DEPARTMENT OF
Professional &
Financial Regulation
STATE OF MAINE

- OFFICE OF SECURITIES
- **BUREAU OF INSURANCE**
- CONSUMER CREDIT PROTECTION
- **BUREAU OF FINANCIAL INSTITUTIONS**
- OFFICE OF LICENSING AND REGISTRATION

Report of the Commissioner of Professional and Financial Regulation

To the

Joint Standing Committee on Business, Research and Economic Development

Sunrise Review Regarding the Practice of Licensed Midwifery

Submitted Pursuant to Resolve 2007, Ch. 115

February 15, 2008

Sunrise Review: Practice of Licensed Midwifery

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Sunrise Review: Practice of Licensed Midwifery

Sunrise Review: Overview

Under Maine law (Title 5, section 12015, subsection 3), a process is prescribed for evaluating proposals that would establish a licensing board or otherwise regulate an unregulated occupation or profession. The same process is required when proposals are put forward to substantially expand regulation of an occupation or profession already regulated by the State. (Appendix A)

The process, known as "Sunrise Review," requires the committee of jurisdiction to take one of three steps in order to obtain relevant information about the proposal to create or expand a regulatory program. The committee could:

A. Hold a public hearing to specifically address the Sunrise Review evaluation criteria contained in Title 32, section 60-J;
B. Request the Commissioner of PFR to perform an "independent assessment" of responses to the evaluation criteria from the group proposing regulation or expansion of regulation, as well as from opponents and other interested parties; or
C. Request the Commissioner of PFR to create a technical committee to assess responses to the evaluation criteria from the parties referenced above.

In the case of options B and C, the Commissioner must report findings to the committee within a set period of time. Committee members review the report, along with any additional material they wish to consider, before making a determination about the proposal. The committee may move forward with legislation to license the occupation/profession or decline to do so.

If the committee determines that licensing is warranted, legislation is drafted and approved at the committee level. As stipulated in Title 5, *"Any recommendation by a joint standing committee to the full Legislature for the establishment or expansion of jurisdiction of an occupational or professional regulatory board must include a written statement describing the manner in which the assessment of answers to the evaluation criteria was conducted and a concise summary of the evaluation."*

Sunrise review is a tool for state policymakers to systematically assess proposals to expand the scope of practice of a regulated profession or establish new regulatory requirements for a previously unregulated profession. Importantly, the purpose of the review is to analyze whether the proposed regulation is necessary to protect the health, safety and welfare of the public.

Sunrise Review also seeks to identify the potential impact of the proposed regulation on the availability and cost of services to consumers. The rationale underlying the requirement for Sunrise Review is that the State of Maine should only impose regulation when public health and safety would be jeopardized without it, and then, it should impose the least burdensome method of regulation.

State regulation should not be used for economic purposes to create unnecessary barriers of entry to a professional that could limit access to services or increase their cost. Nor should it be used to as a vehicle to enhance the status of a particular group of practitioners.

Charge from the Legislature

Legislation to license Certified Professional Midwives (CPMs) through the Office of Licensing and Registration within the Department of Professional and Financial Regulation (PFR) was introduced during the First Regular Session of the 123rd Maine Legislature. LD 1827, *An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access*, was referred to the Joint Standing Committee on Business, Research and Economic Development.

The Committee held a public hearing for LD 1827 on Thursday, May 10, 2007. Testimony was presented in favor of the bill and in opposition to it. The Acting Commissioner of PFR, Anne Head, testified neither for nor against LD 1827. She indicated that the legislation would trigger Maine's Sunrise Review statute contained in Title 32, Chapter 1-A.

The Committee convened a work session on May 10th, following the public hearing, and voted to amend the legislation by creating a Resolve to require the Commissioner of PFR to conduct an independent assessment of the proposal to license CPMs. The full Legislature approved the Resolve on June 15, 2007. It was signed as Resolve 2007, Chapter 115, by Governor John E. Baldacci on June 21, 2007.

Resolve, Directing the Department of Professional and Financial Regulation To Conduct a Sunrise Review Regarding the Practice of Licensed Midwifery

Sec. 1. Sunrise review of the practice of licensed midwifery. Resolved: That the Commissioner of Professional and Financial Regulation shall conduct an independent assessment of the proposal to license certified professional midwives pursuant to the Maine Revised Statutes, Title 5, section 12015, subsection 3, paragraph B; and be it further

Sec. 2. Reporting date established. Resolved: That no later than February 15, 2008, the Commissioner of Professional and Financial Regulation shall submit a report following the review under section 1 to the Joint Standing Committee on Business, Research and Economic Development. The Committee is authorized to submit legislation on the subject matter of the report to the Second Regular Session of the 123rd Legislature.

Evaluation Criteria

Pursuant to Title 5, section 12015, subsection 3, the Legislative Resolve required the Commissioner of PFR to conduct an independent assessment of responses to evaluation criteria set forth in the statute. The proponents of regulation who initiate the proposal are required to provide their responses and related information to the committee of jurisdiction when the proposal is submitted. The Commissioner must also request, accept and consider responses to the evaluation criteria from opponents of the regulation, as well as from other interested parties.

Title 32, section 60-J establishes thirteen criteria, which must be addressed by the "applicant group" proposing regulation. Opponents and other interested parties must address the same criteria, although responses to all criteria are not required.

The Process

Following enactment of Resolve 2007, Chapter 115, a survey instrument was prepared based on these criteria. The survey was distributed on June 25, 2007 to an interested parties list. The list included individuals and representatives of organizations who testified at the public hearing on May 10th.

Other interested parties were identified based on their expertise in the profession being considered for regulation and/or their familiarity with the licensing process, including representatives of certain licensing programs.

Completed surveys were submitted on behalf of the following organizations:

Maine Association of Certified Professional Midwives (MACPM)
American College of Obstetricians and Gynecologists (ACOG)
Maine Association of Women's Health, Obstetric and Neonatal Nurses (ME AWHONN)
Maine Medical Association
March of Dimes

Once received, survey responses were posted on the Department's website under 'Legislative Reports' (www.maine.gov/pfr/legislative/index.htm), which can be accessed from the site's homepage. (Appendix B)

Following an initial review of submitted surveys in July by the Acting Commissioner and staff members, a list of fifteen follow up questions was developed and distributed to the interested parties list. The questions were intended to elicit additional information, to clarify relevant issues, and to determine if specific points should be addressed to proponents and/or opponents.

The list of follow up questions was used to guide a public meeting held August 20, 2007 in the Central Conference Room at the Department's headquarters in Gardiner. Responses to the questions were submitted in writing and/or offered verbally at the meeting. Fourteen members of the public attended. A list of attendees is included in the appendix of this report. Acting Commissioner Anne Head moderated the meeting and stated that additional comments and material would continue to be accepted. Feedback was received through November.

During the public meeting, it was suggested that facilitated sessions be conducted between proponents of regulation, including Certified Professional Midwives (CPMs), and representatives of the medical profession, including physicians specializing in obstetrics and gynecology. As suggested, those sessions would explore issues of concern to participants, foster greater understanding, and lead to better communications between the parties.

The Department followed up to determine if those sessions would be held during the timeframe of this Sunrise Review. As of this report's filing, facilitated sessions have not occurred. Proponents of regulation have indicated that such efforts may be of interest following the conclusion of the Sunrise Review and subsequent action by the Legislature.

Home Birth and Midwifery Background Information

According to information obtained from the Maine Department of Health and Human Services (DHHS), approximately 138,000 babies were born in Maine during the 10 year period of 1997-2006. Of those, there were 1,376 home births (data from 2006 are preliminary).

On average, 100-150 births occur at home or in a non-medical setting each year in Maine. This represents roughly 1 percent of all births, which DHHS officials believe is consistent with national statistics. During the past decade, the low of 118 home births occurred in 2002, while the high of 157 occurred the following year. In 2006, approximately 135 babies were born at home.

The results of a DHHS study of births in Maine from 1993-2002 indicated that women choosing to deliver at home were older on average than those who chose a medical setting. They were more often married and had more formal education. Home birth mothers, on average, began prenatal care at a later stage of pregnancy.

Although some births in homes and other non-medical settings are attended by Certified *Nurse* Midwives (CNMs), most are attended by other midwives. Of the 135 home births in 2006, for example, 126 were attended by a midwife who was not a CNM.

CNMs are licensed by the Maine State Board of Nursing, which is affiliated with the Department of Professional and Financial Regulation. CNMs are registered professional nurses who, on the basis of specialized education and experience, are authorized to

practice nurse midwifery. CNMs, along with nurse practitioners, nurse anesthetists and clinical nurse specialists, are advanced practice registered nurses (APRN). The Board defines a CNM under the APRN rules as:

> *"a registered professional nurse who has received post-graduate education in a nurse-midwifery program approved by the American College of Nurse-Midwives and who has passed the national certification examination administered by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council, Inc. (A.C.C.).*

There are currently 92 Certified Nurse Midwives licensed in Maine.

There are approximately 22 individuals who have attained the private certification of Certified Professional Midwife (CPM) from the North American Registry of Midwives (NARM) but who are not licensed by the State.

The number of other individuals who practice midwifery in Maine without NARM certification is not known.

Evaluation of Responses to Sunrise Criteria

The Maine Association of Certified Professional Midwives submitted survey responses in support of regulation and is noted in the following pages as "proponent". The other submissions were from the March of Dimes, the American College of Obstetricians and Gynecologists, the Maine Medical Association, and the Maine Association of Women's Health, Obstetric and Neonatal Nurses. All of these organizations oppose this regulatory proposal and are noted as "opponents." Responses are the thirteen specific criteria are summarized on the following pages.

Criteria 1: Data on Group: *A description of the professional or occupational group proposed for regulation or expansion of regulation, including the number of individuals or business entities that would be subject to regulation, the names and addresses of associations, organizations and other groups representing the practitioners and an estimate of the number of practitioners in each group;*

Proponents of licensure indicated that 22 individuals are practicing CPMs in Maine.

Opponents either didn't offer a number or indicated their belief that fewer than 30 individuals are practicing as CPMs in Maine.

Department Analysis: The number of CPMs in Maine appears to be relatively stable and constant. No information is available on the number of non-CPMs practicing midwifery in Maine. State and national CPM organizations are listed below, along with the Maine State Board of Nursing, which has oversight responsibility for CNMs.

Maine Association of Certified Professional Midwives (MACPM)
P.O. Box 875
Bath, Maine 04530
(207) 647-5968 or (207) 522-6043
www.macpm.org

Midwives of Maine (MOM)
C/O Anna Durand, Chair
320 Norway Drive
Bar Harbor, Maine 04649
(207) 288-4243
www.homestead.com/midwivesofmaine/1.html

Midwives Alliance of North America (MANA)
375 Rockbridge Road
Lilburn, Georgia 30047
(888) 923-6262
www.mana.org

North American Registry of Midwives (NARM)
5257 Rosestone Drive
Lilburn, Georgia 30047
(888) 842-4784
www.narm.org

Midwifery Education Accreditation Council (MEAC)
20 East Cherry Avenue
Flagstaff, Arizona 86001
(928) 214-0997
www.meacschools.org

Maine State Board of Nursing
161 Capitol Street
158 State House Station
Augusta, Maine 04333-0158
(207) 287-1133
www.maine.gov/boardofnursing

Criteria 2: Specialized skill. *Whether practice of the profession or occupation proposed for regulation or expansion of regulation requires such a specialized skill that the public is not qualified to select a competent practitioner without assurances that minimum qualifications have been met;*

Both proponents and opponents of regulation recognize the importance of specialized skills required to practice midwifery.

Proponents provided detailed information about the knowledge and skills that must be demonstrated in order to attain CPM certification from the North American Registry of Midwives (NARM), which is based in Georgia. The certification process contains an educational component and an experiential aspect. Exams are required, as are continuing

education and renewal every three years. More details about CPM certification requirements and the skills associated with them are found in Appendix C.

Opponents contend that education and training beyond that which is currently required of CPMs through NARM is necessary to protect the well-being of both women and babies, especially when complications occur. The opponents also contend that licensing, particularly if the word "professional" is part of the designation, may lead some consumers to believe CPMs have medical training or an advanced educational background, which may not be the case.

Department Analysis: Although proponents of licensure emphasize that childbirth is a "normal female process and not pathology" and state that midwifery is "not the practice of medicine," the list of skills and areas of knowledge required for certification by NARM is extensive. That list includes the capacity to monitor vital signs, to recognize impending shock or other complications, and to administer anti-hemorrhagic medications and oxygen, and utilize other medically-related products and devices.

Throughout the sunrise process, proponents have seemingly argued both sides of the case for regulation. They emphasize, on one hand, that they are not engaged in the practice of medicine; that they are exceedingly well trained through NARM; and that their birth outcomes are comparable to, or better than, those in a medical setting. On the other hand, they contend that public health and safety are at risk without licensure.

Criteria 3: Public health; safety; welfare *The nature and extent of potential harm to the public if the profession or occupation is not regulated, the extent to which there is a threat to the public's health, safety or welfare and production of evidence of potential harm, including a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against practitioners of the profession or occupation in this State within the past 5 years;*

Proponents believe licensing CPMs will establish a minimum standard of training and experience, thus protecting the public by offering consumers a way to distinguish between CPMs and unlicensed practitioners of midwifery who may not have the same knowledge or qualifications. Proponents also believe licensure will result in greater cooperation from medical professionals and hospital administrators, enabling CPMs to more easily obtain certain medications, make use of laboratory facilities, and transfer a client when complications are identified. Additionally, proponents contend that licensure will expand access to midwifery services by encouraging more CPMs to train in Maine or relocate to this State.

Opponents raise several concerns about licensing the practice of midwifery. The Maine Medical Association's primary concern is that licensure may encourage more women to give birth at home and therefore away from medical professionals and facilities that may be needed if complications occur. The MMA also believes cooperation between CPMs and doctors would likely *not* be increased by licensure and may actually deteriorate.

The March of Dimes expresses concern about the provision in the proposed legislation (LD 1827) that would permit CPMs who may lack medical training to administer medications.

The Maine Section of the Association of Women's Health, Obstetric and Neonatal Nurses focuses its concerns on the training of CPMs, noting that it is conducted by non-medical educators at schools that are neither accredited by states nor affiliated with a college or university.

Department Analysis: It should be noted that some midwifery schools, including Birthwise Midwifery School in Bridgton, are accredited through the Midwifery Education Accreditation Council (MEAC). The organization's website states the purpose of MEAC is *"to establish standards for the education of competent midwives, and to provide a process for self-evaluation and peer evaluation for diverse educational programs. MEAC is a non-profit organization approved by the U.S. Secretary of Education as a nationally recognized accrediting agency."*

The question of whether licensing is needed to protect the public is *central* to the Sunrise Review process. Neither proponents nor opponents provided specific examples of harm resulting from care provided by midwives.

The Maine Medical Association did indicate that a number of women are transferred from the care of midwives to hospitals each year as a result of complications, and made one reference to a possible prosecution of a midwife in the Brunswick area a few years ago. No specific details, however, were provided on any of these cases and none could be found through Department research.

Without evidence of problems having been caused by CPMs or other midwives, the public health and safety threshold of Maine's Sunrise Review process is not met. Proponents, in fact, submitted a study from the British Medical Journal indicating that 'intended out-of-hospital births' have similar favorable outcomes to low-risk pregnancies in hospital settings.

The study, purportedly the largest of its kind, tracked 5,400 births in the year 2000 and indicated a neonatal mortality rate of 1.7 births per 1000, which is comparable to the experience of low-risk women in hospitals. The study also indicated a Cesarean Section outcome in 3.7% of the births, compared with 24% of births in the United States during the same period of time.

In written comments and during the August public meeting, CPMs made a persuasive case that their knowledge and skills are extensive. They presented convincing material to support claims that their practices are safe and their clients are well protected. It is evident that CPMs believe their practices could be strengthened and safety enhanced through better rapport with doctors and other medical professionals, but they did not demonstrate how the current state of those relationships has adversely impacted pregnant women in Maine to any measureable degree.

One case was described in which a CPM client experienced bleeding that required transfer to a hospital. The client reportedly spent several hours in the emergency room before treatment was administered. The CPM suggested that this delay may have resulted from the fact that a midwife was the primary provider of care throughout the pregnancy, rather than a physician. There is no way to substantiate this claim.

Federal law prohibits medical facilities from denying access and treatment to pregnant women. At the same time, one of the barriers to better collaboration between midwives and medical professionals outside these emergency hospital settings is the issue of liability. Proponents and opponents of licensure both indicated that some doctors fear the liability exposure that occurs when they provide medical services to a woman who is primarily in the care of a midwife. Establishment of a licensing program, however, would likely not alter the liability issue, notwithstanding the immunity provision contained in the legislative proposal which is intended to shield doctors from liability as a result of the actions of midwives working with their patients.

Access to prescription medications by CPMs is an issue that all parties addressed. Information received by the Department suggests that prescribed medications are almost always obtained by CPMs. The use of prescription medications by midwives who are not Certified Nurse Midwives with prescriptive authority falls in a gray area of law. A pregnant woman who has an established doctor/patient relationship could have a midwife pick up a prescribed medication at a pharmacy or hospital as the patient's agent and then administer the drug to the patient. It is not clear what happens if there is no established doctor/patient relationship.

Proponents assert that the practice of midwifery is not the practice of medicine nor does it involve medical procedures. However, the proposed legislation includes a provision for the establishment of a formulary for drug use by licensed midwives including, but not limited to, antihemorrhagic medications and oxygen. Unless the Legislature were to specifically grant prescriptive authority to CPMs, which it has resisted doing in the case of several currently licensed health care occupations including licensed psychologists, establishing a regulatory program would not resolve this issue.

During the August public meeting held at the Department, the Maine Medical Association's representative indicated a willingness to explore the access concerns and expressed some level of optimism that a resolution could be identified.

Criteria 4: Voluntary and past regulatory efforts. *A description of the voluntary efforts made by practitioners of the profession or occupation to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public;*

Proponents indicate that two levels of self-regulation currently exist for CPMs in Maine. The first is Midwives of Maine (MOM), which developed "Standards of Practice" in 1983. Since 1997, when the CPM certification became available, MOM has required members to obtain this certification. On the national level, as previously noted, NARM grants the CPM certification and provides a grievance process. This process can result in the revocation of the CPM certification. Proponents, however, believe this grievance process does not provide adequate public protection, since someone with a revoked NARM-issued certification may still practice in Maine without the prospect of penalty or other disciplinary action.

Opponents, in this case the Maine Medical Association, questioned why proponents wish to move beyond self-regulation to protect the public but want to exempt non-CPM midwives from the licensure requirement. The MMA response asks "what would be the point of having enhanced regulation, if unlicensed, non-credentialed midwives could continue to practice in the state?"

Department Analysis: In the absence of evidence that unlicensed midwifery poses a threat to public safety, it is legitimate to question why voluntary regulation through NARM and other organizations isn't adequate. The practice of midwifery has been ongoing for generations. Voluntary organizations offering education, support, credentialing and oversight have been established within the past three decades.

All information presented during the Sunrise Review process suggests that these voluntary efforts are effective in providing educational resources and networking opportunities for interested midwives. Voluntary organizations such as NARM also provide a means for women and families to obtain information and guidance about home birth and the selection of a midwife.

