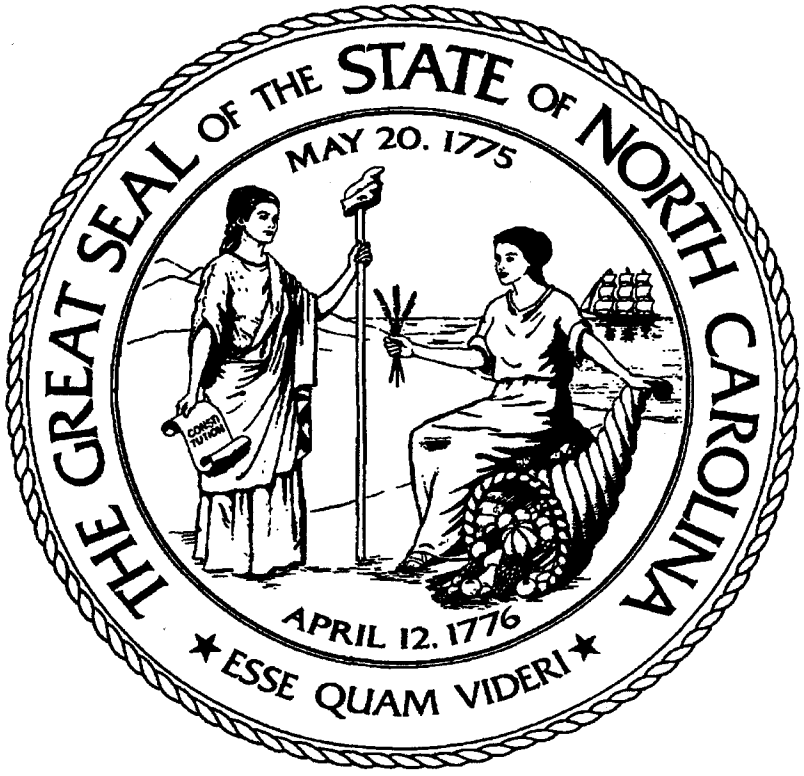


# LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

Assessment Report
For

# Certified Professional Midwives

**Senate Bill 875**
**House Bill 1077**


LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

May 30, 2000

The Legislative Committee on New Licensing Boards is pleased to release this assessment report on the licensing of professional midwives. This report constitutes both the preliminary and final assessment report.

Brad Sb

Senator Brad Miller, Chairman

LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS
(1999-2000)

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Senator Brad Miller, Chairman

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| Senator Fletcher Hartsell | Representative John Bridgeman |
| Senator R.L. Martin | Representative Jerry Dockham |
| Senator R.C. Soles, Jr. | Representative Verla Insko |
| Senator Allen Wellons | Representative Mickey Michaux |

Staff: Ms. Cindy Avrette, Committee Counsel
Ms. Mary Shuping, Research Assistant

## PREFACE

The Legislative Committee on New Licensing Boards is a 9-member joint committee of the House and Senate created and governed by Article 18A of Chapter 120 of the General Statutes. The primary purpose of the Committee is to evaluate the need for a new licensing board or the proposed licensing of previously unregulated practitioners by an existing board. The Committee has been in existence since 1985.

The Committee solicits written and oral testimony on each licensing proposal in carrying out its duty to determine whether the proposal meets the following criteria:

1) Whether the unregulated practice of the profession can substantially endanger the public health, safety, or welfare, and whether the potential for such harm is recognizable and not remote or dependent upon tenuous argument.

2) Whether the profession possesses qualities that distinguish it from ordinary labor.

3) Whether practice of the profession requires specialized skill or training.

4) Whether a substantial majority of the public has the knowledge or experience to evaluate the practitioner's competence.

5) Whether the public can effectively be protected by other means.

6) Whether licensure would have a substantial adverse economic impact upon consumers of the practitioner's good or services.

The Committee issues an assessment report on its findings and recommendations. The recommendation in the report is not binding on other committees considering the proposal.

# CERTIFIED PROFESSIONAL MIDWIVES

## SENATE BILL 875 & HOUSE BILL 1077

### BACKGROUND[1]

With regard to HB 1077/SB 875, the term "midwife" generally refers to a "direct entry midwife" and not a "certified nurse midwife". A direct entry midwife is an "... independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college or university based program distinct from the discipline of nursing." A direct entry midwife attends women at out-of-hospital births. A certified nurse midwife is a person certified by the American College of Nurse-Midwives and approved to practice midwifery in North Carolina by the Midwifery Joint Committee, a committee composed of members of the North Carolina Medical Board and the Board of Nursing. A certified nurse midwife may practice midwifery in a hospital or a non-hospital setting.

**Current Standards.** Currently, only certified nurse midwives may practice midwifery in North Carolina, and they must practice under the supervision of a physician licensed to practice medicine who is actively engaged in the practice of obstetrics.[2] However, there is evidence that some people in North Carolina practice midwifery without the statutory-required approval. Many of the people who practice midwifery without this approval are Certified Professional Midwives (CPM) who have met the standards for

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[1] Portions of the background information are taken from *Response to Questions for the Legislative Commission on New Licensing Boards.* Prepared by Magi King, CPM, and Giselle Kovac, LM. April 2000. A copy of the questionnaire is found in Attachment A.

[2] G.S. 90-178.3. Article 10A of Chapter 90 of the North Carolina General Statutes is found in Attachment B. A comparison of Certified Nurse Midwives (Article 10A of Chapter 90 of the North Carolina General Statutes) and Certified Professional Midwives (proposed in SB 875/HB 1077) is found in Attachment C.

certification set by the North American Registry of Midwives (NARM). There are currently 15 to 20 Certified Professional Midwives in North Carolina who are members of the North Carolina Midwifery Alliance.

**Need for Certification/Approval.** Consumer demand for direct entry midwives who assist in out-of-hospital births is being met by anyone who identifies himself or herself as a midwife. In addition, direct entry midwives who assist in out-of-hospital births do not have access to ultrasounds, lab work, or doctor consultations. Finally, doctors would be more likely to provide back-up medical services for patients of direct entry midwives if the midwives had legal status; however, without that status, physicians are concerned about their liability and being associated with a case managed by an unrecognized practitioner.

## SB 875/HB 1077
## CERTIFIED PROFESSIONAL MIDWIVES

**Who must be certified/approved.** SB 875/HB 1077 would require that anyone who practices midwifery must be approved by the North Carolina Supervisory Council of Certified Professional Midwives. "Midwifery" is defined in the bills as "the provision of prenatal, intrapartum, and postpartum care for women experiencing normal pregnancies and newborn care for their infants." (See below)

Prenatal Care includes all of the following:

- Obtaining historical and physical assessments of pregnant women.
- Obtaining and assessing the results of routine lab tests.
- Supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medications.

Intrapartum Care includes all of the following:

- Assisting women during uncomplicated labor.

- Assisting with the spontaneous delivery of infants in the vertex presentation from 37 to 42 weeks gestation.
- Performing amniotomy.
- Performing emergency episiotomies and repairing lacerations with the use of local anesthesia.

Postpartum Care includes all of the following:

- Management of the normal third stage of labor.
- Repair of first and second degree lacerations resulting from childbirth.
- Administration of oxytoxic drugs after delivery if an emergency situation exists.
- Performance of evaluation examinations in the days and weeks following pregnancy.

Newborn Care includes providing all of the following routine assistance to newborns:

- Establishing respiration, including the use of oxygen.
- Maintaining thermal stability.
- Performing routine physical assessment, including APGAR scoring.
- Performing eye prophylaxis for opthalmia neonatorum.

