next subcommittee meeting will be Wednesday, May 12 at 1:00 p.m. in Durham (same place). The subcommittee's tasks will be to decide:

1. how the members of the regulatory board will be appointed
2. authority of the regulatory board
3. responsibilities of the board
4. decision on final recommendations to present to the full committee for its approval on May 26

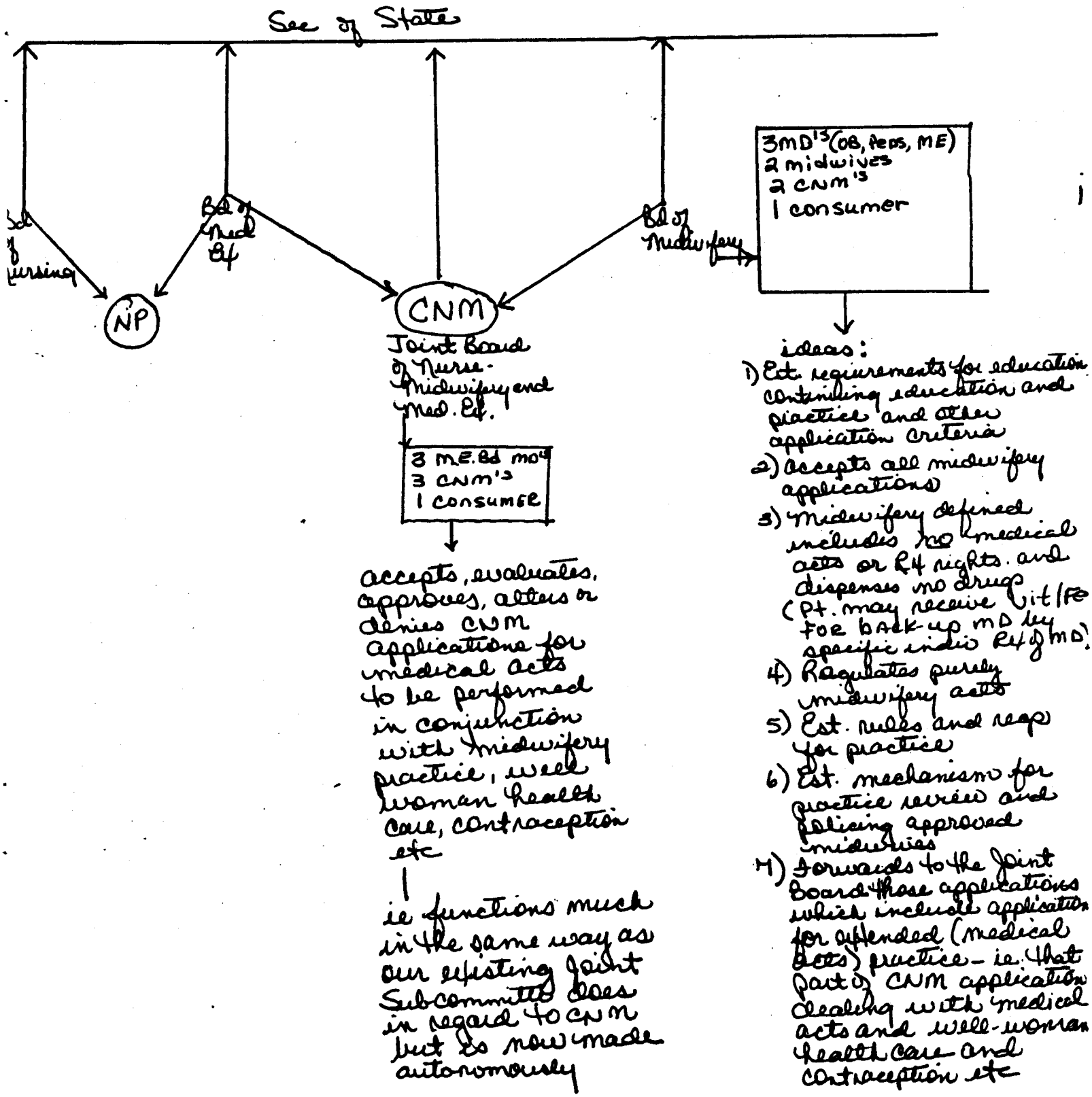
Since there will be a lot to accomplish, we will attempt to convene promptly at 1:00 p.m. If you will not be able to attend the meeting, please leave a message for Debbie Stanford at 761-2390. If you will not be able to attend but wish your views to be presented, please forward them to Debbie at the North Central Regional Office, Division of Health Services, 720 Coliseum Drive, Winston-Salem, NC 27106 as soon as possible.

Enclosed you will find an additional chart which Linda May would like you to consider.

Dear Friends and Fellow Sub-committee members.