Finally, the question raised by the Maine Medical Association is important. If proponents believe public health and safety are jeopardized by the absence of regulation, the Department questions why they would want to exempt an unknown number of midwives from regulation.

Criteria 5: Cost; benefit. *The extent to which regulation or expansion of regulation of the profession or occupation will increase the cost of goods or services provided by practitioners and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers;*

Proponents do not foresee that a state licensure program would increase the cost of their services to their clients nor would there be substantial increase in cost to either the State of Maine or CPM licensees. They envision a license fee that would be "sufficient to cover administrative costs without being excessive, so as not to necessitate a significant increase in the fee a CPM must charge for her care."

Opponents express concern that an independent licensing program for CPMs would require substantial funding. The MMA estimated the license fee in this scenario to be

approximately $1,000 per license. As an alternative, if a licensing program were to be established, MMA suggested including it within the Board of Complementary Health Care Providers or the Maine State Board of Nursing. The Maine Association of Women's Health, Obstetric and Neonatal Nurses suggested that a CPM licensing program would not be appropriate for the Board of Nursing.

Department Analysis: The proponents' legislative proposal provides for regulation of midwives through an independent licensing board located within the Department. The cost of creating an independent licensing program regardless of the type or level of regulation would be prohibitive. Including a midwife program within an already existing program would be possible from an administrative perspective, however, that approach would not be without substantial increased costs which cannot be justified given that no rational connection exists between midwifery and the occupations currently regulated by the Board of Complementary Health Care Providers.

Criteria 6: Service availability of regulation. *The extent to which regulation or expansion of regulation of the profession or occupation would increase or decrease the availability of services to the public;*

Proponents believe regulation of CPMs would increase the availability of midwife services by enhancing the visibility of their practices, by providing greater assurances to the public about the knowledge and skills of licensees, and by attracting more CPMs to Maine. Proponents contend that more CPMs are needed to meet the needs of women who desire out-of-hospital birth, especially in rural parts of the state.

Opponents believe the number of health care professionals in Maine is adequate to meet the needs of pregnant women. The Maine Association of Women's Health, Obstetric and Neonatal Nurses indicates that approximately 100 obstetricians and nurse midwives are practicing in Maine, along with more than 100 family medicine physicians. Additionally, the organization states that under MaineCare, all pregnant women are guaranteed coverage.

Department Analysis: Typically, imposing new licensing requirements on a group of individuals not previously regulated causes the availability of services to decrease.

Criteria 7: Existing laws and regulations. *The extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from nonregulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners;*

Department Analysis: Proponents and one opponent noted that childbirth has been considered by the legal system to be a normal process and not one that involves the practice of medicine. Partly for this reason, no regulation of midwifery has been implemented in Maine, with the exception of the Certified Nurse Midwife process through the Maine State Board of Nursing. The Maine Medical Association indicates

that the criminal statutes and those related to malpractice negligence can be utilized to address harm caused by an unlicensed midwife.

Criteria 8: Method of regulation. *Why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate;*

Proponents propose to license the use of the title "Certified Professional Midwife." They did not choose registration or certification because of their belief that these regulatory mechanisms would not provide adequate accountability for midwives. Proponents also decided against 'licensing to practice', because they do not wish to prohibit unlicensed midwifery by those who engage in the practice within their ethnic, cultural or religious community.

Opponents did not provide a response.

Department Analysis: Licensure is a designation used to describe the highest level of state regulation. The state grants licensure to an individual who has complied with a legislatively mandated set of minimum educational, experiential, and training and competency standards, and has paid the required licensing fee. Regulation through licensure encompasses the setting of eligibility standards, examination requirements, and a complaint process to resolve consumer complaints. The complaint process typically involves investigation of complaints and a disciplinary process whereby the licensing authority imposes discipline in situations where the licensee has violated state law or board rule.

Certification is a term that connotes training or an examination process administered usually by a private trade or professional association. Obtaining certification status by the service provider is voluntary. The state has no enforcement or regulatory role. Certification is used to enhance the stature of those certified within the profession or occupation.

State licensing programs that safeguard the public require a clear public threat and a mechanism for protecting people from that defined threat. In most regulated professions the foundation for licensure is a set of nationally accepted minimum standards and a clearly defined scope of practice.

If proponents believe 1) that licensing is necessary to safeguard the public from harm and 2) that their proposal meets the threshold health and safety criteria, the Department is unclear why midwives without NARM certification should be allowed to continue unlicensed practice.

Criteria 9: Other states. *A list of other states that regulate the profession or occupation, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on the profession or occupation in terms of a before-and-after analysis;*

Only the proponents offered information regarding criteria 9, indicating that 24 states regulate midwives.

Department Analysis: In addition to a review of state information from the Midwives Alliance of North America and the North American Registry of Midwives, the Maine State Board of Nursing sought information from its counterparts in the other states. The Board received responses from virtually all states. Depending on the source of information, as well as the definition of "regulation," states with regulatory practices in place for midwives (non-Nurse Midwives) number between 20 and 24.

Some of the states that regulate have a licensing process. Others offer a registration mechanism. The regulating authorities vary. Several states maintain an independent midwifery board within a health agency or professional licensing department, while others include midwifery within other licensing programs, such as a medical board.

Although reviewing the regulation of midwives in other states is useful to an extent, it should be remembered that each state applies different standards when determining if a profession or occupation should be licensed. Further, standards within states change over time. In Maine, Sunrise Review was established after virtually all current licensing programs were created by the Legislature. It is debatable whether some of the occupations currently licensed in Maine would have met the Sunrise Review standards used to recommend licensure.

Criteria 10: Previous efforts. *The details of any previous efforts in this State to implement regulation of the profession or occupation;*

Respondents do not believe previous licensing of midwives has been pursued in Maine. The Maine Medical Association indicated that the subject may have been discussed within the Legislature in the late 1970s. Research by the Department did not identify previous regulatory attempts that resulted in legislation.

Criteria 11: Mandated benefits. *Whether the profession or occupation plans to apply for mandated benefits;*

Proponents state that applying for mandated benefits is not contemplated "at this time."

Opponents did not provide a response.

Department Analysis: The term "mandated benefits" in the context of Sunrise Review refers to a process by which insurance companies are *required* by State law to provide insurance coverage for certain services or procedures rendered to consumers. The phrase implies State-required insurance coverage for the service provided.

It is worth noting that when a legislative proposal calls for mandated insurance coverage and required payment to providers for certain procedures, the proposal is forwarded to the

Insurance and Financial Services Committee. That Committee typically requests a separate study conducted by the Department's Bureau of Insurance which reviews the proposal and files a report on the estimated cost of the mandate, were it to be enacted into law.

Criteria 12: Minimal competence. *Whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are;*

Proponents are seeking to use the CPM certification through NARM as the basis for licensure in Maine. They propose that applicants for licensure should be CPMs in good standing who must renew their CPM certification every three years (as required by NARM), as long as they hold a Maine license. Proponents indicate that these NARM certification requirements include:

- Documentation of minimum clinical experience;
- Either a diploma from a MEAC accredited midwifery program or successful completion of the Portfolio Evaluation Process (PEP);
- Passing grade on the NARM written exam;
- Passing grade on the NARM skills exam (PEP candidates only);
- Ongoing continuing education credits;
- Current CPR and Neonatal Resuscitation certificates; and
- Ongoing Peer Review

Opponents believe minimal competence must be demonstrated through standards that substantially exceed those proposed by the proponents. Three responding opponents mentioned standards comparable to those required of Certified Nurse Midwife licensees as being appropriate for licensure as CPMs.

Department Analysis: none required.

Criteria 13: Financial analysis. *The method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by current or proposed licensees through dedicated revenue mechanisms.*

Proponents believe the cost of establishing a licensing program will be minimal. They propose the use of NARM's certification credential and grievance process as ways to reduce expenses for the State and ultimately the licensees.

Opponents The Maine Medical Association stated that the cost of establishing an independent licensing program for CPMs could not be supported by the number of individuals who would seek licensure, and indicated that use of NARM's certification and processes could "constitute the unconstitutional delegation of regulatory authority to a private organization."

***Department Analysis*:** The state's sole justification for imposing license requirements is to protect the public from a defined harm through the disciplinary process. That state function could not legally be delegated to a private entity.

Conclusions and Recommendations

Information presented to the Department of Professional and Financial Regulation suggests that the 22 CPMs practicing in Maine are knowledgeable, compassionate and sincerely dedicated to the welfare of women and children. The competence of these CPMs is suggested through good birth outcomes and the absence of examples in which serious medical problems have resulted from the care they provide, as well as though favorable feedback from current and former clients.

Throughout the Sunrise Review process, proponents sought to demonstrate that CPM preparation through NARM is rigorous and their skills are substantial. The Department has reviewed those educational and training requirements and believes they are at least adequate to prepare an individual for practice as a CPM.

During the public meeting in August, a number of participants suggested that licensure would benefit the public by elevating the professional status of CPMs. Several proponents suggested that "turf battles" for clients might be part of the reason why some physicians object to home births attended by midwives. The determining factor in any sunrise analysis is whether public safety and health are jeopardized by the absence of state regulation. Thus, questions about the need for heightened professional recognition or acceptance are not considered in the Department's analysis.

This analysis must focus on the criterion outlined in Maine law. The first three (3) are worthy of additional emphasis in this concluding section of the report. With regard to criteria 1, "Data on Group," several state and national midwife organizations provide considerable information and resources to both midwives and individuals seeking midwifery services. Readily accessible information through the Internet and elsewhere is available to Maine residents.

Criteria 2 deals with the specialized skills required of the occupation proposed for regulation or expanded regulation. In this case, as previously noted, there is no indication that the level of training through NARM has ever proven to be inadequate in protecting CPM clients.

The third criterion addresses the central issue of public health and safety. The Department concludes that a case has not been made that public health and safety is jeopardized by the unlicensed practice of midwifery by CPMs or any other midwife in the State of Maine. To the contrary, evidence indicates that current voluntary educational and credentialing options provide adequate protection for the small number of women who choose home birth assisted and supported by midwives.

Based on the information received and discussed above, the Department concludes that State regulation of midwives is not warranted and recommends no action be taken on the proposal that is the subject of this independent assessment.

PLEASE NOTE: Legislative Information ***cannot*** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

Resolve, Directing the Department of Professional and Financial Regulation To Conduct a Sunrise Review Regarding the Practice of Licensed Midwifery

Sec. 1 Sunrise review of the practice of licensed midwifery. Resolved: That the Commissioner of Professional and Financial Regulation shall conduct an independent assessment of the proposal to license certified professional midwives pursuant to the Maine Revised Statutes, Title 5, section 12015, subsection 3, paragraph B; and be it further

Sec. 2 Reporting date established. Resolved: That no later than February 15, 2008, the Commissioner of Professional and Financial Regulation shall submit a report following the review under section 1 to the Joint Standing Committee on Business, Research and Economic Development. The committee is authorized to submit legislation on the subject matter of the report to the Second Regular Session of the 123rd Legislature.

Title 32, Chapter 1-A, GENERAL PROVISIONS

Subchapter 2: SUNRISE REVIEW PROCEDURES (HEADING: PL 1995, c. 686, §2 (new))

§60-J. Evaluation criteria

Pursuant to Title 5, section 12015, subsection 3, any professional or occupational group or organization, any individual or any other interested party, referred to in this section as the "applicant group," that proposes regulation of any unregulated professional or occupational group or substantial expansion of regulation of a regulated professional or occupational group shall submit with the proposal written answers and information pertaining to the evaluation criteria enumerated in this section to the appropriate committee of the Legislature. The technical committee, the Commissioner of Professional and Financial Regulation, referred to in this subchapter as the "commissioner," and the joint standing committee, before it makes its final recommendations to the full Legislature, also shall accept answers and information pertaining to the evaluation criteria from any party that opposes such regulation or expansion and from any other interested party. All answers and information submitted must identify the applicant group, the opposing party or the interested party making the submission and the proposed regulation or expansion of regulation that is sought or opposed. The commissioner may develop standardized questions designed to solicit information concerning the evaluation criteria. The preauthorization evaluation criteria are: [1995, c. 686, §2 (new).]

1. Data on group. A description of the professional or occupational group proposed for regulation or expansion of regulation, including the number of individuals or business entities that would be subject to regulation, the names and addresses of associations, organizations and other groups representing the practitioners and an estimate of the number of practitioners in each group;

[1995, c. 686, §2 (new).]

2. Specialized skill. Whether practice of the profession or occupation proposed for regulation or expansion of regulation requires such a specialized skill that the public is not qualified to select a competent practitioner without assurances that minimum qualifications have been met;

[1995, c. 686, §2 (new).]

3. Public health; safety; welfare. The nature and extent of potential harm to the public if the profession or occupation is not regulated, the extent to which there is a threat to the public's health, safety or welfare and production of evidence of potential harm, including a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against practitioners of the profession or occupation in this State within the past 5 years;

[1995, c. 686, §2 (new).]

4. Voluntary and past regulatory efforts. A description of the voluntary efforts made by practitioners of the profession or occupation to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public;

[1995, c. 686, §2 (new).]

5. Cost; benefit. The extent to which regulation or expansion of regulation of the profession or occupation will increase the cost of goods or services provided by practitioners and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers;

[1995, c. 686, §2 (new).]

6. Service availability of regulation. The extent to which regulation or expansion of regulation of the profession or occupation would increase or decrease the availability of services to the public;

[1995, c. 686, §2 (new).]

7. Existing laws and regulations. The extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from nonregulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners;

[1995, c. 686, §2 (new).]

8. Method of regulation. Why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate;

[1995, c. 686, §2 (new).]

9. Other states. A list of other states that regulate the profession or occupation, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on the profession or occupation in terms of a before-and-after analysis;

[1995, c. 686, §2 (new).]

10. Previous efforts. The details of any previous efforts in this State to implement regulation of the profession or occupation;

[1995, c. 686, §2 (new).]

11. Mandated benefits. Whether the profession or occupation plans to apply for mandated benefits;

[1995, c. 686, §2 (new).]

12. Minimal competence. Whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are; and

[1995, c. 686, §2 (new).]

13. Financial analysis. The method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by current or proposed licensees through dedicated revenue mechanisms.

[1995, c. 686, §2 (new).]

PL 1995, Ch. 686, §2 (NEW).

§60-K. Commissioner's independent assessment

1. Fees. Any applicant group whose regulatory proposal has been directed to the commissioner for independent assessment shall pay an administrative fee determined by the commissioner, which may not exceed $500. The commissioner may waive the fee if the commissioner finds it in the public's interest to do so. Such a finding by the commissioner may include, but is not limited to, circumstances in which the commissioner determines that:

A. The applicant group is an agency of the State; or [1995, c. 686, §2 (new).]

B. Payment of the application fee would impose unreasonable hardship on members of the applicant group. [1995, c. 686, §2 (new).]

[1995, c. 686, §2 (new).]

2. Criteria. In conducting the independent assessment, the commissioner shall apply the evaluation criteria established in section 60-J to all of the answers and information submitted to the commissioner or otherwise collected by the commissioner pursuant to section 60-J.

[1995, c. 686, §2 (new).]

3. Recommendations. The commissioner shall prepare a final report, for the joint standing committee of the Legislature that requested the evaluation, that includes any legislation required to implement the commissioner's recommendation. The commissioner may recommend that no legislative action be taken on a proposal. If the commissioner finds that final answers to the evaluation criteria are sufficient to support some form of regulation, the commissioner shall recommend an agency to be responsible for the regulation and the level of regulation to be assigned to the applicant group. The recommendations of the commissioner must reflect the least restrictive method of regulation consistent with the public interest.

[1995, c. 686, §2 (new).]

PL 1995, Ch. 686, §2 (NEW).

§60-L. Technical committee; fees; membership; duties; commissioner's recommendation

1. Fees. Any applicant group whose regulatory proposal has been directed to the commissioner for review by a technical committee shall pay a fee determined by the commissioner as required to administer the technical committee, which fee may not exceed $1,000. The administrative fee is not refundable, but the commissioner may waive all or part of the fee if the commissioner finds it in the public's interest to do so. Such a finding by the commissioner may include, but is not limited to, circumstances in which the commissioner

determines that:

A. The applicant group is an agency of the State; or [1995, c. 686, §2 (new).]

B. Payment of the application fee would impose unreasonable hardship on members of the applicant group. [1995, c. 686, §2 (new).]

[1995, c. 686, §2 (new).]

2. Technical committee membership. The commissioner shall appoint a technical committee consisting of 7 members to examine and investigate each proposal.

A. Two members must be from the profession or occupation being proposed for regulation or expansion of regulation. [1995, c. 686, §2 (new).]

B. Two members must be from professions or occupations with a scope of practice that overlaps that of the profession or occupation being proposed for regulation or expansion of regulation. If there is more than one overlapping profession or occupation, representatives of the 2 with the greatest number of practitioners must be appointed. [1995, c. 686, §2 (new).]

C. One member must be the commissioner or the commissioner's designee. [1995, c. 686, §2 (new).]

D. Two members must be public members. These persons and their spouses, parents or children may not be or ever have been members of, and may not have or ever have had a material financial interest in, the profession or occupation being proposed for regulation or expansion of regulation or another profession or occupation with a scope of practice that may overlap that of the profession or occupation being proposed for regulation. [1995, c. 686, §2 (new).]

The professional and public members serve without compensation. The chair of the committee must be the commissioner, the commissioner's designee or a public member. The commissioner shall ensure that the total composition of the committee is fair and equitable.

[1995, c. 686, §2 (new).]

3. Meetings. As soon as possible after appointment, a technical committee shall meet and review the proposal assigned to it. Each committee shall investigate the proposed regulation and, on its own motion, may solicit public input. Notice of all meetings must be printed in the legislative calendar at an appropriate time preceding the meeting.

[1995, c. 686, §2 (new).]

4. Procedure for review. Applicant groups are responsible for furnishing evidence upon which a technical committee makes its findings. The technical committee may also utilize information received through public input or through its own research or investigation. The committee shall make a report of its findings and file the report with the commissioner. The committee shall evaluate the application presented to it based on the information provided as required by section 60-J. If the committee finds that additional information is required to assist in developing its recommendations, it may require that the applicant group provide this information or may otherwise solicit information for this purpose. If the committee finds that final answers to the evaluation criteria are sufficient to support regulation of a profession or occupation not currently regulated, the committee must also recommend the least restrictive method of regulation to be implemented, consistent with the public interest. Whether it recommends approval or denial of an application, the committee may make additional recommendations regarding solutions to problems identified during the review.

[1995, c. 686, §2 (new).]

5. Commissioner report. After receiving and considering reports from the technical committee, the commissioner shall prepare a final report, for the joint standing committee of the Legislature that requested the review, that includes any legislation required to implement the commissioner's recommendation. The final report must include copies of the committee report, but the commissioner is not bound by the findings and recommendations of the report. In compiling the report, the commissioner shall apply the criteria established in section 60-J and may consult with the technical committee. The recommendations of the commissioner must reflect the least restrictive method of regulation consistent with the public interest. The final report must be submitted to the joint standing committee of the Legislature having jurisdiction over occupational and professional regulation matters no later than 9 months after the proposal is submitted to the technical committee and must be made available to all other members of the Legislature upon request.

