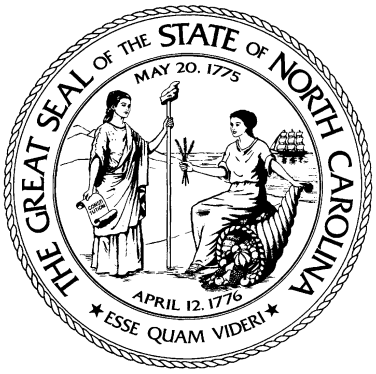
JOINT LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

Final Report

NORTH CAROLINA MIDWIFERY LICENSING ACT: LICENSURE/FEES

Senate Bill 662
House Bill 522



JOINT LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

July 1, 2011

The Joint Legislative Committee on New Licensing Boards is pleased to release this final assessment report on the creation and licensure of the North Carolina Council of Certified Professional Midwives.

Senator Tommy Tucker
Chair

JOINT LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS
(2011-2012)

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PREFACE

The Legislative Committee on New Licensing Boards is a 9-member 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 a final assessment report on its findings and recommendations. The recommendation in the report is not binding upon other committees considering the proposal.

BACKGROUND[1]

Current Standards

Midwifery is not currently licensed within the State of North Carolina. There is a need within the State for a person to have the freedom to choose the manner, cost, and setting for giving birth.

Further, access to prenatal care and delivery services is limited by the inadequate number of providers of midwifery services and the practice of midwifery may help to reduce this shortage.

There is a need for the safe and effective delivery of newborn babies and the health, safety, and welfare of their mothers in the delivery process. In the interest of public health, the State should promote the regulation of the practice of midwifery for the purpose of protecting the health and welfare of women and infants.

Midwifery is a profession in its own right and it is not the practice of medicine.

[1] **Source:** *Response to Questionnaire for the Legislative Committee for New Licensing Boards.* A copy of the questionnaire is attached to this report.

LICENSING REQUIREMENTS

§ 90-178.11. Definitions.

The following definitions apply in this Article:

- **Antepartal**. – Occuring during pregnancy.
- **Certified nurse midwife**. – A person approved to practice nurse midwifery under Article 10A of the North Carolina General Statutes.
- **Certified professional midwife** (CPM). – A person who has obtained national certification from the North American Registry of Midwives (NARM).
- **Consultation**. – The exchange of information and advice regarding the client condition and indicated treatment with a licensed physician or certified nurse midwife.
- **Council**. – The North Carolina Council of Certified Professional Midwives, a subcommittee of the Division of Health Service Regulation.
- **Department**. – The North Carolina Department of Health and Human Services.
- **Division**. – The Division of Health Service Regulation within the Department of Health and Human Services to which the North Carolina Council of Certified Professional Midwives reports.
- **Intrapartal**. – Occurring during the process of giving birth.
- **Licensed physician**. – A physician duly licensed in this State to practice medicine under Article 1 of this Chapter and specializing in obstetrics and gynecology.
- **Licensee**. – A certified professional midwife who holds the CPM credential and is licensed to practice midwifery under this Article.
- **Midwife**. – A person who is trained to (i) give the necessary care and advice to women during pregnancy, labor, and the post-birth period, (ii) conduct normal deliveries as the midwife's own responsibility, and (iii) care for the newly born infant and is able to recognize the warning signs of abnormal conditions requiring referral to or collaboration with a licensed physician or certified nurse midwife.
- **Midwifery**. – The practice of midwifery as defined under G.S. 90-178.2(3).
- **NARM**. – The North American Registry of Midwives.
- **Postpartal**. – Occurring subsequent to birth.

§ 90-178.12. License required; exemptions.

On or after January 1, 2012, no person shall practice or offer to practice midwifery as defined in this Article or otherwise indicate or imply that the person is a licensed certified professional midwife unless the person is currently licensed as provided in this Article.

The provisions of this Article do not apply to the following:

- An individual approved to practice midwifery under Article 10A of the North Carolina General Statutes.
- A physician licensed to practice medicine under Article 1 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 under Article 9A.
- The rendering of childbirth assistance in an emergency situation.
- Individuals who are present at or assisting the certified professional midwife in the birth process, including 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 certified professional midwife licensed under the provisions of the legislation.