I am still trying --- and frequently do my deepest thinking while driving. So I submit for your consideration the following ideas. I would appreciate feedback either individually or at the next meeting.

Thanks, Linda May



MINUTES

MIDWIFERY MODEL LEGISLATION SUBCOMMITTEE

May 12, 1982

Members Present: Ann Woodward, Dr. Kermon, Linda May, Linda Glenn, Mary Edith Rogers, Lois Isler, Dan Domizio

Others Present: Svea Oster, Sandy Moulton, Chris Hoke

All members present felt they would be in attendance at the meeting on the 26th, with the exception of Lois.

Dan listed the following as things that must be considered in appointment of members to the regulatory board:

(1) Definition of midwifery
(2) Laws at present time
(3) Potential changes in the law

Dan and Linda May read letters they had received from Dr. Brame expressing his feelings on the issues before this committee.

Authority of Regulatory Board

Would be involved in setting standards for professional midwives.

There was discussion as to what/how regulatory board would function. Will they have the task of regulating all midwives or only those with structured curriculum and training, particularly focused on those people who perform home births without pay.

What appointment mechanism will be used in selecting members?

Appropriate to have members appointed by the groups they represent, but important to keep politics out of it as much as possible. In case of consumer representative, they are appointed by ("state official") the governor.

What authority does this board have?

Mary Edith stated that if the board is given responsibilities then they should also be given the authority to carry them out.

There was further discussion on how responsibilities would be defined and authority vested in the regulatory board.

Mary Edith Rogers suggested that the committee look at feasibility of including a public health person.

Linda May stated that the Board may request that one of people already defined be in public health rather than add another person to the Board. There was further discussion between Linda May and the group on this issue.

Ann Woodward suggested that one of individuals already identified be a representative of the health department. This issue is to be discussed further at a later time (May 26th meeting).

Responsibilities of the Board

1. Establish education and other credentialing criteria
2. Process applications
3. Establish rules for practice
4. Monitoring/enforcing midwifery practice
5. Issuing/revoking/repealing licenses for practice of midwifery with associated medical acts.
6. FEES - Not in excess of _____; setting and collecting of registration - sending in names and information licensing - Chapter 90

Linda Glenn asked if it was possible for a couple of members of this committee to meet with the Board of Medical Examiners and express their ideas/opinions. Dr. Kermon felt that the Board would be agreeable to such a meeting. (Linda to arrange meeting with Board to lay out list of what are midwifery acts.) (Bryant Paris needs to be contacted to get on agenda for 14th of June. Lists could be distributed to members.) There was discussion as to the definition of midwifery. Linda May pointed out that definitions had been written by the entire committee at the last meeting. Dan responded that at that point, the committee had not reached the level of detail that it is now faced with and felt that the entire committee should review this again.

There was discussion as to what point should two level system be developed?

Dr. Kermon responded that any service outside that of delivery of a child would be performing a medical act and the Board (BME) would not approve it. The only way this would be changed is through legislation.

Alternatives to bring before Dr. Travethan's meeting: Multiplicity of Approvals/or change the Laws. Recommend in model legislation that changes be made in acts now defining responsibilities and authority of BME.

Time frame for submission of proposed legislation is January 1983. Sandy stated that they needed it by October. Sandy and Chris also suggested that someone, other than group members, write the technical legislation.

Lois stated that it is very important to watch carefully what terms are introduced in bringing this information before the public. Group was in agreement that there was some confusion in the terminology.

Due to lack of time, recommendations (Agenda item #4) was not discussed.

Ronald H. Levine, M.D., M.P.H.
STATE HEALTH DIRECTOR

DIVISION OF HEALTH SERVICES
P.O. Box 2091
Raleigh, N.C. 27602-2091

Historical Review of the Practice of Midwifery in North Carolina

In 1917, the North Carolina Legislature enacted a law requiring midwives to obtain a permit to practice from the State Board of Health and to register with the local health department. This law was revised in 1935 to authorize the State Board of Health to promulgate and enforce rules and regulations governing the practice of midwifery. The role of training and supervising these permitted midwives became that of the Public Health Nurses. Individual training and group workshops supplemented a midwifery manual, which was provided to each midwife.

Over the years, the number of practicing midwives declined, and after 1963 no new permits were issued under this original statute. The long range plan was to let midwifery phase out by attrition and then repeal the statutes. With the renewed interest in home deliveries and midwifery in the late 60's and early 70's, accompanied by requests for applications to obtain permits to practice midwifery, this plan had to be re-evaluated. After 1963, requests for applications were denied to lay midwives and Certified Nurse-Midwives. In order to practice midwifery, Certified Nurse-Midwives obtained approval to practice from the Joint Subcommittee of the Board of Nursing and the Board of Medical Examiners. However, the Board of Medical Examiners has had a policy of denying such approval if the delivery site is to be the home setting. Since 1978, the Joint Subcommittee has requested that a Certified Nurse-Midwife sign a statement of agreement that deliveries be confined to the hospital setting.

