

The North American  
Registry of Midwives

**Planning  
for  
Legislation  
Handbook**

*The North American Registry of Midwives*

# Preparing for Midwifery Legislation

## A Grassroots Guide for Midwives and Consumers

The information in this handbook has been developed by the North American Registry of Midwives and is based on our experience working personally on legislation in our own states as well as assisting and advising legislative efforts in many other states.

We are grateful to the many midwives and consumers who have been working on legislation in their states and who have shared their experience and suggestions with us, especially the fantastic folks in Virginia, Utah, and Wisconsin who worked for several years at this before successfully passing their midwifery licensure legislation.

We are also grateful for the tireless efforts of Susan Hodges of Citizens for Midwifery who has devoted years of her life to promoting safe birthing options for mothers and families, and who has created an organization and a web site ([www.cfmidwifery.org](http://www.cfmidwifery.org)) with many valuable resources for those who are lobbying for midwifery legislation; to Debbie Pulley, who, as chair of the MANA Legislative Committee, has worked on legislative activity with many midwives; and to Pam Maurath of the Midwifery Task Force who has offered valuable assistance to MANA, MEAC, and NARM throughout our growing years and whose wisdom and experience in politics has guided us to the level where we may now advise others.

The material in this handbook, except where otherwise credited, is copyrighted by NARM but is offered to all those who seek to promote safe birth options through legislation to license midwives. For more information on NARM and the Certified Professional Midwife credential, contact NARM at 1-888-353-7089 or [info@narm.org](mailto:info@narm.org), or through our web site at [www.narm.org](http://www.narm.org)

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# Introduction

This handbook is for groups of midwives and consumers who are interesting in pursuing legislation to license direct-entry midwives using the CPM credential as eligibility for licensure. Our assumption is that you have already decided to seek licensure, so the handbook does not address the pros and cons of licensure. By the time you are ready to start with the tasks in this book, you have probably spent months in discussion about whether to do it or not.

Often it is a change in the political climate that spurs midwives to seek licensure. There may have been investigations by the medical or nursing boards, cease and desist orders issued, or other types of harassment. Midwives who have practiced openly for many years suddenly find themselves facing possible criminal charges or pressure to stop practicing or move to another state. New midwives, or those interested in becoming midwives, have second thoughts about dedicating their lives to a profession that may be against the law and may cost their family a lot of money to defend. The lack of a clear and favorable legal status is a detriment to the growth of the profession, and the result will be a lack of midwifery and home birth options for the upcoming generations of birthing women. The future of midwifery depends on making the practice clearly legal.

The reason that midwives can be criminally charged even when there is no law against midwifery is that there are Medical Practice Acts and Nurse Practice Acts in every state that say that only specific licensed professionals may perform the acts listed in those practice acts. So, a midwife may be charged with practicing medicine or nursing without a license. There is only one way to remove that deterrent: to exempt direct-entry midwifery from the medical practice acts. It is possible to pass a law that exempts midwifery from the medical practice acts but does not require licensure or regulation. Mississippi has a law that does that, but several other states have tried unsuccessfully to add midwifery to their list of exempted professions. That can only be done through the state legislature, and most state legislators do not want to “give permission” to an undefined and unregulated group of people to do as they please when it comes to practicing medicine. The other solution is to pass a law that clearly defines midwifery, and defines it as NOT the practice of medicine or nursing. In this case, defining midwifery means defining who can do it and what they can and can’t do. This usually happens in the form of a state license to practice.

In 2007 and 2008, there were two fairly unusual laws passed that did not authorize licensure but did define the practice as legal though unregulated. The 2007 Missouri law says that anyone with an NCCA-accredited credential in “toxology” (childbirth) can practice legally. That, in effect, allows CPMs to practice legally in a state that previously considered them felons. Because of multiple political factors, this law is vulnerable to change in upcoming sessions. The 2008 Maine law allows CPMs to carry a specific list of medications, but does not require licensure for practice. Both of these laws give CPMs a legal right to practice, but do not provide the benefits or restrictions of licensure (for both the midwives and the public).

Licensure usually requires some state control over what you can do and how you can do it; that’s what regulation is. A state doesn’t give you licensure as a reward for years of exemplary service; licensure is seen by the state as a means of insuring public safety. The important part of setting up licensure is to safeguard public safety and also allow midwives to practice with autonomy and without micromanagement of their protocols. The best midwifery laws authorize licensure by a board or department, set criteria for eligibility, define terms, and authorize the board to develop rules and regulations for practice. The law itself should not contain the regulations because regulations need to change as needed, and the law is difficult to change. Regulations can be changed by the board, which is still a complicated administrative procedure but is not as politically charged as changing a law. Individual legislators may try to add specific details to the law that are based on a personal experience or a scare story told to them by a physician. While it is tempting to add

to or modify your law to get a favorable vote from a legislator, once you start adding individual protocols it is hard to find a place to stop. Keep the details of regulation OUT of your law. A compromise is to have in the law a list of things that will be addressed in regulations. The law doesn't say how they will be addressed, just that they will be addressed. You can then assure your legislator that his specific issue will be addressed in the regulations.

It is important to have several people as a core group of volunteers who can devote the better part of a year to organizing the lobbying effort. At the outset, most people (maybe all of them) will say "I will help but I can't devote much time". No busy mother or midwife can say "I have nothing else to do for a year". The first task is to get them involved; the dedication of time will come later at a rate that is manageable by those who become obsessed with making this work! Start by calling for a discussion meeting with all the midwives – you may have to meet several times. A few leaders will emerge who find the discussion fascinating. The midwives also need to identify a few consumers who will take an active role in lobbying. Consumers are an essential part of this plan. Depending on the political climate, the midwives may have to stay in the background if they fear identifying themselves too publicly as midwives. Hopefully, that won't be the case and you will have a good group of midwives and mothers (and fathers) who can help. This small group will hold all the pieces together and insure communication among those who are working on different aspects or in different parts of the state. Outside of this group, there needs to be a really big group of supporters who will write letters and meet with legislators and show up when a display of support is needed. They need to be from all over the state representing all legislative districts. Without a core group to coordinate everything, these supporters will not know how to help in an effective manner. When a core group is identified, study this handbook and divide the tasks based on interest and talent. Each coordinator can then work with the larger group of volunteers on the specific tasks that arise throughout the process.

The material in this booklet is for those who are seeking a licensure law. We hope it will be helpful, and we welcome suggestions for future editions from those who continue to participate in the process.

# Legislative Planning

## A timeline of tasks

### Phase 1

#### 6-12 months before the Legislative Session

Identify a core group of 4-8 team leaders who will coordinate these tasks. All of these volunteers need computers and e-mail. These job descriptions may be split or combined, depending on the number of volunteers and their particular talents.

##### **Coordinator of the Database**

Collect names and addresses of all possible supporters including midwives, families of midwives, and clients of midwives. Also consider childbirth educators, doulas, and their clients, homeschoolers, and La Leche groups. E-mail addresses are very important. Put all this information in a database with a column for legislative districts (senate and house). Add to this list constantly until your bill passes.

##### **Coordinator of the Legislature**

Make a list of state legislators, including their districts and their committee assignments, locate the legislative web site that lists all legislators, their addresses and e-mails, and the committee schedules. Draw up a map of your state divided into legislative districts. Match your supporters with their legislators. Look for districts where you have not identified supporters, and seek to find a few names in those districts. The state legislative web site will have a lot of information about how the legislature works in your state, including the dates and deadlines of the session and rules for drafting and submitting legislation. This coordinator should become familiar with everything on the legislative web site, how to find information on it, and how to track the bills. This person needs computer access, but does not have to live close to the capitol.

##### **Coordinator of Information**

Develop the handouts and flyers that will be used throughout the year. This person should like to write and be somewhat good at it. Information for the flyers can be found from many sources, such as NARM, the Big Push list, and Citizens for Midwifery. Flyers need to be sent to supporters and to legislators. Flyers can be of general information about midwifery, the bill, or specific aspects of the bill (responses to questions that continue to arise). This person will also write weekly, then daily, updates on the legislative effort for the e-mail list.

##### **Coordinator of Bill Writing**

Research other states' midwifery licensure bills, laws licensing other practitioners in your state, and recommendations for bill writing within your legislature. Find any current or expired laws affecting midwifery in your state. Put together ideas from all these sources on what your bill should contain. Work on the concept with the whole group of midwives, write as part of a smaller team, and then with the sponsor and legislative attorneys.

##### **Coordinator of Lobbying**

Coordinate efforts to get letters written in support of your bill. Develop suggested content, and outline basic strategies of communication between the supporters and the legislators. Arrange meetings between supporters and their legislators and prepare them for the task. Arrange for teams of supporters to lobby at the legislature, and provide them with information on how to do this. This person may need to register with the state as a lobbyist. You can also seek the assistance of a professional lobbyist, but will still need someone in this position to coordinate volunteer efforts. It is most helpful if this person lives near the state capitol and can make frequent visits to the legislature during the session.

\*\* It would be very helpful to have an active web site. Although a webmaster is not essential for effective lobbying, a web site with updates and sample letters can give supporters the information they need to write their letters and talk to their congressmen.

\*\*\* Your core group should become members of the Big Push yahoo group. It is a huge resource for information and feedback on pursuing licensure legislation for CPMs. To join, send an e-mail to thebigpushformidwives-subscribe@yahoogroups.com. Put Subscribe in the header, and in the body include your name, state, and a brief update on the legislative efforts that are taking place.

## **Phase II**

### **Organizing your approach**

#### **1. Organize your midwives**

Legislation to license midwives will not always have universal support by the midwives. Many do not want to be regulated. It is extremely important that all midwives have an opportunity to talk about the pros and cons, and to have their concerns aired. Keep all the midwives “in the loop” as much as you can during the preparatory phase, and also during the session. Encourage them all to get e-mail if possible, and assign someone to phone those who don’t have e-mail. Have regular meetings where everyone can discuss the issues and have input into the decisions that are being made. Involving as many as possible in the planning and decision making will assure that you have a good group to do the lobbying when it’s needed.