The commissioner may recommend that no legislative action be taken on a proposal. If the commissioner recommends that a proposal of an applicant group be approved, the commissioner shall recommend an agency to be responsible for the regulation and the level of regulation to be assigned to the applicant group.

[1995, c. 686, §2 (new).]

PL 1995, Ch. 686, §2 (NEW).

Summary of the Development of the NARM Certified Professional Midwife credential

NARM has developed a legally defensible process of educational evaluation and psychometrically sound instruments for assessing entry level midwifery knowledge and skills for those practicing in out-of-hospital settings. CPMs are educated as direct entry midwives through a variety of competency-based educational routes, including the Portfolio Evaluation Process (PEP), which was designed to bring about curriculum consistency and to evaluate the education of individuals choosing alternative routes of adult education.

The didactic and clinical components of the certification process were determined by:

- A delineation of skills necessary for safe practice was defined by the Interorganizational Worksgroup, a group of certified nurse-midwives and direct-entry midwives who met in 1991 to determine the skills necessary for the safe out-of-hospital practice of midwifery. This study was funded by the Carnegie Institute.
- A series of Task Force meetings of diverse groups of midwives were held in 1993-1995 to determine the didactic and clinical education and experience necessary for competent, entry level practice
- A comprehensive role delineation study, also called a task or job analysis study, was conducted in 1995 and 2001, including extensive analysis to identify the key elements for public protection. The job analysis is repeated every 6 years.
- A curriculum of educational competencies was developed based on the task force work and the job analysis survey to determine the knowledge and skills that must be mastered through one of the approved adult educational pathways Attainment of these competencies is verified by the preceptor through demonstration in clinical settings through 75 prenatal exams, 40 births, newborn and postpartum exams.
- Examination specifications were developed based on the relevant content and cognitive areas identified in the task analysis.
- Examination item (question) writing is accomplished utilizing panels of practicing midwives supervised by experienced test developers.
- Examination item content, sensitivity, format, and editorial review are accomplished using panels of practitioners and professional test developers and editors.
- The passing standard (cut score) is developed utilizing panels of subject matter experts and the widely accepted Angoff method
- Applicants for certification must demonstrate attainment of knowledge and skills through preceptor verification, and must pass a hands-on Skills Assessment and an 8-hour written exam.
- Ongoing statistical test and item analysis is conducted to ensure the proper performance of each examination form.

This credential has been accredited by the National Commission on Certifying Agencies, which evaluates relevant aspects of the development and administration of a credential, including the job analysis, standard setting, test development and review, statistical analysis of test performance, governance, and financial stability.

The Education of a Certified Professional Midwife

A Certified Professional Midwife has successfully completed a program of midwifery education approved by the North American Registry of Midwives which includes both didactic and clinical experience, the sum of which, on average, takes 3- 5 years to complete.

The acquisition of the required knowledge and skill is evaluated in four ways:

1. The preceptor/instructor verifies that the candidate has demonstrated a competent understanding of all didactic components based on discussion and interaction, including definitions, signs and symptoms, differential diagnosis for risk assessment, treatment and assessment, follow-up, and referral or transport.

2. The preceptor/instructor verifies that the candidate has demonstrated competent ability in providing care to clients in a clinical setting for 75 prenatal exams, 20 births as an assistant, 20 births as a primary midwife, 20 newborn exams, and 40 postpartum exams. The candidate must provide all aspects of care as a primary midwife but must be under the physical, on-site supervision of the preceptor.

3. The competent performance of skills is assessed during a hands-on Skills Assessment – a demonstration exam performed for and scored by a NARM-trained Qualified Evaluator. A passing score must be obtained.

4. The candidate must pass a 350 item, 8-hour written exam that covers all aspects of midwifery care as defined by the NARM Job Analysis

Educational Components

(1) The didactic component of the educational process must include the procurement of knowledge which may be demonstrated in either a classroom or clinical setting, of at least, the following:

(i) Midwifery Counseling, Education, and Communication:
Childbirth Education
Physical and emotional process of pregnancy and birth
Informed Consent
Confidentiality
Diet, Nutrition, and vitamins
Prenatal testing and lab work
Female reproductive anatomy and physiology
Prenatal exercise
Breast self-exam
Environmental and teratogenic hazards to pregnancy
Benefits and risks of birth site options
Preparing for birth at home or birth center

Emergency care plan

(ii)General Healthcare Skills
Universal Precautions and aseptic technique
Recognizing and managing symptoms of shock
Adult and infant CPR
Appropriate use of medications in childbirth, such as
lidocaine or other numbing agents for repair of lacerations
medical oxygen
metherigine and pitocin to prevent postpartum hemorrhage
eye prophylasix
RhoGam
Vitamin K
Benefits and risks of ultrasound

(iii) Appropriate use and care of equipment such as:
Bag and Mask
bulb syringe
delee suction
hemostats
lancets
suturing equipment
urinary catheter
vacutainer collection tubes

(iv) Appropriate evaluation of laboratory records such as
hematocrit
blood sugar
HIV
Hepatitis B & C
Rubella
Syphilis
Group B Strep
Gonorrhea culture
Blood type and Rh factors
Rh antibodies
Chlamydia
PAP smear

(v) Maternal Health Assessment
Health, reproductive, and family health history
Complete initial physical examination to identify normalcy, including
head, eyes, ears, nose, and throat
weight and height
vital signs
thyroid
lymph glands
breasts

reflexes
heart and lungs
abdominal palpation
kidney pain
pelvic landmarks, uterus, cervix, and vagina
musculo-skeletal system
vascular system

(vi) Prenatal Care, including
Routine prenatal examinations for
health and well being
signs and symptoms of infection
vital signs
nutritional status
blood work or lab results
urine for glucose, protein, ketones
fetal heart rate
assessment of fetal growth and well being
fetal position by palpation

(vii) Recognize and respond or refer for potential complications such as
bleeding
hypertension
any abnormal signs in the prenatal exam (blood work, growth, etc)
malpresentation
multiple gestation
vaginal birth after cesarean
preterm labor
post-date pregnancy
premature rupture of membranes

(viii) Labor, Birth and Immediate Postpartum, including
Signs of prodromal or active labor
Maternal comfort measures for labor
Maternal vital signs
Normal and abnormal labor patterns
Fetal lie, presentation, position, and descent
Effacement and dilation of the cervix
Normal, spontaneous, vaginal birth

(ix) Appropriate response to abnormal conditions in labor, such as
signs of fetal distress
variations in presentation
maternal exhaustion
excessive bleeding

(x) Immediate care and assessment of the newborn

(xi) Immediate care and assessment of the mother

(xii) Delivery of the placenta
(xiii) Assessment and repair of the perineum

(xiv) Postpartum
Daily and weekly assessment of mother and newborn
Breastfeeding support
Filing birth certificate
Assessing, treating, or referring for
postpartum depression
uterine or breast infections
abnormal newborn jaundice

(xv) Well Baby Care
Assessment of normal or abnormal newborn conditions, and referral as necessary, in first six weeks, including
respirations
temperature
hearth rate and rhythm
appropriate weight gain
appropriate size and growth
reflexes
elimination patterns
feeding patterns
thrush, jaundice, diaper rash, cradle cap, colic
any significant deviation from normal

(xvi) Metabolic screening for the newborn

2) The clinical component of the educational process must
(i) include prenatal, intrapartal, and postpartal care as well as newborn care
(ii) be at least one year in duration, and
(iii) be equivalent to 1,350 clinical contact hours under the direct supervision of one or more preceptors approved by the North American Registry of Midwives; and
(iv) be based upon a job Analyses designed and implemented in accordance with the standards set by the National Commission on Certifying Agencies or its successor, which identifies core topics that must be mastered for the performance of midwifery skills in an out-of-hospital setting; and
(v) require the student to receive an assessment of competency as an assistant at a minimum of 20 births, and as primary midwife at a minimum of 75 prenatal exams, 20 initial exams, 20 births, 20 newborn exams, and 40 postpartum exams; and
(vi) include certification in adult CPR and Infant CPR or Neonatal Resuscitation.
(vii) document clinical experience in an out-of-hospital setting.

(b) He or she has passed a written and practical skills examination for the practice of midwifery, which is developed following the standards set by the National Commission for Certifying Agencies or a successor, and is administered by the North American Registry of Midwives or a successor organization.

NARM and Accreditation: FAQ

The Certified Professional Midwife (CPM) credential is accredited by the National Commission on Certifying Agencies (NCCA), the certifying arm of the National Association for Competency Assurance (NOCA).

Accreditation by the NCCA requires an extensive evaluation of the development and administration of the credential. The NCCA sets national standards for these required components of an accredited credential:

▶ The Job or Task Analysis that determines the knowledge and skills to be assessed

▶ The linking of the results of the Job Analysis to the test blueprint

▶ The item writing process to develop a bank of appropriate questions for the exam

▶ The cut-score process to set the passing score for each version of the exam

▶ The equating process to assure validity of each form of the exam

▶ Item analysis and statistical evaluation of test performance to assure reliability of scores

▶ Appropriate reporting of scores and assumptions made on the basis of scores

▶ Appropriate testing management and consultation with professional psychometricians

In addition, the NCCA evaluates the accrediting agency to assure that standards are met for:

- Governance, Board of Directors, Organization, Financial Stability, and Resources

- Published Policies and Procedures for Applications, Testing, Appeals, Confidentiality, Accountability, Discipline, Non-discrimination, Test Security, Records Retention, and Recertification

- Published description of assessment instruments including development and validation, eligibility, and administration

- Analyzed, defined, and published performance domains related to the purpose of the credential and the knowledge, skills, and abilities related to the performance domains

- Yearly evaluation of test statistics including pass/fail rate, passing point, average score, standard error of measurement, standard deviation, and reliability estimate such as a Kuder-Richardson score.

The NCCA has accredited over 180 credentials offered by 77 accrediting organizations, most of them in the health care field.

Other credentials accredited by the NCCA include:

Certified Nurse-Midwife

Certified Midwife

Certified Critical Care Nurse

Certified Case Management Nurse

Certified Women's Health Care Nurse Practitioner

Certified Neonatal Nurse Practitioner

Advanced Oncology Certified Nurse

Certified Inpatient Obstetrical Nurse

Certified Respiratory Therapist

Registered Occupational Therapist

Certified Orthopedic Technologist

Certified Master Addictions Counselor

Certification in Infection Control

Certified Dietary Manager

Registered Dietician

Certified Registered Nurse Anesthetist

Registered Clinical Exercise Physiologist

Certified Acute Care Nurse Practitioner

Certified Adult Nurse Practitioner

Certified Cardiac/Vascular Nurse

Certified Family Nurse Practitioner

Certified Gerontological Nurse Practitioner

Certified Medical-Surgical Nurse

Basic and Advanced Nursing Administration

Certified Pediatric Nurse

Certified Perinatal Nurse

Certified Psychiatric and Mental Health Nurse

Certified Safety Professional

Certified Financial Planner

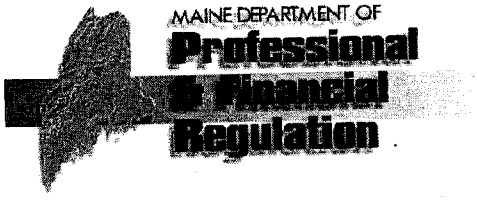
Registered Diagnostic Medical Sonographer

Registered Diagnostic Cardiac Sonographer

Registered Vascular Technologist

Certification in Nuclear Medicine Technology

(for more information, see www.noca.org)



Sunrise Review: Request for Information from Interested Parties

LD 1827 "An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access"

Department of Professional and Financial Regulation
Office of the Commissioner
June 25, 2007

Sunrise Review Survey: Regulation of Certified Professional Midwives

Please return the completed survey to the Commissioner's Office by **July 25, 2007**. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. **Group or organization you represent: ACOG**

2. **Position on proposed legislation.** Does this group or organization support or oppose state regulation of certified professional midwives? **Opposes**

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational group proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation, including the number of midwives who are not certified;

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

(c) An estimate of the number of potential licensees in each group. **Around 28**

2. **Specialized skill.** Please describe whether practice of midwifery requires such a specialized skill that the public is not qualified to select a competent individual without assurances that minimum qualifications have been met. **Delivering babies and caring for pregnant women is a huge responsibility. Although in Maine, no special training is legally required to perform this function, the development of a licensing board to regulate lay midwives who are certified only by there own set of criteria and not by**

either a medical board or the nurse midwifery board will give the public a false sense of security about the competence of these individuals.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if midwives, whether or not certified, are not regulated by the State; and

(b) The extent to which there is a threat to the public's health, safety or welfare without state regulation (*Please provide evidence of the potential harm, including:* a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against midwives in *this State* within the past 5 years). **Unknown**

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by midwives to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation of midwives will increase the cost of services provided by midwives and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

6. **Service availability under regulation.** Please describe the extent to which regulation of midwives would increase or decrease the availability of services to the public. **There is no current lack of access to obstetrical care in Maine and will not be whatever the status of lay midwives.**

7. **Existing laws and regulations.** Please discuss the extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated health practitioners.

8. **Method of regulation.** Please describe why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate.

9. **Other states.** Please provide a list of other states that regulate midwives, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on midwives in terms of a before-and-after analysis.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in this State to implement regulation of midwives.

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are. **The appropriate minimum standards are those to which certified nurse midwives (CNM)s are subject.**

12. **Financial analysis.** Please describe the method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by potential licensees through dedicated revenue mechanisms.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

Date: _July 10_, 2007

Completed by: Name: Jay A. Naliboff, MD

Title: Vice Chair, Maine Section, ACOG

Mailing address: 328 Tower Rd
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An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access

Sunrise Review

Executive Summary:

Maine has a rich and long history of women giving birth outside the hospital under the care of midwives, either in private homes or maternity homes. There are many people still among us who were born at home or gave birth to their own children at home or in local maternity centers. Maine's rural nature and the independent spirit of its people lends itself well to this local, individualized, personal model of care that midwives continue to offer today. The midwives of Martha Ballard's time (Maine's now well-known midwife who served the Augusta area around the turn of the 19th century) were in some ways very much the same as modern midwives in terms of the philosophy of care, and in other ways quite different. Midwives today have benefited from the scientific discovery that has led to better understanding of the birth process and it's possible complications. Some of these medical advances in the form of procedures, tools and medications have been incorporated into the modern midwife's comprehensive care.

Certified Professional Midwives (CPMs) see themselves as the descendants of these traditional midwives and are committed to preserving this choice for birthing families by continuing to provide safe and excellent midwifery care outside the conventional hospital setting. The citizens of Maine continue to seek out the care of these midwives and currently 1% of all Maine births happen at home or in freestanding birth centers. The 22 practicing CPMs are currently the only credentialed practitioners offering home birth services in Maine.

Maine CPMs typically have small private home birth practices where they may travel up to 2 hours to provide care. Care with a CPM generally begins in the first trimester of pregnancy, and extends to the 6-week post partum visit, typically spending an hour with clients per visit. CPMs perform the standard procedures and offer the laboratory tests that are routinely done in medical practices with a special emphasis on individualized care, nutrition, and lifestyle issues. The safety of planned home birth attended by Certified Professional Midwives has been most recently confirmed by a study published in the British Medical Journal (BMJ.2005 Jun 18; 330 (7505):1416).

Over 1200 CPMs currently practice in every state of the Union and 24 states have adopted some form of regulation for direct-entry midwives. Some of these licensing laws are quite old (some are century old statutes that have been more recently renovated for their current situations) and some are brand new and have benefited from the experience that other states have had with their legislation. The state of Maine currently does not regulate and never has regulated direct-entry midwives, a status Maine shares with about 17 other states.

For over 25 years, the direct-entry midwives of Maine have been practicing quietly and meeting together as a professional organization (Midwives of Maine, M.O.M.). Much occurred in the profession during that period of time including:

* the national professional organization initiated the development of a defensible national credential (CPM) that is competency-based
* midwifery schools opened and began training direct-entry midwives within institutions
* a national accrediting agency for midwifery schools was formed and approved by the Federal Department of Education
* many states passed laws regulating direct-entry midwives
* the alternative healthcare movement grew
* an accredited midwifery school opened in Bridgton, Maine.

The topic of state licensure for direct-entry midwives has been discussed at length within M.O.M. for many years. During this time we watched state after state adopt licensing laws, watched midwives in other states harassed and even jailed for practicing, and became increasingly frustrated with the barriers to practice such as lack of access to restricted supplies and poor collaboration with other maternity care providers, both of which are necessary for safe practice. These discussions became more serious in the past couple of years, and in 2006 M.O.M. reached consensus on the bill that has been submitted to the 123rd legislative session.

The licensing and regulation of CPMs is an issue of public safety. The numbers of home birth midwives has doubled in the state of Maine in the past 10 years and following national trends is likely to continue to increase. The national CPM credential first developed in 1997 has done much to assure the public that their midwives have met agreed-upon standards for knowledge and experience. However, there are several things that **the CPM credential alone does not provide**:

1. An effective local disciplinary mechanism to respond to complaints made by clients, peers and other involved parties.
2. A clearly defined scope of practice.
3. A clear legal status in their state, making midwives vulnerable to civil lawsuits, harassment, and non-cooperation with other care providers.
4. Access to restricted supplies and medications that are within our scope of practice and necessary for safe midwifery practice.

State licensing will provide the following important protections for the public:

1. Licensure will provide parents with assurance that their midwife has met state and national standards and is being held accountable in her practice.
2. The public will have a state licensing board to contact with complaints.
3. Licensure will provide a disciplinary mechanism with which to respond to cases of negligence or misconduct on the part of the midwife.
4. Licensure will provide a defined scope of practice for CPMs to work within.
5. Legal recognition of CPMs will encourage better collaboration between midwives and other maternity care providers and hospitals when such

collaboration is indicated. This will ultimately result in better care for pregnant women under the care of midwives.

6. Licensure will allow midwives access to a limited number of restricted supplies and medications necessary for safe and responsible midwifery practice.

As out-of-hospital birth becomes a more mainstream option for pregnant families all across the U.S., the CPMs in a majority of states are working on or have completed the process of becoming licensed practitioners. Our neighboring states, New Hampshire and Vermont both license CPM's; New Hampshire has one of the oldest statutes (it was originally adopted over 25 years ago). The midwives in Maine feel it is time for CPMs to be legally recognized and regulated in the state of Maine.

An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access

Sunrise Review, March 2007

1. ***Data on the group.*** *A description of the professional or occupational group proposed for regulation or expansion of regulation, including the number of individuals or business entities that would be subject to regulation, the names and addresses of associations, organizations, and other groups representing practitioners and an estimate of the number of practitioners in each group;*

The Maine Association of Certified Professional Midwives, MACPM, is an organization of Certified Professional Midwives (CPMs) dedicated to maintaining the safe practice of out-of-hospital midwifery, and to making care by CPMs accessible to women and families in Maine through the mechanisms of licensure and professional advocacy. The purpose of MACPM, which was formed in 2006, is to "advance the practice and art of midwifery; to educate the public on the merits of midwifery; and to create and maintain a law governing the practice of midwifery in the state of Maine." MACPM has 15 members who are CPMs in Maine.