**Who is exempt from certification/approval.** The following persons would be exempt from approval by the Council:

- Certified nurse midwives licensed under Article 10A of Chapter 90 of the General Statutes.
- Physicians.
- Physician assistants and nurse practitioners when performing medical acts under rules adopted by the NC Medical Board.
- Registered nurses engaged in the practice of nursing.
- Persons rendering childbirth assistance in emergency situations.

- Persons rendering childbirth assistance whose religious beliefs are contrary to the requirements of SB 875/HB 1077 and the persons render this assistance at the request of the person receiving the childbirth assistance.

**Qualifications for certification/approval.** To qualify for approval in North Carolina as a Certified Professional Midwife (CPM), a person must meet all of the following requirements:

- Be at least 18 years old.
- Complete an application provided by the NC Supervisory Council of Certified Professional Midwives.
- Submit evidence of certification by the North American Registry of Midwives.[3]
- Pay the required fees.

**Nonresident Certification/Approval.**

NC Resident – Approved in Another State. The Council may approve a person who resides in North Carolina as a CPM if the person has been approved to practice as a CPM in another state whose standards of competency are substantially equivalent to the requirements for approval in this State. The person must submit an application and pay all required fees.

Nonresidents. The Council may approve a nonresident who submits an application and pays the required fees as a CPM if the nonresident meets at least one of the following requirements:

- The nonresident meets the requirements set forth in SB 875/HB 1077.
- The nonresident resides in a state that recognizes approvals issued by the Council.

[3] The North American Registry of Midwives (NARM) is an international certification agency that establishes and administers certification for the CPM credential. The educational requirements for the CPM credential are found on page 11 of Attachment A,, responses to the questionnaire.

**Fees.** The fees established by the Council may not exceed the following:

| Type of Fee | Maximum Fee Amount |
|---|---|
| • Issuance of approval | $200.00 |
| • Renewal of approval (every 3 years) | $150.00 |
| • Reinstatement | $200.00 |
| • Late fee | $25.00 |

**The North Carolina Supervisory Council of Certified Professional Midwives.**

Membership: The Council consists of seven (7) members as follows:

➢ ***Initial Membership.***

- 1 CPM appointed by the General Assembly upon recommendation by the President Pro Tempore of the Senate.
- 2 women who have received care from a CPM, appointed by the General Assembly, one upon recommendation by the President Pro Tempore of the Senate and one upon recommendation by the Speaker of the House of Representatives.
- 1 physician who has experience working with midwives practicing in out-of-hospital settings, appointed by the General Assembly upon recommendation by the Speaker of the House of Representatives.
- 3 CPM's appointed by the Governor.

➢ ***Subsequent Membership.*** After the expiration of the terms of the initial members, the members will be elected by majority vote of the certified professional midwives. Members will serve terms of three years and may not serve more than two consecutive terms.

Powers of the Council: The Council's powers and duties include:

- Adoption of rules, including fees.
- Determining qualifications and fitness of applicants.
- Employing and fixing the compensation of personnel employed by the Council.

- Issuing, denying, revoking, or suspending approvals.
- Conducting investigations in connection with disciplinary actions.

## FINDINGS AND RECOMMENDATIONS

On May 30, 2000, the Committee found that, based upon the fact that the practice of midwifery is currently regulated under Article 10A of Chapter 90 of the General Statutes, Practice of Midwifery, the following questions were not applicable to SB 875 and HB 1077, Certified Professional Midwives:

- Whether the unregulated practice of the profession can substantially endanger the public health, safety, or welfare, and whether the potential for such harm is recognizable and not remote or dependent upon tenuous argument.
- Whether the profession possesses qualities that distinguish it from ordinary labor.
- Whether practice of the profession requires specialized skill or training.
- Whether a substantial majority of the public has the knowledge or experience to evaluate the practitioner's competence.
- Whether the public can effectively be protected by other means.
- Whether licensure would have a substantial adverse economic impact upon consumers of the practitioner's good or services.

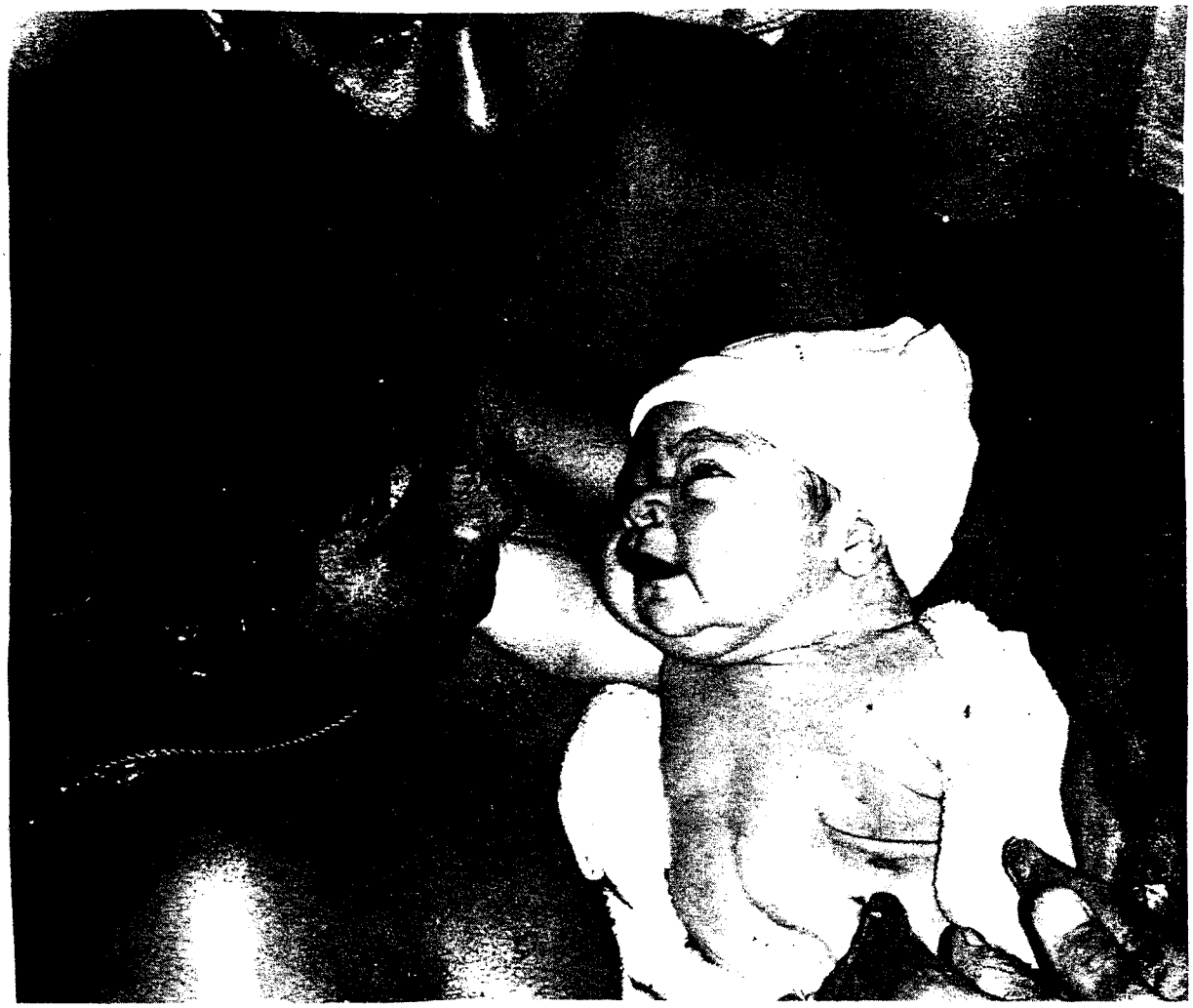
Therefore, the Legislative Committee on New Licensing Boards recommends that the provisions of SB 875 and HB 1077 be considered by a substantive committee.