Prepare a written history of midwifery in your state, including any previous relevant laws, legal actions against midwives, or previous legislative efforts. Be as specific as possible about your current legal status, including any judgments or rulings relating to midwifery. Include information on CNMs and how they are regulated, and their involvement in home birth. List information on other states that have licensure and brief pertinent details about how it works

Set up e-groups for communication. You could need as many as three separate e-groups. Your coordinators and primary activists may need their own e-group for the daily work of their committee. Another group could be for all the midwives in the state for ongoing communication and for discussions beyond your regular meetings. A much larger group for all the supporters will be helpful in coordinating the lobbying efforts. It can be confusing to keep track of what is being said in each group, so try to include everyone in the larger group, too. Early organizing work may be discussed within the coordinator e-group, and the midwife group may want to debate the philosophy of licensure; but by the time you are in session almost all communication should be done in the largest group. You may want to include advisors from other states who have recently passed legislation, or from national organizations like NARM and CfM, in your e-groups. NARM sends representatives each year to at least two relevant conferences: the National Conference of State Legislators (NCSL, which meets in July) and the Council on Licensure, Enforcement, and Regulation (CLEAR, which meets in September and January). They might seek to educate your state legislators or regulatory directors at those meetings, if informed in time.

#### **2. Organizing your supporters**

The coordinator of the database and the coordinator of the legislature can work together to develop a database that matches all legislators with constituents from their district. A database like Access, or a spreadsheet like Excel, works best for this process. This should be an ongoing process with new names being added throughout the year. You can find the name, address, and other information on any legislator in the country by going to [www.vote-smart.org](http://www.vote-smart.org) and typing in your 9-digit zip code.

Identify a larger group of supporters who will help with a lot of the work. Each part of the state should have one or more people who will work more closely with the supporters in that area and with the pre-session lobbying of legislators in those areas. These regional coordinators can maintain more personal

communication with supporters (and legislators) and can also thank people regularly for their time, interest, and/or contributions.

Some money needs to be raised and spent on printing and postage. Consider incorporating as a non-profit (see more information in this booklet), but be aware of the limitations on spending for lobbying if you are a non-profit. It may not be worth the expense and trouble of incorporating if you are raising money only for this purpose. Organize garage sales, or direct-mail requests for funds, and assign a treasurer to manage the funds.

The coordinator of information should write a letter to send to the supporter list, stating your goals and time frames for the legislative session. Ask your supporters to mention the benefits of licensing DEMs whenever appropriate to anyone involved politically; ask for contributions to help defray expenses, ask for more names for the mailing list. Thank these people at every chance, by phone, mail, or e-mail. Let them know when you want them to make personal contact with their legislators and that you will send more information before that time.

Send e-mail to your supporters weekly with reminders of what you are doing and what you want them to do. Tell them who their legislators are, where they live, and what they do for a living. Encourage supporters to make informal contact with them and say something supportive about their interest in having licensed midwives. Legislators are also dentists, accountants, lawyers, insurance salesmen, businessmen, farmers. There are many ways to make casual contact with them before you actually have a bill to bring to them. Encourage supporters to have discussions with their personal doctors in support of legislation during the year. Doctors will almost always lobby their legislators against the bill; and they will receive information from their state medical association against the bill once it is filed. If they have personal contacts with patients who support midwives, that opposition may be softened.

A note about e-lists: The success of a lobbying effort depends on quick and timely communication, which is why group e-lists are necessary. The e-list can eventually generate lots and lots of posts, which may annoy some of your more casual supporters. Use the e-lists for major announcements and updates, but keep most of the back-and-forth on individual e-mails with those who are involved or you may have some of your consumers asking to be taken off due to the quantity of e-mail. Consumers are more likely to write letters and make visits if they receive a personal phone call from a regional coordinator than a mass e-mail, especially if followed up by a personal e-mail with specific instructions from the regional coordinator. People are more likely to help with this if they have a personal relationship with someone who is involved, such as their midwife or doula, or a friend who cares about the issue. Those key people need to stay in touch personally with their group of friends who are on the bigger support list.

### **3. Identify your opposition**

Identify the main leaders of the medical association, the hospital association, the nurses association, and the CNMs in your state. Identify their lobbyists, and which legislators receive the most in campaign contributions from these organizations. You will definitely need to talk with the lobbyists for each of these groups, and with some individual CNMs who are most likely to be involved in lobbying. Do the CNMs in your state meet? Are they proposing any legislation this year? A major goal is to keep the CNMs, and especially the state CNM chapter, from lobbying against your bill. Meeting with them early and regularly is essential in most cases. Be familiar with the laws and regulations that they work under. They may be opposed to DEMs having fewer restraints than CNMs do. Point out the CNM's broader scope of practice. Emphasize that DEMs work with normal births. Point out that if DEMs get good regs, CNMs can come back the next year and ask for same (remove physician supervision, etc).

For those midwives who do not see a need for licensure, a good reference is the book written by many midwives who have faced legal prosecution from their states. It can be downloaded at [www.fromcallingtocourtroom.net](http://www.fromcallingtocourtroom.net).

Do not neglect the midwives in your state who might be opposed to legislation. There are many good arguments to make that will assure them that their right to stay unlicensed will always be there, and they won't be any more illegal than they are now. Keep in touch with the midwives in your state on a regular basis, even if they are not part of your committee. You do NOT want your own troops to show up at the legislature opposing your bill. Spend whatever time is necessary early in the process to answer their concerns and address their issues. If you can't win them over, at least get them to agree to stay out of the picture. There will always be a place for underground midwives. Most prosecution of midwives is of unlicensed midwives in unregulated states, and some of licensed midwives in regulated states, but very little time or money is spent going after unlicensed midwives in regulated states. Once licensure is available, there is a general assumption that all midwives are licensed so unlicensed midwives are hardly noticed unless they are involved in an investigation related to a bad outcome. Historically, the odds are that they will be safer once midwifery is licensed, even if they choose to stay unlicensed.

#### **4. Begin drafting the bill**

Collect samples of current midwifery licensing bills. Talk to people who know what is going on nationally. Check NARM's web site for current information, or call NARM representatives for information. See samples elsewhere in this booklet.

Consider the options for who will administer your program. Most DEMs are regulated by the Health Department (or whatever it may be called in a state, Health and Human Services, etc). A few are regulated under the Medical Board. This isn't as bad as it sounds. Avoid at all costs being regulated under the Nursing Board. Some states have a Department of Professional Regulation. These don't always regulate the health professions, but it is coming up as an option in more and more states.

Check into the laws in your state that regulate the funding of licensed professions, and how those laws affect the departments that do the regulating. Some states have laws that say the licensure fees must pay for ALL expenses of regulation. This can make licensure very expensive. It is best to be in a situation where many professions split the costs of the regulatory process, using one central director and a few volunteer advisors. Check out how other professions are regulated and how their fees are set, such as chiropractors, acupuncturists, podiatrists, tattoo artists etc. You don't necessarily need to affiliate with any other profession, but just know how their fees are set and how much they currently pay. Some states now have a requirement that any new licensure bill be accompanied by a Financial Impact Statement written by their appointed agency. The FIS may be different depending on which agency is doing the regulating, so meet with the person writing the statement to see what options there might be. Departments of Health may be eligible for federal funding for their midwifery programs through Title V grants.

If you are trying to have an independent board (generally appointed by the governor) check into the funding issues. These kinds of bills must be accompanied by a financial impact statement, and must include an appropriations bill. It is VERY DIFFICULT to pass a bill that requires state funding.

Begin research and discussion on some of the more controversial areas of licensure such as supervision, medications, malpractice, breeches/twins, VBAC, etc. Discuss the pros and cons. Move from what you want to what you can live with. Write your bill the way you want it, but keep some drafts of additions that you could live with.

See sections on drafting bills in this booklet.

#### **5. Identify your time line**

Initial work should start 6 months to a year before session. Most of the early lobbying should be done while the legislators are in their home offices, and should be done by their own constituents. They will meet, and talk, and even read mail, must more seriously before the legislative session starts. You WILL need a central team at the state capitol almost every day of the session, and you will need to lobby them intensely during the session, but they will listen and think better before the session begins. It is also

VERY IMPORTANT that they hear support from their own constituents. This means personal visits and letters in their home district starting early. Hand-written letters are very effective at this point. Later, you will need an intense push from their constituents by mail, phone, and e-mail when the bill is being considered. Plan your strategy with a time line so you get a lot of it done before the session begins.

## **6. Beginning to lobby the legislators**

Send a one-page flyer to your legislators several times prior to the opening of the session. This flyer can make statements about the benefits of midwifery care and the value to the state of licensing midwives. These are general education flyers, and don't have to be specifically related to the bill. When the session opens, they often don't have time to read any literature. They may be more receptive when they are less busy several months ahead. The flyer can have a tag line to that says something like, "We want midwifery licensure in (our state)."

Before the session begins, when they are still in their home districts, try to have a mailing in their hands every week. Send fact sheets addressing one or two main points in support of midwifery, or letters from their constituents, or letters from midwives, or thank-you notes for meeting with you, anything that keeps the issue in front of them. This will cost some money. Figure out how many legislators you have, and what the cost is for printing and mailing a fact sheet or letter. Seek funding from your supporters by asking them to underwrite one mailing by donating \$50 or whatever. Another good mailing is a birth announcement from someone in their district with a personal note of thanks for supporting their choice to birth at home. AVOID lengthy materials; they are not likely to read it. If they have asked for some research, and you find some to send, add a personal note: "This is the material you ask to see that supports the safety of midwife-attended home birth." Let your note give the message in case they don't read it; underline in yellow the main points of the research or article.

Personal, hand-written letters are a must at this point. Typed letters are all right, but should not appear to be mass produced. The impact of a personal letter is hard to overestimate – it is very important to have these sent as often as possible.

Arrange brief meetings (15-30 minutes) with each legislator and a group of 1-3 supporters. These meetings should take place in the legislator's home town, either at the home or place of business. The key-word here is: plan, plan, plan. Have a few clear points you want to make, have a brief handout to leave with the legislator, stay within your allotted time, but leave room for the legislator to ask questions, and send a thank you note afterwards. Leave a cute treat, like a small bag of M&M's and a note that says Mothers for Midwives, or a small vase of flowers, a bag of homemade cookies, or anything that will make them remember you with a smile. See further suggestions for lobbying in this booklet.

The database or legislative coordinator should keep a record, as best as possible, of any meetings with legislators so that you might identify those who have not had a visit with a constituent. Try to have at least one (more if possible) individual contacts with every legislator. Follow up with thank you notes, birth announcements, holiday cards, or anything to keep your issues on their minds.

Always remember that the legislator's first priority is public safety. The purpose of legislation is NOT to create a professional status for midwives; it is to enact legislation that promotes public safety. They are not there to do a favor for a small group of midwives who don't want to be hassled by the prosecuting attorney. They will pass legislation because it benefits the public. That's why it is so important to have a lot of consumer support for your proposal, and for consumers to demand licensed midwives. That doesn't mean that you should imply that licensed midwives are safer than unlicensed ones. Midwives provide safe care regardless of their licensure status. But the public is safer because they can choose a licensed midwife who is accountable to the state; they can choose a midwife who isn't hampered by a questionable legal status; when a transport is needed, their midwife can accompany them to the hospital without fear of reprisal.