MACPM
PO Box 875
Bath, ME 04530
(207)647-5968 or (207)522-6043
www.macpm.org

There are 22 actively practicing CPMs in Maine. Many of these belong to Midwives of Maine, MOM, which was formed in 1979 as a self-regulatory professional organization for midwives in Maine.

Midwives of Maine
Anna Durand, Chairperson
320 Norway Drive
Bar Harbor, ME 04649
(207)288-4243
www.homestead.com/midwivesofmaine/1.html

The national organization for midwives is the Midwives Alliance of North America, MANA. Membership in MANA includes CPMs, Certified Nurse Midwives (CNMs), Licensed Midwives (LMs), Certified Midwives, (CMs), traditional birth attendants (TBAs), and foreign trained midwives.

Midwives Alliance of North America (MANA)
375 Rockbridge Road
Lilburn, GA 30047
(888)923-6262
www.mana.org

The national certifying body for midwives is the North American Registry of Midwives, NARM. Nationwide, there are over 1000 Certified Professional Midwives.

North American Registry of Midwives (NARM)
5257 Rosestone Dr.
Lilburn, GA 30047
1-888-842-4784
www.narm.org

The educational accrediting body for direct-entry midwifery programs and institutions is the Midwifery Education Accreditation Council (MEAC)Direct-entry midwifery programs accept applicants without the prerequisite of a nursing degree. MEAC has been recognized by the US Education Department since 2001. There are 11 accredited programs in the US, including Birthwise Midwifery School in Bridgton, Maine.

Midwifery Education Accreditation Council (MEAC)
20 East Cherry Ave
Flagstaff, AZ 86001-4607
Phone: 1-928-214-0997
www.meacschools.org

2. ***Specialized skill.*** *Whether practice of the profession or occupation proposed for regulation or expansion of regulation requires such a specialized skill that the public is not qualified to select a competent practitioner without assurances that minimum qualifications have been met;*

A Certified Professional Midwife is a knowledgeable, skilled, and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM), see Appendix A, and is qualified to provide the **Midwives Model of Care**. The CPM is the only international credential that requires knowledge about and clinical experience in out-of-hospital settings. The **Essential Documents** of the Midwives Alliance of North America (MANA) are attached (Appendix B).

Midwives Model of Care™
The Midwives Model of Care™ is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes:

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

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

The Certified Professional Midwife has achieved entry-level proficiency in the following areas:

- Midwifery Counseling, Education, and Communication
- General Healthcare Skills
- Maternal Health Assessment
- Prenatal
- Labor, Birth, and Immediate Postpartum
- Postpartum
- Well-Baby Care

Attached is the list of **NARM Skills**, mastery of which is required in order to obtain a CPM credential (Appendix A). These skills are specialized to the practice of midwifery in general, and midwifery in out-of-hospital settings specifically. In addition, the CPM must demonstrate knowledge of the **MANA Core Competencies** (Appendix B). Professional standards of accountability require midwives to remain active lifelong learners, reinforcing the ideals of competent practice. A CPM must renew certification with NARM every three years with a prescribed number of **Continuing Education Units**, as well as required hours of **Peer Review,** and continuing certification in both adult and infant CPR.

In Maine today, there is no state standard by which a family can determine the skill level of an out-of-hospital attendant. Licensure, based on the CPM credential as administered by NARM, will create a standard by which families can make an informed choice about who attends their birth. The CPM credential gives assurance that the midwife has demonstrated entry-level competence in all of the academic and clinical elements of midwifery care. Assurance from the state that minimum qualifications specific to the profession have been met is the best way to ensure public safety.

3. ***Public health, safety, welfare.*** *The nature and extent of potential harm to the public if the profession or occupation is not regulated, extent to which there is a threat to the public's health, safety, or welfare, and production of evidence of potential harm, including a description of any complaints filed with state law enforcement and certain other relevant authorities that have been lodged against practitioners of the profession or occupation in this State within the past five years;*

The CPM credential specifically requires knowledge about and clinical experience in out-of-hospital settings. For this reason, CPMs are among the primary people who attend out-of-hospital births in the State of Maine. However, in Maine today, anyone can call herself a midwife and attend an out-of-hospital birth. Although we are not aware of specific complaints that have been filed with authorities, we do know of people who have misrepresented their background and skills to the public. In response to these occurrences, Midwives of Maine has attempted to provide some measure of public assurance by requiring members to attain the CPM credential in order to be in primary practice as a guarantee of entry-level skills and knowledge.

Certified Professional Midwives provide comprehensive, evidence-based midwifery care that promotes and protects the health and well being of mothers and babies. Midwifery care promotes a healthy lifestyle including nutritional improvement, proper exercise, avoidance of alcohol, tobacco, drugs and environmental toxins, and a positive birth,

breastfeeding and bonding important to newborn health and development. According to statistical studies, midwifery care also reduces the risks of interventions, including episiotomy, drugs, surgery, and infection. (Appendix G)

Part of the routine care provided by CPMs is the performance of maternal and newborn labwork. Recently, a number of CPMs in Maine who use a large, hospital-affiliated laboratory had their account privileges terminated without notice following a complaint from a hostile obstetrical provider who was incensed to learn that "unlicensed midwives could have privileges at the lab". The termination of the lab services resulted in some mothers and babies being denied access to the most basic care that is essential for the monitoring of well-being.

While pregnancy and birth are most often normal physiologic processes that occur without serious complications, there are some situations that can threaten the health and even the life of the mother and/or baby. CPMs are trained to monitor and evaluate the health and well-being of the mother and baby throughout pregnancy and birth, using customary screenings and monitoring. They are also trained in providing emergency care in the event of such complications as hemorrhage, placental abruption, perineal lacerations, fetal distress, cord prolapse, undiagnosed twins and malpresentations, meconium aspiration, and situations requiring resuscitation. In the absence of the training and knowledge required to attain the CPM credential, there is no assurance that an attendant at an out-of-hospital birth would be able to appropriately identify and successfully respond to potentially damaging or life-threatening complications in the mother and/or the baby.

Failure to license CPMs may pose barriers to obtaining collaborative care. Most low risk women who choose to birth out-of-hospital do not have any complicating factors. Midwives are trained to watch carefully for deviations from normal, and when they occur, to transfer the mother and/or baby to the appropriate caregiver. Because CPMs are not currently licensed in Maine, there have been occasions when communication of vital information regarding care given, health history, and the nature of the current complication have been hindered. There have even been occasions when a hospital, because of a hostile obstetrical provider, refused acceptance of an appropriate emergency transfer. These kinds of occasions put the mother and/or baby at significantly increased risk. Licensed recognition of the CPM will allow women to be more easily transferred to appropriate care while ensuring the highest level of professional communication between the midwife and other healthcare personnel.

It is vitally important to the health and safety of women that anti-hemorrhagic medications be available at the time of birth to be administered by a trained midwife should the need arise. Life threatening hemorrhage is a rare and sometimes unforeseen condition that is easily managed with the use of anti-hemorrhagic agents. Without licensure, access to these medications is restricted and experience in their use is not assured. Although CPMs are trained in the use of anti-hemorrhagic medications and expected to be able to provide them, they cannot always obtain them. Licensure of CPMs ensures that birthing women have immediate access to these life-saving medications. Similarly, CPMs are trained in the use of medical oxygen for compromised mothers and babies. Although CPMs are expected to carry oxygen to births, it is not always available

to unlicensed practitioners. The lack of availability of oxygen could compromise the well-being of a mother or baby. In certain situations, anti-hemorrhagic medications and/or oxygen can mean the difference between life and death.

CPMs across the country have determined to take part in a large, ongoing statistical study in order to better demonstrate the safety of out-of-hospital birth with Certified Professional Midwives. This ongoing effort has resulted in the formation of the Division of Midwifery Research by MANA. In the year 2000, the study documented 5,400 intended out-of-hospital births with CPM's, the largest prospective study of its kind ever undertaken. The study demonstrated a neonatal mortality rate of 1.7 births per 1000, similar to outcomes of low-risk women in hospital settings. It also reported a Cesarean Section outcome in 3.7% of the births, compared to 24% of births in the U.S. during the same year. The study was reported in the British Medical Journal in June 2005. The entire study is attached as Appendix G or may be viewed at www.bmj.com/cgi/content/full/330/7505/1416?ehom.

4. ***Voluntary and past regulatory efforts.*** *A description of the voluntary efforts made by practitioners of the profession or occupation to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public;*

There are currently two levels of self-regulation utilized by direct-entry midwives in Maine. The Midwives of Maine (MOM) has been the self-regulating organization for midwives of the state for many years. MOM developed Standards of Practice in 1983, organizes continuing education opportunities, and provides ongoing Peer Review. In 1997, when the CPM credential became available, MOM voted to require the credential of all primary practicing midwife-members as an assurance of the attainment of uniform, entry-level skills and knowledge.

Nationally, the North American Registry of Midwives (NARM) issues the CPM certification, and as such has the power to regulate its use. There is a grievance procedure available through NARM (Appendix C) that insures that those who are not practicing in accordance with their standards can have their certification revoked.

However, because all states differ in their regulatory processes, there is no legal recourse based on the NARM grievance procedure. Someone may have their CPM revoked at the national level, but that does not prohibit them from continuing to practice in their individual state. NARM can effectively implement a grievance process, but NARM's process alone is not adequate for protecting the public from potentially unsafe providers in Maine. As a professional organization of twenty-two members, MOM has encountered the challenges of providing professional support and peer review to one another, and at the same time, being responsible to oversee the profession and assure public safety. These two professional responsibilities have been found to be in conflict with each other at times.

If, however, the state grants licensure to CPMs and uses the NARM grievance process as a model for a state review process, this has been shown in other states to be adequate to protect the public from harm.

> ***5. Cost; benefit.*** *The extent to which regulation or expansion of regulation of the profession or occupation will increase the cost of goods or services provided by practitioners and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.*

We do not foresee any substantial increase in the cost of CPM care as a result of licensure. We understand that a licensing fee will likely be assessed to CPMs, and it is our expectation that the fee will be sufficient to cover necessary administrative costs without being excessive, so as not to necessitate a significant increase in the fee a CPM must charge for her care.

> ***6. Service availability of regulation.*** *The extent to which regulation or expansion of regulation of the profession or occupation would increase or decrease the availability of services to the public.*

Licensing CPMs will likely increase the availability of out-of-hospital midwifery services to the public over time. Formal licensure and legal recognition for CPMs will increase access to their services largely due to greater visibility and the assurance that licensing provides the consumer. However, the choice of an out-or-hospital birth is one that will continue to be made by a small but growing percentage of women and families.

Many women currently travel long distances in Maine to obtain care from a CPM (up to 2 hours drive). The currently practicing midwives do not adequately cover our large rural state. Some women choose to give birth at home unattended or with less adequately trained midwives because of the lack of CPMs in certain regions. Licensing CPMs could attract more CPMs to the state by offering them a legally recognized credential.

Additionally, the state is home to one of ten nationally accredited institutions for training out-of-hospital midwives. Birthwise Midwifery School in Bridgton, Maine, attracts many students to the state from all over the country and Canada. Licensure will likely allow the state to retain more of those midwives who come to Maine to train. Ultimately, licensure will increase access to and availability of safe, cost-effective, out-of-hospital midwifery services to the childbearing public.

> ***7. Existing laws and regulations.*** *The extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated practitioners.*

To our knowledge there are no existing laws in the state of Maine with regard to the practice of out-of-hospital midwifery. Because childbirth is defined as a normal female process and not pathology, midwifery is not the practice of medicine. This was affirmed

by an opinion issued by the Attorney General more than 25 years ago. Midwifery does not fall under any state agency or under the Medical Practice Act, and therefore there is no current state structure to regulate CPMs.

This lack of regulation has the potential to be seen as a failure of the state to protect the public. Regulation provides assurance of minimum competence, a defined scope of practice and an accountability mechanism, which is lacking at this time.

> ***8. Method of regulation.*** *Why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate.*

The proposal is *to license to use the title*. This method of regulation was chosen in order to provide a mechanism for consumers to choose a midwife. Consumers will be assured that midwives using the title "Licensed Midwife" have met minimum competency standards and are being held accountable by the state to the defined standards of the profession.

This method was chosen over *registration* and *certification* in order to provide a more effective accountability structure for midwives practicing outside the hospital setting.

License to practice was not chosen out of respect for the women who practice this traditional art within their distinct ethnic, religious or cultural communities (i.e. Native American, Amish and Mennonite communities, and others).

> ***9. Other states.*** *A list of other states that regulate the profession or occupation, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on the profession or occupation in terms of a before-and-after analysis.*

There are currently 24 states in the U.S. that regulate direct-entry midwives. Following is a complete list of these states and the type of regulation that each employs (For more information see Appendix D):

Alaska (CPM Licensure)
Arizona (CPM Licensure)
Colorado (CPM Registration)
Florida (Licensure)
Minnesota (CPM Licensure)
New Hampshire (Certification)
New Mexico (Licensure)
Oregon (CPM Licensure)
South Carolina (CPM Licensure)
Texas (CPM Licensure)
Vermont (CPM Licensure)
Washington (Licensure)
Arkansas (CPM Licensure)
California (Licensure)
Delaware (CPM Permit)
Louisiana (CPM Licensure)
Montana (Licensure)
New Jersey (CPM Licensure)
New York (Certification)
Rhode Island (Certification)
Tennessee (CPM Certification)
Utah (CPM Licensure)
Virginia (CPM Licensure)
Wisconsin (CPM Licensure)

The statutes from most of the above listed states can be accessed at http://mana.org/laws.html. The laws from Vermont and Wisconsin are found in Appendices E and F.

We are not aware of any before-and-after analysis for any state that regulates midwives.

> ***10. Previous efforts.*** *The details of any previous efforts in this State to implement regulation of the profession or occupation.*

There have not been any previous efforts to regulate CPMs or any other type of direct-entry midwife in the state of Maine.

> ***11. Mandated benefits.*** *Whether the profession or occupation plans to apply for mandated benefits.*

There are no plans to apply for mandated benefits at this time.

> ***12. Minimal competence.*** *Whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.*

The proposal is to adopt the national CPM credential as the basis for licensure. A precedent for this has already been set; of the 24 states that regulate direct-entry midwives, 18 of them use the CPM credential as a basis for their statute. The national certifying body (NARM) evaluates minimum competency in theoretical education and clinical skills for all its applicants (Appendix A). This relieves the state of the responsibility of determining minimum competence for all applicants for licensure.

The proposal requires that all applicants be CPMs in good standing and that licensed midwives be required to continue to renew their CPM as long as they hold a license. The CPM credential requires the following:

Documentation of the minimum required clinical experiences.
Either a diploma from a MEAC accredited midwifery program or successful completion of the Portfolio Evaluation Process (PEP).
Passing grade on the NARM written exam.
Passing grade on the NARM skills exam (PEP candidates only).
Ongoing Continuing Education credits.
Current CPR and Neonatal Resuscitation certificates.
Ongoing Peer Review

(For more information on the above, see Appendix A)

> ***13. Financial Analysis.*** *The method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonable financed by current or proposed licensees through dedicated revenue mechanisms.*

There will be some expense associated with issuing licenses to CPMs. It is our desire to insure cost neutrality to the state and minimal cost to individual midwives. It is our belief that expenses can be kept to a minimum by utilizing much of the work of NARM, as other states are currently doing. For example, NARM already tests and certifies the knowledge and skills of midwives through the CPM certification process (Appendix A). This is an expense that the state can avoid by adopting the CPM credential as the basis for licensure. NARM already uses a grievance procedure (Appendix C). The state could avoid the costs of investigating a complaint by working collaboratively with NARM to handle grievances. In the end, however, we are aware that there will be some costs associated with issuing licenses. A licensing fee can be assessed to cover these administrative costs. It is important that this fee be adequate to cover costs but not excessive so as to affect the cost of CPM care.

List of Appendices

Appendix A: North American Registry of Midwives (NARM) Certification Process

- NARM Mission Statement
- What is a CPM?
- Certification Process for CPM's
    - Educational Requirements
    - Experience Requirements
    - Skills Requirements
        - NARM/CPM Written Exam Specifications
        - NARM/CPM Skills Assessment Specifications

Appendix B: The Midwives of North America (MANA) Essential Documents

- MANA Core Competencies for Basic Midwifery Practice
- MANA Standards and Qualifications for the Art and Practice of Midwifery

Appendix C: NARM Grievance Procedure

Appendix D: States Using the NARM Written Examination in the Midwifery Regulatory Process

Appendix E: The Vermont Law to License CPM's

Appendix F: The Wisconsin Law to License CPM's

Appendix G: "Outcomes of Planned Homebirths with Certified Professional Midwives: Large Prospective Study in North America," British Medical Journal, June 18, 2005.

APPENDIX A:
NARM Standards for Certification
(Excerpted from the NARM Candidates Information Bulletin)

This Appendix Includes:

- NARM Mission Statement
- What is a CPM?
- Certification Process for CPM's
    - Educational Requirements
    - Experience Requirements
    - Skills Requirements
        - NARM/CPM Written Exam Specifications
        - NARM/CPM Skills Assessment Specifications

North American Registry of Midwives (NARM) Mission Statement

The North American Registry of Midwives (NARM) is an international certification agency whose mission is to establish and administer certification for the credential "Certified Professional Midwife" (CPM). CPM certification validates entry-level knowledge, skills and abilities vital to responsible midwifery practice. This international certification process encompasses multiple educational routes of entry, including apprenticeship, self-study, private midwifery schools, college- and university-based midwifery programs and nurse-midwifery. Created in 1987 by the Midwives Alliance of North America (MANA), NARM is committed to identifying standards and practices that reflect the excellence and diversity of the independent midwifery community, in order to set the standard for midwifery.

NARM affirms that skilled and responsible midwives should be readily available to all families in North America.

NARM affirms the autonomy of independent midwives, the critical importance of their role as guardians of normal birth and the value of their compassionate, skilled and woman-centered care.

NARM affirms a woman's right to choose her birth attendants and place of birth and to involve those she identifies as her family in the bonding of the birth experience.

NARM affirms the safety and viability of planned, midwife-attended birth at home, in hospitals and in freestanding birth centers.

Certification shall not be construed as defining midwifery in its entirety. NARM acknowledges that midwifery encompasses attributes that defy measurement. NARM intends CPM certification to sanction and build a foundation to support midwives' work, while recognizing that their individuality of practice best reflects the needs of the communities they serve. Through CPM certification, NARM seeks to advance the profession of midwifery, to facilitate its integration as a vital component of the health

care system, to ensure its wide availability to pregnant women and their families and to preserve their freedom of choice.

Setting Standards for Midwifery

In response to numerous state initiatives that call for the legalization of midwifery practice and the increased utilization of midwives as maternity care providers, midwives across the United States have come together to define and establish standards for international certification. The North American Registry of Midwives (NARM), the Midwives Alliance of North America (MANA) and the Midwifery Education and Accreditation Council (MEAC) have joined together to create this international, direct-entry midwifery credential to preserve the woman-centered forms of practice that are common to midwives attending out-of-hospital births. These guidelines for certification have been developed with reference to national certifying standards formulated by the National Organization for Competency Assurance (NOCA). NARM has received psychometric technical assistance from Mary Ellen Sullivan, testing consultant; the Florida Department of Business and Professional Regulation Psychometric Research Unit; the Minnesota Board of Medical Practice; Schroeder Measurement Technologies, Inc.; National Measurement and Evaluation, Inc.; and Personnel Research Center.

