LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

Assessment Report
For

Certified Professional Midwives

House Bill 1014
Senate Bill 498

LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

June 6, 2001

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

Ed McMahan

Representative Ed McMahan, Chair

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LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS
(2000-2001)

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PREFACE

The Legislative Committee on New Licensing Boards is a joint committee of the House and Senate created and governed by statute (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.

HOUSE BILL 1014 & SENATE BILL 498

CERTIFIED PROFESSIONAL MIDWIVES

BACKGROUND[1]

With regard to HB 1014/SB 498, 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 are currently 15 -- 20 people who practice midwifery who are not certified nurse midwives but 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 Questionnaire for the Legislative Commission on New Licensing Boards.* 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 HB 1014/SB 498) is found in Attachment C.

certification set by the North American Registry of Midwives (NARM). This number includes only those midwives who are members of the North Carolina Midwifery Alliance.

PROPOSED LICENSURE

HB 1014/SB 498
Certified Professional Midwives

Regulatory Board.

Composition of the Board. The bills establish the North Carolina Supervisory Council of Certified Professional Midwives whose membership is as follows:

Initial Membership:

- One certified professional midwife appointed by the President Pro Tempore of the Senate.
- Two women who have received care from a certified professional midwife, one appointed by the President Pro Tempore of the Senate and one appointed by the Speaker of the House
- One licensed physician who has experience working with midwives practicing in out-of-hospital settings, appointed by the Speaker of the House.
- Two certified professional midwives, appointed by the Governor.
- One certified nurse midwife with experience in out-of-hospital births, 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 and Duties. The Council will have the following powers and duties:

- Examine and determine the qualifications and fitness of applicants.
- Issue, renew, deny, suspend, or revoke approvals.

- Maintain a list of the names and addresses of persons who have been approved.
- Conduct investigations.

Disciplinary Authority. The Council may require remedial education, issue a letter of reprimand, deny, refuse to renew, suspend, or revoke an application or approval if the licensee:

- Gives false information or fails to disclose information in attempting to obtain approval or during the course of any investigation by the Council.
- Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice midwifery, or indicates that the person has deceived, defrauded, or endangered the public.
- Has a habitual substance abuse problem or mental impairment that interferes with the ability to provide appropriate care.
- Has demonstrated gross negligence, incompetency, or misconduct in the practice of midwifery.
- Has had an application for approval or approval to practice midwifery in another jurisdiction denied, suspended, or revoked.
- Has willfully violated the midwifery statute or Council rules.

Injunctions. The Board may seek an injunction against any person who violates the midwifery statute.

Licensure. Any person who performs midwifery must be approved by the Council. "Midwifery" is defined as the "provision of prenatal, intrapartum, and postpartum care for women experiencing normal pregnancies and newborn care for their infants in out-of-hospital settings." Midwifery specifically does not include the practice of medicine.

Exemptions. The following persons would be exempt from approval under the bills:

- Certified nurse midwives.
- Licensed physicians.
- Physician Assistants.
- Nurse Practitioners.
- Nurses.
- Persons rendering childbirth assistance in an emergency situation.
- Individuals who are present at or assisting the certified nurse midwife.
- Midwifery students or assistants who are under the supervision of a certified nurse midwife.
- Persons providing emergency medical care.

Qualifications.

Initial Approvals: An applicant for approval as a certified professional midwife must:

- Be at least 21 years old.
- Have obtained a high school diploma or its equivalent.
- Submit evidence of certification by the North American Registry of Midwives.
- Submit a client-informed consent document which includes:
    - Disclosure of the CPM's qualifications, experience, and training.
    - Written protocol for medical emergencies and transportation to a hospital.
    - Description of the midwifery model of care.
    - Description of the right to file a complaint.
    - Any other information deemed necessary by the Council.
- Have proof of current adult and infant CPR.

Renewals. Approvals will be renewed upon proof of current certification by the North American Registry of Midwives, including:

- Current adult and infant CPR.
- At least five hours of certified education units in a peer review workshop, or five hours of peer review participation.
- 25 hours of continuing education.