## Phase III

### 4-6 weeks before the session opens

#### 1. Identify your sponsors and co-sponsors.

You need a main sponsor for the bill in either the house or senate. It is helpful, but not always essential, to get another one in the other chamber. Co-sponsors are great, too. It is very helpful to have a sponsor who is on the committee that will hear the bill. Check those names, and look for any personal contacts you might have who would know them. Start meeting with them early, and let them know you are looking for a sponsor. Bring someone from their district with you when you talk to them. Seek any personal contacts, especially someone who had a midwife-attended birth, to help you lobby. You do not have to have a sponsor before the session opens, but it is very helpful. It is more important to get a GOOD sponsor than to get a quick one, so don't ask just the most friendly legislator to be the sponsor (co-sponsor would be fine). Go for the ones on the committee, and spend extra time on them. Let them know that the doctors and nurses may oppose the bill (they usually ask early about potential opposition). You want a sponsor who has either been successful previously with medical opposition, or who has a lot of clout with the medical profession. If any legislators happen to also be doctors, try to get them on board as, at least, co-sponsors. They may be unwilling to do this, but give them extra time and attention as they may at least diffuse the opposition.

One thing to remember in choosing a sponsor is that some support of your legislation will be based on who your sponsor is. Legislators may make voting decisions based on loyalties and rivalries with other legislators, and they like to affiliate with influential or powerful legislators. They will even vote against a bill because they don't like the sponsor, or because they have disagreed over previous bills. It is almost impossible to pass a bill that is sponsored by someone who is not well-respected by the other legislators.

Involve your sponsor in writing the bill so they know why you want the wording to stay the way it is. Your sponsor will have to take the bill to a legislative committee that drafts bills to help with the language. This is a good idea, so you don't have legislators trying to "fix" it in committee.

#### 2. Talk with a head person in the department(s) that might become your overseeing agency.

Treat them like a legislator and provide education. You might give them the name and phone of a similar contact in another state whose agency regulates midwives. These agency people can't vote for or against your bill, but they can object to or support the concept of putting your regulation in their agency. Most importantly, when you are talking with legislators, you can mention that so-and-so from the agency has been working with you on the bill, or has made specific suggestions, etc.

#### 3. Identify the path your bill will take.

Most legislatures have two sides, the house and the senate. The bill will first go to the side that has the primary sponsor. In many states, bills pass the house but are stalled in the senate. For this reason, you might try to take it to the senate first. In some states, you can actually propose an identical bill in the other chamber in case it gets stalled on one side. You need both sides to win, but you can do some effective lobbying on the other side and help prepare the road for when it does get through the first chamber. The bill will be given a number and assigned to a committee. It is usually the Health Committee, but check around to see if other committee assignments are possible and get your sponsor to push it toward the committee where you think you have the most supporters. The chair of a committee can keep the bill from being brought up for a vote, so you need a committee where the chair is favorable, preferably is also the sponsor of the bill.

#### 4. Intensify consumer contact with the legislators who are on the committees that will hear the bill.

Be sure they are getting visits and mail from constituents.

JUST BEFORE OR DURING THE SESSION, YOUR BILL WILL BE ASSIGNED TO A COMMITTEE. Then your work intensifies.

## Educational Sessions or Hearings

Some committees will hold an educational hearing to hear presentations about the bill before it actually comes up for a vote. These hearings are dedicated to the one issue being addressed by the bill, and should last 1-2 hours. If your committees don't hold these kind of informational hearings, you should consider scheduling a special event for legislators. This is best held early in the session, before your bill comes up but after it has been filed and assigned. To get the best attendance, hold the event where the legislators are (such as at the capitol) and offer some refreshments (check the rules about gifts to legislators, which may include limits on food). Do a lot of pre-meeting publicity and phone calls asking them to attend. Invite the legislators, their staff members, and consider inviting representatives from your possible licensing agency and even from your opposing groups such as the medical board, nursing board, and CNM chapter. The presentation needs to include a lot of detail about the CPM credential, about the safety of home birth, and about the consumers need for this option. Sometimes, a representative of NARM can come to do the presentation so check into that early in the planning stages. If that doesn't work out, prepare one of your speakers to talk about the CPM credential. Basically, you want to cover three angles:

- 1) The CPM credential; the education involved in becoming a CPM (focus on the equivalency of all routes, and talk with NARM about this); accreditation by the NCCA; the states that license midwives and their satisfaction with the outcomes; what licensure brings to consumers and to the state, etc.
- 2) Specifics on your state and your bill; number of counties with no OB providers (use a colored map for this), number of families having home births in your state every year; if neighboring states license CPMs point out that your state residents can cross state lines to birth with a legal midwife. One example is to say (using your own state stats) 300 families are known to have delivered with a home birth midwife in the state last year; home births with a midwife cost an average of \$3,000; the average, uncomplicated hospital birth costs an average of \$8,000; thus 300 state residents saved a total of \$5,000 each, or one and a half million dollars in one year alone. Address specifics of your bill as appropriate, including any major issues that have been questioned by some of your legislators, such as liability and medications. Only bring these up if they are already being discussed; otherwise focus on what you want them to know.
- 3) Have a few testimonials from consumers or from supportive docs or nurses. Consumers should speak briefly about why they chose a home birth, but avoid any focus on being in control or having it your way. These comments can sound to others as though your experience takes priority over the baby's safety. Let consumers talk about how they looked into the research and discovered that home birth is just as safe as hospital birth for healthy women, with much less high risk intervention such as cesarean. Let another consumer talk about having a home birth with a licensed midwife in another state and how appalled they were when they came to your state and found that midwives are not licensed. Have several stories that illustrate different situations. Let Dad's talk, too. Use parents whose education or credentials would impress the legislators. Get a doc who has provided back up to testify about the good care midwives give, or a nurse to talk about why she had a home birth.

Provide a few handouts. Thank them very much for coming to the informational session. Be sure someone keeps a record of everyone who attends (don't rely on a sign in sheet), and write thank you notes to all of them, including more handouts. Get a few photos. Consider getting the event written up in local newspapers. Send a news item (with photo) to the newspapers of the legislators who attended. They will love this publicity in their home town newspaper about what they are doing in the capitol city!

## Phase IV

### The bill in session

#### **1. During the session, you will need a team of midwives who can be at the legislature several days a week.**

Those are usually the midwives who live closest to the state capitol. Bring them into the fold early and make them an educated part of the committee. Your team needs to be midwives or consumers who are intimately familiar with the bill and the issues and who are articulate and speak well extemporaneously. Identify the members of this team and prepare them well. Have mock lobbying and interview sessions. Identify key dates and who can be there. If any money is available, help with transportation or babysitting costs.

You may need to have one or two of your primary organizers register as lobbyists with the state. Ask one of your legislators who to talk to about registering as a lobbyist. Your state may only require registration if you are paid to lobby, others may require registration if you are representing an organization rather than just expressing a personal opinion. Find out where lobbyists register and get some information from them. You might also make some contacts with other lobbyists who could give you some general advice.

The state web site will identify when and where the committees meet, and what bills are on their agenda. Once the session begins, legislators are at the capitol all week (and sometimes weekends) and may not be in their home towns very often. You will need to lobby them at the legislature. Locate their offices, and know the names of their aides and secretaries. It may be easier to make an appointment through the secretary or aide. If they don't like you, you may never get in to see the legislator at all, so be very friendly. Take gifts (small things, a few cookies or candy, a small vase of flowers, with something that identifies your group). Introduce yourself until they call your name when you approach! Seek their advice on how to best approach the legislator Give many thanks, and write thank you notes to the secretary or aide, or whoever helped you get in.

#### **2. You will lobby heavily to the members of the committee that will hear the bill first.**

Find out how many votes you need for a "do pass" recommendation. Look at their voting records and where they get their money. If anyone has a personal contact with any of their major donors, you can ask them to put some pressure on, or to at least write a letter of support. Identify the constituents of the committee members and ask them to send letters and make phone calls. Educate your supporters on how to write letters and what points to make. Be sure they have the correct addresses to use at the state capitol. Ask for a letter to come from every family member of a supporter, on different days. The first and primary message should be "Support Senate Bill # 4784". They look for that info and may not even read the rest. Phone message are the same. Keep them short and sweet. Do not use form letters or identical e-mails for any of this communication. Anything that seems to be mass produced counts for almost nothing to them, and can in fact work against you.

Get something printed in your newspapers, both the major newspaper in the capitol city and any local newspapers of the legislators. Send a press release or ask for an interview. (See info on media relations). Send letters to the editor about your issue. Have local citizens write to their local newspapers, especially in towns where your legislators live.

#### **3. You must have a group of midwives and consumers in attendance when the bill goes to committee for a vote.**

You should know how the committee members plan to vote before it ever comes up in committee. Delay the bill if you don't have enough committed votes in favor. In the days before the bill comes up, ask for a commitment for a YES vote. Note who the fence-sitter are and who the absolutely negatives are. Focus your lobbying on the fence-sitters, and get their constituents to write (e-mail if time is short).

Keep in mind that even when it is on the agenda it does not always get taken up that day and you may have to keep coming back. Arrive early, and speak to the legislators as they arrive for the committee meeting. Be very pleasant, friendly, and polite even if there are others there lobbying against your bill. Sign in to speak. Sometimes those on the list don't actually get called to speak, but the list is a record of the supporters who were there. If you do get to speak, make it short and simple about why you support this bill. Legislators may ask questions. If you can't answer, refer to someone else in your group who is prepared to speak.

Listen carefully to the questions legislators ask. Educate your sponsor on those issues. Sometimes, you will be able to answer questions or speak on issues, but other times your sponsor will be on his/her own. Educate them on the details or you will be amazed at what comes out of their mouths! Try to be with your sponsors whenever they might be talking about the bill, especially at committee meetings when the bill is being read. Don't contradict what they say in public, but give them better information in private. In public, add to what they say so that the issue is clarified accurately.

It can be helpful to assign a member of your group who is not speaking to take notes of the comments and questions raised by the committee members or by anyone who speaks against your bill. Identify comments by speaker's name if possible. You can target these people for future communication.

Establish an identity that the legislators can recognize. Print bright pink stickers that everyone can wear when lobbying. The stickers can say something like "I support midwives" or "YES for HB 25". Kids, if present, can wear stickers that say "Born with a Midwife". Everyone who comes to the capitol in support, whether speaking or not, should wear these stickers. Give out little packages of M&Ms with a note that says Mothers for Midwives. They will remember you.