***ATTACHMENT A***

# Assessment Report. For the Legislative Committee on New Licensing Boards

## Senate Bill 875 / House Bill 1077

An act to authorize the practice of midwifery by Certified Professional Midwives



Completed by;
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DEFINITIONS

Midwife or Direct Entry Midwife (DEM): An independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A DEM is trained to provide the Midwifery Model of Care to healthy women and newborns throughout the childbearing cycle, primarily in out-of-hospital settings.

Midwifery Model of Care: The Midwifery Model of Care is based on the fact that pregnancy and birth are normal life events. The Midwifery Model of Care includes: monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention. The application of this women- centered model has been proven to reduce the incidence of birth injury, trauma and Cesarean section.

Midwives' Alliance of North America (MANA): An organization of North American Midwives and their advocates. MANA's central mission is to promote midwifery as a quality health care option for North American families.

Certified Professional Midwife (CPM): An independent practitioner who has met the standards for certification set by NARM and is qualified to provide the Midwifery Model of Care.

Certified Nurse Midwife (CNM): A midwife whose training requires the completion of nursing school before beginning the midwifery component of his/her education. CNMs are not required to have training in out-of-hospital settings.

North American Registry of Midwives (NARM): An international certification agency whose mission is to establish and administer certification for the credential "Certified Professional Midwife". The NARM certification process recognizes multiple routes of entry into midwifery and includes verification of knowledge and skills and the successful completion of both the written exam and a skills assessment.

Midwifery Education Accreditation Council (MEAC): A council which promotes quality education in midwifery through accreditation. It creates standards and criteria for the education of midwives that reflect the nationally recognized core competencies and guiding principles of midwifery care set by the Midwives' Alliance of North America.

*(In the following document the term midwife generally refers to a direct-entry midwife who attends women at out-of-hospital births. Any other classification of midwife will be specified. We would also like to clarify that **HB 1077/SB 875** are not seeking licensure, but legal recognition of an already existing national midwifery credential know as the Certified Professional Midwife, referred to as CPM.)*

1. **In what way has the marketplace failed to regulate adequately the profession or occupation?**

For at least the past 20 years, the marketplace has demanded midwives be accessible, regardless of their legal status. In March 1983, a report on midwifery, as ordered by the North Carolina General Assembly, was submitted. Members of the state's Midwifery Study Committee and staff of the Department of Human Resources conducted this study. The results maintained that "it was not clear that the additional medical and obstetrical procedures rendered in the hospital resulted in improved outcomes" as compared to a planned home birth with a qualified attendant. The study also maintained "the significance of the rights of parents to choose the site of delivery and birth attendant." The current law statue # 90-178.1, Chp. 90, Article 10 A ,which resulted from the '83 legislation, granted practice privileges to one midwife and nurse-midwives. However, only 1% of the nurse midwives serve families in a home setting.

The home-birth midwife, Lisa Goldstein from Yancey Co., was recognized in 1983 because she could prove she had been practicing midwifery in NC for over ten years. Although there were other midwives in the state at that time, they could not meet that criterion. Unfortunately, the law did not provide an avenue for these midwives to work their way into the system. Many of them still practice today and have gone on to become Certified Professional Midwives.

At this time, in North Carolina without legal recognition of the CPM or any standard at all, consumer demand for midwives is being meet by any person choosing to self-identify as a midwife. Leaving the market place to sort this out is not in the best interest of the public's health.

As a result of the findings of the state's study, it is clear that it is not the marketplace which has failed to adequately regulate the profession of midwifery, but the legislative process which has failed to heed the demands of the consumers.

2. **Have there been any complaints about the unregulated profession or occupation? Please give specific examples including (unless confidentiality must be maintained) complainants' names and addresses.**

Complaints from consumers about their midwives are extremely rare due to the high level of client satisfaction (*The Future of Midwifery, Pew Health Professions Commission and The University of California, San Francisco, Center for the Health Professions, April 1999, p.8*). The most common complaint about midwifery care is in regard to the difficulties which midwives have in establishing collaborative relationships with the medical community. Physicians and consumers agree that this is the number one obstacle to providing optimum care to home birth families. Some physicians are disturbed by the fact that midwives who serve families birthing outside the hospital are unable to obtain the recognition, as qualified health care practitioners, they need to give them access to ultrasounds, lab work, doctor consultation, etc. These doctors would provide back-up medical services if midwives had legal status, however, without that status, they are concerned about their own liability and being associated with a case managed by an unrecognized practitioner. Many doctors who collaborate with midwives feel pressured and threatened from their peers and superiors, which could result in their loss of hospital privileges and peer support. Midwives want, and consumers need collaborative agreements with physicians, which assure timely medical care when necessary. **The key to insuring optimal outcomes is effective**

**collaboration of caregivers.** Physicians willing to be contacted: Dr. William C. Brannan, MAHEC Women's Health Center, 93 Victoria Rd., Asheville, NC, 828-258-1202; Dr. David Love, 513 N. Justice Street, Hendersonville, NC, 828-693-0736.

As far as complaints about the services of midwives from a consumer, to our knowledge there were complaints regarding the method of payment and collection policies of one midwife.(Names withheld to protect the midwife.) There have been two other separate incidents which raised complaints; one from a physician and one from a local health department. Both complaints found their way to the county District Attorney's office, which assisted in investigations.

The first case occurred in1992 in Buncombe County. The county District Attorney's office became involved because there was concern about a midwife, who was a Registered Nurse and had a license to practice midwifery from another state. The District Attorney's office and the State Bureau of Investigations interviewed midwives in the area and both agencies came to the same conclusion- the midwife in question was clearly stepping outside the community standard of practice in that particular incident and needed to be held accountable in some way. Consequently, she gave up practicing midwifery for 3 years, and was suspended from nursing for a specified time. The DA's office stated that this type of case was not in their jurisdiction and ought to be settled through the establishment of proper legislation.(Nancy Koerber, CPM, was a midwife who was interviewed and involved in reviewing the case. New Dawn Midwifery, 291 Charlotte St., Asheville, NC 828-236-0032)

The second case occurred in March 1998 in Davie County when the local health department decided to investigate a midwife doing home births in the area. The midwife was subsequently arrested and charged with practicing midwifery without a license. There was no complaint from a consumer. The case went to court and though it was dismissed on a for technicality, the county District Attorney, impressed by the overwhelming support for the midwives, made it clear, once again, that this issue must be addressed in the legislature.

3. **In what ways has the public health, safety, or welfare sustained harm or is in imminent danger of harm because of the lack of state regulation? Please give specific examples.**

There are several ways in which public health, safety and welfare have been harmed. They include:

- Midwives' and consumers' inability to access necessary lab work. As a result some conditions may go undetected, perhaps compromising the well being of mother and/or baby making it impossible for midwives to give the best care.
- Midwives and consumers unable to get physicians to consult, back up, or cooperate with midwives. In one incident this resulted in an infant death- the mother was denied help by 2 doctors and then was turned away from an emergency room, due to her affiliation with a midwife and her plans to birth at home.
- With no legal status, midwives may be hesitant to transport to a hospital in a serious situation due to fear of prosecution. This places women and babies in need of medical care at risk.
- Inability for midwives to interact with other healthcare professionals as equal, independent, and qualified caregivers. Currently it is difficult for midwives to share the client's records and exchange important information about the situation with medical staff.
- Currently midwives have no legal access to standard medications needed to safely attend birthing women at home. This compromises the standards of care and safety that midwives can provide.
- Without credentials to show competent level of training, some women may receive substandard care.
- Adherence to a community standard of care currently not mandatory.
- With no state recognition of the national CPM credential, midwives are not required to be accountable to other midwives or the community they serve.
- Currently, women who make an educated and informed decision and choose out-of-hospital birth are being discriminated against by having to accept substandard medical care, including denial of laboratory testing, emergency room care, and physician consultation.