Reciprocity. The Council is authorized to approve an applicant, without examination, for any person who resides in North Carolina and has been approved to practice midwifery in another state whose standards of competency are substantially equivalent to those in North Carolina.

Maximum Licensure Fees. The bills impose the following fees on all persons applying for or renewing approvals as a certified professional midwife:

Fee Type	Maximum Fee Amount
Initial issuance of approval	$400.00
Renewal of approval (every 3 years)	$250.00
Late renewal fee	$150.00

FINDINGS AND RECOMMENDATIONS

Findings. On June 6, 2001, the Committee found that House Bill 1014 and Senate Bill 948 are substantially the same as House Bill 1077 and Senate Bill 875 reviewed by the Committee on May 30, 2000. Therefore, the Joint Legislative Committee on New Licensing Boards again finds 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 House Bill 1014 and Senate Bill 948:

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.

Recommendation. The Joint Legislative Committee on New Licensing Boards again recommends that the provisions of House Bill 1014 and Senate Bill 948 be considered by a substantive committee.

ATTACHMENT A

Response to Questionnaire for

HB 1014/SB 498

CERTIFIED PROFESSIONAL MIDWIVES

Assessment Report, For the Legislative Committee on New Licensing Boards

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

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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.

4/12/00

QUESTIONS FOR THE LEGISLATIVE COMMITTEE
ON NEW LICENSING BOARDS

(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 the Certified Professional Midwife bills are not seeking licensure, but legal recognition of 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 compiled. Members of the state's Midwifery Study Committee and staff of the Department of Human Resources conducted this study. The report defines midwifery, not as the practice of medicine but as health care activities performed to assist pregnant and delivering women and newborn infants. 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 homebirths 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 midwifery law, statue # 90-178.1, Chp. 90, Article 10 A, which resulted from the '83 legislation, granted practice privileges to one midwife doing home birth and nurse-midwives. Although there were several midwives practicing at the time, only one home-birth midwife, Lisa Goldstein from Yancy County, was recognized in '83 because she had documentation which proved she had been practicing in NC for over ten years.

The study's results went on to suggest ways to "ensure that candidates for approval to practice midwifery have fulfilled and educational and experiential standard established either by the American College of Nurse Midwives or an equivalent standard for midwives who are not nurses." Unfortunately, the law did not provide an avenue for other practicing midwives to work their way into the system. Since that time a national standard for midwives who are not nurses has been established, the Certified Professional Midwife (CPM), and is being used by all of the states which have a regulatory process for midwives practicing outside the hospital. This credential would fulfill the requirements of the report. Without NC recognizing this new credential, the consumers are left with little or no choice of care provider – only 4-6 nurse midwives choose to practice outside the hospital and they all work in a small area in western North Carolina. Not only are we limiting the consumers choices, but midwives who move to NC from other states who are CPMs or LMS (licensed midwives) are finding that they cannot legally practice.

In light of the current status of midwifery in North Carolina, 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, as well as the findings of the General Assembly' study.

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 supportive 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 by 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. There have been two separate incidents which raised complaints, one from a physician and one from a local health department. Both complaints found their way to the District Attorney's office, which assisted in investigations.

The first case occurred in1992. The 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. She can be reached at 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 for technical reasons, the 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' are unable 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 are unable to get physicians to consult, back up, or cooperate with midwives.
- 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.
- Midwives are unable 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 midwifery credentials to show a competent level of training, some women seeking midwifery care may receive substandard care.
- Adherence to a community standard of care is currently not mandatory.
- With no state recognition of a 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.
- Currently, with drastically limited access to legal, home birth midwives in North Carolina, some consumers choose to birth at home with no attendant.