§ 90-178.13. The North Carolina Council of Certified Professional Midwives.

Composition and Terms. – The North Carolina Council of Certified Professional Midwives is created. The Council shall consist of seven members who shall serve staggered terms. The Council members shall be appointed by the Secretary of Health and Human Services and the initial Council members shall be appointed on or before October 1, 2011, as follows:

- Four certified professional midwives, one of whom shall serve for a term of four years, two of whom shall serve for terms of three years, and one of whom shall serve for a term of two years.
- One licensed physician who is knowledgeable in midwifery care who shall serve for a term of four years.
- One home birth consumer who shall serve for a term of four years.
- One certified nurse midwife who practices home birth who shall serve for a term of two years.

Upon the expiration of the terms of the initial Council members, members shall be appointed for terms of four years and shall serve until their successors are appointed. No member may serve more than two consecutive terms.

Qualifications. – Each Council member shall be a resident of this State and the certified professional midwife members shall hold current licenses from the Council and remain in good standing with the Council during their terms.

Vacancies. – Any vacancy shall be filled by the Secretary of Health and Human Services. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed.

Removal. – The Council may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. If a Council member is absent from three consecutive Council meetings without excuse, that member shall be removed from office, and a new member shall be appointed by the Secretary of Health and Human Services. An absence shall be deemed excused if (i) caused by a health problem or condition verified in writing by a physician or (ii) caused by an accident or similar unforeseeable tragedy or event, on or before next Council meeting. A member subject to disciplinary proceedings in the member's capacity as a certified professional midwife shall be disqualified from participating in the official business of the Council until the charges have been resolved.

Compensation. – Each member of the Council shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

Officers. – The officers of the Council shall be a chair, a vice-chair, and other officers deemed necessary by the Council to carry out the purposes of this Article. All officers shall be elected annually by the Council for two-year terms and shall serve until their successors are elected and qualified. No person may serve as chair for more than five consecutive years.

Meetings. – The Council shall hold its first meeting within 45 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Council. The Council shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Council members shall constitute a quorum.

Notice of Meeting; Records. – Public notice shall be given for all meetings and all meetings are open to the public. All records are available to the public. Persons wishing to obtain copies of records may request copies, in writing, from the Council.

§ 90-178.14. Powers and duties of the Council.

In consultation with the Division and with guidance from the National Association of Certified Professional Midwives Standards of Practice, the Council shall have the following powers and duties:

- Administer this Article.
- Issue interpretations of this Article.
- Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.
- Employ and fix compensation of personnel that the Council determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.
- Examine and determine the qualifications and fitness of applicants for licensure, license renewal, and reciprocal licensure.
- Issue, renew, deny, suspend, or revoke licensure and carry out any disciplinary actions authorized by this Article.
- Set fees for licensure, license renewal, and other services deemed necessary to carry out the purposes of this Article.
- Maintain a current list of all persons who have been licensed as certified professional midwives under this Article and collect their annual statistics.
- Address problems and concerns of practicing certified professional midwives in order to promote safety for the citizens of this State.
- Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining certified professional midwives exist.
- Maintain a record of all proceedings and make available to all approved certified professional midwives and other concerned parties an annual report of all Council action.
- Adopt a seal containing the name of the Council for use on all official documents and reports issued by the Council.
- Educate the public and other providers of obstetrical care about the role of the licensed midwife.

§ 90-178.15. Requirements for licensure.

An applicant shall be licensed to practice as a certified professional midwife under this Article if the applicant meets the following requirements:

- Completes an application on a form approved by the council.
- Has obtained a certification from NARM and currently holds the title of certified professional midwife (CPM).
- On or after December 31, 2013, has graduated from a Midwifery Education and Accreditation Council (MEAC) accredited school.

- Submits proof to the Council of current cardiopulmonary resuscitation (CPR) certification and neonatal resuscitation (NPR) certification.
- Has read, understands, and agrees to practice under the guidelines set forth in this Article and any rules adopted pursuant to this Article.
- Pays the required fees in accordance with G.S. 90-178.19.

§ 90-178.16. Responsibilities of a licensed midwife; display of license.