In order to provide guidance to the Division of Health Services and because of consumer interest in alternative births, in 1977 the Chair of the Commission for Health Services appointed an Ad Hoc Committee to explore the issue of midwifery in North Carolina. This committee met four times; most of the time consisted of oral presentations by advocates and opponents of lay midwifery and/or home births. Recommendations were formulated with a majority and minority report. These were presented to the Commission for Health Services, and the majority report was adopted, with an amendment, at the May 6, 1978 meeting. Following this, the Governmental Evaluation Commission investigated the issue of midwifery, held public hearings and formulated its recommendations.

In August, 1980, the Commission for Health Services requested the Department of Human Resources to seek the opinion of the Attorney General regarding the authority of the Commission for Health Services, Department of Human Resources, and local health boards and departments over the practice of midwifery. The opinion of the Attorney General's office, given in October, 1980, was that G.S. 130-187 lacked "sufficient standards to enable the above agencies to impose qualifications for the practice of midwifery." No further action was taken in order to allow the 1981 General Assembly to resolve the issue. The resulting action was the enactment of H.B. 695: An Act to Study and Regulate the Practice of Midwifery in North Carolina.

Prepared by: Debbie Stanford, CNM, M.P.H.
January, 1982

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1981
RATIFIED BILL

CHAPTER 676

HOUSE BILL 695

AN ACT TO STUDY AND REGULATE THE PRACTICE OF MIDWIFERY IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. The Secretary of the Department of Human Resources is hereby directed to undertake a study of the safety and efficacy of out-of-hospital delivery, including an examination of the State's role in licensing or otherwise permitting the activities of birth attendants functioning in the nonhospital setting. The Secretary shall consult with representatives of the North Carolina Board of Medical Examiners, the North Carolina Board of Nursing, the North Carolina Commission for Health Services, experts from the fields of obstetrics, public health, nurse midwifery and lay midwifery, as well as citizens who have a strong interest in out-of-hospital delivery. The Secretary shall report the findings of this study to the 1983 Session of the General Assembly.

Sec. 2. G.S. 130-187 is rewritten to read as follows:

"§ 130-187. Regulation of midwives.--No person shall practice midwifery in this State without a permit granted by the Department of Human Resources and also being under the supervision of a physician licensed to practice medicine. The department shall issue a permit to only those applicants who have been certified as Certified Nurse Midwives by the American

College of Nurse-Midwives and who otherwise demonstrate sufficient training and experience."

Sec. 3. G.S. 90-172 is amended on lines 3 and 4 by deleting the words "or a local department of health".

Sec. 4. G.S. 130-112 is amended by deleting everything after the word "registration" on line 5.

Sec. 5. Any individual who has held a valid midwifery permit in North Carolina for more than 10 years may continue to practice midwifery.

Sec. 6. Severability. If any provision of this act or the application thereof to any person or circumstances is held invalid, the invalidity does not affect the provision or application of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Sec. 7. Funding. The provisions of this act shall be implemented without the appropriation of funds by the General Assembly.

Sec. 8. This act is effective July 1, 1981.

In the General Assembly read three times and ratified, this the 25th day of June, 1981.

JAMES C. GREEN

James C. Green

President of the Senate

LISTON B. RAMSEY

Liston B. Ramsey

Speaker of the House of Representatives

10 NCAC 8B .0500; MIDWIFERY PERMITS; has been adopted as follows:

SECTION .0500 - MIDWIFERY PERMITS

.0501 PERMIT APPLICATION

No person shall practice midwifery in North Carolina without a permit granted in accordance with the provisions of this section, except that any individual who had held a valid midwifery permit in North Carolina for more than 10 years may continue to practice midwifery as provided by Section five, Chapter 676, of the 1981 Session Laws. Applications for midwifery permits can be obtained from and should be returned after completion to the Maternal and Child Health Branch of the Division of Health Services, P. O. Box 2091, Raleigh, N. C. 27602.

History Note: Statutory Authority G.S. 130-187; S.L. 1981, Ch. 676, s. 5;
Eff. September 15, 1981.

.0502 QUALIFICATIONS

The division of health services shall grant midwifery permits only to applicants who demonstrate that they meet the following requirements:

(1) The applicant is certified as a certified nurse midwife by the American College of Nurse Midwives;
(2) The applicant is licensed as a registered nurse in North Carolina;
(3) The applicant has completed a nurse midwifery educational program approved by the American College of Nurse Midwives;
(4) The applicant has actively practiced midwifery in the United States within the past five years or has performed 10 deliveries within the past year with the on-site supervision of either an actively practicing certified nurse midwife or a physician whose active practice includes obstetrics.