4. **Is there potential for substantial harm or danger by the profession or occupation to the public health, safety, or welfare? How can this potential for substantial harm or danger be recognized?**

Anytime there is a birth there is a risk, regardless of the setting. However, this risk is statistically proven to be less when the home birth is planned and a well-trained midwife is in attendance. In fact, "physician attended births have never been shown to be safer than midwife attended births for women with normal pregnancies" (Birth, 1994). This evidence is maintained by the US ranking in infant mortality- there are 25 countries with lower infant mortality rates than ours, many of them routinely using midwives. In North Carolina, the potential risks of a home birth do not come from the birth setting or from a well-trained birth attendant, but come largely from the threat of self identifying midwives attending births with out adequate training. The legislature can recognize this danger by legalizing the CPM national credential as the standard for midwives serving families birthing outside the hospital . Thus, protecting the part of the population who will always choose this type of care provider.

5. **Has this potential harm or danger to the public been recognized by other states or the federal government through the licensing or certification process? Please list the other states and any applicable federal law (including citation).**

As with all health professionals in the US, midwives are regulated on a state by state basis. Across the country, states are recognizing the need for out of hospital midwifery regulation. Last year 9 states had midwifery legislation pending. Currently there are 42 states in which midwives can legally practice. These are: AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, ID, IL, KS, LA, ME, MA, MI, MN, MS, MT, ME, NV, NH, NJ, NM, NY, NB, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WA, WV, WI, WY.

To date, there are 15 states with at least 850 midwifery practitioners which have regulatory processes for midwives who practice in out-of-hospital settings. All 15 states use the CPM written exam or full credential for recognition or reciprocity. There are 500 CPM's practicing throughout the U.S. South Carolina has had licensed midwives serving home birth families for more than 15 years. They incorporate the CPM written exam into their licensing process, which was developed prior to the establishment of the CPM credential. In Tennessee, where midwives have been practicing for over 100 years, the legislature recently approved a bill, very similar to our own, utilizing the CPM credential to certify midwives. In 1983, the department of human resources in North Carolina recommended new midwifery legislation. Unfortunately the study commission failed to meet the needs of the consumers when they approved legislation only recognizing Certified Nurse Midwives, who almost exclusively practice in the hospital. Once again, almost 20 years later, our state has the opportunity to provide well trained out of hospital midwives for the public through recognition of the CPM. *

6. **What will be the economic advantage of licensing to the public?**

The economic advantages to the public, which would result from the recognition of the CPM credential, are significant. First and foremost is the decreased cost of an out of hospital birth. The midwifery model of care includes safe **, high quality care with the same or better outcomes at lower costs*** than comparable alternatives *(The Future of Midwifery, Pew Health Professions Commission and The University of California, San Francisco, Center for the Health Professions, April 1999*, p.10). The "low tech" philosophy of midwifery results in lower Cesarean section rates, lower epidural rates, less usage of neonatal resuscitation units and fewer hospital day charges. Therefore, the cost of a normal home birth (about $2000 in the US) is considerably less than the cost of a normal hospital birth (averaging $6,378 in the US). Furthermore, the price of a Cesarean section in the US averages at $10,638.

* see attachment #1 Advantages of Using CPM...
*see attachment # 2 Documented Evidence...Safety...
**see attachment # 3 ... Cost Effective

Nationally, the Cesarean section rate is 23%, while the World Health Organization recommends a rate of 10-15%. Reducing the rate to WHO objectives would save 1.5 billion dollars in the US. The cesarean section rate among midwives is 3.4% (Midwives Alliance of North America, 1999), so costs to consumers, the state, and the insurance companies would additionally decrease for midwife-attended births.

Other economic advantages may include a more consistent fee base among midwives. In addition, consumers whose insurance coverage includes midwifery care would then receive reimbursement.

**7. What will be the economic disadvantage of licensing to the public?**

Due to a relatively small number of CPMs initially, the administrative costs may be high, resulting in the need for CPMs to increase their fees to cover these expenses. However, these sums are modest when compared to hospital charges.

**8. What will be the economic advantages of licensing to the practitioners?**

The economic advantages may come from the practitioners' ability to advertise and increase the numbers of clients they accept. In addition, with legal recognition of the CPM credential, practitioners will be freer to report income and claim continuing education and business expenses on their tax returns.

**9. What will be the economic disadvantages of licensing to the practitioners?**

The economic disadvantages would be paying for administrative fees and CPM testing and certification.

**10. Please give other potential benefits to the public of licensing that outweigh the potential harmful effect of licensure such as a decrease in the availability of practitioners and increased cost to the public.**

Seeing as there is only one harmful economic effect, due to administrative costs, the benefits are as follows;

- Consumers' ability to choose a midwife based on her credentials and level of training which are needed in order to obtain certification.
- The ability of consumers to choose the manner, cost, setting, and caregiver for their birth experience.
- Consumer access to quality, home birth oriented prenatal care and delivery services by providing adequate numbers of trained providers.
- The potential for providing excellent prenatal, intrapartum, and postpartum services to mothers and babies in under served areas.
- Better quality care for consumers due to practitioner access to lab testing, physician consultant and referral.
- Continuity of care- seeing one practitioner to regularly monitor specific conditions or situations which may arise during the pregnancy. It also allows the consumer to bond with her midwife and develop a sense of trust and security. This enhances the quality and safety of her birth experience.
- Setting a standard of care in the community.
- Providing a channel for positive and negative feedback from consumers.
- Ensuring continuing education for midwives.
- Enables referrals among midwives to provide consumers with a caregiver who can best serve them financially, geographically, and physically.

**11. Please detail the specific specialized skill or training that distinguish the occupation or profession from ordinary labor.**

Midwives train in a variety of settings including clinics, offices, homes and hospitals in 2-3 year programs that combine a course of study with a clinical apprenticeship. Although the settings vary, the CPM's training primarily focuses on situations which occur in the home setting.* Throughout training, a holistic approach emphasizes pregnancy and birth as normal life events, giving midwives the foundation and ability to teach their clients how to take responsibility for their own well being. This includes childbirth education, exercise and the importance of good nutrition to physically and mentally prepare women and families for birth. CPM's' specialized skills include risk assessment, nutritional concealing, neonatal resuscitation, CPR, the ability to assess what is within the parameters of normal pregnancy and labor, and efficiency in palpitation without great reliance on ultrasound. The CPM credential is the only midwifery certificate that requires out of hospital experience.

**12. What are the other qualities of the profession or occupation that distinguish it from ordinary labor?**

The Certified Professional Midwife (CPM) is an international credential created by the North American Registry of Midwives that promotes the Midwifery Model of Care which is based on the fact that pregnancy and birth are normal life events. It includes:

- monitoring the physical, psychological, and social well being of the mother throughout the childbearing cycle:
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- minimizing technological interventions; and
- identifying and referring women who require obstetrical attention.