A certified professional midwife licensed under this Article shall have the following responsibilities:

- Provide care for the healthy woman who is expected to have a normal pregnancy, labor, birth, and postpartal phase in the setting of the mother's choice.
- Ensure that the client has signed an informed consent form. This form shall include information to inform the client of the qualifications of the licensee.
- Order routine antepartal or postpartal screening or laboratory analysis to be performed by a licensed laboratory or testing facility, when necessary.
- Develop an emergency plan to be signed by the client and placed in the client's chart. The documentation shall also include referral and transfer plans for the client in the event of an emergency.
- Determine the progress of labor and, when birth is imminent, be available until delivery is accomplished.
- Remain with the postpartal mother during the postpartal period until the conditions of the mother and newborn are stabilized.
- Instruct the parents regarding the requirements of newborn screening.
- Instruct the parents regarding the requirement of newborn hearing screen.
- Maintain a birth certificate for each birth in accordance with the requirements of Article 4 of Chapter 130A of the General Statutes.
- Practice in compliance with the requirements of this Article and any rules adopted pursuant to this Article.

A midwife licensed pursuant to this Article shall display the license at all times in a conspicuous place where the licensed midwife is practicing, when applicable.

§ 90-178.17. License renewal; inactive status; lapsed license.

An initial license to practice as a certified professional midwife shall be valid for three years. After the initial license expires, a license shall be renewed every two years. All applications for renewal shall be filed with the Council and shall be accompanied by the renewal fee in accordance with G.S. 90-178.19 and proof of current certification from NARM. Compliance with NARM recertification requirements shall include (i) remaining in good standing with NARM; (ii) maintaining current cardiopulmonary resuscitation (CPR) and neonatal resuscitation certifications; and (iii) completing any continuing education requirements. A license that has expired for failure to renew may be reinstated after the applicant pays any late and renewal fees as required by G.S. 90-178.19 and complies with any other rules adopted pursuant to this Article.

Upon written request to the Council, the Council may grant a licensed midwife inactive status. While inactive, the midwife shall not practice midwifery as defined in this Article in this State and shall not be subject to license renewal requirements established by the Council. A midwife may change the midwife's status from inactive to active by (i) submitting a written request to the Council, and (ii) fulfilling the requirements for renewal described under subsection (a) of this section.

A midwife who does not seek inactive status and allows the license to expire after a 60-day grace period shall apply for a new license as prescribed in this Article.

§ 90-178.18. Reciprocity.

The Council may, upon application and payment of proper fees, grant a license to a person who resides in this State and has been licensed, certified, or registered to practice as a certified professional midwife in another jurisdiction if that jurisdiction's standards of competency are substantially equivalent to those provided in this Article in accordance with rules adopted by the Council.

§ 90-178.19. Fees.

All fees shall be set by the Council, in consultation with the Division, pursuant to rules adopted under this Article. All fees payable to the Council shall be deposited in the name of the Council in financial institutions designated by the Council as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Council exclusively out of the fees received by the Council as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Council be charged against the State treasury.

§ 90-178.20. Suspension, revocation, and refusal to renew license.

The Council may require issue a letter of reprimand, deny, refuse to renew, suspend, or revoke an application for licensure or a license if the applicant or licensee does any of the following:

- Gives false information or withholds material information from the Council in procuring or attempting to procure a license.
- Gives false information or withholds material information from the Council during the course of an investigation conducted 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 as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.
- Has a habitual substance abuse problem or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Council.
- Has demonstrated gross negligence, incompetency, or misconduct in the practice of midwifery as defined in this Article.
- Has had an application for licensure or a license to practice midwifery in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.
- Has willfully violated any provision of this Article or rules adopted by the Council.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Council after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Council may reinstate a revoked license if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

§ 90-178.21. Third-party reimbursement allowed; no requirement to use licensed certified professional midwife.

A certified professional midwife licensed pursuant to this Article may receive third-party reimbursement from private agencies that provide coverage for maternity and obstetrical care. A managed care organization or insurance company may not require a patient to be served by a licensee instead of a licensed physician or nurse practitioner.

§ 90-178.22. Enjoining illegal practices; vicarious liability.

