#41

SEATTLE MIDWIFERY SCHOOL

EDUCATION
ADVOCACY
EMPOWERMENT

EXECUTIVE SUMMARY

Recent changes in health care delivery and reimbursement systems have affected everyone, from the consumer, to the payor, to the health care professional. In an effort to explore the effect market-driven reform of health care delivery and financing systems has had on midwives and how managed care may affect the profession in the future, the Center for the Health Professions convened a Taskforce on Midwifery in early 1998.

In meeting its charge, the Taskforce has reviewed the available literature and analyzed recent market changes. It is the finding and vision of the Taskforce that **the midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women.**

To fully realize this vision, a number of actions need to be taken. The Taskforce offers fourteen recommendations for educators, policy makers and professionals to consider. The Taskforce on Midwifery proposes these recommendations in the spirit of improving health care and hopes that the report will benefit women and their families through increased access to midwives and the midwifery model of care. The report should serve to inform managed care organizations, health care professionals and others who employ, collaborate with, and reimburse midwives about the midwifery model of care and its benefits. In addition, the authors hope to inform the profession of midwifery about the opportunities and challenges it faces in today's health care delivery environment.

FIVE ISSUE AREAS WITH RECOMMENDATIONS

PRACTICE

Health care practice, the ultimate delivery of services by the professional to the consumer, reflects the efforts of the professional, regulatory, education and research worlds to provide optimal care. However, practice settings and professional practices themselves are not neutral sites; they can either facilitate or impede the provision of high quality care. For example, interprofessional disputes, communication breakdowns, and inappropriate

management can limit access to care, increase costs and lower quality. Four recommendations are offered to health care system administrators and practitioners—including midwives and other professionals—to help ensure that practice structures are designed to provide the best health care possible by making the midwifery model of care readily available to women.

1. Midwives should be recognized as independent and collaborative practitioners with the rights and responsibilities regarding scope of practice authority and accountability that all independent professionals share.

2. Every health care system should integrate midwifery services into the continuum of care for women by contracting with or employing midwives and informing women of their options.

3. When integrating midwifery services, health care organizations should use productivity standards based on the midwifery model of care and measure the overall financial benefits of such care.

4. Midwives and physicians should ensure that their systems of consultation, collaboration and referral provide integrated and uninterrupted care to women. This requires active engagement and participation by members of both professions.

REGULATION AND CREDENTIALING

The regulation and credentialing of midwives, as with all health care professionals, is complicated, challenging and often contradictory. Optimally, laws and regulations would permit full access to midwifery services while protecting the public. Once regulatory parameters are in place, private sector credentialing bodies must avoid unnecessarily limiting midwives within their statutory scope of practice. Building on the four recommendations proposed in the section on practice, the following recommendations offer specific strategies for the appropriate regulation and credentialing of midwives.

5. State legislatures should enact laws that base entry-to-practice standards on successful completion of accredited education programs, or the equivalent, and national certification; do not require midwives to be directed or supervised by other health care professionals; and allow midwives to own or co-own health care practices.

6. Hospitals, health systems, and public programs, including Medicare and Medicaid, should ensure that enrollees have access to midwives and the midwifery model of care by eliminating barriers to access and inequitable reimbursement rates that discriminate against midwives.

7. Health care systems should develop hospital privileging and credentialing mechanisms for midwives that are consistent with the profession's standards, recognize midwifery as distinct from other health care professions, and recognize established processes that permit midwives to build upon their entry-level competencies within their statutory scope of practice.

EDUCATION

Midwifery education not only provides students with the academic and clinical expertise they need to provide care; it also serves as the pipeline of professionals to practice settings. The current evolution of health care will mean a shift in orientation for educators from a supply-driven perspective to one driven by demand. It will also mean a shift in the way health care professionals are educated. The following recommendations will challenge educators to continue to develop faculty, programs, curricula and recruitment policies to meet consumer demands in a changing health care arena.

8. Education programs should provide opportunities for interprofessional education and training experiences and allow for multiple points at which midwifery education can be entered. This requires proactive intra- and interprofessional collaboration between colleges, universities and education programs to develop affiliations and complementary curriculum pathways.

9. Midwifery education programs should include training in practice management and the impact of health care policy and financing on midwifery practice, with special attention to managed care.

10. The profession should recognize and acknowledge the benefits of teaching the midwifery model of care in a variety of education programs and affirm the value of competency-based education in all midwifery programs.

11. The midwifery profession should identify, develop and implement mechanisms to recruit student populations that more closely reflect the U.S. population and include cultural competence concepts in basic and continuing education programs.

RESEARCH

The field of health professions research must continually grow and evolve in order to make its necessary contributions to health care. As with other professions, critical midwifery workforce and practice data remain to be gathered and analyzed. In some cases, relatively minor shifts in focus will result in useful information. Other recommendations will require a significant policy reorientation, creativity or infusion of financial or academic support to realize results.

12. Midwifery research should be strengthened and funded in the following areas:
    - Demand for maternity care, demand for midwifery care, and numbers and distribution of midwives;
    - Analyses of how midwives complement and broaden the woman's choice of provider, setting, and model of care;
    - Cost benefit, cost-effectiveness, and cost utility analyses, including the relationship between knowledge of economic/cost analyses and provider practices;
    - Midwifery practice and benchmarking data (among midwives) with a goal of developing appropriate productivity standards;
    - Descriptions and outcome analyses of midwifery methods and processes;

- Analysis of midwifery practice outcomes, from pre-conception through infancy, using an evidence-based perspective;
- Normal pregnancy, normal labor and birth, healthy parent-infant relationships, and breastfeeding; and
- Satisfaction with maternity and midwifery care.

13. Federal and state agencies should broaden systematic data collection, which has traditionally focused on medicine and physicians, to include midwifery and midwives.

POLICY

Some of the most pressing issues regarding midwifery go beyond the current scope of state regulators, professional associations, educators and practice settings. These issues should be addressed in order to improve health care for women and their families. An already existing body, external to the profession, is best positioned to address and offer objective guidance on these concerns.

14. A research and policy body, such as the Institute of Medicine, should be requested to study and offer guidance on significant aspects of the midwifery profession including:
    - Workforce supply and demand;
    - Coordination of regulation by the states;
    - Funding of research, education and training; and
    - Coordination among the federal agencies whose policies affect the practice of midwifery.

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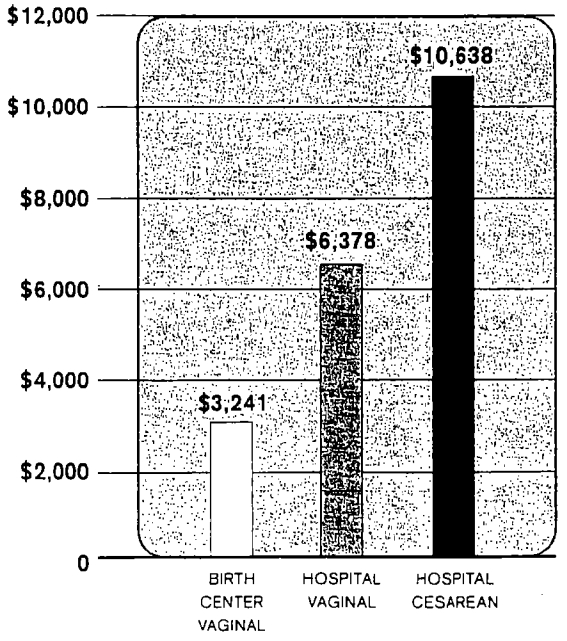
PART I MIDWIFERY CARE IN THE UNITED STATES

OVERVIEW

Midwifery is the approach to childbirth and women's health care that is used extensively in many parts of the world, including Europe, Australia, New Zealand, and Japan. The United States and Canada stand apart as being the only two countries in this peer group where midwives do not play a central role in the care of all or most pregnant women (Rooks, 1997 pp. 393-446; Declercq, 1994). Midwives who are able to fully practice the midwifery model of care may offer choices for women that have not been fully explored or used by health plans or consumers. The subject of this report is whether better care management in today's health care environment can provide opportunities to expand women's access to midwives in the United States.

With almost 4 million children born in the U.S. every year (Ventura *et al.*, 1998), childbirth is one of the most common reasons to use a health care professional and to access the health care system. The costs associated with this care are significant. A 1996 study of 40,000 insured women found that average charges were $7090 for an uncomplicated vaginal birth and $11,450 for a cesarean delivery. Of these totals, the average percentage of charges attributed to physicians was 40-45%. The hospital component of care accounted for the remaining portions (Mushinski, 1998). Although alternative settings for childbirth include homes and birth centers, ninety-nine percent of U.S. deliveries occur in hospitals (Ventura *et al.*, 1998). Childbirth is the single most common cause for hospitalization, accounting for over 20% of all hospital discharges for women (US Bureau of the Census, 1998). As can be seen, however, hospitals are expensive settings for childbirth. (*See Figure 1*)



Source: National Association of Childbearing Centers, 1997.

FIGURE 1 *Birth Charges in the U.S., 1995*

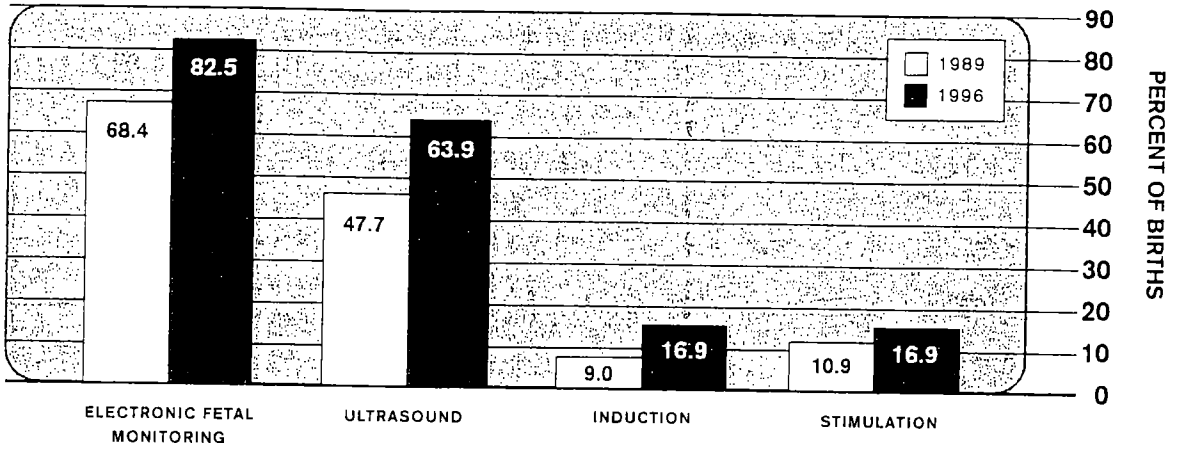


FIGURE 2
Frequency of Use of Obstetric Procedures in the U.S., 1989-1996

Source: NCHS Natality Data for 1989 and 1996 (NCHS, 1993c; Ventura et al, 1998)

Despite these costs, and although the U.S. spends more per capita on health care than any other country, 24 other countries had lower infant mortality rates in 1994[1] (National Center for Health Statistics, 1998) and the maternal death rate in the U.S. has not improved in 15 years even though 50% of those deaths are estimated to be preventable (National Center for Health Statistics, 1998; Chronicle News Services, 1998).

Childbirth is a medical event in the United States, with 93% percent of all U.S. births attended by physicians (Ventura *et al.*, 1998). Most of these attending physicians are surgical specialists in obstetrics although the large majority of births are vaginal deliveries without complicating diagnoses (Agency for Health Care Policy and Research, 1997). Consistent with this approach to childbirth, the use of obstetric procedures increased between 1989 and 1996 (*See Figure 2*). In addition, despite a slight decrease in cesarean section rates (from 22.8% in 1989 to 20.7% in 1996), it seems unlikely that the U.S. will meet the Healthy People 2000 objective for a cesarean section rate of 15% or lower (Ventura *et al.*, 1998).

Based on the evidence, the current approach to pregnancy and childbirth in the United States is often not warranted. Appendix I includes excerpts from the results of an international effort to collect and synthesize information from randomized controlled trials of perinatal care and evidence regarding current labor and birth practices, including those that are frequently used inappropriately, or are harmful or ineffective (Enkin *et al.*, 1995).

1. An alternative to the infant mortality rate in measuring pregnancy outcome is the feto-infant mortality rate, which reduces the effect of international differences in distinguishing between fetal and infant deaths. The U.S. ranks 25th on the infant mortality rate and 23rd on the feto-infant mortality rate (National Center for Health Statistics, 1998).

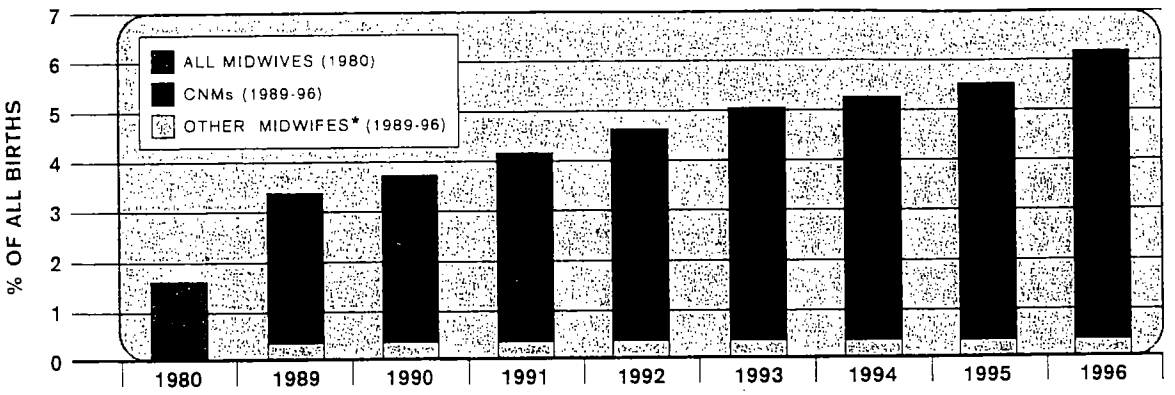


FIGURE 3
Percent of U.S. births attended by midwives, 1980-1996

Source: NCHS Advance Reports of Final Natality Statistics for years 1980, 1989-1996 (NCHS, 1982; NCHS, 1991; NCHS 1993a; NCHS, 1993b; Ventura et al, 1994; Ventura et al, 1994; Ventura et al, 1995; Ventura et al, 1996; Ventura et al, 1997; Ventura et al, 1998).
*"Other Midwives" includes both direct-entry midwives and graduate nurse-midwives not yet certified by the ACNM.

Furthermore, some elements of care that are known to be beneficial to mothers and babies, such as guaranteeing women the consistent presence of a trained caregiver to provide support and encouragement throughout labor and birth, are not available in many hospitals in this country (Maternity Center Association, 1998).

Even prenatal care as it is currently delivered in the U.S. may not be optimal. Kogan and colleagues (1998) found that prenatal care use increased steadily from 1981 through 1995 in the U.S., but suggest that because the rates of low birth weight and preterm birth worsened during the same period, "simply offering more prenatal care services without careful evaluation of the clinical significance of the services provided may not lead to improved birth outcomes."

While the vast majority of U.S. births are attended by physicians and take place in hospitals, this is not the only model available to women in the United States. An approach using the midwifery model of care is less common in this country although gaining in popularity. Midwives attended a quarter of a million U.S. births in 1996 or 6.5% of the total (Ventura *et al.*, 1998), up from 3.6% in 1989 (Rooks, 1997 p. 149).[2] *(See Figure 3)*

In hospitals, the midwifery model is often complementary to the more common medical approach and both models are employed to provide care to women and their families. In some cases and settings, such as with home births and birth center births, the midwifery model is an alternative to the medically oriented approach.

2. Most of these births were attended by nurse-midwives. While the percent of direct-entry midwife attended births has remained stable, the percent of U.S. births attended by nurse-midwives has grown steadily over the past decade. Additional information about direct-entry midwives and nurse-midwives can be found in the following pages.

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 post-partum support; minimizing technological intervention; and identifying and referring women who require obstetrical attention (Burch, 1998).

The Midwifery Model for Pregnancy and Maternity Care

"Whereas medicine focuses on the pathologic potential of pregnancy and birth, midwifery focuses on its normalcy and potential for health. Pregnancy, childbirth and breastfeeding are normal bodily and family functions. That they are susceptible to pathology does not negate their essential normalcy and the importance of the nonmedical aspects of these critical processes and events in people's lives. Midwives know about the medical risks, identify complications early, and collaborate with physicians to assure medical care for serious problems. But attention to the medial aspects of these complex processes, while essential, is not sufficient. Midwives focus on each woman as a unique person, in the context of her family and her life. The midwife strives to support the woman in ways that empower her to achieve her own goals and hopes for her pregnancy, birth and baby, and for her role as mother. Midwives believe that women's bodies are well designed for birth and try to protect, support, and avoid interfering with the normal processes of labor, delivery, and the reuniting of the mother and newborn after their separation at birth."

(Rooks, 1997 p. 2. Excerpted from Midwifery and Childbirth in America *by Judith Rooks. Reprinted by permission of Temple University Press. © 1997 by Temple University. All Rights Reserved.)*

For several decades, researchers, policy analysts and consumer advocates consistently have found that the care provided by midwives differs from the medical model of care in ways that benefit women and their families in terms of quality, satisfaction and costs.[3] Data from the most recent research and preliminary findings from current studies on nurse-midwives reaffirm earlier works and highlight evidence that midwifery care can result in improved outcomes and decreased utilization of resources that translate into cost savings (MacDorman and Singh, 1998; Jackson *et al.*, 1998).