Other qualities which that set midwives apart from ordinary labor are:

- **Only CPMs are required to have experience in out of hospital births.**
- The midwife is on call and available to clients 24 hours a day, 7 days a week.
- The midwife stays with her client throughout labor, delivery, and postpartum periods even if the client is transferred to the hospital.
- The relationship built between the birthing families and the midwife establishes trust between the parties and enables the midwife to address specific needs of the birthing family/mother.
- Lengthy and thorough prenatal visits typically lasting for of at least 1 hour per client.
- Postpartum visits done at home to check mother and baby's well being and ensure nursing is established.
- Midwives maintain flexible schedules to accommodate working parents.
- Midwives view the whole family as being integral parts of the birth experience during the pregnancy as well as the actual birth!
- Midwives maintain a high regard for the bonding of the baby with mother and family after the birth. The baby is encouraged to nurse right away and remain with the mother at all times.

The application of this woman centered model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

*see attachment # 4 The Educational Requirements of a CPM

**13. Will licensing requirements cover practicing members of the occupation or profession? If any practitioners will be exempt, what is the rational for exemption?**

Certification will apply to all midwives who wish to practice legally. The only rational for exemption would be someone who lives in a religious community, doing births within the community and neither advertising nor asking for payment for services rendered.

**14. What is the approximate number of persons who will be regulated and the number of persons likely to utilize the services of the occupation or profession?**

Currently there are approximately 15-20 CPM's in North Carolina. This number does not include midwives who are not members of the NCMA. It is common knowledge that there are other midwives practicing but because they lack legal status, it is impossible to identify them. Midwives serve 1-2% of the population. However, upon legal recognition of the CPM model, the number of certified midwives is expected to increase, as is the client base.

**15. What kind of knowledge or expertise does the public need to evaluate the services offered by the practitioners?**

Consumers should be able to speak with a variety of caregivers to access who is best suited to her/their needs and visions for a birth experience.* The public needs to have a clear understanding of the differences between home, birth center, and hospital births and the risks associated with each. In addition, a woman/family considering out of hospital birth needs to understand her level of responsibility for her good health and the well being of her baby. Most midwives routinely give their prospective clients an informed consent document which explains their training, education and philosophy. All CPM's are required to develop informed consent forms.

**16. Does the occupational group have an established code of ethics, a voluntary certification program, or other measures to ensure a minimum quality of service?**

In North Carolina most of the CPM's are members of the North Carolina Midwifery Alliance. The membership is open to all types of midwives and is made up of CPM's, CNM's and midwives with no credentials at all. The NCMA has voluntarily adopted a code of ethics ** and in recent months has been finalizing a risk assessment for use by it's members.

The CPM credential was created to meet the needs of midwives internationally who were seeking voluntary certification to validate their training and skills in countries and states where no such credential existed. The CPM credential ensures a minimum quality of service through its initial education requirements as well as the continuing education requirements *** and peer review .

- * see attachment # 5, Questions to Ask the Midwife
- ** see attachment # 6, NCMA Code of Ethics
- *** see attachment # 7, CPM continuing education requirements

# ADVANTAGES OF USING THE CERTIFIED PROFESSIONAL MIDWIFE (CPM) FOR STATE LICENSURE AND CERTIFICATION

- ✓ **Meets rigorous credentialing standards**
- ✓ **Validates knowledge, skills and experience**
- ✓ **Is a competency-based evaluation process**
- ✓ **Uses "state-of-the art" testing technology**
- ✓ **Incorporates two (2) examinations**
  - **NARM Written Examination**
  - **NARM Skills Assessment**
- ✓ **Sets a standard for public safety**
- ✓ **Provides a means for reciprocity**
- ✓ **Is cost effective**
- ✓ **Is legally defensible**
- ✓ **Sets a national standard for licensure**
- ✓ **Provides a means of obtaining third party reimbursement**

## Documented Evidence Supporting The Safety Of Out-of-Hospital Deliveries

Evidence published in following literature strongly supports the contention that Midwives who a) have obtained the requisite skills, b) provide care to women who are considered low risk at the initiation of labor and c) have access to obstetrical backup within a reasonable time frame, can provide care that is as safe as in a hospital.

- *Midwifery in America*, a recently published book by epidemiologist Judith Rooks, who was employed as a perinatal epidemiologist for several years by the Centers for Disease Control, concludes in the 70 page chapter on the safety of home birth that "trained midwives can provide a similar level of safety that hospital care provides.

- *Cochrane Database,* systematically reviewed the existing published literature and concluded "that no empirical evidence supports the claim that hospital births are a safer option than planned home birth."

- *Where to be Born*, a book published in 1994 by the National Perinatal Epidemiology Unit at Oxford, which reviews the home birth research from Britain over the past 40 years. The recent statistical review found "There is no evidence to support the claim that the safest policy is for all women to give birth within a hospital"...

- *British Medical Journal* , Fall of 1996, four high quality epidemiological studies and a published editorial all strongly support the headline, "Home Birth: A safe alternative for low risk women."

## The Midwifery Model of Care Proves to be Cost Effective

The average cost of a midwife-attended out-of-hospital birth in the U.S. is $1,200, compared to $4,200 for a physician attended vaginal birth.

***Estimated Health Care cost savings obtainable by utilizing midwifery care for 75% of pregnancies in the U.S.: $8.5 Billion per year**

Studies published in the last few years in such prestigious journals as *The New England Journal of Medicine* and *The Lancet* have shown that ,in the absence of specific indications for it's use, Electronic Fetal Monitoring not only has no demonstrated benefits in reducing childhood disabilities, but may even he dangerous. (Archie Brodsky- a senior research associate at the Harvard Medical Schools Program in Psychiatry and the Law)

***Estimated Health Care cost savings obtainable by eliminating routine use of Continuous Electronic Fetal Monitoring: $675 Million per year**

North Carolina's current Cesarean Section rate is *23%. Unnecessary Cesarean Sections, Curing a National Epidemic,* Mary Gabay and Sidney M. Wolfe, M.D

***Estimated Health Care cost savings obtainable by bringing U.S. Cesarean Section rates into compliance with World Health Organization recommendations of 10-15%: $1.5 Billion per year**

***From $13 billion to $20 billion a year could be saved in health care costs by developing midwifery care, demedicalizing childbirth, and encouraging breast-feeding.**

*Frank A Oski. MD. professor and director. Department of Pediatrics.
John Hopkins University, Baltimore

North Carolina Midwifery Alliance P.O. 2156, Rutherfordton, NC 28139

# The Educational Requirements of a CPM

The North American Registry of Midwives (NARM) administers the Certified Professional Midwife (CPM) credential, the ONLY national credential that sets the standard for education and certification of midwives who practice primarily in out-of-hospital settings.

The NARM Written Examination is used in ALL 15 states that have a regulatory process.

I. A CPM can be educated through a variety of routes including:
- ♦ Programs accredited by Midwifery Educational Accreditation Council
- ♦ Certified as a Certified Nurse Midwife/Certified Midwife
- ♦ NARM Portfolio Evaluation Process (PEP)

II. A CPM must have didactic education that includes:
- A. The Core Competencies developed by the Midwives' Alliance of North America, which include anatomy and physiology relevant to childbirth
- B. Content Areas
  - ✍ Midwifery Counseling, Education and Communication
  - ✍ General Health care Skills
  - ✍ Maternal Health Assessment
  - ✍ Prenatal
  - ✍ Labor, Birth and Immediate Postpartum
  - ✍ Postpartum
  - ✍ Well-Baby Care
- C. Skills areas included in the *Practical Skills Guide for Midwives*

III. NARM requires that the clinical component of the educational process:
- ✔Be at least one year in duration
- ✔Include a minimum of 1350 clinical contact hours
- ✔Be under the supervision of one or more preceptors

IV. The clinical component must include:

A. After observations, the applicant must attend a minimum of 20 births as an *active participant*.

B. Functioning in *the role of primary midwife* under supervision*, the applicant must attend a minimum of:

1. An additional 20 births:
   a. A minimum of 10 of the 20 births attended must be in homes or other out-of-hospital settings; and
   b. A minimum of 3 of the 20 births attended must be with women for whom the applicant has provided at least 4 prenatal visits, the birth, a newborn exam, and 1 postpartum exam.
2. 75 prenatal exams, including 20 initial exams;
3. 20 newborn exams;
4. 40 postpartum exams.