The Council may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Council that any person has violated this Article, the court may grant injunctive relief.

No health care provider shall be liable for an injury to a woman or infant arising during childbirth and resulting from an act or omission by a midwife licensed under this Article, regardless of whether the health care provider has consulted with or accepted a referral from the licensee."

SECTION 2. This act is effective when it becomes law.

FINDINGS AND RECOMMENDATIONS

MIDWIFERY LICENSING ACT LICENSURE/FEES

Findings

The Joint Legislative Committee on New Licensing Boards finds that the sponsors have met the six criteria by which the committee judges licensure proposals.

Specifically, the Committee finds that:

- The unregulated practice of lay midwifery can substantially harm and endanger the safety and welfare of expectant mothers and their newborn babies. There currently is no officially recognized regulatory body authorized by North Carolina state statute to investigate complaints nor any state laws, rules or guidelines to regulate the profession for mothers who choose birth in a non-clinical hospital setting.
- The profession obviously possesses qualities and characteristics that distinguish it from ordinary employment. Also, certified midwifery licensure should at least require a uniform and advanced level of education and training than currently exists particularly for those overseeing child births in non-clinical settings. Current training does not appear sufficient to assure the safety and welfare of those in midwifery non-clinical care.
- North Carolina is one of a small number of states that require physicians to sign birth certificates for deliveries assisted by certified nurse mid-wives. Advocates express a need for safe and effective delivery services outside of the conventional medical hospital and believe licensure will reduce a perceived shortage.
- A significant majority of the public does not have the knowledge or experience to evaluate, select or assess the competence of individuals practicing midwifery outside of a medical facility setting.

- ❖ The public cannot be successfully or effectively protected by other means less licensure for non-medical infirmary childbirth.
- ❖ Licensure would not have a substantial or significant adverse economic impact upon the recipient non-clinical midwifery services.

Recommendation

The Joint Legislative Committee on New Licensing Boards recommends that the practice of midwifery be performed by a licensed professional. This report constitutes final assessment report for midwifery licensure. The report is based on the proposed licensing as set out in Senate Bill 662 and House Bill 522, the response to the committee's questionnaire, and remarks and testimony from interested parties before the committee in the course of meetings held during the 2011 Session of the North Carolina General Assembly.

ATTACHMENT

Response to Questionnaire for the Joint Legislative Committee on New Licensing Boards

QUESTIONS FOR THE JOINT LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

In what ways has the marketplace failed to regulate adequately the profession or occupation?

For over 25 years, the marketplace has demanded midwives be accessible for women who choose to give birth at home, 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 statute # 90-178.1, Chp. 90, Article 10 A, which resulted from the '83 legislation, granted practice privileges to nurse-midwives; however, only a small number of nurse midwives serve families in a home setting. The Certified Professional Midwife (CPM) is the primary caregiver to women who choose to birth at home in North Carolina and across the country. The CPM is the only credentialed care provider who is explicitly trained in attending women who birth at home.
At this time in North Carolina, without legal recognition of the CPM, consumer demand for midwives is being met by any person choosing to self-identify as a midwife. Leaving the marketplace to sort this out is not in the best interest of the public's health.

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 that 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 birthing families. Some physicians are disturbed by the fact that midwives who serve families birthing outside the hospital are unable to obtain the recognition they need, as qualified health care practitioners, to give them access to ultrasounds, lab work, physician consultation, etc. These physicians would provide collaborative 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 physicians 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 relationships with physicians, which assure timely medical care when

necessary. Licensure will improve cooperation with physicians for consultation and referral.

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 client confidentiality). To date, we have not been made aware of any recent serious consumer complaints in North Carolina. However, experience from other states in which midwives are unregulated suggest that it is only a matter of time before a mother or baby will be seriously injured by an inadequately trained midwife. Now that so many of our bordering states have passed laws to license and regulate Certified Professional midwives practicing outside of the hospital, we can expect to see midwives who can't meet those requirements opening practices here in North Carolina. There have been two older incidents, and one recent incident, which resulted in 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 in 1992 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.

The second case occurred in March 1998 in Davie County when the local health department decided to investigate a midwife attending 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 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.