What is a Certified Professional Midwife (CPM)?

A Certified Professional Midwife (CPM) is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the Midwives Model of Care. The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings.

The Certification Process:

The Certified Professional Midwife (CPM) process has two steps: educational validation and certification.

Step 1 – Educational Validation

The Certified Professional Midwife (CPM) may be educated through a variety of routes, including programsaccredited by the Midwifery Education Accreditation Council (MEAC), the American Midwifery Certification Board (AMCB), apprenticeship education, and self-study. If the midwife's education has been validated through graduation from a MEAC-accredited program; certification by the AMCB as a CNM/CM; or legal recognition in a state evaluated by NARM for educational equivalency, the midwife may submit that credential as evidence of educational evaluation and may apply to take the CPM examination. If the midwife is preceptor-trained or received education outside of the United States, with the exception of UK Registered Midwives, s/he must complete the NARM Portfolio Evaluation Process (PEP).

The NARM Portfolio Evaluation Process (PEP) involves documentation of midwifery training under the supervision of a preceptor. Upon successful completion of the documentation portion of PEP, the applicant must successfully complete the NARM Skills Verification. Then the applicant will be issued a Letter of Completion that can be

submitted to NARM's Application Department as validation of midwifery education.

Step 2 - Certification

When the applicant has completed one of the approved educational routes of entry, the applicant may apply to become a Certified Professional Midwife (CPM), and take the NARM Written Examination. The Written Examination consists of 350 multiple-choice questions. This examination is administered in two, four-hour sessions. The NARM Written Examination is the final step in the CPM certification process. This examination is also administered as the final part of national and international legal recognition processes. The NARM Written examination is required for state licensure in all states that license direct entry midwives to attend births primarily in out-of-hospital settings.

North American Registry of Midwives Position Statement:

Educational Requirements to Become a Certified Professional Midwife (CPM)

The Certified Professional Midwife (CPM) is a knowledgeable, skilled professional midwife who has been educated through a variety of routes. Candidates eligible to apply for the Certified Professional Midwife (CPM) credential include:

- Graduates of programs accredited by the Midwifery Education Accreditation Council (MEAC);
- Midwives certified by the American Midwifery Certification Board (AMCB) as CNMs or CMs; and
- Candidates who have completed NARM's competency-based Portfolio Evaluation Process (PEP).

The education, skills and experience necessary for entry into the profession of direct-entry midwifery were mandated by the *Midwives Alliance of North America (MANA) Core Competencies* and the *Certification Task Force*; authenticated by NARM's current *Job Analysis*; and are outlined in NARM's *Candidate Information Bulletin.* These documents describe the standard for the educational curriculum required of all Certified Professional Midwives.

NARM recognizes that the education of a Certified Professional Midwife (CPM) is composed of didactic and clinical experience. The clinical component of the educational process must be least one year in duration and equivalent to 1350 clinical contact hours under the supervision of one or more preceptors. The clinical experience includes prenatal, intrapartal, postpartal, and newborn care by a student midwife under supervision. A supervising midwife (preceptor) must be either:

- A nationally certified midwife (CPM, CNM, or CM); or
- Legally recognized in a jurisdiction, state, or province as a practitioner who specializes in maternity care; or
- A midwife who has practiced as a primary attendant without supervision for a minimum of three years and 50 out-of-hospital births.

The preceptor holds final responsibility for confirming that the applicant provided the required care. The preceptor must be physically present in the same room in a supervisory capacity during that care and must confirm the provision of that care by signing the appropriate NARM forms.

The Certified Professional Midwife practices *The Midwives Model of Care* primarily in out-of-hospital settings. The CPM is the only national credential that requires knowledge and experience in out-of-hospital settings.

General Education Requirements

Educational Content Areas

The education of all entry-level CPM applicants must include the *content areas* identified in the following documents:

A. The Core Competencies developed by the Midwives Alliance of North America
B. The NARM Written Test Specifications (see below)
C. The NARM Skills Assessment Test Specifications (see below)
D. The NARM Written Examination Primary Reference List
E. The NARM Skills Assessment Reference List

Experience Requirements to qualify to sit the NARM exam:

I. As an ***active participant***, the applicant must attend a minimum of 20 births.
II. Functioning in ***the role of primary midwife under supervision***, the applicant must attend a minimum of an additional 20 births:
A. A minimum of ten of the 20 births attended as primary under supervision must be in homes or other out-of hospital settings; and
B. A minimum of three of the 20 births attended as primary under supervision must be with women for whom the applicant has provided primary care during at least four prenatal visits, birth, newborn exam and one postpartum exam.
C. At least ten of the 20 primary births must have occurred within three years of application submission.
III. Functioning in ***the role of primary midwife under supervision***, the applicant must document:
A. 75 prenatal exams, including 20 initial exams;
B. 20 newborn exams; and
C. 40 postpartum exams.
The applicant must competently perform all aspects of midwifery care (prenatal, intrapartal and postpartal) under the direct supervision of the preceptor.

Skills Requirements

During the course of their educational process, all CPM applicants are expected to acquire the full range of entry-level midwifery skills as defined in the NARM *Test Specifications and Skills Assessment Specifications* **(included below)**.

Other Required Documentation

The applicant must provide:

I. A copy of both sides of current CPR (Adult and either Infant or Neonatal Resuscitation) Certification;
II. Written verification of:
A. Practice guidelines;
B. An informed consent document;
C. An emergency care plan.
III. Documentation and verification of experience, knowledge and skills on the appropriate NARM forms.

Appendix A Cont'd.

Written Test Specifications For CPM/NARM Exam

I. Midwifery Counseling, Education and Communication: (5% of Exam - 17 Examination Items)

A. Provides interactive support and counseling and/or referral services to the mother regarding her relationships with her significant others and other healthcare providers

B. Provides education, support, counseling and/ or referral for the possibility of less-than optimal pregnancy outcomes

C. Provides education and counseling based on maternal health/reproductive family history and on-going risk assessment

D. Facilitates the mother's decision of where to give birth by exploring and explaining:

1. the advantages and the risks of different birth sites
2. the requirements of the birth site
3. how to prepare, equip and supply the birth site

E. Educates the mother and her family/support unit to share responsibility for optimal pregnancy outcome

F. Educates the mother concerning the natural physical and emotional processes of pregnancy, labor, birth and postpartum

G. Applies the principles of informed consent

H. Applies the principles of client confidentiality

I. Provides individualized care

J. Advocates for the mother during pregnancy, birth and postpartum

K. Provides culturally appropriate education, counseling and/or referral to other health care professionals, services, agencies for:

1. genetic counseling for at-risk mothers
2. abuse issues: including, emotional, physical and sexual
3. prenatal testing and lab work
4. diet, nutrition and supplements
5. effects of smoking, drugs and alcohol use
6. situations requiring an immediate call to the midwife
7. sexually transmitted diseases and safe sex practices
8. blood borne pathogens: HIV, Hepatitis B, Hepatitis C
9. complications of pregnancy
10. environmental risk factors
11. newborn care including normal/abnormal newborn activity, responses, vital signs, appearance, behavior, etc.
12. postpartum care concerning complications and self-care
13. contraception
14. female reproductive anatomy and physiology
15. monthly breast self examination techniques
16. implications for the nursing mother
17. the practice of Kegel exercises
18. risks to fetal health, including

a) TORCH viruses (toxoplasmosis, rubella, cytomegalovirus, herpes, other)
b) environmental hazards
c) teratogenic substances

II. General Healthcare Skills: (5% of Exam – 17 Examination Items)

A. Demonstrates the application of Universal Precautions as they relate to midwifery

B. Uses alternative healthcare practices (nonallopathic treatments) and modalities

1. herbs
2. hydrotherapy (baths, compresses, showers, etc.)

3. visualization
C. Refers to alternative healthcare practitioners for non-allopathic treatments
D. Manages shock by:
1. Recognition of shock, or impending shock
2. Assessment of the cause of shock
3. Treatment of shock
a) Provide fluids orally
b) Position mother flat, legs elevated 12 inches
c) Administer oxygen
d) Keep mother warm, avoid overheating
e) Administer/use non-allopathic remedies
f) Encourage deep, calm, centered breathing
g) Activate emergency medical services
h) Prepare to transport
E. Understands the benefits and risks and recommends the appropriate use of vitamin and mineral supplements including: (Prenatal Multi-Vitamin, Vitamin C, Vitamin E, Folic Acid, B-Complex, B-6, B-12, Iron, Calcium, Magnesium)
F. Demonstrates knowledge of the benefits and risks and appropriate administration of the following pharmacological (prescriptive) agents:
1. lidocaine
2. medical oxygen
3. methergine
4. prescriptive ophthalmic prophylaxis ointment (e.g., erythromycin)
5. Pitocin®
6. RhoGam
7. Vitamin K
a) Oral
b) IM
G. Demonstrates knowledge of benefits/risks of ultrasounds
1. provides counseling
2. makes appropriate referrals
H. Demonstrates knowledge of benefits/risks of biophysical profile
1. provides counseling,
2. makes appropriate referrals.
I. Demonstrates knowledge of how and when to use instruments and equipment including:
1. Amni-hook® / Ammnicot®
2. bag and mask resuscitator
3. bulb syringe
4. Delee® (tube/mouth suction device)
5. hemostats
6. lancets
7. nitrazine paper
8. scissors (all kinds)
9. suturing equipment
10. urinary catheter
11. vacutainer/blood collection tube
12. multidose vial; single dose ampule
J. Evaluates laboratory and medical records
1. hematocrit/hemoglobin
2. blood sugar (glucose)
3. HIV
4. Hepatitis B and C
5. Rubella
6. Syphilis (VDRL or RPR)
7. Group B Strep
8. Gonorrhea Culture
9. Complete Blood Count
10. Blood type and Rh factors
11. Rh antibodies
12. Chlamydia
13. PAP smear

III. Maternal Health Assessment: (10% of Exam – 35 Examination Items)

A. Obtain and maintain records of health,
reproductive and family medical history and possible implications to current pregnancy, including
1. personal information/demographics
2. personal history, including religion, occupation, education, marital status, economic status, changes in health or

behavior and woman's evaluation of her health and nutrition
3. potential exposure to environmental toxins
4. medical condition
5. surgical history
6. reproductive history including:
a) menstrual history
b) gynecologic history
c) sexual history
d) childbearing history
e) contraceptive practice
f) history of sexually transmitted infections
g) history of behavior posing risk for sexually transmitted infection exposure
h) history of risk of exposure to blood borne pathogens
i) Rh type and plan of care if negative
7. family medical history
8. psychosocial history
9. history of abuse
10. mental health
B. Perform a physical examination, including assessment of:
1. general appearance/skin condition
2. baseline weight and height
3. vital signs
4. HEENT (Head, Eyes, Ears, Nose and Throat) including:
a) hair and scalp
b) eyes: pupils, whites, conjunctiva
c) thyroid by palpation
d) mouth, teeth, mucus membrane, and tongue
5. lymph glands of neck, chest and under arms
6. breasts
a) evaluates mother's knowledge of self breast examination techniques
b) performs breast examination
7. torso, extremities for bruising, abrasions,moles, unusual growths
8. baseline reflexes
9. heart and lungs
10. abdomen by palpation and observation for scars
11. kidney pain (CVAT)
12. pelvic landmarks (internal)
13. pelvic measurements (internal)
14. cervix (by speculum exam)
a) Papanicolaou (Pap) test results
b) gynecological culture results
15. size of the uterus and ovaries (by bimanual exam)
16. condition of the vulva, vagina, cervix,
perineum and anus
17. musculo-skeletal system
a) joint pain
b) muscular strength
c) spine straightness and symmetry, posture
18. vascular system (edema, varicosities, thrombophlebitis)

IV. Prenatal: (25% of Exam - 88 Examination Items)
A. Assess results of routine prenatal physical exams including ongoing assessment of:
1. maternal psycho-social, emotional health and well-being
2. signs and symptoms of infection
3. maternal health by tracking variations and change in:
a) blood pressure
b) color of mucus membranes
c) general reflexes
d) elimination/urination patterns
e) sleep patterns
f) energy levels
4. nutritional patterns
5. hemoglobin/hematocrit
6. glucose levels
7. breast condition/implications for breastfeeding
8. vaginal discharge/odor
9. signs of abuse
10. urine for protein, glucose, ketones
11. fetal heart rate/tones auscultated with

fetoscope or dopplar
12. vaginal discharge or odor
13. estimated due date based upon:
a) last menstrual period
b) last normal menstrual period
c) length of cycles
d) changes in mucus condition or ovulation history
e) date of positive pregnancy test
f) date of implantation bleeding
g) quickening
h) fundal height
i) calendar date of conception/ unprotected intercourse
14. assessment of fetal growth and well-being
a) auscultation of fetal heart
b) correlation of weeks gestation to fundal height
c) fetal activity and responsiveness to stimulation
d) fetal palpation
B. Records results of the examination in the prenatal records
C. Provides prenatal education, counseling, and recommendations for:
1. nutritional, and non-allopathic dietary supplement support
2. normal body changes in pregnancy
3. weight gain in pregnancy
4. common complaints of pregnancy:
a) sleep difficulties
b) nausea/vomiting
c) fatigue
d) inflammation of the sciatic nerve
e) breast tenderness
f) skin itchiness
g) vaginal yeast infections
h) symptoms of anemia
i) indigestion/heartburn
j) constipation
k) varicose veins
l) sexual changes
m) emotional changes
n) fluid retention
5. Physical preparation
a) preparation of the perineum
b) physical activities for labor preparation (e.g., movement and exercise)
D. Recognizes and responds to potential prenatal complications/variations by identifying/assessing:
1. antepartum bleeding
a) first trimester
b) second trimester
c) third trimester
2. identifying pregnancy-induced hypertension
3. assessing, educating and counseling for
pregnancy-induced hypertension with:
a) nutritional/hydration assessment
b) administration of calcium/magnesium supplement
c) stress assessment and management
d) non-allopathic remedies
e) monitoring for signs and symptoms of increased severity
f) increased frequency of maternal assessment
g) hydrotherapy
4. identifying and consulting, collaborating or
referring for:
a) pre-eclampsia
b) gestational diabetes
c) urinary tract infection
d) fetus small for gestational age
e) intrauterine growth retardation
f) thrombophlebitis
g) oligohydramnios
h) polyhydramnios
5. breech presentations
a) identifying breech presentation
b) turning breech presentation with:
(1) alternative positions (tilt board, exercises, etc.)
(2) referral for external version
(3) non-allopathic methods
c) management strategies for unexpected breech delivery

6. multiple gestation
a) Identifying multiple gestation
b) management strategies for unexpected multiple births
7. vaginal birth after cesarean (VBAC)
a) identifying VBACs by history and physical
b) indications/contraindications for out-of hospital births
c) management strategies for VBAC
d) recognizes signs, symptoms of uterine rupture and knows emergency treatment
8. identifying and dealing with pre-term labor with:
a) referral
b) consultation and/or treatment including:
(1) increase of fluids
(2) non-allopathic remedies
(3) discussion of the mother's fears - emotional support
(4) consumption of an alcoholic beverage
(5) evaluation of urinary tract infection
(6) evaluation of other maternal infection
(7) bed rest
(8) pelvic rest (including no sexual intercourse)
(9) no breast stimulation (including nursing)
9. assessing and evaluating a post-date pregnancy by monitoring/assessing:
a) fetal movement, growth, and heart tone
variability
b) estimated due date calculation
c) previous birth patterns
d) amniotic fluid volume
e) maternal tracking of fetal movement
f) consultation or referral for:
(1) ultrasound
(2) non-stress test
(3) biophysical profile
10. treating a post-date pregnancy by stimulating the onset of labor
a) sexual/nipple stimulation
b) assessment of emotional blockage and/
or fears
c) stripping membranes
d) cervical massage
e) castor oil induction
f) non-allopathic therapies
g) physical activity
11. identifying and referring for:
a) tubal pregnancy
b) molar pregnancy
c) ectopic pregnancy
d) placental abruption
e) placenta previa
12. identifying premature rupture of membranes
13. managing premature rupture of membranes in a full-term pregnancy:
a) monitor fetal heart tones and movement
b) minimize internal vaginal examinations
c) reinforce appropriate hygiene techniques
d) monitor vital signs for signs of infection
e) encourage increased fluid intake
f) support nutritional/non-allopathic treatment
g) stimulate labor
h) consult for prolonged rupture of membranes
14. consult and refer for pre-term rupture of membranes
15. establishes and follows emergency contingency plans for mother/baby

V. Labor, Birth and Immediate Postpartum (35% of Exam - 123 Examination items)

A. Facilitates maternal relaxation and provides comfort measure throughout labor by administering/encouraging:
1. massage
2. hydrotherapy (compresses, baths,

showers)
3. warmth for physical and emotional comfort (e.g., compresses, moist warm towels, heating pads, hot water bottles, friction heat)
4. communication in a calming tone of voice, using kind and encouraging words
5. the use of music
6. silence
7. continued mobility throughout labor
8. pain management :
a) differentiation between normal and abnormal pain
b) validation of the woman's experience/ fears
c) counter-pressure on back
d) relaxation/breathing techniques
e) non-allopathic treatments
f) position changes
B. Evaluates/responds to during first stage:
1. assess maternal/infant status based upon:
a) vital signs
b) food and fluid intake/output
c) dipstick urinalysis
d) status of membranes
e) uterine contractions for frequency, duration and intensity with a basic intrapartum examination
f) fetal heart tones
g) fetal lie, presentation, position and descent with:
(1) visual observation
(2) abdominal palpation
(3) vaginal examination
h) effacement, dilation of cervix and station of the presenting part
i) maternal dehydration and/or vomiting by administering:
(1) fluids by mouth
(2) ice chips
(3) oral herbal/homeopathic remedies
2. anterior/swollen lip by administering/ supporting
a) position change
b) light pressure or massage to cervical lip
c) warm bath
d) pushing the lip over the baby's head while the mother pushes
e) deep breathing and relaxation between contractions
f) non-allopathic treatments
3. posterior, asynclitic position by encouraging and/or supporting:
a) the mother's choice of position
b) physical activities (pelvic rocking, stair climbing, walking, etc.)
c) non-allopathic treatments
d) rest or relaxation
e) manual internal rotation ("dialing the phone")
4. pendulous belly inhibiting descent by:
a) positioning semi-reclining on back
b) assisting the positioning of the uterus over the pelvis
c) lithotomy position
5. labor progress by providing:
a) psychological support
b) nutritional support
c) non-allopathic treatments
d) physical activity
e) position change
f) rest
g) nipple stimulation
C. Demonstrates the ability to evaluate/support during second stage
1. wait for the natural urge to push
2. encourage aggressive pushing in emergency situations
3. allow the mother to choose the birthing position
4. recommend position change as needed
5. perineal massage
6. encourage the mother to touch the newborn during crowning
7. assist in normal spontaneous vaginal birth with perineal support
8. provide an appropriate atmosphere for the moment of emergence
9. document labor and birth