3. Steele, 1941; Laird, 1955; Frontier Nursing Service, 1958; Metropolitan Life Insurance Company, 1958; Levy et al., 1971; Browne and Isaacs, 1976; Reid and Morris, 1979; Cherry and Foster, 1982; Tom, 1982; Office of Technology Assessment, 1986; Krumlauf et al., 1988; Bell and Mills, 1989; Brown and Grimes, 1995; Margolis and Kotelchuck, 1996; Oakley et al., 1996.

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Education

1994 to 98	Masters Degree in Public Health, University of Washington
1967 to 70	Journalism and American Studies, Honors College, Oregon State University

Voluntary Activities (partial list)

University of California San Francisco Center for the Health Professions

2000	Member, Taskforce on Emerging Health Professions
1998	Member, Taskforce on Midwifery, Pew Health Professions Commission

Health Alliance International

1993 to present	Chairperson, Board of Directors

Health Mothers, Health Babies Coalition of Washington State

1992 to 93	Chairperson, Board of Directors

Washington State Department of Health

1992 to 93	Member, Statewide Perinatal Advisory Committee

Washington State Higher Education Coordinating Board

1992 to 95	Education Advisory Committee, Statewide Health Personnel Resource Plan
1990 to present	Advisory Committee, Health Professional Loan Repayment and Scholarship Program

Midwives Alliance of North America

1983 to 87	Editor, MANA Newsletter

Midwifery Education Accreditation Council

1994 to 96	Representative to National Certification Task Force
1997 to present	Treasurer, Board of Directors

Midwives Association of Washington State

1999 to present	Member, Board of Directors
1988 to 89	Treasurer, Board of Directors
1983 to 89	Founding Member/Consumer Representative, Board of Directors

Carnegie Foundation for the Advancement of Teaching

1989 to 90	Consultant, National Seminar on Midwifery Education

Publications (partial list)

1999	"Evolution and Current Status of Direct-Entry Midwifery Education, Regulation and Practice in the United States, with Examples from Washington State," Journal of Nurse-Midwifery, July/August 1999
1988	"Direct-Entry Midwifery in the U.S.A." in The Midwife Challenge, edited by Sheila Kitzinger, Pandora Press, London, 1988

Presentations (partial list)

1999	""Midwifery Education in the New Millenium," Midwifery Educators Conference, Eugene, OR
1998	"Innovations in Maternity Care: Direct-Entry Midwifery," American Public Health Association Annual Meeting, Washington, DC
1998	"Midwifery in the Mainstream: The Washington Experience," Midwives Alliance of North America, Grand Traverse, MI
1997	"Midwifery in Washington State," American Anthropological Association, Washington, DC

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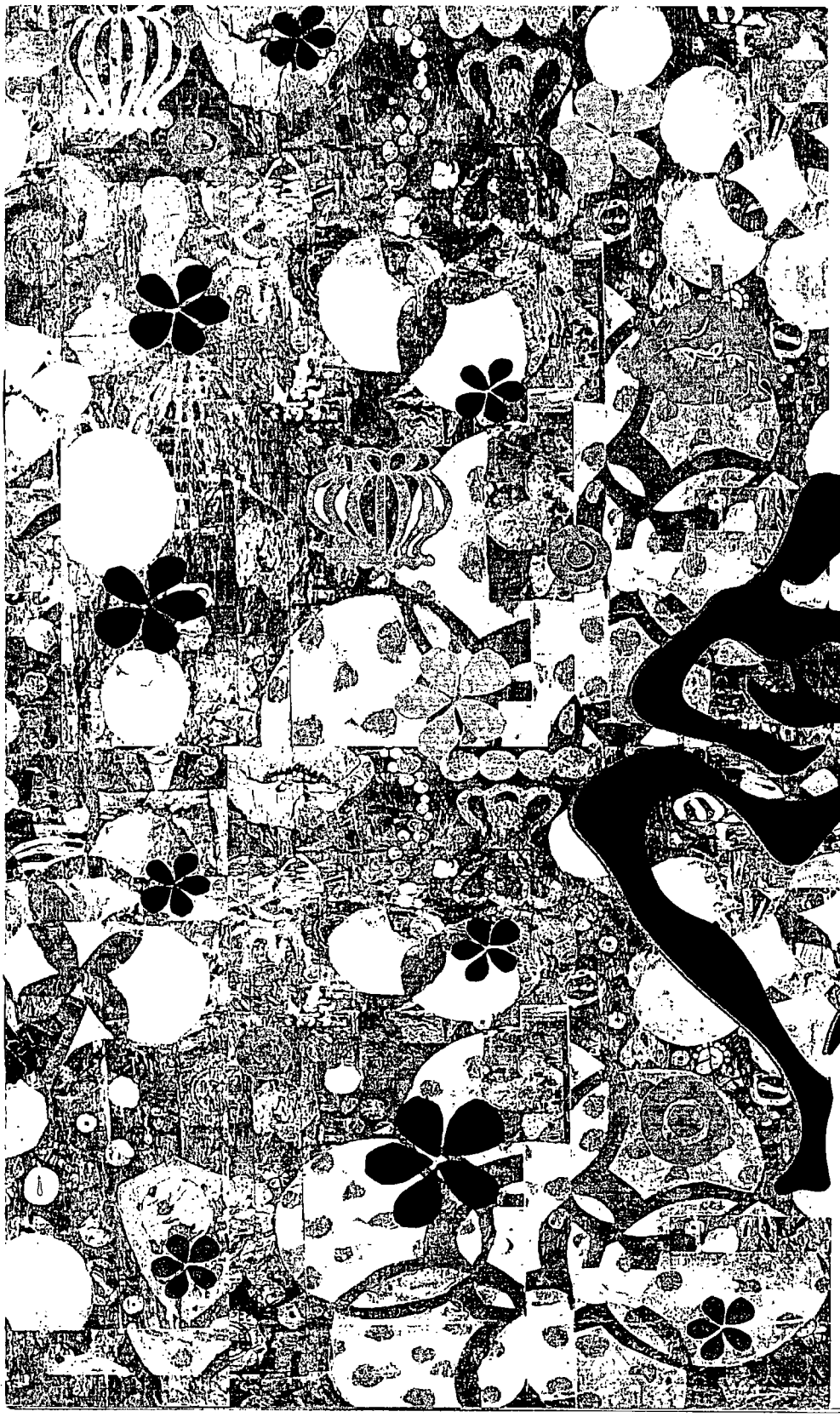

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MIDWIFERY IN WASHINGTON STATE:
AN INNOVATIVE MODEL FOR EDUCATION AND PRACTICE

Jo Anne Myers-Ciecko, MPH

Presented at the American Public Health Association Annual Meeting, November 1999, Chicago,IL

INTRODUCTION Direct-entry midwives in Washington State are licensed health professionals. They must complete a three-year midwifery education program or the equivalent, which includes at least 100 births, before taking the state licensing examination. Licensed Midwives provide complete maternity care including prenatal, intrapartum, and postpartum care for mothers and newborns. Most provide home birth services and many have privileges in freestanding birth centers. Licensed Midwives own and operate 7 of the 10 licensed birth centers in the state. Licensed Midwives are independent practitioners, required to consult a physician only when there are deviations from normal. In 1998, Licensed Midwives attended 918 births or 1.1% of all births in the state. Three-fourths of births attended by Licensed Midwives were in the client's home.

REGULATION The original statute regulating direct-entry midwifery was adopted in 1917. The law required two years of schooling and many foreign-trained midwives were licensed by the state before immigration was restricted and hospitalization became the norm for childbirth in the 1930s and 40s. The old law was re-activated in the mid-1970s when growing demand for home births led to the re-emergence of midwifery. It was revised in 1981 to incorporate contemporary international standards for midwifery education and practice.

MEDICAID The Medical Assistance Administration, responsible for the state's Medicaid program, recognized Licensed Midwives as qualified providers in the early 1980s and began reimbursement for birth center deliveries after a birth center licensing law was adopted in 1986. In 1996, the agency re-opened an earlier decision not to provide reimbursement for planned home deliveries when a new director asserted that low income women should have access to the same range of services available to women with private insurance or the personal resources to pay out of pocket. A task force, comprised of representatives from midwifery, medicine, nursing, public health, insurance companies, and a various state agencies, recommended in favor of changing the policy to cover home birth services. They identified barriers to the coverage of home birth services and devised solutions that included such quality assurance measures as practice guidelines, an incident review process, data collection and evaluation methods, and definitions for appropriate midwife-physician consultation relationships. Marijke vanRoojen is the current representative of the Midwives Association of Washington State on the task force.

HEALTH PROFESSIONAL SCHOLARSHIPS In 1989, the legislature made state health professional scholarships available to midwifery students who would commit to work in underserved areas. Approximately 15 Licensed Midwives have received scholarship support from the state. I represent the midwives on the advisory committee to the Higher Education Coordinating Board which administers the scholarship and loan repayment program.

HEALTH CARE REFORM In 1993, responding to public demand for health care reform, the legislature adopted a number of laws affecting the delivery of health services, including a requirement that certain insurance carriers provide for the inclusion of every category of licensed health professional, a mandate that includes Licensed Midwives. The Office of the Insurance Commissioner subsequently committed resources to assure access to the full range of health care services by addressing barriers to the integration of complementary providers in health plans. Since 1997, an independent work group representing insurance carriers, health professional groups, and primary care providers has tackled the difficult subjects of coding and billing, scope of practice, consultation and referral relationships, and identification and evaluation of meaningful outcome data. At a recent meeting of the workgroup, insurance plans requested that various provider groups present sample evidence-based practice guidelines. Victoria Taylor, representing the Midwives Association of Washington State, presented draft guidelines for non-pharmocologic pain relief.

JOINT UNDERWRITING ASSOCIATION In 1993, the legislature also created a Joint Underwriting Association to assure that Licensed Midwives, Certified Nurse-Midwives and Licensed Birth Centers would be able to obtain malpractice insurance. Midwives may purchase $1 million/$3 million coverage for $2400/ year plus $100 additional premium for every birth every 24 in a year. Karen Hays, a Certified Nurse-Midwife, chairs the Board of Directors of the Joint Underwriting Association. Victoria Taylor , a Licensed Midwife, administers the quality assurance program for the JUA, which includes midwifery practice data collection, reporting and regular site visits.

HEALTH PROFESSIONAL RESOURCE PLAN In 1994, the Department of Health and several other state agencies produced the Health Personnel Resource Plan, a report and recommendations that placed Licensed Midwives in a generalist provider category and called for their increased utilization. LeeAnne Shelley represented the Midwives Association on the provider advisory group.

MIDWIFERY MODEL OF CARE LeeAnne was asked to describe her practice at a recent meeting of the Office of the Insurance Commissioner's workgroup as an example typical of the model of care provided by Licensed Midwives. LeeAnne is President of the Midwives Association of Washington State and founder of the Puget Sound Birth Center (PSBC), a freestanding birth center located near Microsoft headquarters in a suburb of Seattle. PSBC is a community resource center, offering classes and access to a variety of care providers, including 18 community-based midwives who attend home births and also have privileges at the birth center.

The Puget Sound Birth Center philosophy states that pregnancy and childbirth are normal, healthy processes. The midwives endeavor to empower women by helping them master the challenges of pregnancy and birth. Their goal is to promote family bonding while maintaining safety for the mother and baby, making this a growing experience for the birthing woman and family.

The vast majority of the prenatal visit time is spent talking in a family room setting. The midwives consider prenatal visits a time for learning, exploring issues, preparing for parenting, and dealing with the social stresses of life as they relate to the pregnancy. The first prenatal visit can take 1 to 2 hours. Subsequent prenatal visits are generally 45 minutes to 1 hour long. All the same prenatal testing is available to clients as is in an obstetricians office.

Any family, friends or support professionals that the mother wants at the birth are welcomed. PSBC reports that in about 50% of their cases, the fathers or partners choose to "catch" their baby; and in about 80% of their cases, the mother chooses to give birth in the Jacuzzi tub. Birth plans are taken very seriously, unobtrusively monitoring labor with a minimum of vaginal examinations. The midwife with whom the mother starts her labor will stay with her all throughout the labor and birth.

Moms, families and babies are never separated. Baby exams are done right next to mom with everything being explained. Early breastfeeding is encouraged and supported. Before leaving the birth center, parents are taught what to expect in the next days and weeks and how to monitor their baby's health.

A home visit is done during the first 24 hours, and a clinic visit occurs from 2-5 days. Moms are checked again at 1 week and 3 weeks. A 6 week postpartum visit is scheduled to do family planning and to make sure that all is back to normal. This schedule is flexible and is adjusted according to the family's needs.

EDUCATION: SEATTLE MIDWIFERY SCHOOL The Seattle Midwifery School, the first midwifery program to be located in Washington and recognized by the state, was founded in 1978. SMS is a private nonprofit organization, which now provides training programs for direct-entry midwives, birth doulas, postpartum doulas, and childbirth educators. The school maintains a multi-disciplinary library of midwifery and related literature. More than 120 midwives, 1,500 doulas, and 50 doula trainers have graduated from SMS and are practicing throughout the United States and abroad. Midwifery students complete 60 credits of academic work which includes core midwifery courses, basic health and nursing skills, related fields such as epidemiology, nutrition, genetics, counseling, education skills, and professional issues. In addition, they must complete 64 credits in preceptorships with midwives where they participate in nearly 1500 hours of

clinical training and ongoing clinical seminars. Suzy Myers is a senior SMS faculty member. She was a lay midwife and member of the original Fremont Women's Birth Collective when they founded the school. She has been a member of the Board of Directors continuously since then and has been a core faculty member and preceptor for over 15 years. Suzy earned her Masters Degree in Public Health after becoming a Licensed Midwife and is a member of the local health department's infant mortality review committee. She maintains an active midwifery practice in southeast Seattle, with her partner, Marge Mansfield. Suzy has also contributed to planning a pilot project at a local hospital, which is interested in establishing privileges for Licensed Midwives. LeeAnne, Victoria and other MAWS members have also been advisors to the proposal and are now working on a position statement to address concerns regarding preservation of the midwifery model of care in the hospital setting.

EDUCATION: BASTYR UNIVERSITY Washington state currently recognizes one other midwifery education program. Bastyr University offers a midwifery certificate program for naturopathic physicians who want to include birth care in their general practice. Because enrollment is limited to naturopathic physicians or students, it is not considered a direct-entry program. Graduates of the certificate program are naturopathic doctors specializing in natural childbirth. They adhere to the midwifery model of care and to the international definition of a midwife. In their role as naturopathic midwives, they augment the midwifery model of care with the naturopathic principles of practice and, as physicians, may exceed the midwifery scope of practice by providing ongoing pediatric, gynecologic and family care. Morgan Martin is the director of the program and an active member of the Midwives Association, participating here in the Medicaid task force meeting.

STUDY In 1998, I surveyed Licensed Midwives who were current residents of Washington State to find out more about their backgrounds, practices, and professional challenges.
METHODS An 81-item survey was mailed to these midwives in February and March 1998, soliciting demographic information, educational preparation, employment status, certain practice characteristics, and perceived barriers to practice.
RESULTS Responses were received from 63 (58%) of the 109 qualified midwives to whom surveys were distributed.
DEMOGRAPHICS Respondents ranged in age from 30 to 60 years and the median age was 41. Most were married or partnered and/or had 1 or more children. One-fourth had at least one child under 5 years of age.

TABLE 1 DEMOGRAPHICS (n=63)

Characteristic	Number	Percentage
Female	62	98%
Euro-American	60	95%
Married/partnered	48	76%
1 or more children	51	81%
Children under 5 years of age	16	25%

BACKGROUND AND PRIOR EDUCATION One-half of all respondents had significant prior experience in midwifery or related fields prior to enrolling in one of the state-approved midwifery education programs and one-fourth had completed all or part of a nursing program. Nearly two-thirds had earned a bachelor's degree or higher. Those who had had midwifery apprenticeships prior to beginning their formal midwifery education were more likely to be working as midwives or were doing related work.

Fifty-four of 63 had graduated from the Seattle Midwifery School, 6 from Bastyr University and the other 3 from institutions in other jurisdictions. A median of 7 years had elapsed since respondents had completed their midwifery education but 27% had graduated less than three years earlier. Only 1 respondent reported that her primary clinical training took place only in-hospital while 26 (41%) reported their training was primarily community-based in the home or birth centers and 36 (57%) had both in-hospital and community-based clinical training. The median number of all births attended as a student was 110 and the median number of births managed as a student was 55. 14 (22%) of all respondents received state health

professional scholarship support for their education and all of these were working as midwives (12) or doing midwifery-related work (2).

TABLE 2 BACKGROUND AND PRIOR EDUCATION (n=63)

Characteristic	Number	Percentage
Bachelor's degree or higher	40	63%
Major area of study		
Biology or health Science	20	32%
Nursing	15	24%
Liberal arts	13	21%
Psychology	7	11%
Prior midwifery apprenticeship	16	25%
State scholarship recipient	14	23%

Of the total 63 Licensed Midwife respondents, 6 were also licensed as naturopathic physicians, 14 as registered nurses, 5 as nurse-practitioners, 3 as massage therapists and 1 as a physician's assistant. One-third of the respondents were Certified Professional Midwives (CPMs) or had applications in process to become CPMs.

MIDWIFERY PRACTICE Fifty-seven (90%) of the respondents were working as midwives or doing related work. While 41 (65%) of 63 respondents reported working as midwives, 9 of these had been in practice for just 1 year and another 6 for just 2 to 3 years. The 41 respondents working as midwives were typically self-employed in solo practices and as a group were providing services to women in 29 of 39 counties statewide. Most attended less than 2 births/month in 1997 but would have liked to attend 4 births/month. The 16 respondents doing midwifery-related work were employed part-time in a variety of settings including public health departments, community health centers, and midwifery education programs.