You will need supporters at the capitol whenever your bill is being debated in committee or on the floor, but you can also lobby even when your bill is not active. You should have people in the capital every day possible. When the legislative bodies are in session, they are usually in an area that is not accessible to the public, but you can send notes in to them. Your note can ask them to come out and see you, and they usually will for a very short visit. They may not be able (or willing) to come out and talk to you, so your note should also say that you want them to support House Bill 25 – the Midwife Bill. When sending a note to your own specific legislator, always mention that you are their constituent.

If the bill does not get through the committee, or gets a "do not pass" recommendation, you may be able to introduce it in the other house if you have a sponsor there. You should already have someone lined up in the other house to help support your bill should it pass your first side, but if it doesn't pass then move to the other side and start over.

Timing is everything in getting a bill through this process. If the bill is brought up too soon, you may not have enough yes votes. If it is brought up too late, it may not have time to get through all the other committee and floor votes. It is a very common strategy behind the scenes to stall a bill until it doesn't have time to get through. Then, the committee members can vote for it to please their constituents, knowing the session will end before the bill gets all the way through, thus appeasing the opposition.

#### **4. If your bill does pass, it will then go to the floor or to the full senate or house for a vote.**

Repeat your lobbying efforts, this time with the legislators who will vote when it comes to the floor. Again, when it comes up for a vote you need to have a group of supporters there that day. They should be visible, wearing stickers or buttons with the message. Have lots of phone calls and e-mails arriving that day (and the day before) to all legislators saying simply VOTE FOR BILL # xxx. Find out if there are special rules about house actions and votes. For example, in some states if the bill does not pass on the floor they can immediately vote to expunge the vote, meaning that it can come up again for a vote later. Get a list of those who voted, and work on those who did not vote or who voted against the bill. Even if you can't bring it back up for another vote, use this list to prepare for next year.

Constant communication with your midwives and supporters is essential during this process. Send an update every evening about the day's events. Encourage people to call or e-mail their legislators when things are happening fast. Postal mail is not quick enough at this point, so switch to electronic communication. Some capitols have wireless web service now and you can e-mail while you are there!

Watch for, and be prepared for, amendments that may be suggested for your bill. They can do this without your permission. You might even prepare amendments that address some of the concerns that you have been hearing from the legislators during your lobbying, so that your own wording will be used instead of half-thought-out last minute ideas.

**5. If the bill passes both the committee and the floor, it will then move to the other house for a similar process.**

Do all the same things again. Ask those who have already voted in favor to speak to their friends in the other house. Or use their names when you lobby, especially to those you know are receptive. Pepper your lobbying with names of those whom you have been talking to, such as the director/supervisor of the agency that will administer the regulation, or the lobbyist or head of the Medical Association, or the chair of the committee in the other house, etc. Drop names. Sometimes that's all they hear.

If time is short, skip the legislators who are definitely not going to support you and focus on the ones who seem to be waffling. Know how many votes you need to pass, and concentrate on getting the numbers. Again, timing is everything. You don't want the bill to come up for a vote before you have enough committed YES votes, and expect that some you hope will vote yes will change their mind if they think the bill is going to fail anyway.

Keep the lobbying going just as intensely on the second side, even harder if the senate is your second side. They are a harder group to influence. Keep up the media response, letters to the editors, and especially letters and phone calls from their constituents. Find them in the halls of the legislature in the days before your bill comes up, and speak for just a few minutes. Thank them a lot. Send a TY note with a fact sheet. Meet with their aides or staff.

Watch for last minute tricks, such as an opponent proposing a substitute bill which replaces yours with something entirely unacceptable (this happened unsuccessfully in Tennessee and Utah in the last few days of the session). If amendments were made to the bill by one house after it had been approved by the first house (or if each house passed different version of the same bill) it must be reconciled by having the final version approved again by each house. This can be a trick, too, if the amendments are done in the final days of the session and there is not time to take it back through the other house. Your sponsor should know if these stalling techniques are permitted in your legislature and what can be done to prevent (or fix, if necessary) these roadblocks.

Also, remember that even after a bill passes, the governor can veto it (and will probably receive some urging to do so). Talk to the governor's liaison and see if anything is brewing there. You may need to ask people to write or call the Governor if s/he is receiving other calls for a veto.

**6. If you are successful in your first try for legislation, you are very lucky!**

Don't be too discouraged if you don't pass the first time. Each year is another step closer to victory. Many states have taken several tries to get their legislation passed. Build on your experiences. Start earlier the next year if you were late getting going this year. Meet with those legislators all year long. Have pregnant women write letters saying why they want a midwife. Be sure to keep a list of how all legislators voted the previous year. Send thank-you notes to those who voted for your bill, and let them know you will be bringing it back next time. Visit with them during the off season and ask for tips on how to do it better. Visit with those who voted against your bill and find out more about why they didn't support it. Don't be hostile; be their friend. You want them to remember you next year in a positive way. Keep track of which legislators get re-elected or replaced. Start lobbying any new legislators as soon as they

get elected. Add to your mailing list of consumers and supporters. Remind them to talk about midwifery legislation to every political person they come across all year.

Get together after the session with as many of those who helped as possible. Have a discussion about things that worked and things that didn't, and what went as planned and where were the surprises. Keep good notes. You may think you will never forget the details of the past few weeks, but a year later you may be glad to review the notes!

Most important of all, don't give up! Give yourself a big pat on the back for everything you DID accomplish this year. Thank yourself, and thank all the members of your team who worked tirelessly for this year's efforts. Have a party to celebrate the end of the session, regardless of the outcome. You will have learned a lot, and after a rest you will be ready to work on it again!

#### **7. If your bill DOES pass, write thank-you notes to all the legislators who voted for your bill.**

Another idea to consider is to write letters to the editor in their home-town newspapers or in the state newspaper briefly describing the new law and also thanking the legislators for their support by name. All legislators like to receive acknowledgement for their support and a public recognition of their support will greatly please them. Do be cautious about any legislator who might NOT want the publicity, such as a physician legislator or one whom you know received a lot of pressure from the docs in their community. One good reason to take every opportunity to thank these folks is that your regs will likely have to go through the legislative committees for approval so you will need their support again. Give them every chance to remember you in a positive light. Do not mention the names of legislators who voted against your bill because you still may need their support on your regs, and you don't want to offend them intentionally!

Katie Prown, who was instrumental in the work to pass legislation in Wisconsin, has these excellent suggestions for post-legislative thank you letters. Remember not to copy letters verbatim; they should not look like form letters. Put these concepts into your own words.

“Letters should be no more than 200 words, and be sure to include your name and address. Some general points to make (and please remember that we need to mention safety because that's the issue our supporters voted on and how they plan to promote or defend their votes during the upcoming election):

- SB 477, the proposal to license Certified Professional Midwives, will expand childbirth options for families across the state and increase access to safe and affordable maternity care for families who choose out-of-hospital birth.
- SB 477 is a victory for the citizens of (your state) and an inspiring example of how government can and does work for the people. Getting this law passed was an all-volunteer, statewide grassroots effort that brought together people from both sides of the aisle and all walks of life. It was this diverse group of committed supporters that made it possible for the bill to pass through both houses in one session on a budget of under \$3000, despite opposition from well-financed lobbies seeking to establish a medical monopoly over maternity care in Wisconsin.
- The (state) legislature is often accused of being beholden to powerful interests and of accomplishing little of importance this session, but SB 477 is proof that government can and does work for the people and that our representatives in the Assembly and the Senate in both parties can work together to promote good public health policy.

#### **For those legislators who deserve special thanks:**

- I want to thank my representative/senator for his/her hard work in getting SB 477 passed and for his/her commitment to promoting good public health policy. His/her reputation as a strong leader who isn't beholden to special interests helped this bill pass through many critical turns. And thank you to Governor

(name) for responding to the concerns of voters from across the state and signing this important piece of legislation into law.

- Rep/ Senator X's unwavering support and guidance through the labyrinth of the legislative process was the primary reason for this bill's success, and I want to thank him/her for the time and attention s/he gave this issue, for recognizing its importance, and for taking a leadership role in helping to get SB 477 passed."

The people at NARM really like to work with the legislative effort in each state, and are always available to act as advisors before and during your session. Please keep us on your e-lists, and let us know what is happening. [testing@narm.org](mailto:testing@narm.org) or 1-888-353-7089

### **Special notes for the support team – the people who are behind the scenes but who can't go to the legislature as often as necessary:**

Stay in touch daily with your legislative team, whether by phone or e-mail.

Keep in mind that the people on the legislative team who go to the capital several days a week for weeks on end have made a personal sacrifice for all the midwives and mothers who want to see this happen. Their lives are disrupted in a way that is hard to imagine unless you are there, and it is emotionally and physically taxing. They often suffer a financial hardship as a result of this work in the form of extra gasoline, babysitters, quick meals from take-out, last-minute printing, long distance calls, higher cell phone bills, and even deferring their usually work (whether as midwives or other kinds of work) resulting in a lack of usual income. The people on the legislative team need lots of support from those who can't be there. Give praise whenever you can; show your confidence in their decisions even if you aren't quite following everything that is going on. Contribute financially to the cost of this effort. If you are able, offer to babysit, or run errands, or drop off dinner to the families. The families of the legislative team need to know how much you appreciate everything their wife/mother is doing. They need to feel proud of the work she is doing, because they are very definitely going to resent the time she is spending away from the family.

It often takes years of work to pass a bill, and that means going back to the legislature year after year, as well as several months of work between sessions. It is important to keep the momentum going so that the legislators realize that the Midwifery Issue is not going away.

When the bill is defeated after lots of work, it is easy for those who have committed a lot of time and energy to feel very disappointed and discouraged. Those feelings are exacerbated if they also feel a lack of support, or if disagreements about how anything was handled lead to a sense of blame or personal disappointment from others. It is very important to nurture and support one another through this period, even if there are personal disagreements about any specific part of it.

# Avoiding Burnout

- Show your support with phone calls and emails or notes of appreciation to those who are shouldering lots of responsibility.
- Read your e-mail every day. Write back so there is a sense of the whole community being involved.
- Offer to run errands, help with childcare, or drop off food for the family. Add a thank-you note or a bunch of flowers.
- Contribute financially to the costs of the work: printing, mailing, etc, as well as personal expenses such as long distance calls, gasoline, cell phone bills, etc.
- Let the families know how much you appreciate their sacrifice in the project, and how proud you are of what their wife/mother is doing for everyone.
- Share in the tasks that must be done; help coordinate the supporters in your area so that more people will write or make phone calls; ask neighbors, relatives, church friends, school friends, all to help support this effort by contacting their legislators. Report back to your legislative team on everything you are doing. Go to at least one legislative hearing or lobby day. SHARE the ENERGY as well as the WORK so that everyone feels a personal ownership in the process and an investment in the outcome.