The recent event occurred in Rowan County in 2010 in which Amy Medwin, CPM was arrested for misdemeanor unlicensed practice of midwifery and was found guilty and an appeal has been filed. Similar charges have been filed against her in Mecklenburg County. To our knowledge, the affected consumers are not the origin of the complaint. There is no indication that she failed to maintain the standard of care.

The criminal justice system is an expensive and decidedly inefficient means to regulate the practice of midwifery in North Carolina.

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.

Due to the legal status, approximately one-third of CPMs in the State are practicing, and the ones that are practicing are doing so "underground." As a result, some women who choose to birth at home are unable to locate a midwife and instead give birth at home unattended. Studies have shown that unattended birth carries increased risk of injury or death.

Due to the inadequate number of practicing CPMs in the state, some North Carolina women are traveling to bordering states such as Virginia, Tennessee or South Carolina (where CPMs are licensed) for supported out of hospital birth. This is counter to the welfare of North Carolina mothers.

- Because the CPMs are not licensed, they are unable to develop collaborative relationships with physicians for consultation or referral. This is counter to safety.
- With no state recognition of the CPM credential, midwives are not required to be accountable to other midwives or the community they serve.
- Intrapartum transfers of care to the hospital are encumbered by the legal status of midwives; this results in inadequate transfer of information, which is counter to safety.
- Women who transfer to the hospital are often discriminated against for their choice of birth setting and care provider due to their care provider's legal status. This all too often results in hostile treatment, defensive medicine and even the involvement of Child Protective Services for something that is considered normal throughout much of the country and our region.
- Currently midwives have no legal access to standard emergency medications (e.g. anti-hemorrhagic medicine) needed to safely attend birthing women at home. This compromises the standards of care and safety that midwives can provide.
- With no legal status, midwives may be hesitant to transport a patient to a hospital in a serious situation due to fear of prosecution. This places women and babies who are in need of medical care at risk.
- Without credentials to show a competent level of training, some women may receive substandard care from non-credentialed, or otherwise unfit, midwives.
- Without regulation, the consumers do not have assurances that the standards of care are being maintained.
- Planned home birth under the care of a CPM has increased significantly in recent years in our and all over the country. As a result, the likelihood of all these concerns is increasing.

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?

Every birth comes with risk, irrespective 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). 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 without 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. In the Reference 1 study, outcomes for all women who

chose to give birth at home in North America, under the care of Certified Professional Midwives, were prospectively tracked for the year 2000. In comparing these outcomes to those of low risk women choosing to give birth in hospital, it is concluded that both are equally safe. Under trained midwives, or sustaining an environment in which women give birth at home unattended in the absence of credentialed and regulated midwives, clearly presents the potential for substantial harm to the public.

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 citations).

The CPM credential is awarded by the North American Registry of Midwives and the credential is accredited by the National Commission on Credentialing Agencies which is the accrediting arm of the National Organization of Competency Assurance. These are the same agencies that accredit the Certified Nurse Midwife credential. Currently, there are 27 states in which CPMs are legally authorized to practice including our surrounding states of Virginia, Tennessee South Carolina. *Indeed, North Carolina stands out in the region for its lack of regulation.* In 2008, both Missouri and Maine enacted legislation authorizing CPMs to practice and more recently in 2009 Idaho enacted licensing legislation for CPMs. In 2010, Wyoming enacted legislation to license and regulate CPMs.

What will be the economic advantage of licensing to the public?

The global cost of a planned home birth can be considered one third (1/3) the cost of a normal birth in hospital. The cesarean section rate (occurring after transfer to hospital) is a factor of five lower for planned home birth than for comparable women planning to birth in hospital, and this procedure dramatically increases cost. Also, the incidence of preterm, low birth weight babies is reduced with midwifery care and this is a source of significant human and economic cost to the state. The state of Washington contracted with a third party consultant to evaluate the cost of their midwifery program and concluded that the licensed midwives saved the state over one million dollars a year. Also, through licensure, more consistent fees are to be expected along with insurance reimbursement options.

What will be the economic disadvantage of licensing to the public?