TABLE 3 MIDWIFERY PRACTICE

Characteristic (n=41)	Number	Percentage
Working as a midwife	41	65%
Employed in related work	16	25%
Solo practitioner	32	78%
Self-employed	38	93%
$\leq$ 3 years in practice	15	37%
> 10 years in practice	11	27%
Service area > 30 mile radius	20	49%

NUMBER OF BIRTHS The median number of births in 1997 attended by the 30 respondents who reported attending any births was 19 and by the 34 respondents who attended any births in 1997 was 17.5. The range was from 1 to 86 births in 1996 and 1 to 78 births in 1997. The total number of births attended by respondents in 1996 was 677 and in 1997 was 750. Midwives who had been in practice more than 3 years were much more likely to have attended 12 or more births in 1997 than midwives in practice for 3 years or less. 56% of the midwives currently working as midwives said they would ideally attend 4 to 6 births/month 5 years from the time of the study.

TABLE 4 NUMBER OF BIRTHS

Number of births attended	Mean	Median	Range
In 1996 (n=30)	22.6	19	1 to 86
In 1997 (n=34)	22.0	17.5	1 to 78

Respondents commonly attended births in more than one county and in geographically diverse areas. Thus any one midwife was likely to have served both rural and urban populations. The radius of the area served was more than 30 miles for 49% of the midwives and 3 midwives working in very rural counties each reported a service area radius of more than 90 miles.

PLACE OF BIRTH AND POSTPARTUM VISITS Most midwives reported that 90% or more of the births they attended took place in the client's home. 28% of the respondents reported generally making 2 to 3 postpartum visits, while 45% made 4 visits and the remainder made 5 or more visits. Those who made 4 visits generally scheduled visits on the first and third days postpartum and then at one week and six weeks.

PHYSICIAN CONSULTATION RELATIONSHIPS Two models for physician consultation arrangements were reported. Approximately one-half of the respondents said they consulted primarily with one physician (generally an obstetrician for perinatal care and a pediatrician for newborn care) while the other half reported relationships with a number of physicians. Telephone contact was the most frequently reported method of maintaining relationships. Difficulty obtaining appropriate physician consultation was not considered a significant barrier to practice by most respondents.

SOURCE OF PAYMENT The median charge for complete maternity care by survey respondents was $2200, though the range was from $1400 to $3000. There were wide variations among individual midwives reporting source of payment, including 3 midwives who reported all clients were self-pay and 3 reporting 90% or more of their reimbursements were Medicaid fee-for-service. Most midwives reported having 1 or more managed care contracts, though 23% (with 6 missing) reported having no contracts. The median number of contracts was 3 per midwife. Reimbursement through managed care organizations (combining privately and publicly-funded clients) represented 37% of all payment. Medicaid clients, whether payment was received through managed care organizations or direct fee-for-service billing, represented 34% of all payments received. State scholarship recipients reported on average that 48% of payments received were for Medicaid clients.

TABLE 5 SOURCE OF PAYMENT

Source of payment (n=37)	**Median**
Self-pay	29%
Fee-for-service (FFS)	15%
Preferred provider/managed care organization (MCO)	21%
Medicaid/FFS	18%
Medicaid/MCO	16%

NET INCOME IN 1997 Net income in 1997 reported by 37 of the respondents who were working as midwives (4 missing) ranged from less the $10,000 to over $40,000, with the mean between $10,000 and $20,000. Ten (62%) of the 16 midwives doing related work reported net incomes of less than $10,000 for part-time employment, while 2 reported net incomes over $30,000.

TABLE 6 NET INCOME IN 1997

Respondents working as midwives
- Range: less than $10,000 to over $40,000
- Mean: between $10,000 and $20,000

Respondents doing midwifery-related work
- 62% reported incomes of less than $10,000 for part-time employment
- 8% reported incomes over $30,000

BARRIERS TO PRACTICE The three most significant barriers to practice identified by respondents working as midwives were (1) difficulty obtaining third party reimbursement, (2) inadequate compensation and (3) difficulty obtaining contracts with managed care plans. These payment-related issues seemed to be of wide concern, having no clear relationship to geographic location, the size of the practice, the number of managed care contracts held, or the percentage of income received from managed care organizations. The cost of malpractice insurance was identified as the fourth most significant barrier to practice. Among respondents currently working as midwives, those who identified cost as a barrier were less likely to carry malpractice insurance, to have attended more than 24 births in 1997, or to have reported net incomes of more than $30,000. Midwives who attended more than 24 births in 1997 were not only more likely to carry malpractice insurance but also to have 5 or more managed care contracts ($p<.05$). Respondents working as midwives also reported not enough women seeking services as an important issue.

Among respondents not currently working as midwives, the other most significant barriers to practice were (1) few or no opportunities for employment other than self-employment, (2) being on-call all or most of the time, and (3) child care or other family obligations. They also identified cost of malpractice insurance, an unwillingness or inability to establish their own business, lack of hospital privileges, difficulty obtaining reimbursement and managed care contracts as important barriers.

All respondents with children under age 5 were more likely to report child care and being on-call as significant barriers to practice, but having young children was not associated with whether or not a respondent was working as a midwife or doing related work or with the number of births attended.

TABLE 7 BARRIERS TO PRACTICE
(Scale from 1 = no significance to 4 = very significant)

	Working	Not working
Few or no opportunities for employment	2.1 (2)	3.2 (4)
Unwilling or unable to establish own business	1.6 (1)	2.7 (3)
Cost of malpractice insurance	2.5 (3)	3.0 (3)
Fear of malpractice litigation	1.8 (2)	2.4 (2)
Difficulty obtaining third party reimbursement	2.7 (3)	2.5 (2)
Difficulty obtaining managed care contracts	2.6 (3)	2.5 (2)
Inadequate compensation	2.7 (3)	2.3 (2)
Lack of hospital privileges	2.3 (2)	2.7 (3)
Difficulty securing physician consultation	1.9 (2)	1.8 (2)
Peer support	1.7 (2)	1.9 (1)
Community support	2.0 (2)	2.0 (2)
Midwifery is invisible or lacks credibility	2.5 (3)	2.1 (2)
Not enough women seeking my services	2.6 (3)	2.5 (2)
Being on-call all or most of the time	2.5 (2)	3.2 (4)
Childcare/family obligation	2.0 (2)	3.0 (4)
Personal health problems	1.3 (1)	1.5 (1)

In open-ended questions, midwives were asked what they liked most about being a midwife and what they felt was their most significant contribution to the health and well-being of childbearing women and their families. One-half of all respondents (49%) recorded some combination of client education and empowerment. One midwife said, "Although my practice is small, all women and families have expressed high satisfaction with my education and empowerment focus, combined with high standards for safety." Another said, "I think teaching and encouraging thoughtful decision-making, especially to teens." A third said, "The gift of love and acceptance when they (women) are open and vulnerable; the courage to push them to find their own strengths, which they will need to be parents." And a fourth said, "Good midwifery care teaches women and their families that they have both power and responsibility for their health and their lives. I think this lesson leads to healthier living, both physically and emotionally."

DISCUSSION The study results show that most midwives in this sample were practicing midwifery or doing midwifery-related work and that they would like to be doing more births. Licensed Midwives appear to be practicing in areas of need and serving a range of clientele as evidenced by the widely-varied geographic locations and the percentage of payment received for Medicaid clients.

CONCLUSION Marijke van Roojen received the MAWS annual award this year for her contributions to the taskforce on Medicaid reimbursement for home birth. Marijke is a Licensed Midwife in Olympia, the state capitol. Her initial training as a midwife was at Maternidad la Luz in El Paso, Texas and she practiced midwifery in Oregon. Marijke is also a trained and experienced conflict resolution specialist. She has worked with numerous organizations and public agencies. As the principal representative of MAWS on the Medicaid Task Force, Marijke's breadth of knowledge and her communication skills have served her well. Although the task force recommended over two years ago to change Medicaid policies and to reimburse for home births, agency personnel changes and interprofessional skirmishes have kept the agency from taking action. Most recently, a neonatologist has been threatening to block all forward progress because he has concerns about births taking place in water. Marijke gathered all available literature, surveyed midwives across the state, and worked with the MAWS Board to clarify their position on this issue. She has kept up a running conversation with the physician involved while working with agency representatives to maintain forward motion on other aspects of the implementation plan. MAWS has decided to take a firm position in support of women's right to choose water birth and against any agency setting limits on practice when there is no evidence to support such action.

The midwifery model of care as defined nationally emphasizes the central role of the childbearing women in making informed decisions concerning her own health and well-being as well as that of her baby. The midwife's role is to provide comprehensive care and education for women and their newborns, encompassing their physical and emotional needs and fostering self-determination throughout the childbearing cycle. This philosophy of care speaks to the unique opportunity for education and empowerment presented by the childbearing experience. Licensed Midwives in Washington state expressed similar beliefs and values when describing their initial attraction to midwifery as well as their most important accomplishments as midwives. Licensed Midwives in Washington State have demonstrated a tremendous commitment to changing the health care system to ensure that women have access to informed and meaningful choices. Like their counterparts in other states across the U.S., these direct-entry midwives are an underutilized resource that has much to offer the nation.

LICENSED MIDWIVES IN WASHINGTON STATE

- Today there are 110 Licensed Midwives in Washington State.
- Approximately 80% maintain active midwifery practices or are employed in related fields such as public health, family planning, or community clinic administration.
- Since 1980, Licensed Midwives have attended between 1 and 2% of all births in the state or nearly 20,000 births total.
- Licensed Midwives provide comprehensive care to childbearing women from early pregnancy through the postpartum period, attending births in either the woman's home or a freestanding birth center.
- Licensed Midwives are typically self-employed, carry liability insurance, and are preferred providers in two or more managed care plans.
- Licensed Midwives in Washington State have consistently provided important leadership in the direct-entry midwifery profession nationwide. Approximately 10% of all midwives (including Certified Nurse-Midwives) in the U.S. today are Licensed Midwives. The majority of these are found in just four states: Washington, Texas, California and Florida. Washington's Licensed Midwives are frequently cited as an excellent example of what can be accomplished when rigorous professional standards, public policy, and a commitment to meeting the needs of childbearing women work together.

Scope of practice

Licensed Midwives provide care during the normal childbearing cycle. They consult with physicians when a case deviates from normal and may refer clients to them if complications arise. In an emergency, a midwife is trained and equipped to carry out life-saving measures. Their scope of practice includes:

- Prenatal care
- Education and counseling regarding pregnancy, birth and infant care
- Continuous support during labor
- Delivery of the baby
- Care of the newborn
- Postpartum care of the mother
- Family planning services

Midwives may conduct deliveries in hospitals, birth centers or in home settings. They are licensed to perform all of the procedures that may be necessary during the course of normal pregnancy, birth and the postpartum/newborn period, including the administration of selected medications.

Licensure requirements

- Graduate of 3 year school accredited by the state (or equivalent program in another jurisdiction)
- Participate in a minimum of 100 births
- Provide primary care, under supervision, for a minimum of 50 women in the prenatal, intrapartum and postpartum periods
- Successsfully pass national certification examination administered by the North American Registry of Midwives and additional state-specific test

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Education and training

- Seattle Midwifery School: This nationally-accredited three-year program provides direct-entry midwifery education that serves as a model nationwide. Most Licensed Midwives in Washington State are graduates of SMS. Students must complete one year of prerequisite courses prior to admission. The curriculum is comprised of 130 credits which include courses in gynecology, embryology, nutrition, midwifery care, pharmacological and alternative treatments, basic health and nursing skills. Students also complete over 1500 hours of clinical training under the supervision of Licensed Midwives, Certified Nurse-Midwives and/or Physicians.
- Bastyr University: This nationally-accredited four year university offers a midwifery program, approved by the state, for naturopathic physicians planning to provide full-scope maternity care. These ND/LMs hold dual licenses and offer services that blend the two scopes of practice.
- Foreign-trained midwives: These midwives are eligible for licensure in Washington State if they can provide evidence of formal training that is equivalent to that required under state law.

History of Licensed Midwives in Washington State

- 1917 midwifery law adopted
- 1978 Seattle Midwifery School founded
- 1980 University of Washington Health Policy Analysis Program publishes comprehensive and favorable report on "Midwifery Outside of the Nursing Profession"
- 1981 midwifery law revised, international standards incorporated
- 1983 Midwives Association of Washington State (MAWS) founded
- 1984 Bastyr College midwifery program approved by the state
- 1988 Washington Department of Social and Health Services recommends increased utilization of midwives in state maternity care
- 1989 Licensed Midwives eligible for State Health Professional Scholarship Program
- 1993 Legislature creates Joint Underwriting Association to provide liability insurance
- 1993 "Every category of provider" law requires health insurance carriers to include Licensed Midwives
- 1994 State Health Personnel Resource Plan calls for increased utilization of Licensed Midwives
- 1995 Office of Insurance Commissioner invites Licensed Midwives to join dialogue with health care plans and participate in Clinician Workgroup on the Integration of Complementary Medicine
- 1995 Midwives Association of Washington State, Washington State Medical Association, and Washington Obstetrical Society begin series of meetings to resolve scope of practice and other regulatory issues
- 1996 MAWS adopts "Practice Guidelines for Risk Screening and Indications for Consultation and Referral"
- 1996 Quality Midwifery Associates implements quality assurance program for midwives with liability insurance
- 1997 Medical Assistance Administration Task Force on Home Birth recommends Medicaid change policy to cover home births
- 1999 Licensed Midwives in Washington State are featured in PEW Health Professions Commission Report on the Future of Midwifery
- 1999 MAWS adopts new "Content of Care" guidelines
- 2000 MAWS will submit application for approval of Peer Review Program to the State Office of Quality Assurance
- 2000 Legislature includes Licensed Midwives in statute guaranteeing women direct access to the women's health care provider of their choice (eliminating need for gatekeeper referral)

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Bibliography

Janssen, P. et al. (1994) Licensed midwife-attended, out-of-hospital births in Washington state: are they safe? Birth 21(3):141-148.

Outcomes of births attended out-of-hospital by licensed midwives in Washington State were compared with those attended by physicians and certified nurse-midwives in hospital and certified nurse-midwives out-of-hospital between 1981 and 1990. Outcomes measured included low birthweight, low five-minute Apgar scores, and neonatal and postneonatal mortality. Associations between attendant and outcomes were measured using odds ratios to estimate relative risks. Mutivariate analysis using logistic regression controlled for confounding variables. Overall, births attended by licensed midwives had a significantly lower risk for low birthweight than those attended in hospital by certified nurse-midwives, but no significant differences were found between licensed midwives and any of the comparison groups on other outcomes measured. When the analysis was limited to low-risk women, certified nurse-midwives were no more likely to deliver low-birthweight infants than were licensed midwives but births attended by physicians had a higher risk of low birthweight. The results of this study indicate that in Washington State the practice of licensed nonnurse-midwives, whose training meets standards set by international professional organizations, may be as safe as that of physicians in hospital and certified nurse-midwives in and out –of-hospital.

Myers-Ciecko, J. (1999) Evolution and current status of direct-entry midwifery education, regulation, and practice in the United States, with examples from Washington State. Journal of Nurse-Midwifery. 44(4):384-393.

Describes the re-emergence of direct-entry midwifery in the United States, and focuses specifically on more than 1,000 midwives nationwide who are licensed in the 16 states where direct-entry midwifery is legal and regulated and/or certified by the North American Registry of Midwives. Professional developments of direct-entry midwives are highlighted, including the establishment of core competencies and articulation of values, the creation of a certification process, and the development of education program accreditation. The current status of licensed midwives in Washington state, where state policies have supported the development of direct-entry midwifery and the integration of direct-entry midwives into managed care systems, is presented as one examples of the evaluation of professional direct-entry midwifery in this country. Additionally, recommendations from the UCSF Center for the Health Professions Taskforce on Midwifery are discussed.

Dower, CM, Miller JE, Taskforce on Midwifery. (1999) Charting a course for the 21st century: the future of midwifery. San Francisco: Pew Health Professions Commission and UCSF Center for the Health Professions.

Report and recommendations from a Taskforce on Midwifery, convened by the University of California at San Francisco Center for the Health Professions in 1998, to explore the effects of market-driven changes on midwifery. Consisting of eight experts from across the country, the Taskforce was charges with exploring the impact of health care system developments on midwifery, and identifying issues facing the profession and the roles midwives play in women's health care. The Taskforce answered its charge by offering 14 recommendations related to midwifery practice, regulation, education, research, and policy. The recommendations incorporate the Taskforce vision that the midwifery model of care should be embraced by, and available to all women and their families. Licensed Midwives in Washington State are featured as a model for other states considering direct-entry midwifery education and practice

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Licensed Midwife-Attended, Out-of-Hospital Births in Washington State: Are They Safe?

Patricia A. Janssen, BSN, MPH, Victoria L. Holt, RN, MPH, PhD, and Susan J. Myers, LM, MPH

ABSTRACT: *The safety of out-of-hospital births attended by midwives who are licensed according to international standards has not been established in the United States. To address this issue, outcomes of births attended out of hospital by licensed midwives in Washington state were compared with those attended by physicians and certified nurse-midwives in hospital and certified nurse-midwives out of hospital between 1981 and 1990. Outcomes measured included low birthweight, low five-minute Apgar scores, and neonatal and postneonatal mortality. Associations between attendant and outcomes were measured using odds ratios to estimate relative risks. Multivariate analysis using logistic regression controlled for confounding variables. Overall, births attended by licensed midwives out of hospital had a significantly lower risk for low birthweight than those attended in hospital by certified nurse-midwives, but no significant differences were found between licensed midwives and any of the comparison groups on any other outcomes measured. When the analysis was limited to low-risk women, certified nurse-midwives were no more likely to deliver low-birthweight infants than were licensed midwives, but births attended by physicians had a higher risk of low birthweight. The results of this study indicate that in Washington state the practice of licensed nonnurse-midwives, whose training meets standards set by international professional organizations, may be as safe as that of physicians in hospital and certified nurse-midwives in and out of hospital. (BIRTH 21:3, September 1994)*

Place of birth and choice of birth attendant have long been contentious issues among providers and recipients of intrapartum care. In 1983 the American College of Obstetricians and Gynecologists (ACOG) was joined by the American Academy of Pediatrics in issuing a joint statement that opposed free-standing alternative birth centers and endorsed only the hospital as a safe environment for labor, delivery, and the postpartum period; this position was reiterated in 1988. The ACOG also released a policy statement in 1991 that disapproved of home birth (1).