D. Demonstrates the ability to recognize and respond to labor and birth complications such as:
1. abnormal fetal heart tones and patterns by:
a) increase oxygen
(1) administer oxygen
(2) encourage deep breathing
b) change maternal position
c) facilitate quick delivery if birth is imminent
d) evaluate for consultation and referral
e) evaluate for transport
2. cord prolapse by
a) change maternal position to knee-chest
b) activate emergency medical services/ medical backup plan
c) apply counter-pressure to the presenting part
d) place cord back into vagina
e) keep the presenting cord warm, moist and protected
f) monitor FHT and cord for pulsation
g) increase the mother's oxygen supply
h) facilitate immediate delivery, if birth is
imminent
i) prepare to resuscitate the newborn
3. variations in presentation
a) breech
b) nuchal hand/arm
(1) apply counter pressure to hand/or arm and the perineum
(2) sweep arm out
c) nuchal cord
(1) loop finger under the cord, and sliding it over head
(2) loop finger under the cord, and sliding it over the shoulder
(3) clamp cord in 2 places, cutting the cord between the 2 clamps
(4) press baby's head into perineum and somersault the baby out
(5) prepare to resuscitate the baby
d) face and brow
(1) prepare for imminent birth
(2) prepare resuscitation equipment
(3) prepare treatment for newborn bruising/swelling
(4) administer arnica
(5) position the mother in a squat
(6) prepare for potential eye injury
e) multiple birth and delivery
f) shoulder dystocia
(1) reposition shoulders to oblique diameter
(2) reposition the mother to:
(a) hands and knees (Gaskin maneuver)
(b) exaggerated lithotomy (McRobert's position)
(c) end of bed
(3) flex shoulders of newborn, then corkscrew
(4) extract the posterior arm
(5) apply supra-pubic pressure
(6) apply gentle traction while encouraging pushing
(7) sweep arm across newborn's face
4. vaginal birth after cesarean (VBAC)
5. management of meconium stained fluids
a) prepare to resuscitate the baby
b) instruct the mother to stop pushing after delivery of head
c) clear the airway with suction of mouth and nose
d) prepare to resuscitate the baby
6. management of maternal exhaustion by:
a) nutritional support
b) adequate hydration
c) non-allopathic treatments
d) evaluate the mother's psychological condition
e) increase rest
f) monitor vital signs
g) monitor fetal well-being
h) evaluate urine for ketones
i) evaluate for consultation and/or referral

E. recognize/consult/transport for signs of
1. uterine rupture
2. uterine rupture
3. amniotic fluid embolism
4. stillbirth
F. assesses the condition of, and provides care or the newborn:
1. keep baby warm
2. make initial newborn assessment
3. determine APGAR score at:
a) 1 minute
b) 5 minutes
c) 10 minutes (as appropriate)
4. keep baby and mother together
5. monitor respiratory and cardiac function
by assessing:
a) symmetry of the chest
b) sound and rate of heart tones and respirations
c) nasal flaring
d) grunting
e) retractions
f) circumoral cyanosis
g) central cyanosis
6. stimulate newborn respiration:
a) rub up the baby's spine
b) encourage parental touch, and call newborn's name
c) flick or rub the soles of the baby's feet
d) keep baby warm
e) rub skin with blanket
7. responding to the need for newborn resuscitation:
a) administer mouth-to-mouth breaths
b) positive pressure ventilation for 15-30 seconds
c) administer oxygen
d) leave cord unclamped until placenta delivers
8. Recognize and consult or transport for apparent birth defects
9. Recognizes signs and symptoms of Meconium Aspiration Syndrome and consults or refers as needed
10. Support family bonding
11. Clamping the cord after pulsing stops
12. Cutting the cord after clamping
13. Caring for the cord:
a) evaluating the cord stump
b) collecting a cord blood sample
14. administer eye prophylaxis
15. assess gestational age
G. assist in placental delivery and responds to blood loss:
1. remind mother of the onset of third stage of labor
2. determine signs of placental separation
such as:
a) lengthening of cord
b) separation gush
c) rise in fundus
d) contractions
e) urge to push
3. facilitate the delivery of the placenta by:
a) breast feeding/nipple stimulation
b) change the mother's position
c) administer non-allopathic treatments
d) perform guarded cord traction
4. after delivery, assess the condition of the placenta
5. estimate blood loss
6. respond to a trickle bleed by:
a) assess origin
b) respond to uterine bleeding by:
(1) breastfeeding/nipple stimulation
(2) fundal massage
(3) assess fundal height and uterine size
(4) non-allopathic treatments
(5) express clots
(6) empty bladder
(7) assess vital signs
c) respond to vaginal tear and bleeding with:
(1) direct pressure on tear
(2) suturing
(3) assessment of blood color and volume

7. respond to postpartum hemorrhage with:
a) fundal massage
b) external bimanual compression
c) internal bimanual compression
d) manual removal of clots
e) administer medication
f) non-allopathic treatments
g) maternal focus on stopping the bleeding/ tightening the uterus
h) administer oxygen
i) treat for shock
j) consult and/or transfer
k) activate medical emergency backup plan
l) prepare to increase postpartum care
H. Assess general condition of mother:
1. assess for bladder distension
2. encourage urination for bladder distension
3. perform catheterization for bladder distension
4. assess lochia
5. assess the condition of vagina, cervix and perineum for:
a) cystocele
b) rectocele
c) hematoma
d) tears
e) lacerations
f) hemorrhoids
g) bruising
6. repair the perineum:
a) refer for repair
b) administer a local anesthetic
c) perform basic suturing of:
(1) 1st degree tears
(2) 2nd degree tears
(3) labial tears
d) provide alternate repair methods (nonsuturing)
7. provide instruction for care and treatment of the perineum
8. facilitate breastfeeding by assisting and teaching about:
a) colostrum
b) positions for mother and baby
c) skin-to-skin contact
d) latching on
e) maternal hydration
f) maternal nutrition
g) maternal rest
h) feeding patterns
(1) maternal comfort measures for engorgement
(2) letdown reflex
(3) milk expression

VI. The Postpartum Period: (15% of Exam – 54 Items)
A. Completes the birth certificate
B. Provides contraceptive/family planning education and counseling
C. Performs postpartum reevaluation of mother and baby at:
1. day-one to day-two
2. day-three to day-four
3. 1 to 2 weeks
4. 6 to 8 weeks
D. assess, and provides counseling and education as needed, for:
1. postpartum-subjective history
2. lochia vs. abnormal bleeding
3. return of menses
4. vital signs, digestion, elimination patterns
5. breastfeeding, condition of breasts and nipples
6. muscle prolapse of vagina and rectum (cystocele, rectocele)
7. strength of pelvic floor
8. condition of the uterus (size and involution), ovaries and cervix
9. condition of the vulva, vagina, perineum and anus
E. educates regarding adverse factors affecting breastfeeding
1. environmental
2. biological
3. occupational
4. pharmacological
F. Facilitate psycho-social adjustment

G. Knows signs and symptoms, differential diagnosis, and appropriate midwifery management or referral for:
1. uterine infection
2. urinary tract infection
3. infection of vaginal tear or incision
4. postpartum depression
5. postpartum psychosis
6. late postpartum bleeding/hemorrhage
7. thrombophlebitis
H. Assesses for, and treats jaundice by:
1. encourage mother to breastfeed every 2 hours
2. expose the front and back of newborn to sunlight through window glass
3. assess newborn lethargy and hydration
4. consult or refer
I. Provide direction for care of circumcised penis
J. Provide direction for care of uncircumcised penis
K. Treat thrush on nipples
1. dry nipples after nursing
2. non-allopathic remedies
3. refer for allopathic treatments
L. Treat sore nipples with:
1. apply topical agents
2. expose to air
3. suggest alternate nursing positions
4. evaluate baby's sucking method
5. apply expressed milk
M. treat mastitis by:
1. provide immune system support including:
a) nutrition/hydration
b) non-allopathic remedies
c) encourage multiple nursing positions
d) apply herbal/non-allopathic compresses
e) apply warmth, soaking in tub or by shower
f) encourage adequate rest/relaxation
g) assess for signs and symptoms of infections
h) teach mother to empty breasts at each feeding
i) provide/teach gentle massage of sore spots
j) consult/refer to:
(1) La Leche League
(2) lactation counselor
(3) other healthcare providers

VII. Well-Baby Care: (5% of Exam - 16 Items
A. Provide well-baby care up to six weeks
B. Instruct on newborn care including normal/abnormal newborn activity, responses, vital signs, appearance, behavior, etc.
C. Assess the current health and appearance of baby including:
1. temperature
2. heart rate, rhythm and regularity
3. respirations
4. appropriate weight gain
5. length
6. measurement of circumference of head
7. neuro-muscular response
8. level of alertness
9. wake/sleep cycles
10. feeding patterns
11. urination and stool for frequency, quantity
and color
12. appearance of skin
13. jaundice
14. condition of cord
D. instructs mother in care of:
1. diaper rash
2. cradle cap
E. Advises and facilitates treatment of thrush
F. Advises and facilitates treatment for colic
G. Recognizes signs/symptoms and differential diagnosis of:
1. infections
2. polycythemia
3. cardio-respiratory abnormalities

4. glucose disorders
5. hyperbilirubinemia
6. birth defects
7. failure to thrive
8. newborn hemorrhagic disease (early and late onset)
H. Provide information for referral for continued well-baby care
I. Support integration of baby into family
J. Perform or refer for newborn metabolic screening

Skills Assessment Test Specifications for CPM/NARM Exam

I. General Healthcare Skills
A. Demonstrates aseptic technique
1. Handwashing
2. Gloving and ungloving
3. sterile technique
B. Demonstrates the use of instruments and equipment including:
1. Blood pressure cuff
2. Doppler or fetoscope
3. Gestation calculation wheel/calendar
4. Newborn and adult scale
5. Stethoscope
6. Tape measure
7. Thermometer
8. Urinalysis Strips
C. Injection Skills
1. Proper use of equipment
a) Syringe
b) Single dose vial
c) Multi dose vial
d) Sharps container
2. Demonstration of skill
a) Checking appearance, name, and expiration date
b) Observation of sterile technique
c) Drawing up fluids in the syringe
d) Injection of fluids
e) Disposal of needles
D. Oxygen
1. Proper set up of oxygen equipment
2. use of cannula and face mask
3. regulation of flow meter

II. Maternal Health Assessment
A. Performs a general physical examination, including assessment of:
1. Baseline weight and height
2. Vital signs: blood pressure, pulse, and temperature
3. Baseline reflexes
4. Abdomen, spine, and skin
5. Heart and lungs (auscultate)
6. Breast Examination
7. Kidney pain; Costovertable Angle Tenderness (CVAT)
8. Deep tendon reflexes of the knee
9. Extremities for edema

III. Prenatal
A. Performs prenatal physical exam including assessment of:
1. determination of due date by wheel or

calendar
2. vital signs: blood pressure, pulse, temperature
3. respiratory assessment
4. weight
5. urine for:
a) appearance: color, density, odor, clarity
b) protein
c) glucose
d) ketones
e) PH
f) Leukocytes
g) Nitrites
h) Blood
6. costrovertebral angle tenderness (CVAT)
7. deep tendon reflexes (DTR) of the knee
8. clonus
9. fundal height
10. fetal heart rate/tones ausculated with fetoscope or doppler
11. fetal position, presentation, lie
12. assessment of edema

IV. Labor, Birth and Immediate Postpartum

A. performing a newborn examination by
assessing:
1. the head for:
a) size/circumference
b) molding
c) hematoma
d) caput
e) sutures
f) fontanels
g) Measurement
2. the eyes for:
a) jaundice
b) pupil condition
c) tracking
d) spacing
3. the ears for:
a) positioning
b) response to sound
c) patency
d) cartilage
4. the mouth for:
a) appearance and feel of palate
b) lip and mouth color
c) tongue
d) lip
e) cleft
f) signs of dehydration
5. the nose for:
a) patency
b) flaring nostrils
6. the neck for:
a) enlarged glands; thyroid and lymph
b) trachea placement
c) soft tissue swelling
d) unusual range of motion
7. the clavicle for:
a) integrity
b) symmetry
8. the chest for:
a) symmetry
b) nipples
c) breast enlargement including discharge
d) measurement (chest circumference)
e) count heart rate
f) monitor heartbeat for irregularities
g) auscultate the lungs, front and back for:
(1) breath sounds
(2) equal bilateral expansion
9. the abdomen for:
a) enlarged organs
b) masses
c) hernias
d) bowel sounds
10. the groin for
a) femoral pulses
b) swollen glands
11. the genitalia for:
a) appearance
b) testicles for:
(1) descent
(2) rugae

(3) herniation
c) labia for:
(1) patency
(2) maturity of clitoris and labia
12. the rectum for:
a) patency
b) meconium
13. Abduct hips for dislocation
14. the legs for:
a) symmetry of creases in the back of the legs
b) equal length
c) foot/ankle abnormality
15. the feet for:
a) digits, number, webbing
b) creases
c) abnormalities
16. the arms for symmetry in:
a) structure
b) movement
17. the hands for:
a) number of digits, webbing
b) finger taper
c) palm crease
d) length of nails
18. the backside of baby for:
a) symmetry of hips, range of motion
b) condition of the spine:
c) dimpling
d) holes
e) straightness
19. temperature: axillary, rectal
20. reflexes:
a) flexion of extremities and muscle tone
b) sucking
c) moro
d) babinski
e) plantar/palmar
f) stepping
g) grasp
h) rooting

V. Well-Baby Care

A. Assesses the general health and appearance
of baby including:
1. temperature
2. heart rate, rhythm and regularity
3. respirations
4. weight
5. length
6. measurement of circumference of head
21. skin condition for:
a) color
b) lesions
c) birthmarks
d) milia
e) vernix
f) lanugo
g) peeling
h) rashes
i) bruising
22. length of baby
23. weight of baby

APPENDIX B:
Midwives Alliance of North America (MANA) Essential Documents

Core Competencies for Basic Midwifery Practice

Approved by the MANA Board – October 3, 1994

I. Guiding Principles of Practice

The midwife provides care according to the following principles:

A. Midwives work in partnership with women and their chosen support community throughout the care giving relationship.

B. Midwives respect the dignity, rights and the ability of the women they serve to act responsibly throughout the caregiving relationship.

C. Midwives work as autonomous practitioners, collaborating with other health and social service providers when necessary.

D. Midwives understand that physical, emotional, psycho-social and spiritual factors synergistically comprise the health of individuals and affect the childbearing process.

E. Midwives understand that female physiology and childbearing are normal processes, and work to optimize the well-being of mothers and their developing babies as the foundation of caregiving.

F. Midwives understand that the childbearing experience is primarily a personal, social and community event.

G. Midwives recognize that a woman is the only direct care provider for herself and her unborn baby; thus the most important determinant of a healthy pregnancy is the mother herself.

H. Midwives recognize the empowerment inherent in the childbearing experience and strive to support women to make informed decisions and take responsibility for their own well-being.

I. Midwives strive to insure vaginal birth and provide guidance and support when appropriate to facilitate the spontaneous process of pregnancy, labor and birth, utilizing medical intervention only as necessary.

J. Midwives synthesize clinical observations, theoretical knowledge, intuitive assessment and spiritual awareness as components of a competent decision making process.

K. Midwives value continuity of care throughout the childbearing cycle and strive to maintain continuous care within realistic limits.

L. Midwives understand that the parameters of "normal" vary widely and recognize that each pregnancy and birth are unique.

II. General Knowledge and Skills

The midwife provides care incorporating certain concepts, skills and knowledge from a variety of health and social sciences including, but not limited to:
A. Communication, counseling and teaching skills
B. Human anatomy and physiology relevant to childbearing
C. Community standards of care for women and their developing infants during the childbearing cycle, including midwifery and bio-technical medical standards and the rationale for and limitations of such standards
D. Health and social resources in her community
E. Significance of and methods for documentation of care through the childbearing cycle
F. Informed decision making
G. The principles and appropriate application of clean and aseptic technique and universal precautions
H. Human sexuality, including indication of common problems and indications for counseling
I. Ethical considerations relevant to reproductive health
J. The grieving process
K. Knowledge of cultural variations
L. Knowledge of common medical terms
M. The ability to develop, implement and evaluate an individualized plan for midwifery care
N. Woman-centered are, including the relationship between the mother, infant, and their larger support community.
O. Knowledge and application of various health care modalities as they apply to the childbearing cycle

III. Care During Pregnancy
The midwife provides health care, support, and information to women throughout pregnancy. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. Identification, evaluation, and support of maternal and fetal well-being throughout the process of pregnancy
B. Education and counseling for the childbearing cycle
C. Preexisting conditions in a woman's health history which are likely to influence her well-being when she becomes pregnant
D. Nutritional requirements of pregnant women and methods of nutritional assessment and counseling
E. Changes in emotional, psycho-social and sexual variations that may occur during pregnancy
F. Environmental and occupational hazards for pregnant women
G. Methods of diagnosing pregnancy
H. Basic understanding of genetic factors which may indicate the need for counseling, testing, or referral
I. Basic understanding of the growth and development of the unborn baby
J. Indications for, risk, and benefits of bio-technical screening methods and diagnostic tests used during pregnancy
K. Anatomy, physiology and evaluation of the soft and bony structures of the pelvis

L. Palpation skills for evaluation of the fetus and uterus
M. The causes, assessment and treatment of the common discomforts of pregnancy
N. Identification of, implications of, and appropriate treatment for various infections, disease conditions and other problems which may affect pregnancy
O. Special needs of the Rh- woman

IV. Care During Labor, Birth and Immediately Thereafter
The midwife provides health care, support, and information to women throughout labor, birth and the hours immediately thereafter. The determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. The normal process of labor and birth
B. Parameters and methods for evaluating maternal and fetal well-being during labor, birth and immediately thereafter, including relevant historical data
C. Assessment of the birthing environment, assuring that it is clean, safe and supportive, and that appropriate equipment and supplies are on hand
D. Emotional responses and their impact during labor, birth, and immediately thereafter
E. Comfort and support measures during labor, birth and immediately thereafter
F. Fetal and maternal anatomy and their interactions as relevant to assessing fetal position and the progress of labor
G. Techniques to assist and support the spontaneous vaginal birth of the baby and placenta
H. Fluid and nutritional requirements during labor, birth and immediately thereafter
I. Assessment of and support for maternal rest and sleep as appropriate during the process of labor, birth and immediately thereafter
J. Causes of, evaluation of, and appropriate treatment for variations which occur during the course of labor, birth and immediately thereafter
K. Emergency measures and transport for critical problems arising during labor, birth or immediately thereafter
L. Understanding of and appropriate support for the newborn's transition during the first minutes and hours following birth
M. Familiarity with current bio-technical interventions and technologies which may be commonly used in a medical setting
N. Evaluation and care of the perineum and surrounding tissues