As long as licensing fees remain low and commensurate with other states, licensing should not significantly impact the cost to the public. Indeed, through legal recognition and regulation, licensing is expected to further increase the supply of midwives, which should have a positive effect on overall healthcare costs.

What will be the economic advantages of licensing to the practitioners?

In the fullness of time, licensing should support better reimbursement from both the public and private sectors. Currently there are a multitude of states that provide Medicaid reimbursement to licensed CPMs, who, as noted previously, provide care at a fraction of the cost of a planned hospital birth.

What will be the economic disadvantages of licensing to the practitioners?

Primarily, licensing fees are the primary disadvantage of licensure.

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

Licensing is expected to increase the number of practitioners as they are currently practicing in violation of the Midwifery Practice Act. At the end of 2009, the North American Registry of Midwives reported there were 29 CPMs in North Carolina; however, only 9 were known to be practicing. Other benefits include:

- Improved collaboration between healthcare providers.
- Improved treatment when there are transports.
- The CPM is the only healthcare professional explicitly trained and equipped for out of hospital birth. They should be integrated into our State's emergency planning. This need was highlighted in the aftermath of Hurricane Katrina when hospital facilities became non-operational and pregnant women and newborns were left particularly vulnerable. Our state is similarly at risk to severe hurricanes.
- Improved maternal health. There is considerable evidence that the incidence of preterm low birth weight babies is reduced in women who receive midwifery care. This is the largest source of our excess bad outcomes in North Carolina.
- Much of North Carolina is medically underserved and this is particularly true for maternity care in many of our rural counties. By licensing CPMs, who serve a disproportionate number of rural underserved women, we can look forward to improved access to maternity care providers. Note that the current trend is to consolidate maternity services into large facilities and group practices and so it is believed we are on a negative trend as more smaller hospitals are closing their maternity wards.
- Reduced medical interventions.
- Providing a channel for positive and negative feedback from consumers.
- Providing a means for professional discipline.
- Providing a means for the state to understand key trends in this important area of public health.
- Assuring that birth certificates for babies born outside of the hospital are accurate and secure.
- Assuring that standards are set and maintained.
- The ability of consumers to choose the manner, cost, setting, and caregiver for their birth.

It should be noted that some segments fear that by licensing CPMs, rates of planned home birth will increase. While this opinion originates from those who oppose this option, the experience since the late 1970's shows that this is not the case and that the relative rate of planned home births tends to remain constant irrespective of licensing

status; however, general awareness among women that this is a safe choice, with many benefits, is increasing and the rate of planned home birth attended by CPMs increased by over 50% in 2008 in North Carolina, independent of licensure.

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

The Certified Professional Midwife (CPM) is a nationally recognized and accredited credential developed and maintained by the North American Registry of Midwives that promotes the Midwives 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 without degrading safety.
- Identifying and referring women who require obstetrical attention.
- 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 midwives and families 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 at least 1 hour per client. This emphasis on maternal health and making healthy choices results in improved outcomes.
- Postpartum visits done at home to check mother and baby's well being and ensure a positive nursing relationship is established.
- Midwives maintain flexible schedules to accommodate working parents.
- Midwives view the whole family as being integral participants in pregnancy and birth.
- Midwives encourage mothers to nurse their babies right away and remain with the mother at all times, which is key to the establishment of successful breastfeeding.
- Midwives continue to provide monitoring, screening, counseling and support to mothers and their newborns during the first six weeks after birth.

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

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

Certified Professional Midwives train in a variety of settings including clinics, offices, homes and hospitals that combine a didactic course of study with clinical skills training. The student midwife is evaluated four ways. Her knowledge and skills are documented and adequacy is attested by a qualified instructor. She must have acquired a minimum set of experiences which are comparable to other providers of primary maternity care and she must pass an extensive written and clinical skills national board examination. The CPM's training primarily focuses on situations that occur in the home setting and concentrates on the acquisition of specialized skills, including risk assessment, nutritional counseling, labor monitoring and support, neonatal resuscitation, CPR, and the ability to assess what is within the parameters of normal pregnancy and labor, efficiency in palpitation without great reliance on ultrasound and all of the related knowledge and skills needed to perform the duties of a midwife. The CPM credential is the only midwifery educational, training and credentialing model that requires out of hospital experience.