Evidence from countries where home birth is practiced by trained midwives demonstrates that this method can be safe (2,3). Neonatal mortality rates are repeatedly as low as or lower than those for physician-attended, in-hospital births. Study designs, however, have been flawed by small sample sizes or lack of a comparison group (4–11).

Although the proportion of childbearing women delivering out of hospital is small compared with other countries, in the last two decades the increasing trend has been toward out-of-hospital birth and midwifery-attended birth in the United States. The number of births attended by all midwives in nonhospital settings doubled between 1975 and 1990 (12). In Washington state births attended by midwives increased from 0.1 percent of all births in

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1975 to 5.8 percent in 1991 (13), and in 1991, 1.7 percent of all births occurred at home or at birth centers (14).

Washington is one of 15 states in the United States that currently licenses midwives who are not necessarily nurses to attend out-of-hospital births (15). It has the only state licensing program with academic requirements that meet international standards of midwifery care set by the International Confederation of Midwives and the International Confederation of Obstetricians (16). This study compared birth outcomes of out-of-hospital deliveries attended by Washington state-licensed midwives with those attended in hospital by physicians and certified nurse-midwives, and with those attended out of hospital by certified nurse-midwives. This study is the first to address the safety of licensed midwifery practice in the United States, using both a large population-based sample and an epidemiologic design. It is also the first to address the safety of a state licensing program meeting international academic standards.

Methods

This study used birth certificates linked to infant death certificates for births in Washington state in the years 1981 through 1990. Since licensed midwives attend births at home or at birth clinics and currently do not have hospital privileges in this state, births attended by licensed midwives were identified by first examining all out-of-hospital births including births at home, at a birth center, or at another medical facility. Attendant identification codes (based on the first five letters of the attendant's last name and the first letter of the first name) were then verified with a list of names of midwives licensed in Washington obtained from the state's Department of Health. Verification of the birth attendant was deemed necessary because the Washington state birth certificates correctly identify the type of attendant at out-of-hospital births only 30 percent of the time (16). Using these methods, we identified 6944 licensed midwife-attended, out-of-hospital births in the state between 1981 and 1990.

Licensed midwives are licensed under the state's Midwifery Act (17). To be eligible to sit for the licensing examination, they are required to have attended a state-accredited midwifery education program that is at least three years in duration and that includes specific curricula. In addition, they must have observed 50 births and provided care for another 50 pregnancies in each of the antepartum, intrapartum, and postpartum periods. Alternatively, midwives who were trained out of state or the United States can obtain licensure by documenting equivalent academic credentials and experience and successfully completing the state's licensing examination.

Three other cohorts of births were established for comparison with licensed midwife births. The first group included physician-attended, in-hospital births matched to licensed midwife-attended births for birth year, county of birth, and mother's age, in a 4 : 1 ratio (n = 27,694). We restricted these births to those that would not have merited antepartum referral to a physician if the pregnancy had been cared for by a licensed midwife, to make the two groups comparable. In doing so we eliminated the bias in favor of licensed midwife-attended births that may have resulted from the referral of high-risk women out of licensed midwife care before labor and delivery. Thus, 3221 births with the following antepartum risk factors were eliminated from the physician group: multiple pregnancy, abnormal lie, placenta previa, gestational age less than 37 weeks, and maternal conditions including eclampsia, rubella, cardiac conditions, Rh sensitization, syphilis, epilepsy, chronic hypertension, and renal disease. We elected to control for diabetes and preeclampsia in the analysis rather than restrict physician births with these risk factors, because if the diagnosis of diabetes or preeclampsia was equivocal or the condition very mild, out-of-hospital birth may still have been an option. Births for which gestational length was missing were eliminated (1147). A total of 23,596 births remained in this cohort for analysis.

The second comparison group included all hospital births attended by certified nurse-midwives. These practitioners are nurses who have completed a core academic curriculum in midwifery and have managed a minimum of 20 births. They are graduates of two-year college programs in nursing, baccalaureate programs, or master's degree programs. They are accredited nationally, have passed a certification examination set by the American College of Nurse-Midwives (18), and are licensed to practice by the state (17). Identification codes for nurse-midwives on the birth certificate were verified using a list of names of state-registered, certified nurse-midwives obtained from the Washington Department of Health. In-hospital births attended by nurse-midwives numbered 14,893. Nurse consultants stated that in some cases physician-performed instrumental or operative deliveries of nurse-midwife patients may still be attributed to the nurse-midwife on the birth certificate (personal communication, Katherine Carr, CNM, PhD, consultant in midwifery and perinatal nursing, Seattle, Washington, 4 April 1993). To ensure that these potentially

misclassified births were excluded, the nurse-midwife-attended, in-hospital group was restricted to women who had spontaneous vaginal deliveries (n = 14,777).

The third comparison group consisted of out-of-hospital births attended by certified nurse-midwives. In a few instances, licensed midwives and certified nurse-midwives attending out-of-hospital births had identical identification codes. The births attended by these practitioners were separated into the appropriate attendant group by matching the county of birth with counties in which each midwife was known to have practiced. If the areas in which those with the same identification code who delivered babies overlapped, these births were excluded. Thirteen such births were excluded, and 4054 births remained in this cohort.

Birth outcomes were identified using linked birth and death certificates. Variables chosen for analysis included low birthweight (<2500 g), low five-minute Apgar score (<7), neonatal mortality (0–27 days), and postneonatal mortality (28 days–1 yr). These variables were chosen because, in contrast to most other pregnancy and birth outcomes, they are thought to be recorded with over 90 percent accuracy in Washington state (19). An assessment of postneonatal mortality was included to capture those deaths that may have been postponed to the postneonatal period by more rapid access to neonatal intensive care for babies born in the hospital.

The association between birth attendant and birth outcome was measured by the relative risk estimated by the odds ratio (OR). Potential confounders or effect modifiers that were examined were maternal age (<20 yrs, 20–34 yrs, 35–39 yrs, ≥40 yrs); race and ethnicity (white, other); marital status (married, unmarried); occupation (professional, clerical/sales/service, nonprofessional, housewife); number of prior pregnancies (none, one, ≥2); history of fetal deaths after 20 weeks (yes, no); parity (0, ≥1); trimester of first prenatal visit (1, 2, 3); classification of residence (urban, rural); county of birth (King, Pierce, Snohomish, other); smoking status (current, nonsmoker); preeclampsia (yes, no); and diabetes (yes, no). To permit exploration of confounding relationships, unconditional logistic regression was used to obtain maximum likelihood estimates of the OR associating type of birth attendant with the four specified birth outcomes (20). Confidence intervals were estimated by the standard error of the coefficient estimates and the normal approximation (21). Variables were considered to be confounders if the OR changed 10 percent or more with their inclusion in the model.

Preliminary analysis revealed that a few licensed midwives were delivering some high-risk women at home, including those carrying twins or babies in the breech position. To compare the practice of licensed midwifery with that of other birth attendants using women of similar risk status, a second analysis was undertaken. In this analysis, women with any antepartum risk factors identified on the birth certificate (multiple pregnancy, abnormal lie, placenta previa, gestational age less than 37 weeks or unknown, eclampsia, rubella, cardiac conditions, Rh sensitization, syphilis, epilepsy, chronic hypertension, renal disease) were excluded from all of the attendant groups. As in the first analysis, we elected to control for diabetes and preeclampsia. These low-risk groups contained 93 percent of the entire licensed midwife cohort, 88 percent of the entire nurse-midwife in-hospital cohort, and 95 percent of the entire nurse-midwife out-of-hospital cohort.

Results

Most women giving birth were white: over 95 percent of those with out-of-hospital births and nearly 90 percent in-hospital births (Table 1). There were no births to women under 15 years of age in the out-of-hospital cohorts, and the in-hospital nurse-midwives delivered the largest proportion of teenagers (8.2%). Similarly, in-hospital midwives delivered slightly more unmarried women (16.5%), although marital status did not vary appreciably among the four cohorts. A higher proportion of women with professional and technical jobs were in the nurse-midwife in-hospital group, and women with clerical, sales, or service jobs were almost twice as likely to be among an in-hospital cohort as an out-of-hospital cohort. Women choosing birth at home were substantially more likely not to be working outside the home compared with those giving birth in hospital. Place of residence was similar among all cohorts with the exception of the nurse-midwife in-hospital group, who were more likely to live in an urban area.

Table 2 shows pregnancy-related risk factors for the study population. Licensed midwives and out-of-hospital nurse-midwives delivered the lowest proportion of nulliparous women and women with prior pregnancies; the licensed midwives had the lowest proportion of women with no prior pregnancies and the highest proportion of women with five or more prior pregnancies, followed by out-of-hospital nurse-midwives. Fewer women delivered by licensed midwives received prenatal care in the first trimester, and more did not receive care until the last trimester than the in-hospital groups; nurse-midwife out-of-hospital births followed this trend to

Table 1. Demographic Characteristics of Pregnancies Attended by Licensed Midwives, Physicians, and Certified Nurse-Midwives (%)

Characteristic	LM* (n = 6944)	MD† (n = 23,596)	Attendant CNM‡ In-Hospital Births (n = 14,777)	CNM Out-of-Hospital Births (n = 4054)
Mother's race				
White	95.2	87.9	89.1	96.5
Other	4.3	11.4	9.8	3.3
Unknown	0.5	0.8	1.1	0.1
Mother's age (yrs)				
≤19	4.2	4.1	8.2	5.6
20–34	84.8	85.2	82.9	86.1
35+	10.9	10.6	9.0	8.3
Unknown	0.1	0.1	0.04	0.1
Marital status				
Married	86.3	85.0	83.0	89.4
Unmarried	13.0	14.9	16.5	10.3
Unknown	0.7	0.2	0.5	0.2
Mother's occupation				
Professional/technical	20.6	19.6	25.9	20.4
Nonprofessional	14.7	14.0	12.5	14.1
Clerical, sales, service	12.0	22.6	19.4	12.4
Housewife	55.1	41.4	39.7	52.8
Unknown	0.6	2.5	2.4	0.3
Residence				
Rural	53.4	51.0	44.2	49.4
Urban	46.6	49.0	55.8	50.6
County of birth				
King	32.2	32.7	44.2	30.7
Pierce	10.3	10.7	28.1	11.9
Snohomish	16.4	16.9	0	17.1
Other	41.1	40.7	27.7	40.3

* *Licensed midwives, out-of-hospital births.*
† *Medical doctors, in-hospital births.*
‡ *Certified nurse-midwives.*

a lesser degree. The proportion of women with prior fetal deaths after 20 weeks was higher in the physician and licensed midwife groups than among all women attended by nurse-midwives. Smoking during pregnancy was most common in the physician group, followed by the nurse-midwife in-hospital group. This trend was repeated with diabetes and preeclampsia.

Overall, the relative risk (RR) for low birthweight among the licensed midwife-attended births was significantly decreased (0.5) compared with the in-hospital nurse-midwife-attended births, when adjusting for parity, and trimester when prenatal care began (Table 3). No differences occurred in risk for low birthweight for the other two comparison groups. No statistically significant differences occurred between licensed midwife-attended births and any of the comparison groups in relative risk of a low five-minute Apgar score or in neonatal or postneonatal death.

The second analysis, restricting all births to those without antepartum risk factors, resulted in licensed midwife-attended births having a significantly lower risk of low birthweight than did births attended by physicians (RR = 0.7, 95% CI 0.5–0.9), whereas licensed midwives no longer differed significantly from in-hospital nurse-midwives in risk of low birthweight (RR = 0.8, 95% CI 0.6–1.2). No significant differences were observed between licensed midwives and other caregivers for any other outcome examined (Table 4).

Discussion

The findings of this study corroborate those of other studies evaluating infant outcomes in out-of-hospital births attended by midwives that reported no difference or an improvement in outcomes compared with physician-attended deliveries in hospitals (2,4,5,22,23).

Table 2. Risk Factors in Pregnancies Attended by Licensed Midwives, Physicians, and Certified Nurse-Midwives (%)

Characteristic	LM (n = 6944)	MD (n = 23,956)	Attendant CNM In-Hospital Births (n = 14,777)	CNM Out-of-Hospital Births (n = 4054)
Parity				
None	23.8	37.0	40.3	29.0
1+	75.1	62.1	59.1	70.6
Unknown	1.1	0.9	0.6	0.4
Number of prior pregnancies				
None	13.8	25.9	28.7	18.3
1	24.5	29.6	30.0	27.8
2+	61.1	44.0	40.7	53.8
Unknown	0.6	0.5	0.65	0.2
Trimester prenatal care begun				
First	62.0	78.5	79.6	68.5
Second/third/none	37.3	19.7	18.9	31.3
Unknown	0.7	1.8	1.5	0.3
Fetal deaths >20 wks				
None	93.8	95.3	97.6	95.4
≥1	3.6	3.7	1.7	1.4
Unknown	1.8	1.7	0.6	3.2
Smoking status				
No	71.0	58.78	66.0	57.5
Yes	10.7	16.9	13.1	9.5
Unknown	18.3	22.8	20.9	33.4
Diabetes				
No	98.0	87.0	90.6	94.9
Yes	0.3	1.6	0.8	0.2
Unknown	1.7	11.5	8.5	4.9
Preeclampsia				
No	98.0	85.4	89.4	94.7
Yes	0.3	3.1	1.9	0.3
Unknown	1.7	11.5	8.7	5.0

Table 3. Risk of Adverse Birth Outcomes by Delivery Attendant and Site

	No. LM	Rate/1000	No. MD	Rate/1000	RR	95% CI
LM or MD*						
Low birthweight†	76	10.9	389	16.5	0.8	0.6–1.0
Low 5-minute Apgar	75	10.8	237	10.0	1.2	0.9–1.5
Neonatal death‡	12	1.7	23	1.0	1.4	0.7–3.0
Postneonatal death	21	3.0	63	2.7	1.1	0.7–1.8
LM or CNM in hospital§				CNM		
Low birthweight‖			301	20.4	0.5	0.4–0.7
Low 5-minute Apgar			149	10.1	1.1	0.8–1.5
Neonatal death**			23	1.6	0.9	0.4–2.3
Postneonatal death			38	2.6	1.1	0.6–1.9
LM or CNM out of hospital††				CNM		
Low birthweight			36	8.9	1.4	0.9–2.1
Low 5-minute Apgar			40	9.9	1.1	0.8–1.7
Neonatal death			7	1.7	1.0	0.4–2.5
Postneonatal death			17	4.2	0.7	0.4–1.4

* *All RRs for LM/MD analysis adjusted for mother's age, parity, and county of birth.*
† *RR adjusted additionally for smoking.*
‡ *RR adjusted additionally for trimester prenatal care began.*
§ *All RRs for LM/CNM analysis adjusted for parity.*
‖ *RR adjusted additionally for trimester prenatal care began.*
** *RR adjusted additionally for county of birth.*
†† *All RRs for LM/CNM out of hospital adjusted for parity.*

Table 4. Risk of Adverse Birth Outcomes among Low-Risk Women by Delivery Attendant and Site

	No.	*Rate/1000*	*No.*	*Rate/1000*	*RR*	*95% CI*
LM or MD* (LM: n = 6456; MD: n = 23,596)						
Low birthweight†	59	9.1	389	16.4	0.7	0.5–0.9
Low 5-minute Apgar	67	10.4	237	10.0	1.1	0.8–1.4
Neonatal death‡	9	1.4	23	1.0	1.3	0.6–1.8
Postneonatal death	19	2.9	63	2.6	1.1	0.6–1.8
LM or CNM in hospital§ (CNM: n = 12,933)						
Low birthweight‖			140	10.8	0.8	0.6–1.2
Low 5-minute Apgar			123	9.5	1.2	0.9–1.6
Neonatal death**			8	0.6	3.0	1.0–8.7
Postneonatal death			34	2.6	1.2	0.6–2.1
LM or CNM out of hospital†† (CNM: n = 3840)						
Low birthweight‡‡			25	6.5	1.7	1.0–2.8
Low 5-minute Apgar			36	9.3	1.2	0.8–1.8
Neonatal death			5	1.3	1.2	0.4–3.5
Postneonatal death			17	4.4	0.7	0.3–1.3

* *All RRs for LM/MD analysis adjusted for mother's age, parity, and county of birth.*
† *RR adjusted additionally for smoking.*
‡ *RR adjusted additionally for trimester prenatal care began.*
§ *All RRs for SM/CNM analysis adjusted for parity.*
‖ *RR adjusted additionally for trimester prenatal care began.*
** *RR adjusted additionally for trimester prenatal care began, county of birth.*
†† *All RRs for LM/CNM out of hospital adjusted for parity.*
‡‡ *RR adjusted additionally for smoking, trimester prenatal care began.*

A recent small study in Washington state correlated type of practitioner with birth outcomes, concluding that licensed midwives had a lower rate of negative outcomes than physicians (11). The present study, using 10 years of data, confirmed earlier results with a larger sample size and compared outcomes of birth attended by licensed midwives with those attended by nurse-midwives and physicians.