V. NARM Skills Assessment

VI. The NARM Written Examination is the final step. This is a 350 question exam, requiring approximately 8 hours to complete. Students who successfully complete one of the above educational programs may sit for the NARM Written Examination.

Questions to Ask the Midwife *

1. What is your education and training as a midwife?
2. How many years have you been practicing?
3. What is your general philosophy about pregnancy and birth?
4. Are you a mother yourself? How old are your children ?
5. How were your children born?
6. Do you work alone or with a partner or assistant? If you work with someone, what is his or her experience?
7. How many births have you attended as the primary caregiver?
8. Do you attend births in a birthing center, hospital, or at home?
9. How many births are you attending now?
10. Who takes over for you if you go on vacation or get sick?
11. Do you have guidelines of restrictions about who can give birth at home?
12. Do you require that I see a physician during my pregnancy even if everything is all right?
13. What are your fees and what do they include?
14. Does insurance cover fess for your services?
15. What payment arrangements do you make?
16. How often will I see you?
17. What are your guidelines concerning weight gain, nutrition, and exercise?
18. Do you require that I take a childbirth education class? Do you teach a childbirth preparation class?
19. If I'm planning a home birth, do you come to my home anytime before I go into labor?
20. When should I call you after my labor begins?

21. How so you handle emergencies?

22. How many women whom you have attended have had to go to the hospital?

23. In what situation would I have to go to the hospital?

24. Would you be permitted to stay with me in the hospital?

25. What kind of equipment do you bring to a birth?

26. Do you examine the baby after birth?

27. Do you have a pediatrician you work with or recommend?

28. Can my partner and children be as involved in the birth as we wish?

29. How often do you come see me after I give birth?

30. Do you provide or know of anyone who will help new mothers after birth?

31. Will you help me with breast-feeding?

32. What can you tell me about circumcision?

* Taken from Gentle Birth Choices By Barbara Harper, R.N. copyright 1994
Please see book for more information!

# CODE FOR ETHICAL MIDWIFERY PRACTICE

The adoption of a code of ethics is one way to achieve the goal of safe midwifery care in North Carolina. Additionally, the observance of ethical standards increases an awareness of midwifery, by both current and future practitioners, as a unique calling, responsive to the needs of birthing women. Finally, articulation of ethical standards is essential to the recognition of midwifery as a profession by the broader society.

A. CLIENT RIGHTS

An ethical midwife will respect the personal rights of her clients, including:

1. The right to be treated with respect and dignity without reference to age, marital, socioeconomic, ethnic, national, political, mental, physical, or religious status.

2. The right to use informed choice in her care, by having access to relevant information upon which to base decisions.

3. The right to freedom from coercion in decision making.

4. The right to accept or refuse treatment.

5. The right to full disclosure of financial factors involved in her care at the initial interview or prenatal.

6. The right to know who will participate in her care and obtain additional consultation of her choice.

7. The right not to be abandoned, neglected, or discharged from care without opportunity to find other care.

8. The right to absolute privacy except where this right is pre-empted by law.

B. MIDWIFE RIGHTS

A midwife recognizes the importance of respect for her own rights as a care provider, including:

1. The right to refuse care to clients with whom no midwife/client relationship has been established.

2. The right to discharge clients from her care, provided adequate referral to other care is extended.

3. The right to receive honest, relevant information from clients upon which to base care.

4. The right to receive reasonable compensation for services rendered.

C. MIDWIFE RESPONSIBILITIES

A midwife recognizes certain obligations and responsibilities which are intrinsic to ethical midwifery practice, including:

1. The obligation to serve as the guardian of normal birth, alert to possible complications but always on guard against arbitrary interference in the birthing process for the sake of convenience or the desire to use human beings in scientific studies and training.

2. To respect the client's right of confidentiality except in the case where vital information must be shared with other care providers. Inform the client of this up front.

3. The obligation to provide complete, accurate and relevant information to the client so that she can make informed choices regarding her health care.

4. The obligation, when referring a client to another health care provider, to remain responsible for the client until she is either discharged or formally transferred.

5. The obligation to refrain from gossip about other midwives, and to discuss concerns directly with the midwife personally first.

6. The responsibility to develop and utilize a safe and efficient mechanism for medical consultation, collaboration, and referral, in keeping with your region's standard of practice.

7. The obligation to continue professional development through ongoing evaluation of knowledge and skills, and continuing education, including diligent study of all subjects relevant to midwifery practice.

8. The responsibility to assist others who wish to become midwives by honestly and accurately evaluating their potential and competence, and sharing midwifery knowledge and skills, to the degree possible without violating another section of this code.

9. The responsibility to maintain accountability for all midwifery care delivered under her supervision. Assignment and delegation of duties to other midwives or apprentices should be equal to their educational preparation and demonstrated proficiency.

10. The obligation to accurately document the client's history, condition, physical progress and other vital information obtained during client care.

D. UNPROFESSIONAL CONDUCT

Conduct by a midwife which is likely to deceive, defraud or injure clients, or which results from conscious disregard for the health and welfare of the client under the midwife's care, includes:

1. Knowingly or consistently failing to accurately document a client's condition, responses, progress, or other information obtained during care. This includes failing to make entries, destroying entries, or making false entries in records pertaining to midwifery care.

2. Performing or attempting to perform midwifery techniques or procedures in which the midwife is untrained by experience or education.

3. Failing to give care in a reasonable and professional manner, including maintaining a client load which does not allow for personalized care by the primary attendant; or having a practice radius which covers such a large area, as to make impossible personal attention and safe midwifery care.

4. Client Abandonment

   a. Discharging a client without ethical reason and/or appropriate referral to another caregiver

   b. Leaving a client intrapartum or postpartum without providing adequate care for mother and infant

5. Failure to disclose what midwifery services are included in the fee, and expectation of the fee payment schedule.

6. Delegation of midwifery care or responsibilities to a person who lacks the ability or knowledge to perform the function or responsibility in question.

7. Manipulating or affecting a client's decisions by withholding or misrepresenting information, in violation of the client's right to make informed choices in her health care.

8. Failure to participate in the peer review guidelines adopted by NCMA.

# Recertification

*Please retain this information for your records.*

- Certification Renewal begins January 1998.
- Certification renewal is due every three years.
- Notification, including the necessary Recertification Forms will be sent 3 months before the NARM Certification lapses.
- Thirty (30) Continuing Education Contact Hours are required during the three year period.
- One Contact Hour is defined as fifty five (55) clock minutes of time. To be awarded .5 (half ) Contact Hours the time period is thirty (30) minutes to fifty five (55) minutes. Less than 30 contact minutes will ***not*** be awarded Continuing Education Contact Hours.

## MANDATORY AREAS

A. Peer Review--5 Contact Hours
   Participates in Peer Review *and or*
   Attends Peer Review Workshop
B. Current Adult CPR and either infant CPR or Neonatal Resuscitation
C. Affirmation of current use of Informed Consent
D. Demographic information

## TWO OPTIONS FOR RECERTIFICATION

1. MANDATORY AREAS+ 25 Contact Hours from a mixture of Categories

2. MANDATORY AREAS+ Retaking the NARM Written Examination.

## CONTINUING EDUCATION CATEGORIES

*Category 1* (maximum-25 Contact Hours) MEAC, ACNM, BRN, ACOG, ASPO/Lamaze and ICEA are examples approved sources for Continuing Education Contact Hours

Any class or course work that is granted Contact Hours in a health profession related to women's health or midwifery.