What other ideas do you have for avoiding burnout? Keep a list on this page, and send your ideas to [testing@narm.org](mailto:testing@narm.org)

# Lobbying All Year

There are several things that can be done to help keep midwifery issues in front of the legislators when they are not in session. These are things that can be done between sessions so that supporters do not lose their momentum and so the legislators are reminded all year how important midwifery is to their constituents.

Keep the cards and letters coming! Urge supporters to send birth announcements (another future Missouri voter...), or holiday cards with a personal note, or birthday cards on each legislator's birthday. Send a card on YOUR child's birthday (every year on this day I remember how important it is to have midwives in our community...).

Pregnant women can send letters saying how they wish they could have a midwife, or that they are thinking about going out of state to have the baby so they can have a midwife.

If any other state passes a midwifery licensure law (or even when the proposed law in another state passes through a committee), send press releases to the state and local newspapers about the progress being made in other states and about how much your state needs midwives. If any newspaper prints the article, cut it out and send it to the legislators. If you get news articles about midwifery in other states, forward those articles to the legislators.

Keep a list of how the current legislators voted on the bill (if a proposed a bill was defeated). Send thank-you notes to all of them – send thank you notes to those who voted for the bill, and send notes to those who voted against it but thank them for considering the bill and hoping they will learn more about how important this issue is before the next legislative session. Have a party with a group of friends and ask all of them to write a short thank you note. The thank-you note is the beginning of next year's effort!

Research the things that are important to the legislators. Mention bills that they have supported in the past sessions. Find out what their other interests or vocations are, and mention those things to show how much you have in common, or find people in those areas who will also write letters in support throughout the year. Legislators are in the news all year, and there is material to build from in finding common ground.

Increase support for midwifery from the medical community by talking to doctors personally throughout the year. Doctors are everywhere in addition to their own offices – they are neighbors, parents of other kids, serving on community and church boards, etc. Talk in a casual, non-threatening way about why midwifery is a reasonable choice. Making inroads in this way may help reduce their opposition next time, and may even gain some support.

Volunteer in political campaigns. Get to know the incumbents and the challengers, and discuss midwifery in a casually supportive manner. Give a day or two to stuff envelopes for them. Attend political fund raisers (some are not expensive!) and find a minute or two to discuss midwifery. Even if the politician is very busy, inroads can be made with their staff which will pay off later on. Keep lists of contacts made, and write thank you notes again to remind them that you were there and that you appreciate the time they took to listen to your concerns. Focus on the legislators who are influential, or who are on the committee where your bill will likely be heard. You don't have to actually live in their district to attend fund raisers – they like support from all over the state.

Hold events to raise money for next year's work toward passing legislation. Keep supporters in the loop with what is being done and how important everyone's involvement is all year. Send an occasional e-mail (not too many; some people will be overwhelmed and want off of the list) or newsletter about the group's activities.

Write articles about midwifery (or about a personal experience having a home birth) for local newspapers. Many communities have small newsletters or magazines of interest to parents – write for them. If there is a local magazine for older people, have a grandparent supporter write about home birth from the grandparent's view. Send these articles to the legislators when they get printed. Send them to ALL the legislators! Show them what “good press” home birth is!

Identify groups who might be interested in the midwifery issues, such as women's groups or groups with similar political interests. Gather names and e-mail addresses of those who might join the lobbying effort next year. Add to the database all year.

What other ideas does your group have for activities between sessions? Keep a list here, and send your ideas to [testing@narm.org](mailto:testing@narm.org).

# Lobbying Your Legislator

Lobbying your legislator can take many forms, from 30 minute visits in their home town, to 10 minute updates in their capitol office, to 2 minute visits in the hallway, to letters, e-mails, and phone calls. Each type of communication may benefit from a specific strategy.

**In all verbal communication, don't waste your time and theirs by not knowing what to say. Plan, plan, plan what you want to say. Identify the main points you want to make BEFORE you meet with them:**

- Identify yourself (say you are their constituent if you are, otherwise don't mention it)
- Say what you want them to do BRIEFLY
- Ask what their concerns are and LISTEN
- Thank them for talking with you.

**If you have 15-30 minutes in an unrushed meeting:**

- Whenever possible, let one of the visitors be a constituent of that legislator, or at least mention the names of some whom they may have received letters from.
- Establish rapport, if possible. Acknowledge mutual acquaintances, or clarify that you are a constituent, or anything you have in common. Preparing ahead will help (identify their interests, children or grandchildren, personal history, where went to school, spouse's occupation, anything you can find from the website or from someone who knows them), or just noticing personal items in their office or home.
- Plan 2-3 points you want to make, and be brief and clear about those points. Prepare answers to the most likely questions. See suggestions for main points and answers to questions elsewhere in this booklet.
- Ask what their concerns are, and listen carefully. Don't preach at them. **YOU ARE NOT LIKELY TO CHANGE THEIR MINDS JUST BY GIVING THEM FACTS.** It's too bad, but it's true. You change their minds by finding things you and they agree on and then building on that logic. If they think home births are unsafe, you don't want to tell them they are wrong. Get them to agree that we all want safe births for mother and baby. Ask why they think home births are unsafe. Then build on those points by giving a few facts in support of the safety of home births and then move on to ask if there are other concerns. Ask what it would take to change their minds on that issue. If they can begin to think about what would change their minds, they will work on the logic rather than the emotion, and you may be able to give them (or send them later) the information they need. End the discussion by reiterating the common ground you have found.
- Leave a one-page handout on colored paper (something they will notice), and if you can leave a small gift like candy or flowers so they will think of you after you're gone. Also leave your calling card or put a contact name and phone number on the flyer so they can get in touch with you or another appropriate contact. Thank them for letting you come to talk to them.
- Afterwards, send a thank you note. Continue to send something to remind them of your issues, either regular short notes or flyers, or holiday cards, or birth announcements.
- Also makes notes about your visit as soon as it is over, including any concerns expressed or anything you said you would send; note the secretary or receptionist's name in case you get a chance to use it again. Note any personal information shared. You may find this will come in handy if you lobby this person again, or you can share the information with other lobbying teams. Especially share the list of concerns

that any legislator expresses, along with any identification of what it would take to address those concerns.

### **If you have a 10 minute visit in their capitol office during the session:**

- Follow an abbreviated version of the above, being sure to acknowledge and thank the secretary or aide who is part of their staff. If your bill has a number and/or committee assignment, focus on asking for support in that context.
- Try to avoid spending too much time on a philosophical discussion; there's just not time. Determine 2-3 main points you'd like to make and stay on topic. Give the legislator a chance to express concerns. Give reassurance if those concerns are being addressed, or that you will take those concerns to your committee. Above all, don't tell them they are wrong even if they are. Give them information that addresses those concerns and let them change their mind. Drop names about the other legislators who support your bill (especially if those two legislators have also supported other bills together) or organizations who have signed on as supporters.
- Leave a fact sheet with a large heading that says "Vote FOR HB125" followed by a few main points.

### **If you have a 2 minute meeting in the hall:**

- If you can't get a meeting in their office, try to catch them in the halls between meetings. To do this, you will need to know what they look like. In some cases, there are photo directories available. Most legislative web sites have photos along with a brief personal description. If you can identify which committees they are on, you can go to the capitol during those committee meetings and try to identify them and catch them upon leaving.
- Always wear your pink sticker or other visual identification that indicates you are in support of the mid-wife bill.
- If they are in the full session, you can also try to call them out of their sessions for a short visit. Talk to some of the other lobbyists to find out how to do this. Usually, outside the closed doors of the session there is a desk with small slips of paper to fill out. You put the legislator's name, and your name, and a brief message, and a page takes the message in to the legislator. If they are not too busy, they will come outside to meet with you for just a few minutes. Be brief and efficient, and give them something to look at when they go away – a flyer or handout, anything with your group name, bill number and how you want them to vote. There is always the chance that the legislator will not come out; they may be too busy or too caught up in a debate at the time, or they may just not want to talk to you! Be sure to put your group name on the request slip and a short message, such as "I would like to talk with you just a few minutes in support of House Bill 125", so that even if they don't come out they will know what you want.

### **E-Mail**

- All state legislators have an e-mail address now. Some are made public and others are hard to find. The information is on the state legislative web site and is also available at [www.vote-smart.org](http://www.vote-smart.org). E-mail is the least effective form of communication and should only be used for last minute lobbying. It may annoy the legislators if their e-mail boxes are flooded with e-mails too soon. Wait until a day or so before each vote to use the e-mail approach. If using e-mail, put Vote FOR House Bill 125 in the header of the post. Sometimes that is all they read. They also prefer to receive e-mail from their own constituents, so perhaps organize your supporters so they send e-mail only to their own legislators (and SAY in the first line of the post who you are and where you are from).

- If you have been asked to limit the e-mail to only those from constituents, you might want to identify that in the header in case they are culling out the repetitive mails. For example, the header could say “From Birmingham: Vote for HB 125”, something that identifies your post as both from a constituent and in favor of the bill.

## **Phone Calls**

- Phone calls can be made to the legislators at the state capitol. The numbers should be on the web site. Phone calls are like e-mail: they are most effective right before the vote is taken. You will most surely be leaving a message, either on a machine or with a secretary. Write out what you want to say before you call. Identify yourself by name and say if you are a constituent. Ask them to vote FOR House Bill 125, the bill to license midwives. Keep it short and sweet. Probably, an aide is going to be keeping a list of phone messages and just listing how many people call in for or against a certain bill. That’s all the information you need to leave. Be courteous, and thank them for listening.

## **Letters**

- Handwritten letters are a very effective method of communication. As usual, they should be short and sweet. No more than one page. Prior to the session, send letters to their home address. You can send letters more than once, maybe several times in the months leading up to the session, with different messages but all saying please vote for the midwife bill. Identify yourself and your town if in their district. If the bill has a number and name, use it in the first sentence when asking them to vote for it. Then personalize your letter. Tell something about yourself and why you support midwifery licensure. Always thank them for their time. If the legislature is in session, you may want to send it to their state capitol address. Use the proper form of address.

# Sample Letter:

Your name

Address, City, state, zip

Phone, e-mail if desired

Date

The Honorable John Jones

Address

Dear Senator Jones (or Representative Jones),

I am writing to ask you, as my senator, to vote in favor of House Bill 125 to license midwives. The passage of this bill is very important to me, to my family, and to our community.