A comparison was made between birth outcomes of home births attended by nurse-midwives and licensed midwives versus physicians in another study in Washington state using 1984–1985 birth certificate data (10). Rates of low birthweight were 0.7 percent for the midwives and 4.1 percent for physicians. Neonatal death rates were 1.5 and 5.2 percent, respectively, and postneonatal death rates were 3.8 and 3.4 percent. The contrast between physician and midwife outcomes in that study may have been due to the inclusion in the physician group of preterm births or births to mothers with medical conditions. Midwife-attended births should have better outcomes than physician-attended births if midwives refer high-risk clients appropriately to physicians, or, as in our study, similar outcomes compared with a truly low-risk physician-attended group.

The National Birth Center Study, which prospectively evaluated outcomes of 11,814 women giving birth in birth centers in the United States, reported low rates of neonatal death (1.3/1000 including intrapartum deaths), low birthweight (0.8%), and low Apgar scores (0.6 percent of infants born in birth centers, and another 0.6 percent for births in which an intrapartum transfer took place) (8). These findings are similar to this study's results for licensed-midwife-attended births out of hospital.

The finding that nurse-midwife-attended births in hospital had twice the risk of low birthweight as licensed-midwife-attended births can be evaluated in terms of gestational age. Almost 5 percent of pregnancies in the former group ended before 37 weeks, compared with 2.2 percent of the latter group and 2.4 percent of the nurse-midwife out-of-hospital group. It is possible that lower-income women who choose to deliver in hospital seek care by or are referred to midwives because their fees are less than those of physicians or because they are the only caregivers of indigent women in their community, and that these women are also at increased risk for low-birthweight babies. Our finding that this increased risk diminished when restricting the analysis to those women considered low risk supports this hypothesis.

Although this study was population based and was one of the largest to compare birth attendants, several potential limitations must be considered in interpreting the findings. First, information is lack-

ing on births in which an intrapartum transfer took place. Transfers occur in 8 percent (2) to 16 percent (4,7,8,23,24,25) of intended out-of-hospital births. This shortcoming was addressed in part by using an out-of-hospital cohort as one of our comparison groups. We still, however, cannot compare outcomes of transferred patients between the two out-of-hospital groups.

To address this issue partly, we examined outcomes for intrapartum transfers for the two years, 1989 and 1990, in which data about transfers were recorded on the birth certificates (31 percent of all licensed midwife births in this study occurred during this time). Since we could not discern the identity of the caregiver before the transfer, we examined neonatal deaths of infants of all women who were transferred to the hospital after an attempted delivery at home or at a birthing center. We restricted this analysis to births in which the baby weighed 2500 g or more, since only 1 percent of babies delivered by licensed midwives were of low birthweight. No deaths occurred during transfer or after an attempted delivery at home. Three deaths occurred after an attempted delivery at a birth center; causes were listed as anomaly of the abdominal wall, injury to the common femoral artery, and sudden infant death syndrome. Only 15 percent of birth center births were attended by licensed midwives during the study period, and if deaths are in proportion to births by practitioner type at this birth site, it is unlikely that they attended the births of these three infants. Therefore, we are reassured that knowledge of the status of babies born after intrapartum transfer from licensed midwife care would probably not alter our results substantially.

Second, the study was limited by missing or inaccurate data on birth certificates. Outcome variables that we assessed are known to be recorded with accuracy; however, we could not assess maternal morbidity factors such as infection and hemorrhage. The potential for misclassification of attendant in this study was overcome by careful checking of attendants with licensing rosters, and, in the case of identical identification codes, matching counties of birth with counties in which midwives were known to have practiced. We are therefore confident that no birth attendant was misclassified.

Third, the relatively small numbers of deaths among newborns and infants resulted in imprecise estimates of odds ratios. Although we calculated the study to have 80 percent power to detect an increase in relative risk for neonatal mortality of 1.7 or greater based on rates for Washington state in 1990, our low-risk study population had much lower rates. Therefore, comparisons between groups resulted in estimates with relatively wide confidence intervals.

Fourth, the study population was predominately white, and results cannot be generalized with certainty to other racial or ethnic groups. A large study group, a population-based design, and a time span of 10 years are factors that make the results of this study generalizable to other populations with a similar racial and ethnic composition.

Education of birth attendants influences practice outcomes. Planned home births attended by trained nonnurse-midwives have better outcomes than those attended by persons with less training (26,27). Licensed midwives in Washington have extensive academic and clinical training with a requirement for management of more pregnancies in the intrapartum period than that called for by the American College of Nurse-Midwives. Their high level of preparation may be responsible for low rates of adverse outcomes in their practice.

Safe intrapartum care also requires screening in the antepartum period. The reduced relative risk of low birthweight in the licensed midwife group compared with the in-hospital nurse-midwives in our first analysis suggests that screening for prematurity or intrauterine growth retardation was successful. The ability of nonnurse-midwives to select low-risk women for home birth also was demonstrated by others, who reported a rate of low birthweight of 4.9 percent among women in general who sought midwifery services, compared with 1.4 percent in women who were selected for home delivery (2).

The results of this study have several implications. If birth can be conducted safely out of hospital, there are advantages in cost. Licensed midwives charge less than physicians for their services (11), and a substantial savings is achieved by eliminating hospital costs. With the reassurance of safety, women may feel free to choose home birth to enjoy its attendant benefits of privacy, comfort, and increased autonomy. A matched cohort study (n = 483) found that childbirth was perceived to be considerably more painful in hospital than at home (28). A random survey of 2400 births in England and Wales reported that 92 percent of women who were delivered at home, but had their previous baby in hospital, preferred the home delivery (29).

Women may also seek to avoid unnecessary medical intervention by giving birth at home. In a prospective study that compared outcomes of 1707 lay midwife-attended home births with a sample of low-risk, physician-attended births, no significant differences were reported in neonatal outcomes or

labor-related complications (4). However, the rate of assisted deliveries in physician-attended births was 26.6 percent compared with 2.1 percent in the midwife group (including referrals to physicians), and the cesarean section rate was 16.5 percent compared with 1.5 percent (4). This discrepancy in obstetric procedures was described in other matched studies (5,6).

Decreases in frequencies of adverse outcomes among licensed midwife births resulting from restricting antepartum risk factors suggest the need for universally accepted criteria for screening women for their suitability for out-of-hospital birth. A professional midwives' association could set standards for screening and establish a central data registry to which licensed midwives could send copies of their records. A registry would aid the organization in ensuring that professional standards were being maintained, and also overcome some of the problems encountered with data quality when using birth certificate data.

The results of this study suggest that the appropriate practice of licensed nonnurse-midwives whose training meets international standards may be as safe as that of physicians delivering women in hospital settings and that of certified nurse-midwives in and out of hospital. Additional study of these types of obstetric caregivers in larger populations is warranted to confirm these findings.

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EVOLUTION AND CURRENT STATUS OF DIRECT-ENTRY MIDWIFERY EDUCATION, REGULATION, AND PRACTICE IN THE UNITED STATES, WITH EXAMPLES FROM WASHINGTON STATE*

Jo Anne Myers-Ciecko, MPH

ABSTRACT

This paper describes the re-emergence of direct-entry midwifery in the United States, and focuses specifically on the over 1,000 midwives nationwide who are licensed in the 16 states where direct-entry midwifery is legal and regulated, and/or certified by the North American Registry of Midwives; it does not focus on direct-entry midwives or nurse-midwives who are certified by the American College of Nurse-Midwives Certification Council, Inc. Professional developments of direct-entry midwives are highlighted, including the establishment of core competencies and articulation of values, the creation of a certification process, and development of education program accreditation. The current status of licensed midwives in Washington State, where state policies have supported the development of direct-entry midwifery and the integration of direct-entry midwives into managed care systems, is presented as one example of the evolution of professional direct-entry midwifery in this country. Additionally, recommendations from the UCSF Center for the Health Professions *Taskforce on Midwifery*, which address particular areas of concern for direct-entry midwives, are discussed. J Nurse Midwifery 1999;44: 384–93 © 1999 by the American College of Nurse-Midwives.

This paper describes the evolution of direct-entry midwifery from a grassroots movement to a legitimate profession with national standards for accreditation of direct-entry midwifery education programs and examination and certification of individual direct-entry midwives.† Public policies and other considerations affecting the status of direct-entry midwives and examples from Washington State are discussed in light of recommendations made by the UCSF Center for Health Professions *Taskforce on Midwifery* (1). An estimated 1,000 direct-entry midwives currently hold state licenses or are certified by the North American Registry of Midwives (NARM) (1). Most births attended by these midwives occur in homes or in birth centers (3). This experience in noninstitutional, community-based care permeates the philosophy and practice of direct-entry midwives.

EVOLUTION OF DIRECT-ENTRY MIDWIFERY

Background

After the dramatic decline in the number of direct-entry midwives in the United States in the first half of this century (4–5), direct-entry midwifery re-emerged during the 1960s and 1970s as a grassroots movement among women seeking home births (6). This movement built upon the earlier prepared childbirth and natural birth movements, yet it was a localized phenomenon among specific feminist women's health activists, holistic health care providers, back-to-nature enthusiasts, and religious or spiritual communities. Since very few physicians or nurse-midwives were either willing or able to attend home births, women who distrusted the over-medicalization of birth and wanted more personalized care turned to each other for support. Some formed study groups and read the medical literature on childbirth while sharing what they were learning from practical experience. *The Birth Book* written by Raven Lang in 1972, was the first publication to describe the home birth movement, including stories about women having home births in Santa Cruz, California (7–8). In 1975, Ina May Gaskin published *Spiritual Midwifery*, a book that described her apprenticeship with a family physician and the births she and other lay midwives were attending in their community, The Farm, in Summertown, Tennessee (9). Other midwives organized home-study courses or taught basic midwifery skills in intensive workshops (10).

A group of young women in Seattle organized themselves as the Fremont Women's Clinic Birth Collective

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† Direct-entry midwives begin their education in midwifery directly, rather than through nursing. While the American College of Nurse-Midwives (ACNM) Certification Council, Inc. (ACC) now has a provision for certifying non-nurses as Certified Midwives (CMs), they currently represent less than 1% of all direct-entry midwives in the US and are not the focus of this paper. CMs are discussed in another paper in this issue (2).

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and began attending home births, supported by several like-minded young physicians (11). In 1978, these midwives founded the Seattle Midwifery School, one of several small independent schools launched during that period. Birth centers run by direct-entry midwives, including The Maternity Center in El Paso, Texas, and the Northern New Mexico Birth Center in Taos, New Mexico, also began to accept students who traveled from across North America to obtain short, intensive clinical training (10). Women who had experienced home births with midwives formed consumer organizations or joined with midwives to organize state midwifery associations. These state associations typically established their own standards for training and practice within the context of political concerns and the legal status of midwifery in each specific state.

Midwives Alliance of North America

Midwives and their supporters across the country soon realized the importance of developing a more unified body, and several unsuccessful attempts at national organization were made. Finally, in 1982 the Midwives Alliance of North America (MANA) was established to "honor diversity in midwifery educational background and practice styles while fostering unity among all midwives." The creation of MANA followed a meeting of direct-entry midwives and nurse-midwives convened by Sister Angela Murdaugh, CNM, then President of the American College of Nurse-Midwives (ACNM) (12). Membership in MANA has never been limited to midwives with specific credentials and all midwives are encouraged to participate. In February 1999, MANA had over 1,000 members, two-thirds of whom were midwives and one-third of whom were associate members. MANA has always had a fairly significant non-midwife membership comprised of consumers, aspiring midwives, and other health care professionals who support midwifery (Kelly Daniels, MANA Membership Chair, personal correspondence, 1999). Despite ongoing internal debate about the pros and cons of professionalization, MANA adopted standards of practice in 1985, created a board to test basic midwifery knowledge through a written examination in 1987, adopted core competencies in 1989, and issued a statement of values and ethics in 1991 (13).

What had begun as a grassroots movement responding to consumer demand for home births has gradually taken form as a professional body. Starr asserts that the "legitimization of professional authority involves three distinctive claims: first, that the knowledge and competence of the professional have been validated by a community of peers; second that this consensually validated knowledge and competence rest on rational, scientific grounds; and third, that the professional's judgement and advice are oriented toward a set of substantive values, such as health" (14). All three elements are now present among professional direct-entry midwives in the United States.

DEVELOPMENT OF AUTHORITY FOR DIRECT-ENTRY MIDWIVES

Midwifery Values and Ethics

Direct-entry midwives are oriented to a set of substantive values that have been informed by serving women who choose to give birth at home or in birth centers—a choice that suggests a commitment to assume or share responsibility for decisions about their own health care. The Statement of Values and Ethics adopted by MANA in 1991 affirms the midwives' view of women as individuals with unique value and worth (15): "We value women and their creative, life-affirming and life-giving powers which find expressions in a diversity of ways. We value a woman's right to make choices regarding all aspects of her life." The mother and baby as a whole, the importance of relationships, personal responsibility, informed choice, the sharing of information and diversity among midwives are also stated as values. Social scientists who have studied direct-entry midwifery practice describe the distinctive nature of midwifery care and out-of-hospital birth, as well as beliefs and practices that are consistent with MANA's statement of values and ethics.

Sullivan and Weitz, for instance, interviewed midwives in both Arizona and Massachusetts during the early 1980s (16). They found a striking congruence in the midwives' beliefs about pregnancy and childbirth, despite considerable divergence in their educational backgrounds and in the legal status of midwifery in these two states. The researchers attributed this to a shared philosophy that emphasizes a wellness orientation, holistic and individualized care, and shared responsibility between the midwife and the mother. Sakala, who conducted in-depth interviews with midwives attending home births in Utah in 1985, found that they were motivated by a desire to avoid the iatrogenic consequences of conven-

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tional obstetric interventions (17). They also emphasized individualization of technique and providing care for the mother in the context of her overall life circumstances. They defined continuity of care as an approach that includes long prenatal visits to build trusting relationships and intrapartum support that began early in labor. These midwives also emphasized respect for the knowledge, resources, and capability of the mother and her close family and friends, thus employing prenatal and intrapartum empowerment as a fundamental therapeutic technique.

Development of a National Certification Process for Direct-Entry Midwives

In addition to their orientation to these values, direct-entry midwives are now able to claim legitimate professional authority through the validation of knowledge and competence by a community of peers—knowledge and competence that rest on rational, scientific grounds. MANA's Interim Registry Board began to administer a written test to validate knowledge of individual midwives in 1989, however, candidates were not required to provide evidence of their qualifications and skills were not evaluated. In 1991, the board incorporated separately as the North American Registry of Midwives (NARM) and work was begun to set standards for the qualification of professional midwives and the comprehensive evaluation of competency (18). NARM is committed to "identifying standards and practices that preserve the unique, woman-centered forms of practice that are common to midwives attending out-of-hospital births."

A Certification Task Force was convened in 1992 to oversee the establishment of standards, policies and procedures for the certification of midwives. The Task Force met periodically over the next 6 years while NARM initiated a pilot project aimed first at the certification of experienced midwives and later, at entry-level midwives. Completing the certification process entitles a midwife to use the title "Certified Professional Midwife" or "CPM." The first group of experienced midwives became CPMs in 1995. Although certification remains entirely voluntary, over 400 experienced and entry-level midwives elected to complete the process in order to become CPMs between 1995 and April 1999 (Sharon Evans, NARM, personal correspondence).

In early 1996, NARM performed a comprehensive job analysis and translated the results into new specifications for both the written examination and a clinical skills assessment (18). Citizens for Midwifery commissioned an independent review of the NARM certification process in 1997. Experts in competency-based education and assessment from the Ohio State University Vocational Instructional Laboratory examined the processes used to develop the certification tests and testing procedures and reported that NARM's process represented "best practice" within certification industry standards: "The development of the content specifications based on the job analysis information was focused on the primary purpose of certification—the protection of public health and safety. The procedures used for test item writing, content validation, setting pass/fail scores, and the development of the overall certification process represent a system explicitly designed to optimize fairness and accuracy in certification testing" (19).

During the pilot project, entry-level midwives were required to establish eligibility by providing extensive documentation that a supervisor or preceptor had assessed specific skills, knowledge, and abilities. They were not required to have completed a formal educational program. Applicants had to provide evidence of a minimum number of clinical experiences encompassing prenatal, intrapartum, newborn, and postpartum care. This included attending a minimum of 20 births as an active participant and another 20 births in the role of primary midwife, while working under supervision. Ten of these had to be births in homes or other out-of-hospital settings, and at least 3 of the total of 40 births had to be with women for whom the applicant had provided primary care during at least 4 prenatal visits, the birth, a newborn exam, and a postpartum exam. In addition, the applicant had to have conducted 75 prenatal exams, including 20 initial exams; 20 newborn exams; and 40 postpartum exams. Once eligibility was established, entry-level applicants were required to pass the written examination as well as an assessment of clinical skills conducted by a specially trained CPM (20).

At the final meeting of the Certification Task Force in 1998, it was decided that NARM should separate the two processes of educational evaluation and certification while keeping essentially the same clinical experience requirements in place (21). Entry-level midwives who are graduates of educational programs accredited by the Midwifery Education Accreditation Council (MEAC) and midwives certified by the ACNM Certification Council (ACC) are now only required to pass the NARM written examination to become CPMs. All other midwives, including those who have not completed formal educational programs and those who have graduated from nonaccredited programs, must establish that their educational preparation has met the requisite knowledge and skills by submitting a portfolio that documents their experience and includes a comprehensive assessment by a supervising midwife. Portfolio applicants are then required to complete both the written examination and a NARM-administered skills assessment.

Development of an Evaluation Process for Direct-Entry Education Programs

The Midwifery Education Accreditation Council (MEAC) was founded in 1991 by a coalition of midwifery educators to create a mechanism for evaluation of direct-entry midwifery education programs (22). Each school is required to articulate the philosophy and purpose of its program, to provide a curriculum based on MANA's core competencies and NARM's knowledge and skills requirements, and to meet other standards. The core competencies identified by MANA include skills and knowledge in the following areas: general social and health sciences; antepartum, intrapartum, postpartum, and neonatal care; family planning/well woman care; and professional and legal aspects of midwifery practice. The accreditation process includes preparation of a self-evaluation report by faculty and staff of the program and site visits conducted by representatives of MEAC. The agency's standards and procedures follow guidelines established by Congress in the Higher Education Act (23).