V. Postpartum Care
The entry-level midwife provides health care, support and information to women throughout the postpartum period. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes, but is not limited, the following:
A. Anatomy and physiology of the mother during the postpartum period
B. Lactation support and appropriate breast care including evaluation of, identification of, and treatments for problems with nursing
C. Parameters and methods for evaluating and promoting maternal well-being during the postpartum period
D. Causes of, evaluation of, and treatment for maternal discomforts during the

postpartum period
E. Emotional, psycho-social, and sexual variations during the postpartum period.
F. Maternal nutritional requirements during the postpartum period including methods of nutritional evaluation and counseling
G. Causes of, evaluation of, and treatments for problems arising during the postpartum period
H. Support, information and referral for family planning methods as the individual woman desires

VI. Newborn Care
The entry-level midwife provides health care to the newborn during the postpartum period and support and information to parents regarding newborn care. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. Anatomy, physiology and support of the newborn's adjustment during the first days and weeks of life.
B. Parameters and methods for evaluating newborn wellness including relevant historical data and gestational age
C. Nutritional needs of the newborn
D. Community standards and state laws regarding indications for, administration of, and the risks and benefits of prophylactic bio-technical treatments and screening tests commonly used during the neonatal period
E. Causes of, assessment of, appropriate treatment, and emergency measures for neonatal problems and abnormalities

VII. Professional, Legal and Other Aspects
The entry-level midwife assumes responsibility for practicing in accord with the principles outlined in this document. The midwife uses a foundation of knowledge and/or skill which includes the following:
A. MANA's documentation concerning the Art and Practice of Midwifery
B. The purpose and goal of MANA and local (state or provincial) midwifery association
C. The principles and practice of data collection as relevant to midwifery care
D. Laws governing the practice of midwifery in her local jurisdiction
E. Various sites, styles and modes of practice within the larger midwifery community
F. A basic understanding of maternal/child health care delivery systems in her local jurisdiction
G. Awareness of the need for midwives to share their knowledge and experience

VIII. Woman Care and Family Planning
Depending upon education and training, the entry-level midwife may provide family planning and well-woman care. The practicing midwife may also choose to meet the following core competencies with additional training. In either case, the midwife provides care, support and information to women regarding their overall reproductive health using the foundation of knowledge and/or skill which includes the following:
A. Understanding of the normal life cycle of women
B. Evaluation of the woman's well-being including relevant historical data

C. Causes of, evaluation of, and treatments for problems associated with the female reproductive system and breasts
D. Information on, provision of, or referral for various methods on contraception
E. Issues involved in decision-making regarding unwanted pregnancies and resources for counseling and referral

Standards and Qualifications for the Art and Practice of Midwifery

Revised at MANA Business Meeting, October 2, 2005

The midwife practices in accord with the *MANA Standards and Qualifications for the Art and Practice of Midwifery* and the *MANA Statement of Values and Ethics*, and demonstrates the clinical skills and judgments described in the *MANA Core Competencies for Midwifery Practice.*

1. **Skills**: Necessary skills of a practicing midwife include the ability to:
• Provide continuity of care to the woman and her newborn during the maternity cycle. Care may continue throughout the woman's entire life cycle. The midwife recognizes that childbearing is a woman's experience and encourages the active involvement of her self-defined family system.
• Identify, assess and provide care during the antepartal, intrapartal, postpartal and newborn periods. She mayalso provide well woman and newborn care.
• Maintain proficiency in life-saving measures by regular review and practice
• Deal with emergency situations appropriately
• Use judgment, skill and intuition in competent assessment and response.

2. **Appropriate equipment and treatment**: Midwives carry and maintain equipment to assess and provide care for the well-woman, the mother, the fetus, and the newborn; to maintain clean and/or aseptic technique; and to treat conditions including, but not limited to, hemorrhage, lacerations, and cardio-respiratory distress. This may include the use of non-pharmaceutical agents, pharmaceutical agents, and equipment for suturing and intravenous therapy.

3. **Records**: Midwives keep accurate records of care for each woman and newborn in their practice. Records shall reflect current standards in midwifery charting, and shall be held confidential (except as legally required). Records shall be provided to the woman on request. The midwife maintains confidentiality in all verbal and written communications regarding women in her care.

4. **Data Collection**: It is highly recommended that midwives collect data for their practice on a regular basis and that this be done prospectively, following the protocol developed by the MANA Division of Research. Data collected by the midwife shall be used to inform and improve her practice.

5. **Compliance**: Midwives will inform and assist parents regarding public health requirements of the jurisdiction in which the midwifery service is provided.

6. **Medical Consultation, Collaboration, and Referral**: All midwives recognize that there are certain conditions for which medical consultations are advisable. The midwife shall make a reasonable attempt to assure that her client has access to consultation, collaboration, and/or referral to a medical care system when indicated.

7. **Screening**: Midwives respect the woman's right to self-determination. Midwives assess and inform each woman regarding her health and well-being relevant to the appropriateness of midwifery services. It is the right and responsibility of the midwife to refuse or discontinue services in certain circumstances. Appropriate referrals are made in the interest of the mother or baby's well-being or when the required or requested care is outside the midwife's personal scope of practice as described in her practice guidelines.

8. **Informed Choice**: Each midwife will present accurate information about herself and her services, including but not limited to:
- her education in midwifery
- her experience level in midwifery
- her practice guidelines
- her financial charges for services
- the services she does and does not provide
- her expectations of the pregnant woman and the woman's self-defined family system.

The midwife recognizes that the woman is the primary decision maker in all matters regarding her own health care and that of her infant. The midwife respects the woman's right to decline treatments or procedures, and properly documents these choices. The midwife clearly states and documents when a woman's choices fall outside the midwife's practice guidelines.

9. **Continuing Education**: Midwives will update their knowledge and skills on a regular basis.

10. **Peer Review**: Midwifery practice includes an on-going process of case review with peers

11. **Practice Guidelines**: Each midwife will develop practice guidelines for her services that are in agreement with the *MANA Standards and Qualifications for the Art and Practice of Midwifery*, the *MANA Statement of Values and Ethics*, and the *MANA Core Competencies for Midwifery Practice,* in keeping with her level of expertise.

12. **Expanded scope of practice**: The midwife may expand her scope of practice beyond the MANA Core Competencies to incorporate new procedures that improve care for women and babies consistent with the midwifery model of care. Her practice must reflect knowledge of the new procedure, including risks, benefits, screening criteria, and identification and management of potential complications.

The following sources were utilized for reference: Essential documents of the National Association of

Certified Professional Midwives 2004, American College of Nurse-Midwives documents and standards for the Practice of Midwifery revised March 2003; ICM membership and joint study on maternity; FIGO, WHO, etc. revised 1972; New Mexico regulations for the practice of lay midwifery, revised 1982; North West Coalition of Midwives Standards for
Safety and Competency in Midwifery; Varney, Helen, Nurse-Midwifery, Blackwell Scientific Pub., Boston, MA 1980.

APPENDIX C: NARM Grievance Procedure

(Excerpted from the NARM Candidates Information Bulletin)

NARM Accountability Processes for Addressing a Complaint Against a CPM

The North American Registry of Midwives (NARM) recognizes that each Certified Professional Midwife will practice according to her/his own conscience, practice guidelines and skills levels. Certified Professional Midwives shall not be prevented from providing individualized care.

When a midwife acts beyond Guidelines for Practice, the midwife must be prepared to give evidence of informed choice. The midwife must also be able to document the process that led the midwife to be able to show that the client was fully informed of the potential negative consequences, as well as the benefits of proceeding outside of practice guidelines.

NARM recognizes its responsibility to protect the integrity and the value of the certification process. This is accomplished through the availability of a grievance mechanism. All Certified Professional Midwives will have the opportunity to speak to any written complaints against them before any action is taken against their certificates. All NARM Certified Professional Midwives (CPMs) are encouraged to attend peer review on the local level.

If a conflict arises between a client and a midwife, a community peer review may discuss the details with the midwife. Mediation may be utilized to reach an acceptable outcome. This is to be done on the most local level possible. If this cannot be achieved to the client's satisfaction and the client wishes to take action against the midwife's certificate, a written complaint must be filed. A CPM who has been named in a written complaint to NARM is required to participate in NARM Complaint Review and/or Grievance Mechanism. Failure to participate in the accountability processes will result in revocation of the credential. A CPM with inactive or expired status is bound by all policies regarding NARM Community Peer Review, Complaint Review, and Grievance Mechanism. Failure to respond to a complaint will result in revocation of the credential. NARM accountability processes work to address concerns regarding competent midwifery practice. The NARM Board reserves the right to evaluate, in its sole discretion, the appropriate application of NARM's Complaint Review and Grievance Mechanism. Complaints received by the NARM Board that do not involve issues relating to competent midwifery practice will not be addressed through the Complaint Review or Grievance Mechanism that NARM has established.

A complaint against a CPM may only be made by a client or a party with first hand knowledge of the cause for concern. A complaint will be addressed in Complaint Review only if the client whose course of care has prompted the complaint is willing to sign a records release. With a records release, her chart will be confidentially reviewed and discussed by the midwives participating in Complaint Review. Without permission to

review a client's chart the complaint is closed.

When a complaint is made to local peer review against a CPM, NARM urges the use of the NARM Complaint Review. When a written complaint against a CPM is received by NARM, the first step is Complaint Review. The outcome and recommendations which result from the NARM Complaint Review are sent to the NARM Accountability director and a formal letter stating the outcome is issued to the midwife, complainant, and peer review chairperson. The NARM Accountability Committee may make additional recommendations to the midwife. NARM maintains record of the Complaint Review.

Peer review groups are as local as possible. If an issue becomes contentious within a local group, the peer review group may consist of midwives from a larger vicinity. Recommendations resulting from NARM Complaint Review are not binding. However, the midwife named in the complaint may reach resolution with the complainant by addressing the concerns expressed in Complaint Review. A second complaint against a CPM initiates the NARM Grievance Mechanism. A second complaint may result from another complainant regarding a different course of care, or from a complainant who does not agree that resolution was reached with the outcome of Complaint Review. The outcome of the NARM Grievance Mechanism is binding and failing to meet the stated requirements results in the revocation of a CPM's credential.

NARM will not begin the processes of Complaint Review or Grievance Mechanism with a CPM who is also facing regulatory investigation, or civil or criminal litigation. NARM will proceed with these processes only after such proceedings are concluded. It is the responsibility of the complainant to notify NARM within 90 days of the conclusion of proceeding. Complaints may be made against a CPM whose certification has been revoked.

Complaints must be received within 18 months of the conclusion of care. The status of the CPM at the time of occurrence is irrelevant. Notice of complaints received regarding a midwife whose CPM credential has been revoked will be placed in this person's file in Applications; the original complaint will be kept in Accountability. Should this person reapply for a CPM credential in the future, all fees must be paid prior to NARM continuing the process appropriate to the complaint. Applications will notify Accountability. The complainant will be notified and given the opportunity to pursue the original complaint. If the complainant cannot be located at that time with the information on file, the applicant may proceed with the application. The complaint may be reactivated by the complainant within one year of the CPM's new certification period.

NARM Complaint Review

When a written complaint against a CPM is received by NARM it is referred to NARM's Accountability Committee. The first step in reviewing the complaint is Complaint Review. If resolution is not reached through Complaint Review and the complainant wishes to take action against the CPM's credential, this must be initiated by a formal letter of complaint with NARM. Formal complaints are referred to NARM's Accountability Committee for due process within the Grievance Mechanism.

The suggested format for Peer Review to address a complaint is as follows:

1. The Accountability Committee provides to the Complaint Review group copies of this process, the NARM Complaint Review Conclusion and Summary forms, the written complaint letter, and the midwife's chart and practice guidelines (which were supplied upon request by the midwife named in the complaint).
2. The members of the Complaint Review group read these documents, contacting NARM's Accountability Committee Chairperson with questions. Each member makes a list of questions and points of concern that they intend to address to the midwife during the Complaint Review session. A group discussion of these questions and areas of concern is held prior to the opening of the Complaint Review session. (During the
3. Complaint Review session, the testimony and presentation of events may answer these questions and concerns, or they may be asked directly.)
4. The midwife and complainant are notified to schedule the Complaint Review session. If necessary, additional written or oral testimony is arranged for the scheduled session by the midwife and complainant.
5. The Complaint Review session is begun with the midwife, complainant, and review members present.
6. All parties agree to uphold confidentiality.
7. The agenda for the session is read.
8. The complaint is read aloud.
9. The complainant gives testimony, and any additional testimony on the complainant's behalf is given or read.
10. Reviewers may ask questions of the complainant and supporting testifiers.
11. The complainant and supporting testifiers are excused.
12. The midwife presents the case. Supporting testimony is given or read.
13. Reviewers may ask questions of the midwife and supporting testifiers.
14. The midwife is excused from proceedings.
15. Reviewers discuss the case. Recommendations and findings are made.
16. The outcome of the proceedings is given in writing to the midwife and complainant.

The Complaint Review group provides NARM with their findings and recommendations. In extreme circumstances, NARM may make additional recommendations or requirements to the midwife. Complaint Review Conclusion Forms are available in the Professional Accountability section on the NARM web page.

The Grievance Mechanism

1. Complaints must be filed within eighteen months of occurrence or conclusion of care.
2. All complaints shall be kept confidential.
3. A written complaint to the NARM Board initiates the Grievance Mechanism, which begins with peer review at the most local level possible. Peer review in response to such a written complaint utilizes the NARM Complaint Review process. If prior to the written complaint to NARM, this complaint was addressed by a local peer review process and resolution was not reached, the written complaint to NARM initiates the
4. Grievance Mechanism. The NARM Board then refers the complaint to the

Accountability Committee.

5. The Accountability Committee shall identify a local review committee made up of the midwife's peers (at least 2 CPMs, one of whom will chair, and may include one consumer) at the appropriate local level. The NARM Grievance Mechanism may be a face to face meeting or conducted by teleconference, to be determined at the discretion of the NARM Accountability Committee.
6. Upon receipt of a complaint, the Accountability Committee Chair will respond to the complainant with a letter stating that the complaint has been received and will ideally be heard in review committee within 90 days.
7. The CPM is notified of this pending action, and, within one week of notification, the CPM must submit to the Accountability Committee a complete copy of the client chart and the CPM's own practice guidelines. The chart is then passed on to the local review committee chairperson.
8. The opposing sides are each invited to supply written or verbal testimony for the review. Written testimony must be sent from witnesses directly to the local committee chair. Copies of all written material are supplied to the local level chairperson for dissemination to 1) the CPM, and 2) review committee members, at least 2 weeks before the review. The local review committee chair is also responsible for coordinating the details of the review committee meeting time and location and will notify the involved parties at least 30 days in advance.
9. Complainant must respond within 2 weeks of being notified by the NARM Grievance Mechanism Chairperson with attempts to establish a date for the Grievance Mechanism session. If the complainant does not continue participation in the process, the complaint will be dropped and will not reflect on the CPM in question.

The Proceedings

I. All participants are required to sign a statement of confidentiality. If the session is via teleconference, this will be established prior to the call and reaffirmed verbally at the opening of the session.
II. The complaint shall be read aloud along with the agenda. The agenda will be drawn from a list of proceedings and the material to be presented.
III. Written testimony will be read and verbal testimony given by the complainant. The midwife may be present during this time.
IV. Complainant is excused form the proceedings.
V. The midwife in question will present the case. Then the CPM is excused.
VI. The review committee discusses the case, writes a synopsis, and makes recommendations to the Accountability Committee.
VII. The Accountability Committee derives appropriate action after the synopsis and recommendations are considered. NARM's intention in the Grievance Mechanism is to provide educational guidelines and support where appropriate. Punitive action is only taken when educational avenues have failed and further action is deemed necessary. Actions are limited to the following possibilities:
a. Midwife is found to have acted appropriately and no action is taken against the CPM. If the review process has not resolved the dispute, concerned parties are urged to seek professional mediation.
b. Midwife is required to study areas outlined by the Accountability Committee. The committee will involve the midwife in identifying areas needing further study. Upon

completion of the assigned study, the midwife will submit a statement of completion to the Accountability Committee.

c. Midwife is placed on probation and given didactic and/or skills development work to address the areas of concern. The midwife must find a mentor, approved by NARM, to follow the assigned studies and lend support in improving the areas of weakness. The mentor will report to the Accountability Committee regarding the progress and fulfillment of the probation requirements. While on probation, the midwife may be required to attend births with a more experienced midwife assisting.

d. Midwife's certification is suspended, and the CPM is prohibited from practicing as a primary midwife for a period of time during which the CPM is mentored by another midwife and focuses on specified areas of study. The mentor midwife will report progress to the Accountability Committee. Upon completion of required study and/or experience, the CPM is reinstated. If a midwife on suspension is found to be in deliberate violation of suspension guidelines, this CPM risks certificate revocation.

e. In the case of dishonesty, refusal to inform, negligent or fraudulent action of self-interest in which the certified midwife compromised the well being of a client or client's baby, or non-compliance with the Grievance Mechanism, this CPM's certificate must be revoked. Midwives with revoked certificates may reapply for certification after 2 years. This application must include the full fee. Prior to recertification all outstanding complaints must be resolved, including the completion of previous Grievance Mechanism requirements.

f. If the case involves the abuse of a controlled substance, the midwife in question will be required to participate in a rehabilitation program in addition to the above possible outcomes. Proof of participation and release will be necessary for full reinstatement.

VIII. The midwife in question is notified of findings and appropriate action taken.

IX. The complainant is notified of action taken regarding the midwife. If no action is taken, a compassionate approach is taken to honor the complainant's perspective.

Appeals Process

Appeals are handled directly by the Accountability Committee, all decisions are final.

Revocation of Certification

The NARM Certified Professional Midwife credential may be revoked for the following reasons:

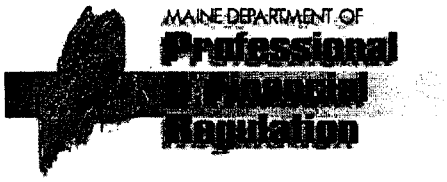
- Falsification of Application information.
- Failure to participate in the Grievance Mechanism or to abide by the conditions set as a result of the Grievance Mechanism.
- Infractions of the Non-Disclosure policy, which threaten the security of the NARM Examinations.
- If the Grievance Mechanism determines that the CPM acted with dishonesty, did not use appropriate informed consent with the client, or that negligent or fraudulent actions compromised the well being of a client or client's baby, the CPM credential must be revoked. Midwives with revoked certificates may reapply for certification after 2 years. Prior to recertification all outstanding complaints must be resolved, including completion of previous Grievance Mechanism requirements.

Grievance Mechanism Forms are available in the Professional Accountability section on the NARM web page (www.narm.org).

Confidentiality

Confidentiality is an integral part of Peer Review and the Grievance Mechanism.
In the case of NARM's Peer Review for Handling a Complaint and the Grievance Mechanism, participants sign confidentiality agreements at the onset of these proceedings. If a CPM breaks the confidentiality of the NARM Accountability process, a formal review will consist of the following:

1. Written statements from at least 2 individuals who have first hand knowledge of the break of confidentiality. Statements must include the details which were revealed, the setting and date of the conversation.
2. NARM Director of Accountability will contact the peer review chairperson (or if the accusation is about that person, another participant in the session) and discuss the details that were revealed in the break of confidentiality. If the details are confirmed as part of the confidential proceedings, this will confirm the accusation.
3. NARM Director of Accountability will contact the person accused and inform her/him that this has been documented and that if another documentation is made in the future, the CPM in question will be put on probation for period of one year during which time she/he must meet requirements assigned by the Accountability Committee.