*Category 2* (maximum-10 Contact Hours)
Course work or classes in women's health and midwifery, or in related fields that are not otherwise approved for Contact Hours.

*Category 3* (maximum-15 Contact Hours)
Documented Research in the field of midwifery , women's health or related fields.

A. Each project will be granted 10 Contact Hours.
   - Articles, thesis, creation of modular course work based on research.

B. Each project will yield 5 Contact Hours
   - Writing as a contributing author in a larger work for publication.
   - Writing technical or experience based articles intended for publication

# Recertification (continued)

C. Teaching classes or facilitating course work related to midwifery or women's health. Each hour of teaching earns one hour of CONTACT HOUR credit.

*Category 4* (maximum-10 Contact Hours)
Document self study or life experience on the form provided. One contact hour equals one CONTACT HOUR.

*Category 5* (maximum-5 Contact Hours) Serving as a Qualified Evaluator (QE)

*Category 6* ( maximum-9 Contact Hours)
Filing MANA Statistics Forms

3 Contact Hours for every 30 MANA Statistics forms

# CPM Certification

- Meets ***rigorous credentialing standards***
- Sets a standard for ***public safety***
- Is the ***"state of the art" in testing technology***
- Is a ***legally defensible process***
- Provides a means for ***reciprocity*** between states
- Provides a ***standard for legislation and state agencies***
- Provides means of obtaining ***third party reimbursement.***

**80% of the babies born in the world today are received into the caring, skillful hands of midwives.**

For More Information.....
Contact:


**The North American Registry of Midwives**
1-888-84-BIRTH (888-842-4784) (C)
CPMinfo@aol.com

**Midwives' Alliance of North America (MANA)**
MANAinfo@aol.com
1-316-283-4543 (C)
1-888-923-6262

**Midwifery Education and Accreditation Council**
220 W. Birch
Flagstaff, AZ 86001
AMABAUL@aol.com
520-214-0997 (C)


***About NARM***

Created in 1987 by the Midwives' Alliance of North America (MANA), NARM is committed to identifying standards and practices that reflect the excellence and diversity of the independent midwifery community in order to set the standard for North American midwifery.

updated 5/98

# The Certified Professional Midwife *(CPM)*

The North American Registry of Midwives

**CPM**

**An International Credential that Promotes the *Midwifery Model of Care***

## THE *CPM*

The ***Certified Professional Midwife*** (CPM) is a response to the public outcry for the *Midwifery Model of Care.*

## A Problem: *the Escalating Maternity Care Crisis*

- Escalating costs
- Unnecessarily high neonatal mortality rates
- Increased use of unnecessary technology
- Unreasonably high cesarean rates,
- Decreasing public satisfaction

***Certified Professional Midwives (CPMs)*** **are skilled professionals qualified to provide the *Midwifery Model of Care*, which is appropriate for the majority of births.**

## The Solution: *the Midwifery Model of Care*

The ***Midwifery Model of Care*** is based on the fact that pregnancy and birth are normal life events.

The ***Midwifery Model of Care*** includes:

- monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- minimizing technological interventions;
- and identifying and referring women who require obstetrical attention.

The application of this woman-centered model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

## How NARM Certification Benefits Government Agencies:

- Cost-effective
- Legally defensible
- May be tailored to meet agency needs

## *CPM* Certification

The North American Registry of Midwives (NARM) is an international certifying body that evaluates and validates midwifery knowledge, skills and experience using three components:

- The **application** process validates experience;
- The **Written Examination** is a test of the knowledge and skills required of a competent midwife;
- The **Skills Assessment** is a hands-on evaluation of essential midwifery skills by a Qualified Evaluator.

The latter two components of the certification process may be used independently for state licensing.

## ARTICLE 10A.
## Practice of Midwifery.



### § 90-178.1. Title.

This Article shall be known and may be cited as the Midwifery Practice Act.

(1983, c. 897, s. 1.)

**Editor's Note.** - Session Laws 1983, c. 897, s. 3 provides: "This Act shall become effective October 1, 1983. Any person who on October 1, 1983, had been a practicing midwife in North Carolina for more than 10 years may continue to assist at childbirth without approval under this Article. Any other person authorized to practice midwifery on September 30, 1983, may continue to practice midwifery without approval under this Article until April 1, 1984. No annual fee shall be collected for 1983."

**Legal Periodicals.** - For note, "Nurse Malpractice in North Carolina: The Standard of Care," see 65 N.C.L. Rev. 579 (1987).

### § 90-178.2. Definitions.

As used in this Article:

(1) "Interconceptional care" includes but is not limited to:

a. Family planning;

b. Screening for cancer of the breast and reproductive tract; and

c. Screening for and management of minor infections of the reproductive organs;

(2) "Intrapartum care" includes but is not limited to:

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; and

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f. Repairing lacerations associated with childbirth.

(3) "Midwifery" means the act of providing prenatal, intrapartum, postpartum, newborn and interconceptional care. The term does not include the practice of medicine by a physician licensed to practice medicine when engaged in the practice of medicine as defined by law, the performance of medical acts by a physician assistant or nurse practitioner when performed in accordance with the rules of the North Carolina Medical Board, the practice of nursing by a registered nurse engaged in the practice of nursing as defined by law, or the rendering of childbirth assistance in an emergency situation.

(4) "Newborn care" includes but is not limited to:

a. Routine assistance to the newborn to establish respiration and maintain thermal stability;

b. Routine physical assessment including APGAR scoring;

c. Vitamin K administration; and

d. Eye prophylaxis for opthalmia neonatorum.

(5) "Postpartum care" includes but is not limited to:

a. Management of the normal third stage of labor;

b. Administration of pitocin and methergine after delivery of the infant when indicated; and

c. Six weeks postpartum evaluation exam and initiation of family planning.

(6) "Prenatal care" includes but is not limited to:

a. Historical and physical assessment;

b. Obtaining and assessing the results of routine laboratory tests; and

c. Supervising the use of prenatal vitamins, folic acid, iron, and nonprescription medicines.

(1983, c. 897, s. 1; 1995, c. 94, s. 30.)

**§ 90-178.3. Regulation of midwifery.**

(a) No person shall practice or offer to practice or hold oneself out to practice midwifery unless approved pursuant to this Article.

(b) A person approved pursuant to this Article may practice midwifery in a hospital or non-hospital setting and shall practice under the supervision of a physician licensed to practice medicine who is actively engaged in the practice of obstetrics. A registered nurse approved pursuant to this Article is authorized to write prescriptions for drugs in accordance with the same conditions applicable to a nurse practitioner under G.S. 90-18.2(b).

(1983, c. 897, s. 1.)

**§ 90-178.4. Administration.**

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(a) The joint subcommittee of the North Carolina Medical Board and the Board of Nursing created pursuant to G.S. 90-18.2 shall administer the provisions of this Article and the rules adopted pursuant to this Article; Provided, however, that actions of the joint subcommittee pursuant to this Article shall not require approval by the North Carolina Medical Board and the Board of Nursing. For purposes of this Article, the joint subcommittee shall be enlarged by four additional members, including two certified midwives and two obstetricians who have had working experience with midwives.

(b) The joint subcommittee shall adopt rules pursuant to this Article to establish:

(1) A fee which shall cover application and initial approval up to a maximum of one hundred dollars ($100.00);

(2) An annual renewal fee to be paid by January 1 of each year by persons approved pursuant to this Article up to a maximum of fifty dollars ($50.00);

(3) A reinstatement fee for a lapsed approval up to a maximum of five dollars ($5.00);

(4) The form and contents of the applications which shall include information related to the applicant's education and certification by the American College of Nurse-Midwives; and

(5) The procedure for establishing physician supervision as required by this Article.