Maternidad la Luz, in El Paso, Texas, was the first direct-entry midwifery education program accredited by MEAC. By April 1999, three programs had received full accreditation and six had been pre-accredited (23). A program that is pre-accredited has not yet graduated students, but has met all other criteria for accreditation. By the end of 1999, MEAC will have completed one full cycle of re-accreditation, having reviewed all of the programs previously accredited or pre-accredited for two or more years. The agency will conduct a complete self-evaluation process before seeking formal recognition by the U.S. Department of Education.

In addition to the 9 MEAC-accredited or pre-accredited programs, 16 other direct-entry midwifery schools have reported that their programs address all of the MANA core competencies and include the clinical experiences required for NARM certification (24). Six of these have stated their intention to seek MEAC accreditation or pre-accreditation status in 1999 (23). Two other schools offer comprehensive programs that are not linked to national standards and 11 offer short courses, workshops, or clinical experiences that are not part of a complete midwifery program. Most of the latter are located in states that do not recognize or regulate direct-entry midwifery.

LEGAL STATUS OF DIRECT-ENTRY MIDWIVERY

According to a 1998 ACNM analysis of available statutes, regulations, and court rulings (25), 16 states regulate direct-entry midwifery practice. Over 700 direct-entry midwives are currently licensed or otherwise regulated in these 16 states (1). Sixty percent of all licensed midwives are located in just 4 states: California, Florida, Texas, and Washington (1). Another 12 states (Alaska, Arizona, Arkansas, Colorado, Louisiana, Montana, New Hampshire, New Mexico, New York, Oregon, Rhode Island, and South Carolina) have regulatory mechanisms that include a wide variation in direct-entry midwifery scope of practice, qualifications for practice, requirements regarding supervision, and arrangements for medical consultation and referral. For example, Florida now requires that midwifery education programs be accredited by MEAC, while New Mexico law provides for apprenticeship training that culminates in the acquisition and evaluation of a specific body of knowledge and skills.

In addition to the 16 states that regulate direct-entry midwifery, there are 13 jurisdictions (Connecticut, District of Columbia, Idaho, Indiana, Kansas, Maine, Massachusetts, Mississippi, North Dakota, Tennessee, Utah, Vermont and Wyoming) where the practice is legal but unregulated, and statutory provisions are unclear in another 5 states (Michigan, Nevada, North Carolina, Ohio, and Wisconsin). Direct-entry midwifery practice is effectively prohibited in 7 states (Alabama, Georgia, Kentucky, Minnesota, Missouri, New Jersey, and Pennsylvania) and legally prohibited in another 10 (Delaware, Hawaii, Illinois, Iowa, Maryland, Nebraska, Oklahoma, South Dakota, Virginia and West Virginia) (25).

The total number of direct-entry midwives who have met state licensing and/or national certification standards is thought to be over 1,000 nationwide, with perhaps 20% of these being both certified and licensed (Sharon Evans, NARM, personal correspondence). The number of midwives who are neither certified nor state licensed is unknown. Births attended by direct-entry midwives are reported in nearly every state, including states where their practice illegal (26). The total number of birth certificate recorded births by "other midwives" has been consistent at less than 1% of all births per year (1,26).

Fourteen of the 16 states that currently regulate direct-entry midwifery practice now require or recognize the NARM written exam as an element in licensure and several states, including Washington state are considering proposals to recognize the CPM. (Pamela Weaver, NARM, personal correspondence).

DIRECT-ENTRY MIDWIFERY IN WASHINGTON STATE

Washington state has a particularly strong history of supporting the development of the direct-entry midwifery profession as well as choice and access to care for childbearing women. The original statute regulating direct-entry midwifery was adopted in 1917 and required 2 years of schooling. A number of foreign-trained midwives were licensed by the state over the next 2 decades. The statute was rediscovered in the mid-1970s and, following a study commissioned by the state legislature, was revised in 1981 to incorporate contemporary inter-

national standards for midwifery education and practice (27). Licensed midwives provide prenatal, intrapartum, and postpartum care and are considered independent practitioners, required only to "consult with a physician whenever there are significant deviations from normal in either the mother or the infant" (28). The Midwives Association of Washington State adopted guidelines in 1996 that specify conditions that require consultation and/or referral (29).

The state Medicaid program recognized licensed midwives as qualified providers in the early 1980s but did not reimburse for any out-of-hospital births until a birth-center licensing law was adopted in 1986. Medicaid therefore, only compensated licensed midwives for prenatal and postpartum care unless the birth was done in a licensed birth center. Recommendations of a Department of Social and Health Services task force that Medicaid policies be changed to cover home birth services will be implemented in 1999 (Jane Beyer, Washington State DHSHS, personal correspondence).

Direct-entry midwives licensed in Washington state provide just one example among many of the midwives across the country who embrace the core values of MANA and have demonstrated that their knowledge and competence meets the standards set by MANA, NARM, and MEAC. Washington state law requires licensed midwives to complete 3 years in a state-approved midwifery educational program, which includes participation in 100 or more births (28). As of January 1999, there were two state-approved educational programs: The Seattle Midwifery School, founded in 1978 and accredited by MEAC in 1997, and Bastyr University's midwifery program, which is designed exclusively for naturopathic physicians. Both programs emphasize training in out-of-hospital birth (30,31).

Since 1981, licensed midwives have attended between 1% and 2% of all births in Washington state (32). Most attend home births, but direct-entry midwives also own and operate seven of the eight licensed birth centers in the state. Currently, 115 midwives are licensed in Washington; it is estimated that 80% are in practice or doing related work. Although the percent of births attended by direct-entry midwives has remained fairly constant, licensed midwives are beginning to make significant inroads into managed care and formal health care systems.

In 1993, responding to public demand for health care reform, the legislature adopted a number of laws affecting the delivery of health services. Certain insurance carriers were required to provide for the inclusion of every category of licensed health professional, a mandate that includes licensed midwives, who are considered to constitute a different category than certified nurse-midwives (33). The state insurance commissioner has committed resources to assure access to the full range of health care services by addressing barriers to integrating every category of provider into all health plans in the state (L. L. Bielinski, Washington Office of the Insurance Commissioner, personal correspondence). The legislature created a Joint Underwriting Association (JUA) in 1993 and mandated participation by all liability carriers in the state to assure that licensed midwives, certified nurse-midwives, and licensed birth centers could purchase malpractice insurance (34). The Midwives Association of Washington State laid the groundwork for a quality assurance mechanism that was further developed by a midwife-owned private company, which now provides risk management services through contracts with the JUA (Victoria Taylor, Quality Midwifery Associates, personal correspondence). The legislature added all midwifery students to the state's health professional scholarship program in 1989 (35). Recipients are obligated to work in health professional shortage areas.

State-wide support through the years has been enhanced by a number of studies on the subject of midwifery and maternity care, including a retrospective study published in 1994 of Washington state linked birth and infant death certificate data, in which outcomes of 6,944 out-of-hospital births attended by licensed midwives were compared with outcomes for 23,596 low-risk hospital births attended by physicians and 14,777 hospital births and 4,054 out-of-hospital births attended by certified nurse-midwives (36). Results indicated that for those data available through birth and death certificates—low birthweight, 5-minute Apgar scores, and neonatal and postneonatal mortality—there were no differences between outcomes for midwife-attended births and those attended by physicians. Another retrospective study, conducted by the Department of Social and Health Services, found very low rates of poor outcomes among Medicaid women in Washington state who planned home births and received some or all of their prenatal care from licensed midwives (37).

In 1998, a survey of all licensed midwives currently residing in Washington state was conducted by the author (38); respondents included 63 (58%) of the 109 midwives to whom surveys were distributed. Sixty-five percent of the respondents were in clinical midwifery practice, 23% were doing related work in public health departments, physician's offices, community clinics, or family planning organizations. Respondents reported attending 1 to 2 births per month on average, although they would have preferred to be doing 3 to 4 per month. Half of the midwives surveyed consulted primarily with one physician, while the other half maintained regular consulting relationships with more than one physician. Most midwives did not consider physician consultation relationships to be a serious barrier to practice.

Study results also indicated that the median charge for complete maternity care by survey respondents was $2,200, with a range from $1,400 to $3,000 (38). Licensed midwives received payment from all sources, including self-pay, fee-for-service insurance plans, preferred provider and managed care organizations, and Medicaid (both fee-for-service and managed care). Medicaid accounted for 37% of all payment received by all survey respondents in 1997, but accounted for 48% of payments to licensed midwives who worked in health professional shortage areas as an obligation of having received state scholarship support for their midwifery education. Most respondents reported having one or more managed care contracts. Even so, the three most significant barriers to practice reported were: difficulty obtaining third-party reimbursement, inadequate compensation per episode of care, and difficulty obtaining contracts with managed care plans.

Group Health Cooperative of Puget Sound was one of the first managed care plans in Washington state to recognize the potential benefit of providing home birth and direct-entry midwifery services (39). Group Health has contracted with licensed midwives since 1996 to make home birth services available to all plan members. The Group Health Cooperative's involvement with direct-entry midwives followed a 1995 survey in which they found that 8 percent of their members were interested in the idea of a midwife-attended home birth and might use such a service if Group Health would provide the same benefits for a home birth that it provides for an in-hospital birth. An internal task force determined that licensed midwives were best qualified to provide home birth services and developed a framework to support integrating them into the co-op. Group Health enrollees may self-refer to a licensed midwife. The midwife provides all prenatal, labor, birth, and newborn postpartum care, and consults with Group Health physicians and nurse-midwives as needed. When home- or birth-center to hospital transports are indicated, they are accepted within the context of the whole system of care. Certified nurse-midwives employed by Group Health may also be involved in the care of women who are transferred to a Group Health Hospital from a home birth. This model of transferring care from an out-of-hospital midwife to an in-hospital midwife is becoming increasingly common in Washington.

NATIONAL RECOMMENDATIONS AND DIRECT-ENTRY MIDWIFERY

UCSF Center for the Health Professions *Taskforce on Midwifery*

In early 1998, the University of California at San Francisco Center for the Health Professions convened a Taskforce on Midwifery to explore the impact of health care system developments on midwifery and identify issues facing the profession and the role midwives play in the health care system (1,40). The Taskforce presented 14 recommendations on midwifery practice, regulation, education, research, and policy, all incorporating the vision that the "midwifery model of care should be embraced by and incorporated into the health care system in order to make it available to all women and their families" (1). Midwives, educators, collaborators, and policy makers were urged by the Taskforce to use the recommendations to develop curricula, practice sites, and laws that fully include midwives and the midwifery model of care with the goal of improving the health care system.

The following is an assessment of several *Taskforce on Midwifery* recommendations as they relate to the status of regulation, education, practice and credentialing, research, and policy for direct-entry midwifery in the United States:

Recommendation 1. *Midwives should be recognized as independent and collaborative practitioners with the rights and responsibilities regarding scope of practice authority and accountability that all independent professionals share.*

Recommendation 2. *Every health care system should integrate midwifery services into the continuum of care for women by contracting with or employing midwives and informing women of their options* (1). As health care systems consider introducing or expanding the use of direct-entry midwives, they should examine the successes and the challenges experienced by licensed midwives in states that recognize the independent and collaborative practice of midwifery. Licensed midwives in Washington state provide an example that might be useful in developing guidelines for the integration of midwifery services.

Recommendation 4. *Midwives and physicians should ensure that their systems of consultation, collaboration, and referral provide integrated and uninterrupted care to women, which requires active engagement and participation by members of both professions* (1). Since most physicians have never worked with direct-entry midwives, they have little direct knowledge of their qualifications or practice. Misinformation and bias regarding the safety of home and birth center practices are commonly encountered when midwives seek to establish consulting relationships. Even though most licensed midwives in Washington state have not considered physician consultation and referral to be a major barrier to practice, their options for physician consultation are often limited by the fact that most physicians have not made themselves available to midwives (38).

Recommendation 5. *State legislatures should en-*

act laws that base entry-to-practice standards on successful completion of accredited education programs, or the equivalent, and national certification and that do not require midwives to be directed or supervised by other health care practitioners (1). The North American Registry of Midwives standards for certification as a CPM, which require completion of an accredited program, or the equivalent documentation and evaluation of knowledge and skills (20), are consistent with this recommendation. Policymakers in various states are already beginning to recognize the utility of employing NARM certification and MEAC accreditation mechanisms in regulatory activities; specifically, 14 states now use the NARM written examination while Florida requires that educational programs be MEAC accredited.

Recommendation 6. *Hospitals, health systems, and public programs, including Medicare and Medicaid, should ensure that enrollees have access to midwives and the midwifery model of care by eliminating barriers to access and inequitable reimbursement rates that discriminate against midwives.*

Recommendation 7. *Health care systems develop hospital privileging and credentialing mechanisms for midwives that are consistent with the profession's standards, recognize midwifery as distinct from other professions, and recognize established processes that permit midwives to build upon their entry-level competencies within their statutory scope of practice* (1). Group Health Cooperative of Puget Sound (described previously) provides a model for accomplishing this recommendation, providing access to midwives and the midwifery model of care in hospital and home settings. Obtaining hospital privileges for direct-entry midwives, however, represents a considerable challenge. Although direct-entry midwives have historically based their practice in the out-of-hospital setting, a few have sought hospital employment or independent admitting privileges. It is plausible that many women would appreciate the option of choosing a direct-entry midwife to attend a planned hospital birth or the opportunity to have their midwives follow them into the hospital when change of location from a planned birth-center or homebirth is indicated. Privileging and credentialing mechanisms that recognize direct-entry midwives would make this possible.

Recommendation 8. *Education programs should provide opportunities for interprofessional education, multiple points of entry, and collaboration and/or affiliation with colleges and universities* (1). Many direct-entry midwifery education programs have provided informal opportunities for physicians, nurses, childbirth educators, and doulas to participate in didactic courses or clinical experiences that expose them to the midwifery model of care and some have actively sought and built relationships with colleges and universities. There is, however, a deep, abiding desire among direct-entry midwives and consumers for midwifery education to remain autonomous in order to preserve the model of education, as well as the model of practice, that developed specifically in response to the needs of women seeking home and birth-center options. These concerns will best be addressed when colleges and universities recognize the value of direct-entry midwifery programs and seek to enter into partnerships for mutual benefit.

Recommendations 9 and 11. *Midwifery education programs should include content related to practice management, the impact of health care policy on midwifery practice, and cultural competence* (1). These topics, already addressed in some programs, will become increasingly significant as more direct-entry midwives enter the mainstream as health care providers with managed care contracts or with jobs in formal health care systems.

Recommendation 10. *The midwifery profession should recognize the benefits of teaching midwifery in a variety of education programs and affirm the value of competency-based education in all midwifery programs* (1). The standards set by MEAC for accreditation of a range of midwifery programs based on MANA Core Competencies are consistent with this recommendation. MEAC recognizes degree and nondegree granting programs. MEAC provides mechanisms for the accreditation of institutions solely devoted to midwifery education, as well as midwifery education programs based in institutions that are accredited by nationally recognized agencies that do not specialize in assessment of midwifery education programs.

Recommendation 12. *Midwifery research should be strengthened and funded in a wide range of areas from the analyses of how midwives complement and broaden the woman's choice of provider, setting; and model of care to studies of normal pregnancy, normal labor and birth, health parent-infant relationships, and breastfeeding; and satisfaction with maternity and midwifery care* (1). Most research activities concerning direct-entry midwives have been conducted at the state level or through private initiative. MANA began collecting data from members on a voluntary basis in 1993 and now has detailed information on the care provided to more than 11,000 women who were initiated as planned home or birth center births under the care of a midwife; this figure includes clients of both direct-entry and CNM members of MANA (41). Several descriptive reports drawn from the data have appeared in the organization's newsletter, including basic demographics, transfer rates and reasons for transfer from intended home and birth center births, medical interven-

tion rates, breastfeeding success, and the perinatal mortality rates for Manitoba and Minnesota.

The homebirth movement and the re-emergence of direct-entry midwifery have drawn the attention of a wide array of researchers, including sociologists, political scientists, anthropologists, historians, lawyers, and public health researchers (42–48). Their work includes analyses of the content of care provided by direct-entry midwives, descriptions of the historical development of the movement, case studies of regulatory issues, and so on. Additionally, a considerable amount of unpublished work has been done by graduate students in academic programs (49–52). Despite the attention given to midwifery in some circles, policy-relevant research involving midwives in the United States are limited by the midwifery profession's own limited resources, a lack of outside funding, and the lack of uniform data collection. These gaps are particularly true of direct-entry midwives.

The Taskforce recommendations for research priorities are comprehensive and far-reaching. Direct-entry midwifery should be included in each of the areas suggested for research. Direct-entry midwives have much to contribute, especially to research on normal pregnancy, labor and birth; and satisfaction with maternity and midwifery care (41).

Recommendation 14. *Federal and state agencies should broaden systematic data collection, which has traditionally focused on medicine and physicians, to include midwifery and midwives* (1). Birth certificate data, a widely used research resource with well-acknowledged limitations, have been used to assess direct-entry midwifery practice in some states, including the comparative study of licensed midwives in Washington described previously (36). In 1995, Declercq examined birth certificate data to determine the demographic and medical risk profiles of the population served by midwives, including women served by direct-entry midwives (53). But, because direct-entry midwives do not complete birth certificate information in some states, there is underreporting of the actual number of births attended by direct-entry midwives.