Sunrise Review: Request for Information from Interested Parties

LD 1827 "An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access"

Department of Professional and Financial Regulation
Office of the Commissioner
June 25, 2007

Sunrise Review Survey: Regulation of Certified Professional Midwives

Please return the completed survey to the Commissioner's Office by **July 25, 2007**. You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. **Group or organization you represent:**

   - *Maine Section of the Association of Women's Health, Obstetric, and Neonatal Nurses*

2. **Position on proposed legislation.** Does this group or organization support or oppose state regulation of certified professional midwives?

   - *Opposes current version of this bill and fears it may well jeopardize the well-being of and quality of care received by women and newborns in the State of Maine.*

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. **Data on group proposed for regulation.** Please provide a description of the professional or occupational group proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation, including the number of midwives who are not certified;

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

(c) An estimate of the number of potential licensees in each group.

2. **Specialized skill.** Please describe whether practice of midwifery requires such a specialized skill that the public is not qualified to select a competent individual without assurances that minimum qualifications have been met.

The practice of midwifery is a specialized skill that requires years of training. AWHONN strongly supports the practice of midwifery by a ***Certified Nurse Midwife (CNM)*** *who is prepared to independently manage most aspects of women's health care.* ***Certified Nurse Midwives*** *are educationally prepared through programs accredited by the American College of Nurse- Midwives and collaborate with other health care professionals to provide primary, gynecological, and maternity care. In addition, as advanced practice registered nurses,* ***Certified Nurse Midwives*** *may have prescriptive privileges and admitting privileges to hospitals.*
In contrast, the Certified Professional Midwife (CPM); or lay midwife, has apprenticeship level knowledge of the birth process, but no required higher education degree, pharmacology training, or collaborative practice agreement with an obstetrician in case of complications. AWHONN contends that self-study and apprenticeship alone are inadequate preparation for midwifery practice. Therefore, the term "Certified Professional Midwife" is misleading to the public. The term "professional" suggests a level of education and professional certification far exceeded by the education, training and credentials typically received by lay midwives. Consumers have a right to make informed decisions about their care, especially when it may result in provision of care by someone ill-prepared to deal with complications that might arise during delivery and post partum. .

LD 1827 would confer a license upon Certified Professional Midwives and contribute to distorting the public's understanding of the limits of their training, skills and credentials. Such confusion creates a real threat to patient safety and would be a disservice to the public.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if midwives, whether or not certified, are not regulated by the State; and

Currently, CPMs are trained by other CPMs at non-accredited schools neither recognized or licensed by the state nor affiliated with a university. In these settings, CPMs have little to no interaction with hospital-based providers who often are called upon to assist nurse midwives in the face of complications.

(b) The extent to which there is a threat to the public's health, safety or welfare without state regulation (*Please provide evidence of the potential harm, including:* a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against midwives in *this State* within the past 5 years).

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by midwives to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public.

5. **Costs and benefits of regulation.** Please describe the extent to which regulation of midwives will increase the cost of services provided by midwives and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

Since CPMs are not nurses and would not be categorized under the State Board of Nursing, which licenses Certified Nurse Midwives, Maine would incur the costs of creating a new licensing board and all administrative costs from licensing this new group.

6. **Service availability under regulation.** Please describe the extent to which regulation of midwives would increase or decrease the availability of services to the public.

Currently in the state of Maine, there is an adequate supply of licensed health care professionals to serve pregnant women. Under MaineCare, all pregnant women are guaranteed coverage, so cost is not a barrier to prenatal access. There are approximately one hundred practicing obstetricians and nurse midwives and over one hundred family medicine physicians available to do the 14,000 births occurring in the state annually. This averages out to approximately 61 births per nurse midwife or physician provider per year, an acceptable workload. Nurse midwives and physicians are readily available to all pregnant women in Maine. Licensing lay midwives would not measurably increase the availability or quality of services available to the public.

7. **Existing laws and regulations.** Please discuss the extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated health practitioners.

CPMs are not educated through traditional colleges and universities, are not nurses or physicians and therefore fall outside the current agencies, such as the Maine State Board of Nursing or the Maine Medical Association. While it may be appropriate to regulate CPMs to ensure public safety, it is inappropriate for the state to license them and suggest professional status and training that has not been earned.

8. **Method of regulation.** Please describe why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate.

9. **Other states.** Please provide a list of other states that regulate midwives, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on midwives in terms of a before-and-after analysis.

Vermont conducted a similar sunrise review about licensing lay midwives and found at http://vtprofessionals.org/downloads/midsunrpt.pdf

The conclusions drawn from the Vermont sunrise review provide a good example of compromise for the state of Maine. While one does not want to deny lay midwives their

livelihood, it is the state's obligation to ensure the public's safety. To adequately do this, Vermont recognized that licensing is not the appropriate solution, but rather heightened regulation of education and practice standards. Codifying this group of caregivers as licensed medical professionals will not overcome the shortfalls in their training and clinical preparedness.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in this State to implement regulation of midwives.

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

The proposed requirements do not exceed the standards of minimal competence. A Certified Nurse Midwife (CNM) or Certified Midwife (CM) must undergo extensive training from a midwifery program accredited by the ACNM. This is in addition to the undergraduate training they receive. In a typical undergraduate setting, pharmacology content is infused into every course in the curriculum, there is exposure to lab procedures, and student nurses gain hands on experience in administering medication under the supervision of their clinical faculty over the 2-4 years of their college level training. Their knowledge and competence are tested routinely in these programs and on NCLEX. A nurse in advanced practice, such as e CNM, would have additional education in order to prescribe medication. A CPM is not required to take any such coursework to be able to safely give medications and cannot prescribe medication, even in an emergency. Patient safety, particularly as emergency needs arise, would be undermined if CPMs are able to achieve licensure without meeting these minimum standards of competency.

12. **Financial analysis.** Please describe the method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by potential licensees through dedicated revenue mechanisms.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

Date: July 24, 2007

Completed by:

Name: Kelley Bowden

Title: Legislative Liaison, ME AWHONN

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Portland, ME 04102
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SUNRISE REVIEW SURVEY: Regulation of Certified Nurse Midwives

General Information

1. Group or organization you represent: The Maine Medical Association (MMA), representing over 2700 physicians, medical students and residents in the state. MMA may be joined by several other medical organizations in support of this response to the survey, including the Maine Chapter of the American College of Obstetrics and Gynecology, the Maine Chapter of the American Academy of Pediatrics, the Maine Academy of Family Physicians and the Maine Osteopathic Association. These organizations, along with MMA, represent the vast majority of physicians in Maine delivering babies and providing medical care to infants and children.

2. Position on proposed legislation. As noted in our testimony presented to the legislature on L.D. 1827, An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access, MMA opposes state regulation of midwives who have not been trained as nurses or physicians. Reference can be made to the written testimony presented at the public hearing by Hector Tarraza, M.D. and other physicians and nurses for a more complete explanation of our opposition. The likelihood of confusion to the public because of the existing practice and titles used by licensed certified nurse midwives (CNM) is another primary reason for our opposition.

Evaluation Criteria (32 M.R.S.A. Section 60-J)

1. Data on group proposed for regulation. Please provide a description of the professional or occupational group proposed for regulation, including:

   (a) The number of individuals or business entities that would be subject to regulation, including the number of midwives who are not certified;

   It is our understanding that there are fewer than 30 such individuals, with approximately 22 of these individuals being certified by a voluntary national organization.

   (b) The names and addresses of associations, organizations and other groups representing potential licensees:

   It is our understanding that The Maine Association of Certified Professional Midwives (MACPM), Midwives of Maine, and the Midwives Alliance of North America (MANA) all may speak for the midwives in one way or another. The addresses of these groups have been provided to you by the proponents of the legislation. (See Sunrise

Review document, dated March 2007, prepared by proponents of the legislation.).

c. An estimate of the number of potential licensees in each group.

We have no reason to question the numbers provided by proponents of the legislation.

2. **Specialized skill.** Please describe whether practice of midwifery requires such a specialized skill that the public is not qualified to select a competent individual without assurances that minimum qualifications have been met.

Certainly the attendance at a delivery requires specialized skills, skills that we would argue require at least the level of education and training of a nurse practitioner. With respect to the question of the ability of the public to select a competent midwife, the certification by the North American Registry of Midwives (NARM) provides a credential that discerning families could consider in choosing a midwife, should a non-nurse midwife be their choice. Licensing, in and of itself, would add little to the existing CPM credential and use of the term "Licensed Certified Professional Midwife" would lead to confusion with the term Certified Nurse Midwife (CNM) as that term is currently utilized in Maine law (nursing statutes).

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if midwives, whether or not certified, are not regulated by the State:

Unlicensed midwives have attended births in Maine for decades, without being regulated in any way by the state. While there is always the potential for harm when an expected normal delivery develops problems, we do not believe that moving from certification to licensure would appreciably change that risk. In fact, it is our position that the harm to the public would increase with licensure, because of the danger that more women would choose to give birth at home, away from the safety of hospital operated birthing centers equipped to deal with an emergency. Granting licensure would lend credibility to this practice, which we believe appreciably increases the risk of injury to mothers and their infants.

(b) The extent to which there is a threat to the public's health, safety or welfare without state regulation (Please provide evidence of the potential harm, including: a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against midwives in this State within the past 5 years.)

We are not aware of complaints, but are aware of numerous instances in which patients being attended to by midwives arrive in the emergency rooms with the mother, fetus or infant or both, in distress. State regulation is not likely to change that situation, which is created not so much by the practice of midwifery as it is by the desire of a small portion of women to give birth at home. Home births represent between 1 to 2 % of all births in the state. While we support the informed choice of such women, we believe it would be unwise for the state to take any action that could encourage more home births, which clearly increases risk to both mother and baby. From information provided by the midwives themselves, we believe that between 5 and 12% of their deliveries end up with a transfer to a hospital. While not all of these transfers are emergencies, many are and constitute concrete evidence that it is not always possible to predict with certainty which deliveries are low risk.

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by midwives to protect the public through self-regulation, private certification, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public.

   MMA does not take issue with the response to this question provided by proponents of the legislation. But in arguing that the voluntary efforts are not adequate, proponents fail to note that the legislation proposed would not prohibit unlicensed midwives from continuing to practice. If licensure is required because the voluntary efforts are not sufficient to protect the public, then any legislative solution must prohibit those midwives who do not meet the requirements of licensure from practicing. What would be the point of having enhanced regulation, if unlicensed, non-credentialed midwives could continue to practice in the state?

5. **Costs and benefits of regulation.** Please describe the extent to which regulation of midwives will increase the cost of services provided by midwives and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

   State licensure of midwives is likely to increase the cost of their service to patients and their families. The significant cost of a license if midwives are asked to support their own regulatory board and the attendant cost of certification and licensing exams will have to be added to the existing costs. The costs to the state would be minimal, as the new licensing board should be self-supporting as are all the other health related professional boards. If the total cost is supported by fewer than 30 licensees, we would anticipate the license fee to be at least $1,000, with a risk that even steeper fees would have to be charged if a significant legal issue or difficult case requiring lots of Attorney General time were required.

If it is determined that a license law should be enacted, the state may wish to consider placing the midwives with an existing board rather than having such a small number of individuals financially support their own board. Certainly the Board of Complementary Healthcare Providers would be one board to consider, as well as the nursing board.

6. **Service availability under regulation.** Please describe the extent to which regulation of midwives would increase or decrease the availability of services to the public.

   We are not familiar with any data suggesting that licensing either adds to or reduces the supply of midwives. We hope that the sunrise process will provide an opportunity for the Department to collect this type of information from other states. If a license is required, then services would at least be temporarily decreased by the inability of those midwives who are not credentialed (and apparently do not wish to be) to continue their practice.

7. **Existing laws and regulations.** Please discuss the extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated health practitioners.

   Because the attorney general's office has opined that childbirth is a normal, healthy process and that attendance of a natural birth is not the practice of medicine, the only legal remedy for an unhappy patient are the laws of malpractice (governed in this case by the laws of negligence) or the criminal statutes. There have been criminal prosecutions of midwives for criminal negligence when the failure to provide trained assistance was egregious in the face of evidence of a problem. In other words, at times, law enforcement has gotten involved when a referral was made to a physician but the referral was made too late in the process. We recall a prosecution in the Brunswick area a few years ago. The state of Vermont recently had such a case, as well.

8. **Method of regulation.** Please describe why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate.

   Intended to be answered by proponents, as the question goes to their intent in preparing the legislation.

9. **Other states.** A list of other states that regulate the profession or occupation, the type of regulation, copies of other states' laws and available evidence from those

states of the effect of regulation on the profession or occupation in terms of a before-and-after analysis.

We have nothing to add to the material provided on this question by the proponents.

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in this State to implement regulation of midwives.

    While we are aware that the legislature engaged in a discussion of this issue in the late 1970's, we are not aware of previous licensing efforts in Maine.

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

    The legislation proposes to delegate to the national certifying body the determination of minimal standards for licensure. No other health professional licensing board delegates this responsibility and MMA strongly opposes such delegation. If it is important for the state to do this, the state itself should set the standard of minimal competence.

12. **Financial analysis.** Please describe the method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by potential licensees through dedicated revenue mechanisms.

As noted above, we do not believe that such a small number of individuals can support the full cost of operating a licensing board. While proponents suggest that costs can be reduced by utilizing the work of their national certifying agency, such action could constitute the unconstitutional delegation of regulatory authority to a private organization.

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

    This question is intended for proponents to answer.

Thank you for the opportunity to provide this information and we look forward to participating in the August 20 meeting.

Gordon H. Smith, Esq.
Executive Vice President
Maine Medical Association

Cc/ Hector Tarraza, M.D.

Jay Naliboff, M.D.

Paul Pelletier, M.D.

Elizabeth Fowlie Mock, M.D., MPH

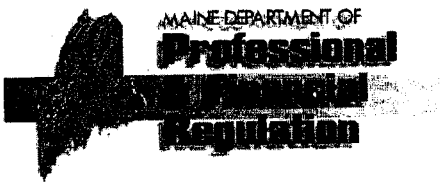
Donald Burgess, M.D.

Erinn Wright, M.D.

Andrew MacLean, J.D.

Douglas Jorgensen, D.O.

John Ginty



Sunrise Review: Request for Information from Interested Parties

LD 1827 "An Act to License Certified Professional Midwives to Promote Greater Public Safety and Access"

Department of Professional and Financial Regulation
Office of the Commissioner
June 25, 2007

Sunrise Review Survey: Regulation of Certified Professional Midwives

Please return the completed survey to the Commissioner's Office by **July 25, 2007.** You may respond to any or all questions. The survey should be e-mailed to Doug Dunbar, Assistant to the Commissioner. The address is doug.dunbar@maine.gov. An electronic version of the survey is available by contacting the Commissioner's Office.

General Information

1. Group or organization you represent:

March of Dimes, Maine Chapter. The March of Dimes is a not-for-profit organization recognized as tax-exempt under Internal Revenue Code section 501(c)(3). Our mission is to improve the health of babies by preventing birth defects, premature birth, and infant mortality.

2. Position on proposed legislation. Does this group or organization support or oppose state regulation of certified professional midwives?

The March of Dimes opposes L.D. 1827 and the certification of midwives without advanced nursing degrees. Lay midwives are not medically trained or supervised by physicians. In Maine, in 2004, 1 in 9 babies were born preterm, before 37 weeks gestation. This translates into 1,475 preterm births. Half of all preterm births occur for reasons still unknown. Time is a key factor during labor and delivery – time that can make the difference between life and death. Medical advances – many developed through research funded by the March of Dimes – provide medical and nursing practitioners with tools to decrease the incidence of maternal and infant mortality and morbidity. The health of both mother and baby are at risk during labor and delivery. It is imperative that highly trained and skilled medical and nursing practitioners are present and leading this most important stage of pregnancy.

Evaluation Criteria (32 M.R.S.A. § 60-J)

1. Data on group proposed for regulation. Please provide a description of the professional or occupational group proposed for regulation, including:

(a) The number of individuals or business entities that would be subject to regulation, including the number of midwives who are not certified;

N/A

(b) The names and addresses of associations, organizations and other groups representing potential licensees; and

N/A

(c) An estimate of the number of potential licensees in each group.

N/A

2. **Specialized skill.** Please describe whether practice of midwifery requires such a specialized skill that the public is not qualified to select a competent individual without assurances that minimum qualifications have been met.

The practice of midwifery by non-medically credentialed persons poses a risk to the health of both the mother and the infant. Certifying non-medically credentialed persons to practice midwifery creates a public perception of advanced learning, skills and competence. The creation of the title "L.M." in the bill may cause confusion among consumers that the individual is a titled medical professional. There is also potential confusion with Certified Nurse Midwives who carry the title C.N.M. and who hold advanced nursing degrees.

3. **Threat to public health, safety, or welfare.** Please describe:

(a) The nature and extent of potential harm to the public, if any, if midwives, whether or not certified, are not regulated by the State; and

The proposed bill would authorize the board to create a protocol and formulary for lay midwives to administer prescription medications. The administration of prescription medication by non-medical personnel poses a threat to both the health of the mother and the infant.

(b) The extent to which there is a threat to the public's health, safety or welfare without state regulation (*Please provide evidence of the potential harm, including:* a description of any complaints filed with state law enforcement authorities, courts, departmental agencies, other professional or occupational boards and professional and occupational associations that have been lodged against midwives in *this State* within the past 5 years).

N/A

4. **Voluntary and past regulatory efforts.** Please provide a description of the voluntary efforts made by midwives to protect the public through self-regulation, private certifications, membership in professional or occupational associations or academic credentials and a statement of why these efforts are inadequate to protect the public.

N/A

5. **Costs and benefits of regulation.** Please describe the extent to which regulation of midwives will increase the cost of services provided by midwives and the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers.

N/A

6. **Service availability under regulation.** Please describe the extent to which regulation of midwives would increase or decrease the availability of services to the public.

N/A

7. **Existing laws and regulations.** Please discuss the extent to which existing legal remedies are inadequate to prevent or redress the kinds of harm potentially resulting from non-regulation and whether regulation can be provided through an existing state agency or in conjunction with presently regulated health practitioners.

N/A

8. **Method of regulation.** Please describe why registration, certification, license to use the title, license to practice or another type of regulation is being proposed, why that regulatory alternative was chosen and whether the proposed method of regulation is appropriate.

N/A

9. **Other states.** Please provide a list of other states that regulate midwives, the type of regulation, copies of other states' laws and available evidence from those states of the effect of regulation on midwives in terms of a before-and-after analysis.

N/A

10. **Previous efforts to regulate.** Please provide the details of any previous efforts in this State to implement regulation of midwives.

N/A

11. **Minimal competence.** Please describe whether the proposed requirements for regulation exceed the standards of minimal competence and what those standards are.

N/A

12. **Financial analysis.** Please describe the method proposed to finance the proposed regulation and financial data pertaining to whether the proposed regulation can be reasonably financed by potential licensees through dedicated revenue mechanisms.

N/A

13. **Mandated benefits.** Please describe whether the profession or occupation plans to apply for mandated benefits.

N/A

Date: July 19, 2007 Completed by:

Amy Carlisle
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