As a mother who has given birth at home with midwives, I am strongly in support of a mother's right to choose where and with whom she will give birth. I had excellent midwives who provided prenatal care, stayed with me during 18 hours of labor and birth, and visited my home three times after the birth. I could not get this kind of care in a hospital.

**OR**

I had three babies in a hospital and was satisfied with my experience, but I have met many mothers who delivered at home with a midwife. I believe they received excellent care from very professional midwives. It is a shame that the state does not recognize these caregivers through licensure. It would be a benefit to our community to have licensed midwives.

**OR**

My daughter plans to give birth at home with a midwife. At first, I did not support this decision but now I do. At the very least, I think these midwives should be licensed so that there are standards to follow and some kind of accountability.

**Or whatever personal comments of 2-3 sentences one cares to make....**

Please vote to support House Bill 125 to license midwives. This bill would greatly improve the availability of health care for families in our state.

Sincerely,

Your signature

# Testifying Before a Legislative Committee

Interested parties are not allowed to give testimony when a bill is being debated in the full House or Senate, but they are allowed to testify when the bill is before a committee.

When a bill is given a number and filed, it will be assigned to one or more committees. If it is not passed out of committee, it may make no further progress toward passage. (Though some legislatures have a process to move a bill out without a Do-Pass recommendation, it is rarely successful.) It is very important to get the bill passed favorably out of committee. For the best chance at passing, lobbying should be done for every committee member before the bill comes to the committee.

The status of each bill, and its place on the committee agenda, will be listed on the web site. Several articulate people should be prepared to speak at the committee meeting, and many more supporters should show up. Usually, the chair asks all in favor (or opposed) to the bill to stand so the committee members can see how many are there. Since there are many bills on the agenda, you may have to wait for hours for your bill to come up. When the bill does come up, your sponsor will be the first to speak and will explain the bill to the committee. Committee members will ask questions of the sponsor, who may call on one or two experts to help answer the questions. You should plan ahead who will assist with the answers. Then the chair will ask if there are people in the audience who want to speak for or against the bill. Time may limit the number who can speak, so put your best speakers forward first. Speakers may also have been required to sign in at the beginning of the meeting.

## Tips for giving testimony:

- Plan ahead. Make notes of what you want to say. Practice out loud before you go.
- Dress appropriately; you will appear as more of a peer if you dress in business attire.
- Try not to read your entire testimony, but use notes as a guide. Look up at your audience, and SMILE. Make eye contact.
- Relax, especially your face, and breathe. Don't rush through it. It's better to make fewer points and Be Engaging, than to look uncomfortable and nervous
- Your time may be limited, so make your important points first.
- Don't make negative statements about your opposition. Be positive. Talk about why home birth is good rather than what is wrong with the hospitals.

## Think of the Testimony Sandwich \*

Garnish: introduce self and thank committee for letting you speak

- Bread: say what you want them to do – support house bill 125 to license midwives
- Filling: your personal connection, what it means to you, in 1-2 main points; why you think home birth is good, or why you think midwives should be licensed or what your personal experience is; maybe list nearby states that license midwives and how you almost went there (or knew someone who did) to have a licensed midwife; or how many other states license midwives or the state you came from licensed midwives.
- Remember to focus on the safety of home birth with a qualified midwife; you want this because it is better for the baby with fewer risky interventions to the mother – avoid any statements that can be interpreted by the uninformed that the mother’s experience is more important than the baby’s health. Also focus the benefits of licensure to the consumer and the state: setting standards, requiring accountability, reliable information for the consumer.
- Bread again: remind them again that you want them to vote for this bill because your state needs licensed midwives
- Plate: thank them again for listening to your reasons for wanting to license midwives.



Thanks to Susan Hodges and Citizens for Midwifery for the "Testimony Sandwich"

# Main Points

(adapted from material provided by the Georgia Midwives Association)

These are some points that can be made in lobbying, in letter writing, and in giving testimony. Work these ideas into your lobbying repertoire. Legislators have a lot of pride in their state, so use the state's name often in your communication as though you are reminding him of his responsibility to represent the state in a more favorable light that it now is. Adapt these as you need to, to specifically address any concerns. Also, see the fact sheets for shorter statements.

- The CPM is a nationally recognized midwifery credential that has received the prestigious certification by the National Commission on Certifying Agencies. The CPM credential is issued by the North American Registry of Midwives (NARM).
- The CPM is the only national credential that requires clinical birth experience in out-of-hospital settings. A nurse-midwife or doctor who is trained exclusively in hospitals is not prepared to practice safely and effectively in the home environment. (State) families should have access to legally practicing CPMs to attend home births. CPMs have the same amount of clinical experience in training as CNMs and Family Practitioners (see handout)
- It would be exorbitantly expensive for the state to create an educational evaluation and credentialing process for direct-entry midwives. The CPM process is already developed and working, and has been found to be psychometrically sound and legally defensible, so the government would incur fewer expenses in licensing CPMs to practice in (state).
- The trend across the country is toward acceptance of the CPM credential for the licensure of direct-entry midwives. All twenty-four (check the number for accuracy each year) states that permit midwives to attend home births use all or part of the CPM process.
- The state should license CPMs because only licensed healthcare providers are eligible for third party reimbursement (insurance and Medicaid). When insurance and Medicaid are not available to pay for midwifery care, then midwifery care is limited to the wealthy who can pay out of pocket for their care.
- Midwifery care is more economical for the state, the insurance companies, and the parents, because a home birth with a midwife costs less than a third of the cost of a hospital birth.
- (State) licenses certified nurse midwives to attend births, but very few (or none if that is the case) provide services out of the hospital. (State) families should have access to midwifery care in all settings, as has been recommended by national and international health research organizations. Licensing CPMs is a way the government of (state) can make midwifery care available to mothers in all settings.
- Allowing for the legal practice of CPMs is good for the state because the CPM credential is good for consumers. In order to be certified, a midwife must have met rigorous requirements for the demonstration of knowledge and skills, and must have passed both a hands-on skills assessment and an 8-hour written examination. Supervised clinical experience in out-of-hospital settings is required, as well as continuing education to maintain certification. If a woman should have a complaint about her midwife, there is a grievance process through the North American Registry of Midwives where the complaint will be heard and evaluated.
- State governments are mandated by the US Constitution to “protect the general welfare” and not to curtail personal freedom in the absence of evidence that such freedom poses a threat to public health and welfare. There is absolutely no evidence that the practice of midwifery in homes poses any threat to public health and welfare. In fact, extensive research has shown the opposite: for women who do not have serious medical conditions or complications, a planned midwife-attended home birth is as safe or safer than a doctor-attended hospital birth. Licensing CPMs is a way the state of (state) can fulfill its obligation to protect the general welfare while protecting our freedom. Licensing CPMs lets the state of (state) make sure that midwives who are practicing have met reasonable and sensible requirements, and are accountable for their practice.

- Some women are going to have home births whether they have legal, trained attendants or not. Because evidence shows that planned, midwife-attended home birth is a responsible choice for most women (at least as safe as doctor-attended hospital birth), and statistically much safer than unattended home birth, the state has a public health obligation to enable direct-entry midwives to practice legally in (state).

**If CNMs are not providing home birth services in your state:**

- Direct-entry midwives, such as CPMs, are the only health care providers known to be attending home-births in (state). They are also the only providers experienced in attending out-of-hospital birth. (State) should give legal status to CPMs in particular because the CPM credential is the only national midwifery credential that requires clinical experience with out-of-hospital birth. CPMs are specialists in home birth.
- Direct-entry midwives typically spend up to an hour for each prenatal visit. Besides the standard measures of well-being, these midwives concentrate on education and preventative care regarding nutrition, exercise, and life-style issues, and also help pregnant women work through any fears or concerns. One result is more full term, full weight, healthy babies, which not only benefits the mother, baby and family, but also saves money because the special medical care for premature and underweight babies is very costly.
- Home birth midwives avoid unnecessary interventions, which saves money and avoids risks of costly complications for both mother and baby. Midwifery expertise includes knowledge of many non-intrusive, “low tech” methods for helping the mother to labor effectively. Home birth midwives do not use drugs for pain relief or for initiating or intensifying labor, and they do not engage in surgery or instrumental deliveries. For one example, midwives at home almost never cut episiotomies, but this is a common intervention in the hospital even though it has been proven ineffective and harmful – uncomfortable for the mother and not infrequently the site of infections during recovery. Women in (state) should be able to choose a midwife and a home birth so they can avoid the many unnecessary procedures and costly, risky interventions that are all but unavoidable in today’s hospital births.
- All states have had direct-entry midwives practicing for decades, with or without regulation, and these midwives are not posing any kind of public health problem or danger to the public welfare. Direct-entry midwives are regulated and legal in 22 (update as new states are added) states where they are part of the health care system. The women and families of (state) deserve no less than the women and families of all these other states. (State) should be on a par with (mention adjoining states if they have licensure) and many other states, or list: Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Louisiana, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin. (check for updates to this list)
- As long as direct-entry midwives are unlicensed, physicians and nurse-midwives are understandably reluctant to consult or receive transports when a change in the mother’s condition indicates that the birth should not take place at home. This means that in the rare cases when a transfer of care is necessary. The midwife cannot stay with the woman. In that case, any information the midwife may be able to provide is unavailable or disregarded by hospital personnel, which breaks continuity of care and lowers the quality of care for the mother and baby. Direct-entry midwives should be able to practice openly and legally in (state) so that doctors and hospital personnel can know them and work with them in the small percentage of situations where transport for medical care becomes advisable.
- As long as direct-entry midwives are unlicensed in (state), the state will not have accurate public health records regarding who is having home births and the outcomes of midwife-attended vs unattended births. (State) should have reasonable regulation and legal status for CPMs so that women can have the option of a midwife-attended home birth and the state government can fulfill its mandate to protect the public welfare.

## **Examples of Personal Statements that can be used in a letter or in a conversation**

(adapted from material provided by the Georgia Midwives Association):

- Be brief and use the personal story to make a point about why midwives should be licensed in your state.
- Tell something brief about who you are before stating why you support the licensure of midwives. Let them see the variety of people who are interested in this, mention what part of the state you are from:
  - I have been a public school teacher for five years in Crittenden County...
  - I have raised four children in the Chicago area...
  - I am a college graduate from (state university)...
  - I served in the Armed Forces in Iraq...
  - I have attended First Baptist Church in Morgantown all my life...
  - My father was a family physician in Greensboro for 35 years....
- Everyone in the family can write a letter: mother, father, grandparents, aunts, etc. Get your neighbors to write, or your church group.
- Tell your story: home birth or hospital birth, what was good and what could be improved, why you chose a midwife or why you think others should have the choice of midwife care.