Will licensing requirements cover all practicing members of the occupation or profession? If any practitioners will be exempt, what is the rationale for the exemption?

Licensing will apply to all midwives who provide out-of-hospital maternity care in North Carolina.

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

The number of Certified Professional Midwives in the US is increasing every year and over 1900 credentials have been awarded. Initially, it is expected that between 20 and 30 CPMs will seek a license. The long term number depends largely on consumer demand. In 2008, over 300 women were under the care of CPMs in our State. It is not known how many planned home births were attended by non-credentialed midwives, but experience in other states suggest that, with licensure, women will turn to licensed CPMs. Also, there may be as many as 300 families crossing state lines seeking care from licensed CPMs and it is anticipated that they would then find care within the state after licensing.

What kind of knowledge or experience does the public need to evaluate the services offered by the practitioner?

Pregnant women should be able to speak with a variety of caregivers to assess who is best suited to both her own and her family's needs. The public needs to have a clear understanding of the differences between home, birth center, and hospital births and the risks and benefits associated with each. CPMs are required to provide prospective clients with detailed information about the risks and benefits of out-of-hospital birth and to disclose their education, training, experience and liability insurance status. CPMs are required to provide each client with informed consent forms and to ensure that clients are fully informed about all aspects of their care.

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

The North American Registry of Midwives (NARM) issues the Certified Professional Midwife (CPM) credential. The professional association for CPMs, The National Association of Certified Professional Midwives (NACPM), dictates the standards of care and scope of practice for CPMs.

References:

1. Johnson, KC, Daviss, BA. *Outcomes of planned home births with certified professional midwives: large prospective study in North America*. BMJ 2005;330;1416-doi:10.1136/bmj.330.7505.1416.
2. Health Management Associates. *Midwifery Licensing and Discipline Program in Washington State: Economic Costs and Benefits.*
3. Fawcett, RM. *Trends in Planned Home Birth in North Carolina.*
4. The Education of a Certified Professional Midwife.
5. NARM and Accreditation: FAQ.
6. Essential Documents of the National Association of Certified Professional Midwives.

Appendix A

Educational Requirements for the Certified Professional Midwife

A Certified Professional Midwife has successfully completed a program of midwifery education approved by the North American Registry of Midwives (NARM) following the standards set by the National Commission for Certifying Agencies (NCCA), which includes intensive didactic and clinical experience, the sum of which takes a minimum of 3- 5 years to complete.

The acquisition of the required knowledge and skills are evaluated in the following ways:

- The instructor verifies that the candidate has demonstrated knowledge and proficiency of all didactic components, including definitions, signs and symptoms, differential diagnosis for Risk Assessment, stabilization and treatment, follow-up, referral, and transport.
- The instructor determines that the candidate has undergone complete and thorough preparation as an assistant midwife, demonstrating those skills at a minimum of 20 births, prior to assuming primary responsibility for:
- 75 prenatal exams
- 20 births from the onset of labor to the delivery of the placenta and the stabilization of mother and newborn
- 20 newborn exams
- 40 postpartum exams
- The candidate must provide all aspects of care as a primary midwife while under the physical, on-site supervision of the instructor.
- The instructor verifies that the candidate has demonstrated skilled proficiency in providing care to clients in out-of-hospital clinical settings.
- The instructor assesses and verifies performance of skills during an intensive, hands-on Skills Assessment, a demonstration exam performed for and scored by a NARM-trained Qualified Evaluator.
- The candidate must pass a 350 item, 8-hour written national board exam that covers all aspects of midwifery care as identified by the NARM Job Analysis.