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 for a low-risk, healthy woman 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, where we have the 5th highest rate of infant mortality (9.2 per 1000 live births) in the country and where we have 30 counties which do not have a practicing obstetrician, current legislation does not legally prevent families from having their babies at home. It does, however, prevent them from legally having a skilled midwife with them- unattended birth being a situation which dramatically increases infant mortality. 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 inability of midwives to establish and maintain collaborative relationships with physicians and easily integrate into health care systems. This includes access to lab work, diagnostic testing, physician consult and hospital admittance. Current limitations are a direct result of the illegal status of midwives in our state. The legislature can minimize this danger by recognizing the CPM international credential as the standard for midwives serving families birthing outside the hospital.

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 38 states in which midwifery is not statutorily prohibited. These are: AK, AR, AZ, CA, CO, CT, DE, FL, HI, ID, IL, KS, LA, ME, MA, MI, MN, MS, MT, ME, NV, NH, NJ, NM, NB, OK, OR, PA, 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. 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*.

*See attachment #1 advantages of Using 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 homebirth (about $2000 in the US) is considerably less that 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. Nationally, the Cesarean section rate is 21.2%, while the World Health Organization recommends a rate of 10-15%. Reducing the rate to WHO objectives would save an estimated 1.5 billion dollars in the US. The cesarean section rate of planned, midwife attended home births 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. Recognition of this credential will allow CPMs to practice and make services available to the public.

**See attachment #2 Documented Evidence...Safety...
***See attachment #3...Cost Effective...

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.

There is only one harmful economic effect, due to administrative costs of licensure. The benefits are as follows;

- Consumers' will have the ability to choose a midwife based on her credentials and level of training which are needed in order to obtain certification.
- Consumers will have the ability to choose the manner, cost, setting, and caregiver for their birth experience.
- Consumer will have access to quality; home birth oriented prenatal care and delivery services by providing adequate numbers of trained providers.

- Consumers in underserved areas will have the potential for receiving excellent prenatal, intrapartum, and postpartum services.
- Consumers will receive better quality care due to practitioner access to lab testing, physician consultant and referral.
- Consumers will have the proven benefit of 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.
- Recognition of the CPM will set a standard of care in the community.
- Consumers will be provided with a channel for positive and negative feedback about the care they receive.
- Midwives will be required to seek continuing education.
- Consumers will be provided with a caregiver who can best serve them financially, geographically, and physically through referrals.

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

Midwives train in a variety of setting 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 CPMs 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. CPMs' specialized skills include risk assessment, nutritional counciling, 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 with birth.

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

The Certified Professional Midwife is an international credential created by the North American Registry of Midwives that promotes the Midwifery Model of Care which is based upon 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 set midwives apart from ordinary labor are:

- **Only CPMs are required to have experience in out-of-hospital birth.**
- Most midwives are 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 which is often established between the birthing family and the midwife. This establishes trust between the parties and enables the midwife to address specific needs of the birthing family/mother.
- Other midwives (CNMs) are not trained for out of hospital births.
- Lengthy and thorough prenatal visits 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.
- Most midwives maintain flexible schedules to accommodate working parents.

- Midwives view that the whole family is giving birth. The father and siblings are considered integral parts of the birthing experience.
- 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 all of the time.

*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 and are not licensed through Article 10A. Exemptions apply to those listed in Chapter 90, Article 10 A, as well as those listed in Article 10B. These include family members or other caregivers invited by the birth mother, persons providing emergency medical care, doulas, or midwifery students or assistants who are under the supervision of a CPM.

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 CPMs in North Carolina. This number does not include midwives who are not members of NCMA. It is common knowledge that there are 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 if 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 assess 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 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. As stated in the current bill, midwives are required to give their prospective clients an informed consent document which explains their training, education and philosophy. All CPMs are required to develop informed consent forms.

*See attachment #5 questions to ask the midwife

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 CPMs are members of the North Carolina Midwifery Alliance. The membership is open to all types of midwives and is made up of CPMs, CNMs, and midwives with no formal credentials. The NCMA has voluntarily adopted a code of ethics** and in recent months has been finalizing a risk assessment for use by its 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 #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 wh 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 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

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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

ATTACHMENT B

Article 10A of Chapter 90 of the General Statutes

Practice of Midwifery

ARTICLE 10A.
Practice of Midwifery.