History Note: Statutory Authority G.S. 130-187;
Eff. September 15, 1981.

.0503 PERMIT ISSUANCE

The division shall grant or deny a permit, or request additional information within 45 days after receipt of an application. If additional information is requested, the division shall grant or deny a permit within 45 days after the receipt of the necessary information.

History Note: Statutory Authority G.S. 130-187;
Eff. September 15, 1981.

.0504 EXPIRATION AND REVOCATION OF PERMITS

(a) Midwifery permits granted by the division shall automatically expire one year from the date of issuance of the permit. Permits shall be renewed only upon submission of an application in accordance with the provisions of this section.

(b) Midwifery permits granted by the division shall automatically be revoked if the permitted midwife:

(1) loses his or her licensure as a registered nurse in North Carolina;
(2) loses his or her certification as a certified nurse midwife by the American College of Nurse Midwives; or
(3) becomes unfit or incompetent to practice midwifery by reason of deliberate or negligent acts or omissions.

(c) Permits that have been automatically revoked shall be renewed only upon submission of an application in accordance with the provisions of this section.

History Note: Statutory Authority G.S. 130-187;
Eff. September 15, 1981.

.0505 APPEALS

All requests for appeal shall be by written petition and should be submitted to: Director, Division of Health Services, P. O. Box 2091, Raleigh, N. C. 27602. All appeals shall be conducted in accordance with G.S. 150A, 10 NCAC 4B, and 10 NCAC 1B.

History Note: Statutory Authority G.S. 130-187;
Eff. September 15, 1981.

DEPARTMENT OF HUMAN RESOURCES

Division of Health Services

APPLICATION FOR A PERMIT TO PRACTICE MIDWIFERY IN NORTH CAROLINA

NAME

ADDRESS: (Street) (City) (Zip) (County) (Phone)

N.C. Registered Nurse Certificate No. Current Renewal No.

EDUCATION (include nursing and nurse midwifery)

	Degree or Certificate	Dates

Attach a copy of certificate given by A.C.N.M.

PROFESSIONAL EXPERIENCE AS A C.N.M. AND/R.N. (beginning with most recent):

	DATES	
	From	To

I have practiced as a Certified Nurse Midwife in the U. S. within the past five years. ☐ Yes ☐ No If NO, provide documentation that in the last year a minimum of ten deliveries have been performed under the on-site supervision of a physician whose practice includes obstetrics or an actively practicing Certified Nurse Midwife.

Name(s) of physician(s) who will provide supervision (give professional address, phone number, medical specialty, and current licensure to practice medicine in North Carolina).

The information submitted is true and accurate to the best of my knowledge.

Signature of Certified Nurse Midwife Applicant Date

Please forward application and any attachments to: Department of Human Resources
Division of Health Services
Maternal and Child Health Br.
P. O. Box 2091
Raleigh, N. C. 27602

DHS Form 3021 8-81
Maternal and Child Health 8-83

DEPARTMENT OF HUMAN RESOURCES

Division of Health Services

Maternal and Child Health Branch

P.O. Box 2091

Raleigh, N. C.

REQUEST FOR SUPPLEMENTAL INFORMATION TO APPLICATION FOR A PERMIT TO PRACTICE MIDWIFERY IN NORTH CAROLINA

House Bill 695 directs the Department of Human Resources to undertake a study of the safety and efficacy of out-of-hospital delivery and to examine the state's role in permitting the activities of birth attendants functioning in the non-hospital setting. The findings of this study will be reported to the 1983 session of the General Assembly.

In order to do a careful and thorough job of studying the safety and efficacy of out-of-hospital births, it will be necessary for the study committee to collect detailed clinical information on as many births as possible delivered by permitted midwives. Your cooperation in the obtaining of this information will be necessary. At present, we are asking you to do the following:

(1) Obtain client consent for release of information to the study committee
(2) Document the client's course and your management in a detailed clinical record (such as the Hollister record)

It is anticipated that the study committee may develop a pregnancy outcome summary form to which you may be asked to transfer information that you have collected on clients who have planned home births.

Although the following are <u>not</u> necessary criteria for the applicant to receive a permit, it would provide the Department of Human Resources with pertinent information regarding the practices of birth attendants in the non-hospital setting. Please send a copy of the protocol which has been developed by the Certified Nurse Midwife and supervising physician(s). It is recommended that this should include the following:

(1) equipment available at birth;
(2) list of conditions which would serve as indications for hospital delivery;
(3) hospital(s) which will be used if necessary;
(4) description of emergency back-up arrangements;
(5) a list of the counties in which you anticipate doing deliveries.