(c) The joint subcommittee may solicit, employ, or contract for technical assistance and clerical assistance and may purchase or contract for the materials and services it needs.

(d) All fees collected on behalf of the joint subcommittee and all receipts of every kind and nature, as well as the compensation paid the members of the joint subcommittee and the necessary expenses incurred by them in the performance of the duties imposed upon them, shall be reported annually to the State Treasurer. All fees and other moneys received by the joint subcommittee pursuant to the provisions of the General Statutes shall be kept in a separate fund by the joint subcommittee, to be held and expended only for such purposes as are proper and necessary to the discharge of the duties of the joint subcommittee and to enforce the provisions of this Article. No expense incurred by the joint subcommittee shall be charged against the State.

(e) Members of the joint subcommittee who are not officers or employees of the State shall receive compensation and reimbursement for travel and subsistence expenses at the rates specified in G.S. 138-5. Members of the joint subcommittee who are officers or employees of the State shall receive reimbursement for travel and subsistence expenses at the rate set out in G.S. 138-6.

(1983, c. 897, s. 1; 1995, c. 94, s. 31.)

**§ 90-178.5. Qualifications for approval.**

In order to be approved by the joint subcommittee pursuant to this Article, a person shall:

(1) Complete an application on a form furnished by the joint subcommittee;

(2) Submit evidence of certification by the American College of Nurse-Midwives;

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(3) Submit evidence of arrangements for physician supervision; and

(4) Pay the fee for application and approval.

(1983, c. 897, s. 1.)

**§ 90-178.6. Denial, revocation or suspension of approval.**

(a) In accordance with the provisions of Chapter 150B, the joint subcommittee may deny, revoke or suspend approval when a person has:

(1) Failed to satisfy the qualifications for approval;

(2) Failed to pay the annual renewal fee by January 1 of the current year;

(3) Given false information or withheld material information in applying for approval;

(4) Demonstrated incompetence in the practice of midwifery;

(5) Violated any of the provisions of this Article;

(6) A mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice midwifery;

(7) Engaged in conduct that endangers the public health;

(8) Engaged in conduct that deceives, defrauds, or harms the public in the course of professional activities or services; or

(9) Been convicted of or pleaded guilty or nolo contendere to any felony under the laws of the United States or of any state of the United States indicating professional unfitness.

(b) Revocation or suspension of a license to practice nursing pursuant to G.S. 90-171.37 shall automatically result in comparable action against the person's approval to practice midwifery under this Article.

(1983, c. 897, s. 1; 1987, c. 827, s. 1.)

**Legal Periodicals.** - For note, "Nurse Malpractice in North Carolina: The Standard of Care," see 65 N.C.L. Rev. 579 (1987).

**§ 90-178.7. Enforcement.**

(a) The joint subcommittee may apply to the Superior Court of Wake County to restrain any violation of this Article.

(b) Any person who violates G.S. 90-178.3(a) shall be guilty of a Class 3 misdemeanor.

(1983, c. 897, s. 1; 1993, c. 539, s. 633; 1994, Ex. Sess., c. 24, s. 14(c).)

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*ATTACHMENT C*

# COMPARISON OF CERTIFIED NURSE MIDWIVES (Article 18A of Chapter 90 of the NCGS) & CERTIFIED PROFESSIONAL MIDWIVES (As proposed by SB 875/HB 1077)

| | CERTIFIED NURSE MIDWIFE<br>*Approved Under Article 10A of Chapter 90 of the General Statutes* | CERTIFIED PROFESSIONAL MIDWIFE<br>*As Proposed Under SB 875/HB 1077* |
|---|---|---|
| **Qualifications** | Must be certified by American College of Nurse Midwives (ACNM) which requires<br>• Licensure as a registered nurse.<br>• Satisfactory completion of a nurse midwife program accredited by the ACNM.<br>• Passage of certification exam. | Must be certified by the North American Registry of Midwives (NARM) which requires:<br>• Satisfactory completion of educational process which may include,<br>➢ Programs accredited by the Midwifery Educational Accreditation Council.<br>➢ Certification as a Certified Nurse Midwife/Certified Midwife.<br>➢ NARM Portfolio Evaluation Process.<br>• Passage of NARM written examination. |
| **Definition of "Midwifery"** | *G.S. 90-178.2(3)* defines "midwifery" as the provision of the following types of care:<br><u>Prenatal</u><br>• Historical and physical assessment;<br>• Obtaining and assessing results of routine lab tests; and,<br>• Supervising use of prenatal vitamins, folic acid, iron, and non-prescription medications.<br><br><u>Intrapartum</u><br>• Attending women in uncomplicated labor.<br>• Assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation.<br>• Performing amniotomy.<br>• Administering local anesthesia.<br>• Performing episiotomy and repair.<br>• Repairing lacerations associated with childbirth. | *SB 875/HB 1077* define "midwifery" as the provision of the following types of care:<br><u>Prenatal</u><br>• Historical and physical assessments;<br>• Obtaining and assessing the results of routine lab tests; and,<br>• Supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medications.<br><u>Intrapartum</u><br>• Assisting women during uncomplicated labor.<br>• Assisting with the spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation.<br>• Performing anmiotomy.<br>• Performing emergency episiotomies and repairing lacerations with the use of local anesthesia. |

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| | CERTIFIED NURSE MIDWIFE<br>*Approved Under Article 10A of Chapter 90 of the General Statutes* | CERTIFIED PROFESSIONAL MIDWIFE<br>*As Proposed Under SB 875/HB 1077* |
|---|---|---|
| | Postpartum<br>• Management of the normal third stage of labor.<br>• Administration of pitocin and methergine after delivery of infant.<br>• 6 week postpartum evaluation exam and initiation of family planning.<br><br>Newborn<br>• Routine assistance to newborn to establish respiration and maintain thermal stability.<br>• Routine physical assessment, including APGAR scoring.<br>• Vitamin K administration.<br>• Eye prophylaxis for opthalmia neonatorum.<br>Intraconceptional<br>• Family planning.<br>• Screening for cancer of the breast and reproductive tract.<br>• Screening for management of minor infections of the reproductive organs. | Postpartum<br>• Management of normal third stage of labor.<br>• Administration of oxytoxic drugs after delivery in an emergency.<br>• Performance of evaluation examinations in the days and weeks following delivery.<br>• Repair of first and second degree lacerations resulting from childbirth.<br>Newborn<br>• Routine assistance to newborns to establish respiration, including use of oxygen, and maintaining thermal stability.<br>• Routine physical assessment, including APGAR scoring.<br>• Eye prophylaxis for opthalmia neonatorum. |
| **Authorized to practice in** | Hospitals and out-of-hospital settings. | Out-of-hospital settings (primarily home births) |
| **Supervision** | Must be supervised by licensed obstetrician. | SB 875/HB 1077 do not address supervision. |
| **Authorization to prescribe medications** | May write prescriptions in accordance with same conditions as apply to nurse practitioners. | |
| **Fees** | Application/Initial Approval $100.00<br>Annual Renewal $50.00<br>Reinstatement $5.00<br><br>*(No fee changes since 1983)* | Issuance of Approval $200.00<br>Renewal of Approval (every 3 years) $150.00<br>Reinstatement $200.00<br>Late Fee $25.00 |
| **Approved by** | Joint Subcommittee of the NC Medical Board and the NC Board of Nursing | North Carolina Supervisory Council of Certified Professional Midwives. |