Sec.
90-178.1. Title.
90-178.2. Definitions.
90-178.3. Regulation of midwifery.
90-178.4. Administration.
90-178.5. Qualifications for approval.
90-178.6. Denial, revocation or suspension of approval.
90-178.7. Enforcement.

§ 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

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.

(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;

(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).)

ATTACHMENT C

Comparison of

Certified Nurse Midwives (Art. 10A, Chapter 90)

&

Certified Professional Midwives (HB 1014/SB 498)

ATTACHMENT C

COMPARISON OF CERTIFIED NURSE MIDWIVES (Article 10A of Chapter 90 of the NCGS) & CERTIFIED PROFESSIONAL MIDWIVES (As proposed by HB 1014/SB 498)

	CERTIFIED NURSE MIDWIFE *Approved Under Article 10A of Chapter 90 of the General Statutes*	CERTIFIED PROFESSIONAL MIDWIFE *As Proposed Under HB 1014/SB 498*
Qualifications	Must be certified by American College of Nurse Midwives (ACNM) which requires • Licensure as a registered nurse. • Satisfactory completion of a nurse midwife program accredited by the ACNM. • Passage of certification exam.	• Must be certified by the North American Registry of Midwives (NARM).
Definition of "Midwifery"	*G.S. 90-178.2(3)* defines "midwifery" as the provision of the following types of care: <u>Prenatal</u> • Historical and physical assessment. • Obtaining and assessing results of routine lab tests. • Supervising use of prenatal vitamins, folic acid, iron, and non-prescription medications. <u>Intrapartum</u> • Attending women in uncomplicated labor. • Assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation. • Performing amniotomy. • Administering local anesthesia. • Performing episiotomy and repair. • Repairing lacerations associated with childbirth.	Define "midwifery" as the provision of the following types of care: <u>Prenatal</u> • Historical and physical assessments. • Obtaining and assessing the results of routine lab tests. • Administering Rhogam. • Supervising the use of prenatal vitamins, folic acid, iron, and non-prescription medications. <u>Intrapartum</u> • Assisting women during uncomplicated labor. • Assisting with the spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation. • Performing anmiotomy. • Performing emergency episiotomies. • Providing IV fluids for hydration.
	<u>Postpartum</u> • Management of the normal third stage of labor. • Administration of pitocin and methergine after delivery of infant. • 6 week postpartum evaluation exam and initiation of family planning.	<u>Postpartum</u> • Management of normal third stage of labor. • Administration of oxytoxic drugs after delivery when needed. • Administration of Rhogam. • Performance of evaluation examinations in the days and weeks following delivery. • Repair of lacerations resulting from childbirth.

	CERTIFIED NURSE MIDWIFE *Approved Under Article 10A of Chapter 90 of the General Statutes*	CERTIFIED PROFESSIONAL MIDWIFE *As Proposed Under HB 1014/SB 498*
	Newborn • Routine assistance to newborn to establish respiration and maintain thermal stability. • Routine physical assessment, including APGAR scoring. • Vitamin K administration. • Eye prophylaxis for opthalmia neonatorum. Intraconceptional • Family planning. • Screening for cancer of the breast and reproductive tract. • Screening for management of minor infections of the reproductive organs.	Newborn • Routine assistance to newborns to establish respiration, including use of oxygen, and maintaining thermal stability. • Routine physical assessment, including APGAR scoring. • Use of vitamin K. • 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.	HB 1014/SB 498 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 Annual Renewal $50.00 Reinstatement $5.00	Issuance of Approval $400.00 Renewal of Approval (every 3 years) $250.00 Late Fee $150.00
Approved by	Joint Subcommittee of the NC Medical Board and the NC Board of Nursing	North Carolina Supervisory Council of Certified Professional Midwives.