## **Some things you can say in a letter or conversation include:**

- I had my babies in (another state) where my direct-entry midwives (or my CPMs) are legal/licensed, and I had wonderful care... For example...
- I've had a home birth and a hospital birth, and I definitely would want another home birth with a midwife because...
- I had my babies in a hospital, but my (friend, sister, neighbor, daughter) told me about her home birth. If I had another baby, I would want a home birth because...
- I have read a report from the Center for Disease Control that interventions in birth are increasing for non-medical reasons. I want a natural childbirth without drugs and interventions and I know I will be most likely to get that kind of care from a midwife and a home birth.
- I want the best care and the safest birth, so I read the research on maternity care, and I learned that midwife-attended home births are actually the optimal care for the majority of women. For example, (cite WHO or other studies from CfM website). This choice should be available here in (state).
- I had my baby at home without any doctor or midwife because we could not find a midwife. Everything went fine, and I'd do it that way again, but I would prefer having a midwife.
- I have had all the children I am going to have. I am writing because this is an important issue for everyone. I have (daughters, daughters-in-law, grandchildren, etc) who are going to have babies and I want them to have this kind of care.
- I am a ...childbirth educator, doula, labor and delivery nurse... USE your credentials to support your authoritative knowledge.

# Answering the Tough Questions

Legislators must make decisions every day on things they know very little about. That's why they turn to others for information. Like most people in our culture, most of them will have assumed that the hospital is the safest place for birth to occur. Even those who were themselves born at home may think that, in this day and time, births should occur in the hospitals. They often go to their medical friends when a health-related bill comes up, and there they will get all kinds of horror stories about what may happen if the state "condones" home birth by passing a licensure law. Some legislators won't even be willing to talk with you about it. You will need to be very polite, but persistent, in trying to communicate with them. Others will have harsh questions, sometime with inflammatory implications, directed at you. Be grateful that the questions are coming, because that means they are willing to dialogue about it.

It's easy to get flustered and angry when a legislator tells you "I don't want to be responsible for a bunch of dead babies"! You need to expect these comments, or questions with a similar tone, and be prepared to answer them. The key is to prepare. Anticipate the hard questions, even unfair questions, and practice responding to them in a calm manner.

## **Remember that confronting someone with facts rarely changes their mind!**

Their attitude toward the issue has to change before they will even listen to the facts. Remember the old saying that you can find statistics to support any position? Well, it's pretty much true, and the legislators know it. There's a time and place for statistics, but that's after they've turned the corner and they WANT to believe you. Then they will accept the statistics that confirm their newfound belief.

To change a belief, you first have to identify that belief, find common ground you can agree on, and then move incrementally toward a more acceptable interpretation of that belief. Each contact you have with a legislator can move him or her closer toward your way of thinking. But telling him how the cow ate the cabbage just won't do it!

## **Consider this scenario:**

**Legislator:** I don't want to be responsible for a bunch of dead babies!

**Midwife:** Of course you don't! Neither do I. We all want babies to be as healthy as possible. One thing that doctors and midwives both agree on is that good prenatal care is one of the most important factors in assuring a healthy baby. Is that something you can agree with, too?

**Legislator:** I guess.

**Midwife:** Did you know that midwives spend about an hour at each prenatal visit with a pregnant mother? They do all the check-ups that a doctor normally does, you know: blood pressure, fetal heart tones, things like that, and then they spend another 45 minutes talking about good nutrition, exercise, reducing stress, taking care of children, and many more things that are always on a pregnant woman's mind. Do you know how long the average physician visit is with a pregnant woman?

**Legislator:** Probably not an hour.

**Midwife:** About six minutes! Can you believe that? Six minutes. A midwife spends ten times longer giving prenatal care and talking about ways to have a healthy baby. This is just one of the many ways that midwifery care addresses the individual needs of pregnant women. That's why their outcomes are so good! Do you believe that home birth outcomes are as good as low risk hospital births, and in some cases even better?

**Legislator:** That's because they dump their bad outcomes at the Emergency Room where some doctor has to take care of the home births gone bad.

**Midwife:** Do you personally know of a home birth client who has been dumped at the Emergency Room?

**Legislator:** I've heard about them.

**Midwife:** Really? First hand? Well, I have been attending births for many years and have never dumped a mother at an Emergency Room. When I have a mother who should deliver in the hospital, I go there with her and try to facilitate her transition into the medical system. I'll tell them what her history is, and why we have come to the hospital, and then I stay with her so she has a familiar support person with her. But I imagine that if a midwife were not welcome in the hospital, if the receiving physician were hostile or punitive, then it might be in everyone's best interest for the midwife to stay away. It's certainly not what she wants to do, and not what the mother wants, but it may be the only choice if the midwife is not welcome as part of the caregiving team. That's what this legislation is all about – making the midwife a part of the health care team. As a licensed professional, she has been trained to assess the mother's risk factors and to transfer care when appropriate. Did you know that in a study of over 5,000 home births, only 12% needed to be referred into a physician's care, and only 3% were considered to be any kind of emergency. And the outcomes are just as good as if all of those mothers had stayed in the hospital. If the outcomes are just as good, shouldn't the mother be allowed to choose from two equally safe options? (provide BMJ article fact sheet for this documentation)

**Legislator:** I'll have to think about that.

**Midwife:** I hope you will. Let me leave you with this handout that explains some of the benefits of licensing midwives to provide this care. I appreciate you time in visiting with me today, and I hope that you will call me with any questions that might arise.

In this scenario, the midwife dealt with two of the more common hostile accusations: that more babies will die and that the bad outcomes will be dumped on the hospital. You can't always predict what questions will be thrown at you, and you won't always have a good answer on the tip of your tongue. Remember that you want to be reassuring rather than confrontational; you want to start from where they are and find a common point of agreement; and you want to move them toward another way of thinking.

Another important thing in dealing with difficult questions is to give them the information you want them to have. Don't be bullied into saying what you don't want to say, and don't repeat their negative as a reply. Don't let them control the information that is exchanged by putting you on the defensive. Know what points you want to make, and stay on those points. If the conversation is heading somewhere you don't want to go, bring it back by acknowledging the question and then saying something like, "But that's not the point, the point is....." or "True, but that's not the significant issue, the important thing is...."

It's impossible to plan for every possible question, and even when planned your answers should sound spontaneous and heartfelt rather than sound as if they were written by someone else. The legislator needs to believe that you believe what you are saying. There are some questions that are fairly predictable, since they have been asked by almost every legislator in every state that has tried to pass a midwifery law. Some of these questions are listed below, with some possible answers to think about. As your team begins talking to legislators, keep a list of the questions that are asked and let your team work on some answers. You can be sure the questions will come up again and again.

#### **Who is going to assume the liability for these midwives?**

**Answer:** There is a provision in the bill that addresses liability. If a mother is transported, the doctor and hospital are only responsible for the care they give after transport; they are not responsible for the midwife's care.

**I want to see midwives carry malpractice insurance.**

**Answer:** There is no malpractice insurance for midwives currently available in this state. If it becomes available, we can address it then. There is a provision in the bill for the regulations to address malpractice insurance. (Only say that if it is true; only have that provision in the bill if the legislators insist on it, and then only say that the regulations will address it, not that it will be required). Do your research, but very few states have any malpractice requirements for any other healthcare provider license. Get the facts to support this in your state. Only one state (Florida) requires malpractice insurance for midwives, and they support it through a state-funded Joint Underwriting Association.

**How does the Medical Association feel about your bill?**

**Answer:** They object to this bill because they consider us competition, and because they fear that home birth is unsafe. But we have ample evidence that both fears are unfounded. Midwives, even when licensed, attend only about 1% of births, not enough to be considered competition for the medical monopoly. Their fear that birth is unsafe is also not based on fact. Home birth for low risk women is just as safe, and sometimes safer, than hospital birth. There is a lot of evidence supporting the safe choice of home birth for low risk women, and the Certified Professional Midwife has received extensive training on early and accurate risk assessment. Mothers who need to be in a doctor's care will be referred into the medical system in a timely manner.

**What do you do when the mother needs a Cesarean?**

**Answer:** She is in the hospital when that determination is made. Cesareans are not done at home. Again, early and accurate identification of risk factors means that mothers who need a Cesarean are already in a doctor's care.

**What kind of medications do midwives use?**

**Answer:** (If your bill has provisions for medications) There are specific medications that are appropriate for use in a home birth, or during a transport, and our bill addresses those medications. Midwives do not use pain medications at all, but are allowed in this bill to administer the routine newborn medications of eye ointment and vitamin K, as well as to carry some life saving medications that would only be used in an emergency; for example, to treat a hemorrhage. (this statement will have to be developed based on which medications are being listed in your bill.) If no medications are authorized in your bill, your comment would be something along the lines of: Midwives attend only low-risk women at birth who rarely ever need any kind of medication. The Certified Professional Midwife is trained to recognize conditions where medications would be appropriate and to transfer care to a physician if medications are needed.

**Doctors have eight years of medical school to be able to do what they do. We don't need any untrained midwives out there catching babies when there are plenty of doctors and hospitals in every part of the state.**

**Answer:** A physician's education is very important for the high risk women who need to see a physician but it is unnecessary for normal, low-risk birth. In fact, most physicians have never even seen a normal birth. They know how to use life-saving technology, but if that technology is applied where it is not needed it actually creates more risk. Mothers who choose home birth do not want that technology applied to them unnecessarily. Midwives are very well trained in the process of normal birth. In fact, Certified Professional Midwives are the ONLY care providers who must have training in out-of-hospital settings. CPMs are specialists in normal birth.

**Midwives should have a written collaborative practice agreement with a physician.**

**Answer:** Physicians will not sign a written practice agreement with a direct-entry midwife. They may claim that they are not "allowed" to do this by their partners, their hospital, or their insurance carrier. ACOG has issued a policy statement saying that they do "not support programs or individuals that advocate for or who provide out-of-hospital births," effectively prohibiting their members from entering into such arrangements.

## **Avoid referring to the current status of midwives as “illegal.”**

Say that midwifery is “not regulated” or that midwives are “unlicensed”. If your bill doesn’t pass this year, you don’t want your own material to be used against the next midwife who is arrested! If you think your “illegal” status is an important point, use it verbally with individual legislators and not in writing or for press releases.