The Didactic Component of the Educational Process for Certified Professional Midwives

Includes the procurement of knowledge of and proficiency in each of following:

Complete initial physical examination and Risk Assessment to identify normalcy, including evaluation of:

- Health, reproductive, and family health history

- Maternal health assessment
- Head, eyes, ears, nose, and throat
- Weight and height
- Thyroid
- Lymph glands
- Breasts
- Reflexes
- Heart and lungs
- Abdominal palpation
- CVA tenderness/kidney pain
- Pelvic landmarks, uterus, cervix, and vagina
- Musculo-skeletal system
- Vascular system

Prenatal care, including routine prenatal examinations and Risk Assessment for:

- Health and well-being
- Signs and symptoms of infection
- Vital signs
- Nutritional status
- Blood work or lab results
- Urine for glucose, protein, ketones
- Fetal heart rate
- Assessment of fetal growth and well-being
- Fetal position by palpation
- Labor, birth and immediate postpartum
- Signs of prodromal or active labor
- Maternal comfort measures for labor
- Maternal vital signs
- Normal and abnormal labor patterns
- Fetal lie, presentation, position, and descent
- Effacement and dilation of the cervix
- Normal, spontaneous, vaginal birth

Appropriate evaluation of laboratory records, including:

- CBC
- Hematocrit/hemoglobin
- Blood glucose
- HIV
- Hepatitis
- Rubella screen
- Group B Strep
- VDRL
- Blood type and Rh
- Antibody screen
- Chlamydia
- PAP smear
- Urine culture and analysis

Primary health and emergency care skills, including appropriate use of:

- Universal precautions and aseptic technique
- Recognizing and managing symptoms of shock
- Neonatal resuscitation/ infant and adult CPR

Pharmacology:

- Anti-hemorrhagic agents: Metherigine and Pitocin
- Lidocaine and numbing agents used in laceration repair
- Medical oxygen
- Eye prophylaxis
- Rhogam
- Vitamin K

Appropriate use and care of equipment, including:

- Ambu bag and mask
- Medical oxygen tanks
- Suction devices: bulb syringe, ResQVac and Delee
- Sterilization of birth instruments: hemostats, scissors, and cord clamps

- Lancets
- Suturing equipment
- Urinary catheter
- Ultrasonic Doppler and fetoscope
- Lab equipment: venepuncture supplies and vacutainer collection tubes
- Blood pressure cuff
- Stethoscope

Postpartum Risk Assessment to identify normal or abnormal newborn conditions and refer as necessary in first six weeks, including:

- Respirations
- Heart rate and rhythm
- Temperature
- Appropriate weight gain
- Appropriate growth pattern
- Reflexes
- Elimination patterns
- Feeding patterns
- Thrush, jaundice, diaper rash, cradle cap, colic
- Any other significant deviation from normal

Daily and weekly assessment of mother and newborn, including:

- Lactation counseling and breastfeeding support
- Metabolic screening of the newborn
- Assessing and referring for postpartum depression and uterine or breast infections
- Filing birth certificate

Proficiency in midwifery counseling, education, and communication, including:

- Informed Consent
- Confidentiality
- Childbirth education
- Physical and emotional aspects of pregnancy and birth
- Diet, nutrition, and supplements
- Prenatal testing and lab work

- Female reproductive anatomy and physiology
- Prenatal exercise
- Breast self-exam
- Environmental and teratogenic hazards to pregnancy
- Benefits and risks of birth site options
- Preparing for birth at home or birth center
- Emergency protocol

The Clinical Component of the Educational Process for Certified Professional Midwives

Includes the procurement of midwifery training and skills and the fulfillment of each of following requirements:

Prenatal, intrapartal, and postpartal care as well as newborn assessment, equivalent to a minimum of 1,350 clinical contact hours under the direct supervision of one or more instructors approved by the North American Registry of Midwives.

A complete and thorough incorporation of Job Analyses designed and implemented in accordance with the standards set by the National Commission on Certifying Agencies (NCCA), which identifies core topics that must be mastered for the performance of midwifery skills in an out-of-hospital setting.

Requirements that the student receive an assessment of skilled proficiency as an assistant midwife at a minimum of 20 births in order to assume responsibility as primary midwife at:

- 75 prenatal exams
- 20 births from the onset of labor to the delivery of the placenta and the stabilization of mother and newborn
- 20 newborn exams
- 40 postpartum exams

Advanced training in neonatal resuscitation; infant and adult CPR.

Documentation of clinical experience in out-of-hospital settings.

Verification that the candidate has passed a written and practical skills national board exam for the practice of midwifery developed and implemented following the standards set by the National Commission for Certifying Agencies and is administered by the North American Registry of Midwives.