Some states, like Arizona and New Mexico, require licensed midwives to report specific procedures and outcomes within the context of regulation. Sullivan and Beeman used this data to review 4 years' experience with licensed midwives in the early 1980s (54). Similarly, state midwifery associations and other private entities, including third-party payors and malpractice insurance providers, often require data collection. However, retrieval of this proprietary information for analysis and public review has proven problematic.

Recommendation 15. *A research and policy body, such as the Institute of Medicine, should be asked to study and offer guidance on significant aspects of the midwifery profession* (1). More than half of all states have explored legislation or public policy changes related to direct-entry midwifery regulation, education, and/or practice in recent years. Florida, which had earlier set aside a direct-entry midwifery statute, reauthorized licensure in 1993. Then Governor Lawton Chiles subsequently called for a dramatic increase in the proportion of midwife-attended deliveries. Florida state law now mandates managed care plan contracting/reimbursement for licensed midwives (55,56). Several direct-entry midwifery education programs have been started, including a publicly funded program at Miami-Dade County Community College. The California Bureau of Health Professions called for the legalization of midwifery as early as 1986, though legislation setting standards for licensure was not adopted until 1993. California law also mandates insurance reimbursement for licensed midwives (57,58).

Even though direct-entry midwifery has been on the agendas of various state legislators for many years, there has been a dearth of public policy discussions, and initiatives programs, related to the goal of recognizing and expanding the use of direct-entry midwives nationally. At least 10% of all midwives in the United States today are direct-entry midwives who are licensed to practice in their state and/or certified by NARM. These midwives represent a valuable resource and their representatives should be included in any group assigned to examine public policies as they relate to the midwifery profession and/or maternal health care.

CONCLUSION

Direct-entry midwifery in the United States is re-establishing itself as a legitimate profession and, as such, is of growing interest to both the private sector and public policymakers. National certification and education program accreditation are two new developments that will support further growth of the profession. While the Washington experience is not representative of direct-entry midwifery in all parts of the country, it provides an example of what can be accomplished when legal, educational, and other supports are in place. The Group Health survey suggests that home birth and birth centers may have wider appeal than is reflected in the current birth statistics.

Public policymakers and health care purchasers seeking innovative models for the delivery of cost-effective, high quality care may find that direct-entry midwives are a maternity care resource that should be examined more closely. Direct-entry midwifery care is an attractive and economical option for healthy women who choose to give birth at home or in a birth center. With increasing public awareness, health plan interest in low-cost, high-quality alternatives; and the continuing professionalization of direct-entry midwifery; this innovative model for

the provision of maternity care could become more widely utilized.

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Key for letter after phone number and sample of time of day compared with other zones:

AK—Alaska Time	7 am
P—Pacific Time	8 am
M—Mountain Time	9 am
C—Central Time	10 am
E—Eastern Time	11 am

The Mother-Friendly Childbirth Initiative

The First Consensus Initiative of the Coalition for Improving Maternity Services (CIMS)

Mission

The Coalition for Improving Maternity Services (CIMS) is a coalition of individuals and national organizations with concern for the care and well-being of mothers, babies, and families. Our mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs.

Preamble

Whereas:

- In spite of spending far more money per capita on maternity and newborn care than any other country, the United States falls behind most industrialized countries in perinatal* morbidity* and mortality, and maternal mortality is four times greater for African-American women than for Euro-American women;
- Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes, yet in the United States, midwives are the principal attendants at only a small percentage of births;
- Current maternity and newborn practices that contribute to high costs and inferior outcomes include the inappropriate application of technology and routine procedures that are not based on scientific evidence;
- Increased dependence on technology has diminished confidence in women's innate ability to give birth without intervention;
- The integrity of the mother-child relationship, which begins in pregnancy, is compromised by the obstetrical treatment of mother and baby as if they were separate units with conflicting needs;
- Although breastfeeding has been scientifically shown to provide optimum health, nutritional, and developmental benefits to newborns and their mothers, only a fraction of U.S. mothers are fully breastfeeding their babies by the age of six weeks;
- The current maternity care system in the United States does not provide equal access to health care resources for women from disadvantaged population groups, women without insurance, and women whose insurance dictates caregivers or place of birth;

Therefore,

We, the undersigned members of CIMS, hereby resolve to define and promote mother-friendly maternity services in accordance with the following principles:

Principles

We believe the philosophical cornerstones of mother-friendly care to be as follows:

Normalcy of the Birthing Process

- Birth is a normal, natural, and healthy process.
- Women and babies have the inherent wisdom necessary for birth.
- Babies are aware, sensitive human beings at the time of birth, and should be acknowledged and treated as such.
- Breastfeeding provides the optimum nourishment for newborns and infants.
- Birth can safely take place in hospitals, birth centers, and homes.
- The midwifery model of care, which supports and protects the normal birth process, is the most appropriate for the majority of women during pregnancy and birth.

Empowerment

- A woman's confidence and ability to give birth and to care for her baby are enhanced or diminished by every person who gives her care, and by the environment in which she gives birth.

* see glossary on next page

- A mother and baby are distinct yet interdependent during pregnancy, birth, and infancy. Their interconnectedness is vital and must be respected.
- Pregnancy, birth, and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies, fathers, and families, and have important and long-lasting effects on society.

Autonomy

Every woman should have the opportunity to:

- Have a healthy and joyous birth experience for herself and her family, regardless of her age or circumstances;
- Give birth as she wishes in an environment in which she feels nurtured and secure, and her emotional well-being, privacy, and personal preferences are respected;
- Have access to the full range of options for pregnancy, birth, and nurturing her baby, and to accurate information on all available birthing sites, caregivers, and practices;
- Receive accurate and up-to-date information about the benefits and risks of all procedures, drugs, and tests suggested for use during pregnancy, birth, and the postpartum period, with the rights to informed consent and informed refusal;
- Receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs.

Do No Harm

- Interventions should not be applied routinely during pregnancy, birth, or the postpartum period. Many standard medical tests, procedures, technologies, and drugs carry risks to both mother and baby, and should be avoided in the absence of specific scientific indications for their use.
- If complications arise during pregnancy, birth, or the postpartum period, medical treatments should be evidence-based.

Responsibility

- Each caregiver is responsible for the quality of care she or he provides.
- Maternity care practice should be based not on the needs of the caregiver or provider, but solely on the needs of the mother and child.
- Each hospital and birth center is responsible for the periodic review and evaluation, according to current scientific evidence, of the effectiveness, risks, and rates of use of its medical procedures for mothers and babies.
- Society, through both its government and the public health establishment, is responsible for ensuring access to maternity services for all women, and for monitoring the quality of those services.
- Individuals are ultimately responsible for making informed choices about the health care they and their babies receive.

These principles give rise to the following steps which support, protect, and promote mother-friendly maternity services:

* Glossary

Augmentation: Speeding up labor.

Birth Center: Free-standing maternity center.

Doula: A woman who gives continuous physical, emotional, and informational support during labor and birth—may also provide postpartum care in the home.

Episiotomy: Surgically cutting to widen the vaginal opening for birth.

Induction: Artificially starting labor.

Morbidity: Disease or injury.

Oxytocin: Synthetic form of oxytocin (a naturally occurring hormone) given intravenously to start or speed up labor.

Perinatal: Around the time of birth.

Rupture of Membranes: Breaking the "bag of waters."

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Wagner M. *Pursuing the Birth Machine: The Search for Appropriate Birth Technology.* Australia: ACE Graphics, 1994. (Dr. Wagner's book has the "General Recommendations" of *The WHO* Fortaleza, Brazil, April, 1985 and the "Summary Report" of *The WHO Consensus Conference on Appropriate Technology Following Birth* Trieste, October, 1986.

Ten Steps of the Mother-Friendly Childbirth Initiative

For Mother-Friendly Hospitals, Birth Centers,* and Home Birth Services

To receive CIMS designation as "mother-friendly," a hospital, birth center, or home birth service must carry out the above philosophical principles by fulfilling the Ten Steps of Mother-Friendly Care:

A mother-friendly hospital, birth center, or home birth service:

1. Offers all birthing mothers:
   - Unrestricted access to the birth companions of her choice, including fathers, partners, children, family members, and friends;
   - Unrestricted access to continuous emotional and physical support from a skilled woman—for example, a doula,* or labor-support professional;
   - Access to professional midwifery care.
2. Provides accurate descriptive and statistical information to the public about its practices and procedures for birth care, including measures of interventions and outcomes.
3. Provides culturally competent care—that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's ethnicity and religion.
4. Provides the birthing woman with the freedom to walk, move about, and assume the positions of her choice during labor and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy (flat on back with legs elevated) position.
5. Has clearly defined policies and procedures for:
   - collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary;
   - linking the mother and baby to appropriate community resources, including prenatal and postdischarge follow-up and breastfeeding support.
6. Does not routinely employ practices and procedures that are unsupported by scientific evidence, including but not limited to the following:
   - shaving;
   - enemas;
   - IVs (intravenous drip);
   - withholding nourishment;
   - early rupture of membranes*;
   - electronic fetal monitoring;

   other interventions are limited as follows:
   - Has an oxytocin* use rate of 10% or less for induction* and augmentation*;
   - Has an episiotomy* rate of 20% or less, with a goal of 5% or less;
   - Has a total cesarean rate of 10% or less in community hospitals, and 15% or less in tertiary care (high-risk) hospitals;
   - Has a VBAC (vaginal birth after cesarean) rate of 60% or more with a goal of 75% or more.
7. Educates staff in non-drug methods of pain relief, and does not promote the use of analgesic or anesthetic drugs not specifically required to correct a complication.
8. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.
9. Discourages non-religious circumcision of the newborn.
10. Strives to achieve the WHO-UNICEF "Ten Steps of the Baby-Friendly Hospital Initiative" to promote successful breastfeeding:
    1. Have a written breastfeeding policy communicated to all health care staff;
    2. Train all health care staff in skills necessary to implement this policy;
    3. Inform all pregnant women about the benefits and management of breastfeeding;
    4. Help mothers initiate breastfeeding within a half-hour of birth;
    5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants;
    6. Give newborn infants no food or drink other than breast milk unless medically indicated;
    7. Practice rooming in: allow mothers and infants to remain together 24 hours a day;
    8. Encourage breastfeeding on demand;
    9. Give no artificial teat or pacifiers (also called dummies or soothers) to breastfeeding infants;
    10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospitals or clinics.

* see glossary

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More Information

For information about this Initiative—its history, ways to use it, what is envisioned for it, creative ways to support CIMS, etc., we have a list of Frequently Asked Questions (FAQs) which you can get by sending an e-mail message to "thedocument@listserv.mcn.org" with "FAQ" in the SUBJECT line. We welcome your comments and suggestions, with evidence-based material supporting your position.

Join the Discussion:

Join our online discussion group to contribute to the dissemination and use of the Initiative, especially if you are willing to serve as a liaison for getting a local birth service designated as mother-friendly. Send an e-mail message to "cims@listserv.mcn.org" typing the word "SUBSCRIBE" in the SUBJECT line.

Rev 8-96

#54

White House Commission on Complementary and Alternative Medicine
Testimony
October 30, 2000
Seattle, Washington

Presented by
Leah Kliger
Director, Integrative Medicine, Evergreen Healthcare,
Kirkland, Washington
425 899 2644 LKliger@echc.org

- Good afternoon, my name is Leah Kliger, Director of Integrative Medicine at Evergreen Hospital and Healthcare in Kirkland, Washington. I want to talk with you today about how you, through educational grants and economic incentives, can provide access to education and training at the local, community levels. This can help our health care system our physicians and nurses, and other community hospitals, forge better alignment between the majority of our medical staff who are not vocal supporters of CAM integration and hundreds of local CAM practitioners. We need new and different language that encourages participation, not words and actions that raise hackles. We need to help our physicians and nurses regain their sense of themselves as healers, not only disease managers, so they can better communicate across the entire health care spectrum.

In 1997 we discovered that 69% of our physicians felt they did not have the knowledge to communicate and confidently talk with their patients about alternative medicine, nor to appropriately refer patients to CAM practitioners. 88% of our physicians indicated they desired information and access to credible scientifically based information. Based on the these needs, Evergreen has an integrative medicine task force, publishes an alternative medicine newsletter and has underwritten a variety of continuing medical education sessions, case conferences, and workshops for care givers and the entire community.

Just two weeks ago on a Friday morning some 40 physicians on our medical staff participated in a workshop led by Dr. Rachel Remen—But it is rare that our physicians and nurses can take time to attend educational sessions since it means giving up both patient care and the income that goes along with running an office or a nursing unit. Typically they can only grab a few hours a year—not nearly enough to change practice patterns nor be the competent guide to CAM services that our patients ask them to be.

Through education, we want to:

- Make it easy for physicians, nurses and other clinicians to have access to reliable and credible sources of scientific data.

- Develop financially self-sufficient models for initiating clinical and educational programs and services.

We need your Help:

1. Make a combination of educational grants, tax credits, and vouchers available to community hospitals, to our medical staff, and to local CAM practitioners. These would pay not only for continuing education sessions and workshops but would also provide economic incentives to the physicians, nurses, and community CAM providers who attend them. For example, we want to develop two way training programs whereby conventionally trained doctors, nurses and CAM practitioners teach each other about specific conditions and approaches and learn new language and philosphy. In a time of scarce resources, we currently have no monetary incentives to offer busy professionals develop curriculum, teach, or even to attend. However, grants, tax credits to physicians and CAM practitioners in private practice, and other incentives would make it financially feasible for learning to occur.
2. We ask you to fully fund CAM research studies that make it easy for community hospitals and physicians to participate. For example, our pediatricians have indicated an interest in participating in CAM research studies about pediatric asthma.. Community hospitals and physicians

have patients—at the local community hospital level, but we don't have the money or resources that make it viable for us to participate in a meaningful way.

3. Develop a no cost or low cost way to have simple, electronic links to credible CAM sites that can be easily linked to physician and hospital websites.
4. Quickly establish an evidenced based national formulary for botanical medicines.

On behalf of our entire community, 650 physicians, our board, our community advisors, our nurses and other caregivers, I want to that you for traveling to the Puget Sound area and carefully listening to our needs. We want our physicians, nurses and care givers to be better able to talk with their patients about CAM, to make appropriate referrals to CAM practitioners, to have more knowledge, and access to resources. I look forward to answering any questions, working with you, and advocating for changes to the current system.

#63

Jerri Spalding Fredin

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PHONE: (206) 526-8091

White House Commission on Complementary & Alternative Medicine Policy

Testimony : Town Hall Meeting Seattle, WA, October 30, 2000

I am **JERRI FREDIN of SEATTLE** and have been an alternative health care activist since 1980.

Today I am speaking on behalf of a statewide volunteer organization, *Citizens for Alternative Health Care*, or CAHC.

My testimony focuses on the question, "*How can access to safe and effective CAM practices and interventions be improved?*"

Currently the #1 barrier to CAM practices and interventions in Washington is the law that grants supreme authority to our state's medical disciplinary board, with no provision for checks and balances. Therefore, to improve access to safe and effective CAM practices and interventions, we must change that law.

Many of us in CAHC know conventional physicians who would like to include safe and effective CAM in their practices but they dare not for fear of losing their licenses.

While Washington has state laws that permit judicial courts to overrule decisions by other state commissions, statutes governing the medical disciplinary board (the *Medical Quality Assurance Commission*) make it an exception.

For this reason, CAHC, with the guidance of a state senator, has proposed five amendments to the laws currently governing our medical disciplinary board.

One of those five, a "checks and balances amendment," stems from the board's 1996 revocation of the medical license of CAM oncologist Dr. Glenn Warner of Bellevue. When Dr. Warner appealed to the King County Superior Court for a reversal of the board's decision — a decision made by just three board members who were neither oncologists nor CAM practitioners — Superior Court Judge Robert Lasnik, who handled the appeal, informed Dr. Warner that *even though he considered the board's decision wrong, he could not overrule it.* Later, following an appeal to our former governor, Dr. Warner was likewise advised that the state's chief executive did not have the authority to intervene. However, the governor's legal counsel acknowledged that *license revocation requirements do need to be changed.*

Our proposed "checks and balances amendment" would give courts the authority to either affirm or overrule contested *Medical Quality Assurance Commission* decisions—an amendment that can benefit both CAM and conventional physicians.

Draft copies of all five of CAHC's proposed amendments have been submitted to your commission.

We seek your support in our endeavor.

Thank you for permitting me to testify.

Jerri Spalding Fredin

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White House Commission on Complementary & Alternative Medicine Policy

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Draft copies of all five of CAHC's proposed amendments have been submitted to your commission.

We seek your support in our endeavor.

Thank you for permitting me to testify.

WRITTEN TESTIMONY

for the

White House Commission on Complementary and Alternative Medicine Policy Town Hall Meeting

October 30, 2000
Seattle, WA

Attached is a copy of the Final Draft for our Health Care Amendments for changing laws governing our state's medical disciplinary board (the Medical Quality Assurance Commission).

The "checks and balances" amendment, referred to in my oral testimony on October 30th, is on the next to the last page and reads:

> "A physician subject to a disciplinary decision by the commission shall have the right of appeal to the state judicial system, and a decision by such court shall affirm or overrule a decision of the commission subject to RCW 34.05.574." (RCW 34.05.574 spells out how judicial courts, as a form of checks and balances to state commissions, can overrule or affirm state commission decisions.)

The above sentence strikes out the following sentence, which excluded the Medical Quality Assurance Commission from any checks and balances:

> "The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer."

The "checks and balances" amendment also requires that no longer can a panel of only three members legally revoke the license of a medical doctor. The amendment reads:

> "For matters of license revocation, a panel of the whole, consisting of regular members who have been appointed by the governor and are serving, must be convened. See RCW 18.71.015,paragraph 5."

Jerri Spalding Fredin, testifying for Citizens for Alternative Health Care
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FINAL DRAFT: HEALTH CARE AMENDMENTS

AN ACT Relating to Health Care; amending RCW 18.71.015, 18.130.180, and 18.130.050.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

RCW 18.71.015 is amended to read as follows:

The Washington state medical quality assurance commission is established, consisting of thirteen individuals, licensed to practice medicine in the state of Washington under this chapter, at least two of whom shall be physicians, a significant portion of whose practices include Integrative treatments, also known as Complementary and Alternative Medicine (CAM), two individuals who are licensed as physician assistants under Chapter 18.71A RCW, and four individuals who are members of the public, at least two of whom are consumers of Integrative treatments. Each congressional district now existing or hereafter created in the state must be represented by at least one physician member of the commission. The terms of office of members of the commission are not affected by changes in congressional district boundaries. Public members of the commission may not be a member of any other health care licensing board or commission, or have a fiduciary obligation to a facility rendering health services regulated by the commission, or have a material or financial interest in the rendering of health services regulated by the commission.

The members of the commission shall be appointed by the governor. Members of the initial commission may be appointed to staggered terms for four years. The governor shall consider such physician and physician assistant members who are recommended for appointment by the appropriate professional associations in the state. In appointing the initial members of the commission, it is the intent of the legislature that, to the extent possible, the existing members of the board of medical examiners and medical disciplinary board repealed under section 336, chapter 9, Laws of 1994 sp. sess. be appointed to the commission. No member may serve more than two consecutive full terms. Each member shall hold office until a successor is appointed.

Each member of the commission must be a citizen of the United States, must be an actual resident of this state, and, if a physician, must have been licensed to practice medicine in this state for at least five years.

The commission shall meet as soon as practicable after appointment and elect officers each year. Meetings shall be held at least four times a year and at such place as the commission determines and at such other times and places as the commission deems necessary. A majority of the commission members appointed and serving constitutes a quorum for the transaction of commission business.

The affirmative vote of a majority of a quorum of the commission is required to carry any motion or resolution, to adopt any rule, or to pass any measure of ordinary business of the commission. Except as stated below, [t]he commission may appoint panels consisting of at least three members. A quorum for the transaction of any business by a panel is a minimum of three members. A majority vote of a quorum of the panel is required to transact business delegated to it by the commission, with the exception of revocation of a physician's license. In order to revoke a physician's license, a majority of the regular commission members must concur with the decision to revoke.

Each member of the commission shall be compensated in accordance with RCW 43.03.265 and in addition thereto shall be reimbursed for travel expenses incurred in carrying out the duties of the commission in accordance with RCW 43.03.050 and 43.03.060. Any such expenses shall be paid from funds appropriated to the department of health.

Whenever the governor is satisfied that a member of a commission has been guilty of neglect of duty, misconduct, or malfeasance or misfeasance in office, the governor shall file with the secretary of state a statement of the causes for and the order of removal from office, and the secretary shall forthwith send a certified copy of the statement of causes and order of removal to the last known post office address of the member.

Vacancies in the membership of the commission shall be filled for the unexpired term by appointment by the governor within 60 days of the start of the vacancy.

The members of the commission are immune from suit in an action, civil or criminal, based on its disciplinary proceedings or other official acts performed in good faith as members of the commission.

Whenever the workload of the commission requires, the commission may request that the secretary appoint pro tempore members of the commission, except as stated below, [w]hen serving, pro tempore members of the commission have all of the powers, duties, and immunities, and are entitled to all of the emoluments, including travel expenses, of regularly appointed members of the commission; however, pro tempore members shall not participate in license revocation decisions.

RCW 18.71.010 Definitions (Also for chapter 19.130 RCW)

The following terms used in this chapter shall have the meanings set forth in this section and in RCW 18.130.020 unless the context clearly indicates otherwise:

(2) The following terms shall have the following meanings, unless the context clearly indicates otherwise.

(a) "Integrative" or "Complementary" health care, also known as "Complimentary" or "Complementary and Alternative Medicine" (CAM), shall mean those health care methods of diagnosis, treatment, or interventions that may depart from conventional health care and the conventional standard of care.

(b) "Conventional" health care shall mean those methods of diagnosis, treatment, or interventions that are offered by most licensed physicians as generally accepted methods of routine practice.

Chapter 18.130 RCW, Regulation of Health Professions-Uniform Disciplinary Act:

RCW 18.130.050 Authority of Disciplining Authority is amended to read as follows:

The disciplining authority has the following authority:

(1) To adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter;

(2) To investigate all complaints or reports of unprofessional conduct as defined in this chapter and to hold hearings as provided in this chapter;

(3) To issue subpoenas and administer oaths in connection with any investigation, hearing, or proceeding held under this chapter;

(4) To take or cause depositions to be taken and use other discovery procedures as needed in any investigation, hearing, or proceeding held under this chapter;

(5) To compel attendance of witnesses at hearings;

(6) In the course of investigating a complaint or report of unprofessional conduct, to conduct practice reviews;

(7) To take emergency action ordering summary suspension of a license, or restriction or limitation of the licensee's practice pending proceedings by the disciplining authority;

(8) To use a presiding officer as authorized in RCW 18.130.095 (3) or the office of administrative hearings as authorized in chapter 34.12 RCW to conduct hearings. ((The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer;)) A physician subject to a disciplinary decision by the commission shall have the right of appeal to the state judicial system, and a decision by such court shall affirm or overrule a decision of the commission subject to RCW 34.05.574.

(9) To use individual members of the boards to direct investigations. However, the member of the board shall not subsequently participate in the hearing of the case;

(10) To enter into contracts for professional services determined to be necessary for adequate enforcement of this chapter;

(11) To contract with licensees or other persons or organizations to provide services necessary for the monitoring and supervision of licensees who are placed on probation, whose professional activities are restricted, or who are for any authorized purpose subject to monitoring by the disciplining authority;

(12) To adopt standards of professional conduct or practice ((;)) for Conventional and Integrative treatments.

(13) To grant or deny license applications, and in the event of a finding of unprofessional conduct (see RCW 18.130.180, paragraph 4) by an applicant or license holder, to impose any sanction against a license applicant or license holder provided by this chapter;

(14) To designate individuals authorized to sign subpoenas and statements of charges;

(15) To establish panels consisting of three or more members of the board to perform duties of ordinary business under this chapter. For matters of license revocation, a panel of the whole, consisting of regular members who have been appointed by the governor and are serving, must be convened. See RCW 18.71.015, paragraph 5.

(16) To review and audit the records of licensed health facilities' or services' quality assurance committee decisions in which a licensee's practice privilege or employment is terminated or restricted. Each health facility or service shall produce and make accessible to the disciplining authority the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to discovery or introduction into evidence in any civil action pursuant to RCW 70.41.200(3).

RCW 18.130.180 Unprofessional Conduct.

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of ((a nontraditional treatment)) an Integrative or Complementary treatment, as defined in RCW 18.71.011 by itself shall not constitute unprofessional conduct, ((provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;)) unless by competent evidence, the Commission can establish that the treatment has a safety risk greater than that of the prevailing treatment. The absence of a prevailing treatment, alone, shall not establish unprofessional conduct. The Commission shall not revoke or deny a license to a person, nor find a licensed health care provider guilty of unprofessional conduct solely because of that person's use of an Integrative therapy as defined in RCW 18.71.011 or because that person's therapy departs from Conventional practice as defined in RCW 18.71.011.

(5) Qualified health professionals licensed under this chapter shall have the right to use any Conventional and/or Integrative treatment they determine appropriate to achieve the best therapeutic outcome. Patients have the right to be treated by a qualified health care provider licensed under this Chapter for any health problem or illness with any Conventional or Integrative treatment that the patient requests. Health care providers have the duty to provide written information to the patient as to the proposed course of treatment, including substances to be used and known side effects.

#64

White House Commission on Complementary and Alternative Medicine
Seattle Town Hall Meeting, October 30-31, 2000

Statement by Don Sloma, MPH, Executive Director, Washington State Board of Health

Welcome to the Northwest, and thank you for the opportunity to share some background on Washington state government's interest in complementary and alternative medicine.

I do not speak today for my current employer, but as the former lead staff to our State Senate's Health and Long Term Care Committee. In that capacity, I worked on our state's 1993 Health Services Act. This was proto-type legislation for President Clinton's ill-fated National Health Security Act. Our bill differed from the federal effort in many ways, not the least of which being that ours actually became law until many of its provisions were repealed in 1995. But two provisions survived that now serve as a statutory base for CAM integration here. These are

1. the "any category of provider" law, and
2. a Health Personnel Resources Plan, including its connection to a health training scholarship and loan forgiveness program.

Others can speak to the specific provisions of these laws as well as how they have been interpreted. I am here to share with you how they got into our state's law books.

Prior to the health reform debates of the early 1990s, Washington enjoyed a good, but quiet reputation in national health policy circles as an interestingly progressive province. We had done a few interesting things like pass comprehensive HIV/AIDS legislation and create a separate state health department. And we had authorized licensure of naturopaths, acupuncturists, chiropractors, midwives and others who did not enjoy such official recognition elsewhere. But few knew that state government had actually examined and debated the value of these "alternative medicine" professions in some detail through the state legislature's Sunset process during the 1980s, and found little reason to reject or limit them. By the end of the 1980s, despite some suspicions in some quarters of established Medicine, these professions were well established here as safe, well-disciplined parts of our health community.

The 1990s brought concern about the medical financing crisis here and around the nation. Double digit inflation, poor health outcomes, increasing rates of uninsurance and underinsurance and so forth. The litany has become as familiar and accepted now as twenty five year old .com millionaires who commute to work on skateboards and pay cash for all their medical care. Then, as today, decrying our nation's health care financing mess was a great way to win elective office. Actually fixing it, was a poor way to stay there.

But never mind. In 1993, our state's political leadership resolved to address the health care financing issue comprehensively. Armed with the recommendations of a "blue ribbon" Health Services Study Commission, our state became the first in the nation to establish the complex series of statutory mandates and regulations that came to be known as health reform. The scheme required all employers and individuals to purchase insurance coverage for a state determined "decent" minimum package of health services. (Optional supplements would also be available) All coverage was to be purchased only from state certified health plans. Minimum benefits, provider network adequacy, quality standards, market conduct standards, risk pooling arrangements and more aspects of these private managed care insurance carriers were to be regulated by the state. In exchange for meeting these standards, a certified health plan would be entitled to sell in a guaranteed market of all of our state's residents, since

universal financial participation by employers and state residents was also mandated. (Those of marginal means were to receive public subsidies to participate as consumers.) In other words, for a time, state policy in Washington defined a closely regulated universal access, private market for the bulk of health care.

We were mindful that such a bold step could create many problems, including the two that led to the provisions you are interested in. For one thing, this closely regulated market could devastate any licensed health care provider whose services were excluded from it. For another, an adequate number of many types of health personnel, especially primary care providers, would be needed. Accordingly, the legislation contained provisions that

1. required every certified health plan to include in their network every category of provider whose scope of state licensed practice included treatment for a condition covered by the minimum benefits package, and
2. established a state health personnel resources plan, which would identify shortage areas and professions (especially primary care providers) and make appropriate recommendations for work force development.

When Congress rejected President Clinton's health reform effort, our state's effort was doomed. Technically, this was because our state's effort hinged upon federal action to suspend the ERISA exemption of employers from state regulation of employer sponsored health benefits plans. Without that, our reform could not ensure a broad enough market, so the rest was simply untenable, financially as well as politically. A major repeal and retrenchment effort began here in 1995. And it may not be over yet.

However, because of some sloppy lobbying by the business community and the insurance industry in 1995 when they orchestrated the repeal of much of our health reform law, the "any category law" was retained. Despite numerous political and legal assaults, the law remains, applying now to any condition covered by a health plan that happens also to be covered by our state's Basic Health Plan.

The health personnel resources plan (HPRP) functioned well during its first few years, but ultimately it too was sacrificed to the reactionary forces that took hold in the wake of our 1993 efforts. Before it was repealed however, the HPRP defined "primary care" providers to include naturopaths, thus making them eligible for our state's health scholarship and loan forgiveness program. The repeal of the HPRP did not undo this, and several naturopaths have benefited from that program. More importantly perhaps, this effort to define a health care provider work force that did not exclude these CAM providers seems to have legitimized some CAM providers as partners with MDs in ways that had not been seen before.

So, our state's now largely defunct health care reform scheme left in its wake two bases for the growth of CAM in our state. But these bases were established less as carefully considered policies to endorse CAM and promote its integration than as a result of care to avoid systematically excluding CAM as an already accepted form of medicine from a system intended to regulate all health interventions. The reasons for this acceptance were tied up both in the state's already established acceptance of CAM practitioners as licensed providers, and in the political activism of CAM associations in an environment full of the will to act on health financing issues much more broadly.

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Robert Nicoloff

Complementary And Alternative Health Professions Regulated In The State Of Washington

Health Profession	First Licensed In Washington State	Scope Of Practice As Currently Defined In Washington State Statutes	Number Currently Licensed
Acupuncturist	1985	Acupuncture means a health care service based on an Oriental system of medical theory utilizing Oriental diagnosis and treatment to promote health and treat organic or functional disorders by treating specific acupuncture points or meridians. Acupuncture includes the following techniques: a) Use of acupuncture needles to stimulate acupuncture points and meridians; b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; c) Moxibustion; d) Acupressure; e) Cupping; f) Dermal friction technique; g) Infra-red; h) Sonopuncutre; I) Laserpuncture; j) Point Injection therapy (aquapuncture); and k) Dietary advice based on Oriental medical theory provided in conjunction with techniques under a) through j). (RCW 18.06.010)	568
Chiropractor	1974	(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body. (2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments, and extremity manipulation insofar as any such procedure is complementary or preparatory to a chiropractic spinal adjustment. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation except for medicines of herbal, animal, or botanical origin, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity. (3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter. "Massage" and "massage therapy" mean a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Massage therapy includes techniques such as tapping, compressions, friction, Swedish gymnastics or movements, gliding, kneading, shaking, and facial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage therapy does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation. (4) Chiropractic care shall not include the prescription or dispensing of any medicine or drug, the practice of obstetrics or surgery, the use of x-rays or any other form of radiation for therapeutic purposes, colonic irrigation, or any form of benipuncture. (5) Nothing in this chapter prohibits or restricts any other practitioner of a "health profession" defined in RCW 18.120.020(4) from performing any functions or procedures the practitioner is licensed or permitted to perform, and the term "chiropractic" as defined in this chapter shall not prohibit a practitioner licensed under chapter 18.71 RCW from performing medical procedures, except such procedures shall not include the adjustment by hand of any articulation of the spine. (RCW 18.25.005)	1,993
Massage Therapist	1975	"Massage" and "massage therapy" mean a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Massage therapy includes techniques such as tapping, compressions, friction, Swedish gymnastics or movements, gliding, kneading, shaking, and facial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage therapy does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation. (RCW 18.108.010)	8,731

Health Profession	First Licensed In Washington State	Scope Of Practice Defined In Washington Statutes	Number Currently Licensed
Midwife	1917	Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant. (RCW 18.50.010)	116
Naturopathic Physician	1919	Naturopathic medicine or naturopathy is the practice by naturopaths of the art and science of the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body. A naturopath is responsible and accountable to the consumer for the quality of naturopathic care rendered. The practice of naturopathy includes manual manipulation (mechanotherapy), the prescription, administration, dispensing, and use, except for the treatment of malignancies or neoplastic disease, of nutrition and food science, physical modalities, homeopathy, certain medicines of mineral, animal, and botanical origin, hygiene and immunization, common diagnostic procedures, and suggestion; however, nothing in this chapter shall prohibit consultation and treatment of a patient in concert with a practitioner licensed under chapter 18.57 or 18.71 RCW. No person licensed under this chapter may employ the term "chiropractic" to describe any services provided by a naturopath under this chapter. "Nutrition and food science" means the prevention and treatment of disease or other human conditions through the use of foods, water, herbs, roots, bark, or natural food elements. "Manual manipulation" or "mechanotherapy" means manipulation of a part or the whole of the body by hand or by mechanical means. "Physical modalities" means use of physical, chemical, electrical, and other noninvasive modalities including, but not limited to heat, cold, air, light, water in any of its forms, sound, massage, and therapeutic exercise. "Homeopathy" means a system of medicine based on the use of infinitesimal doses of medicines capable of producing symptoms similar to those of the disease treated, as listed in the homeopathic pharmacopeia of the United States. "Medicines of mineral, animal, and botanical origin" means medicines derived from animal organs, tissues, and oils, minerals, and plants administered orally and topically, excluding legend drugs with the following exceptions: Vitamins, minerals, whole gland thyroid, and substances as exemplified in traditional botanical and herbal pharmacopoeia, and nondrug contraceptive devices excluding interuterine devices. The use of intermuscular injections are limited to vitamin B-12 preparations and combinations when clinical and/or laboratory evaluation has indicated vitamin B-12 deficiency. The use of controlled substances is prohibited. "Hygiene and immunization" means the use of such preventative techniques as personal hygiene, asepsis, public health, and immunizations, to the extent allowed by rule. "Minor office procedures" means care incident thereto of superficial lacerations and abrasions, and the removal of foreign bodies located in superficial structures, not to include the eye; and the use of antiseptics and topical local anesthetics in connection therewith. "Common diagnostic procedures" means the use of venipuncture to withdraw blood, commonly used diagnostic modalities consistent with naturopathic practice, health history taking, physical examination, radiography, examination of body orifices excluding endoscopy, and laboratory medicine which obtains samples of human tissue products, including superficial scrapings but excluding procedures which would require surgical incision. "Suggestion" means techniques including but not limited to counseling, biofeedback, and hypnosis. "Radiography" means the ordering but not the interpretation of radiographic diagnostic studies and the taking and interpretation of standard radiographs. (RCW 18.36A.020 and 030)	471

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A Guide On The Complaint Process