After an unsuccessful effort to pass legislation in 2005, the state of Nebraska sent the issue to a study commissions. After several sessions in which they were given information about the CPM, the members of the study commission sent some specific questions that they wanted answered for the April, 2006, meeting. The questions illustrate some of the typical questions people will ask, even when you think they have already been given sufficient information. Here are the questions that were asked, and NARM’s responses:

The Nebraska study commission on Direct-Entry Midwifery posed these questions to be answered by the respondents at the meeting on April 20, 2006

### **Questions pertinent to the review of the Direct Entry Midwifery Proposal are as follows:**

**1. Describe the education and training of Direct Entry Midwives, including the typical curriculum. What proportion of education and training programs for DEMs are didactic?**

The CPM is a competency-based credential. 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 learning modalities. The programs that NARM applicants complete for eligibility are varied in the proportion of didactic and clinical training. Our evaluation of learning strategies confirms that the best learning takes place when the didactic and clinical situations are merged, so that the student is able to apply what she is learning directly into a clinical situation. NARM requires that students demonstrate mastery of knowledge and skills, and we allow the learning environments to be tailored to the student.

**2. What educational requirements would be necessary to define a standard for determining whether or not those who claim to be DEMs are qualified to become licensed in Nebraska?**

The best standard to determine a DEM’s qualifications is to require the CPM certification. NARM’s standards have already met national standards for certification, the process is legally defensible, and the exams are used as licensure exams in all of the states that license DEMs to attend home births. The CPM is the “gold standard” for midwifery competency in a home birth setting.

**3. What percentage of deliveries is likely to be performed by licensed midwives if the DEM proposal were to become law?**

The percentage of home births will not likely change in a dramatic fashion. The mothers who have been choosing home birth will still choose home birth. The national average is about 1%. The change that licensure will bring is that the midwives who are attending the home births will have to demonstrate competency in order to be licensed, and the mothers who choose home births will be able to verify that their midwife has met some standards and is accountable to the state.

**4. What criteria would lay midwives have to satisfy in order to sit for the North American Registry of Midwives (NARM) exam? Under the terms of the proposal, who would make these kinds of decisions?**

The criteria for sitting for the NARM exam is already set. Students must have demonstrated knowledge, in clinical or didactic settings, for over 750 topics related to birth, must have demonstrated skills through a practical exam, and must have passed the NARM Written exam, an 8-hour multiple choice standardized test. They must also have performed competently at over 75 prenatal exams, 40 births (20 assisting, 20 as primary care provider), 20 newborn exams, and 40 postpartum exams, all done under the supervi-

sion and evaluation of a qualified preceptor. These clinical numbers are very similar to those required in the training of CNMs and Family Practitioners.

**5. How well do Direct Entry Midwives know the health care system? Are they able to make appropriate referrals?**

One of the most significant skills of a direct-entry midwife is risk assessment. Most of the knowledge and judgment that is evaluated in the NARM process is about risk assessment. The CPM must know how to nurture the normal process of birth, but must also recognize any and all signs of abnormality well before the mother or baby are at risk. Every CPM must have an emergency care plan for transport or referral, which is shared with the client. Every CPM must have an Informed Consent document that details her relationship with referral physicians.

**6. To what extent are Direct Entry Midwives trained to handle medical emergencies? Are they able to recognize when transport is necessary?**

Absolutely. See the answer above. Recognizing abnormalities well before they are posing a danger is a critical task of the CPM. Some doctors who oppose licensure of direct-entry midwives are responding from ignorance and fear. There is an unfounded fear that “tragedies” will be dumped on them at the hospital, and an ignorance about how midwives really do risk assessments and transports. Bringing midwives out from the underground and providing a legal avenue for practice and a system for accountability to the state will go a long way in dispelling unfounded fears about home birth transports.

**7. Discuss the extent of risk associated with home deliveries attended by DEMs. Would this risk be greater than when a home delivery is attended by a CNM, for example? How would these risks compare with a hospital delivery?**

Risks are not greater with DEMs than with CNMs. In fact, a CNM is not required to have any experience at all in home birth settings. The primary task for any home birth midwife, whether DEM or CNM, is risk assessment. Birth is a normal, natural, low risk condition that does not require medical intervention or hospital care. If a situation arises that is not in the realm of normal birth, then the midwife (whether DEM or CNM) must recognize the situation well before it is a crisis, and must transport or refer in a timely and precautionary manner. That is the area of expertise for all home birth care providers. NARM is seeing an increase in the number of CNMs who are seeking the CPM credential as evidence of their recognition of the value of the CPM core knowledge about home birth.

**8. How well prepared are DEMs to evaluate the extent of risk for an expectant mother inquiring about home delivery?**

The first visit with a new client usually takes between 1-2 hours; subsequent visits take 45 minutes to an hour. The midwife evaluates not only the medical condition of the woman’s pregnancy, but her emotional and nutritional needs as well. Lab work is done at the appropriate time during the pregnancy so that appropriate information can assist in the evaluation. A midwife’s care focuses on prevention, so that nutrition and health are optimized. The CPM understands normal pregnancy and birth. She is trained to recognize, but not diagnose or treat, any abnormality. She would refer to a physician for diagnosis and treatment.

**9. What states currently license DEMs? How well has this worked in those states pertinent to health and safety issues, for example? To what extent do DEMs receive third party reimbursement for their services in these states?**

The states that license DEMs, as of April, 2006, are listed below. The licensure programs are working extremely well in all of these states, and there has been no effort by any state licensing agency to terminate the program or to increase the state oversight of midwifery practice due to safety concerns. Third party reimbursement varies a great deal. Many, but not all, states approve licensed midwives for Medic-

aid reimbursement. Third party reimbursement by insurance companies is not regulated by the state, and payment for midwife services is dependant on the specific coverage held by the client.

**States that license DEMs to attend home births:**

- Alaska
- Arkansas
- Arizona
- California
- Colorado
- Delaware
- Florida
- Louisiana
- Minnesota
- Montana
- New Hampshire
- New Jersey
- New Mexico
- Oregon
- South Carolina
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- Wisconsin

All of these states use all or part of the CPM process as eligibility for a license.

NOTE: In 2007, Missouri passed a law providing for the legal practice of CPMs, and in 2008, Maine passed a law allowing CPMs to use specific medications without also providing licensure.

**10. What is the greatest challenge to the practice of a Direct Entry Midwife?**

Licensure and regulation. Without licensure, the DEM does not have a legal avenue to practice and might be charged with practicing medicine without a license. With licensure comes regulation, which in its worst form does not always recognize the Midwifery Model of Care.

**11. Describe or classify the typical prospective mother who chooses a DEM to attend the delivery of her baby.**

There is no “typical” mother. Home birth clients cover all variations in educational level, socio-economic status, income level, and reason for seeking midwife care. In the CPM 2000 Study of over 5000 mothers who birthed with a CPM in that year, compared to the national demographics of mothers delivering in a hospital, the home birth mothers tended to be slightly older, of a slightly lower socio-economic status, higher educational level, and less likely to be African American or Hispanic. Those demographics might not be representative of a specific state population, but were reflective of the nation as a whole.

### **13. What is the greatest risk to a newborn in a home delivery?**

In all studies of place of birth, the greatest risk to a newborn is to be born without the benefit of a qualified birth attendant.

In the CPM 2000 study, the few babies who died had congenital anomalies or died of SIDS. Others include abnormal presentations, cord accidents, and pregnancies over 42 weeks. These risks were no higher than for similar women who had hospital births.

### **14. What is shoulder dystocia and how do you determine its presence? How would a DEM handle the situation if a client had this condition?**

CPMs are trained in handling all potential complications, including shoulder dystocia. Shoulder dystocia is diagnosed if the baby's head delivers but the shoulders do not rotate and emerge soon after the head. Midwives are trained in multiple techniques for resolving shoulder dystocia, and it is not a common cause of fetal morbidity in home births. The advantages of addressing shoulder dystocia at home are that the mother is unmedicated, is able to move into alternate positions to expand the pelvic outlet, and is accustomed to responding immediately to the instructions of the midwife. The midwife is trained in techniques for repositioning or rotating the shoulders, extracting the posterior arm, applying supra-pubic pressure, and in varying the mother's position to include exaggerated lithotomy, hands and knees, and squats or lunges, most of which are impossible to apply if a mother is medicated or restrained in bed.

### **Other aspects of lobbying:**

A legislator will support your bill only if s/he is convinced that:

- It is in the best interest of the people of your state, and
- S/he will get more votes by supporting this bill than by opposing it

That means that they must hear from more people than just the midwives and the home birth families. They must hear from lots of their own constituents. They WILL hear from the medical lobby, and they know there are lots of medical people in their districts. You must get a large base of support from people who are willing to write letters and make phone calls or visits to their legislator and who will support you because they believe that mothers who are choosing home birth should have a qualified birth attendant with them.

### **Seek support from:**

- Friends
- Neighbors
- Relatives
- People you know from church or community groups
- Breastfeeding supporters
- Childbirth educators
- Alternative Healthcare Practitioners (chiropractors, massage therapists, naturopaths, etc)
- Women's Groups (being careful not to co-mingle red flag topics)
- Friendly Healthcare Providers (nurse-midwives, nurses, doctors)

# Facts About the CPM

## Have your facts straight about the CPM credential.

- If you are not sure about something, call NARM to discuss it.
- CPM means “Certified Professional Midwife”.
- The CPM credential is issued by the North American Registry of Midwives (NARM).
- The CPM credential has received accreditation by the National Commission on Certifying Agencies (NCCA), the certifying arm of the National Organization for Competency Assurance.
- CPMs are not untrained or lay midwives. The training of CPMs is competency-based education, which means that NARM documents the attainment of knowledge and skills necessary for competent practice. CPMs receive their education through schools, study groups, and one-on-one training with a qualified instructor or preceptor. All routes of education must verify the same knowledge and skills. CPMs must document competent performance of over 750 individual skills, must complete a clinical preceptorship that is at least one year in duration and equivalent to 1350 clinical hours under supervision. They must pass a hands-on Skills Assessment and an 8-hour written examination.
- NARM requires continuing education every three years for recertification.
- NARM has an accountability process to address complaints about a CPM.
- All 24 states that provide a legal mechanism for direct-entry midwives to attend births out of the hospital setting use all or part of the CPM process for licensure. All 24 states require passing the NARM exam for legal practice.
- The knowledge and skills required for attainment of the CPM credential were determined by a Job Analysis performed in 1995, 2001, and 2008 with hundreds of direct-entry midwives across the country.
- Direct-entry means that entry into the profession was attained through midwifery education and not through medical or nursing schools.

## Giving Interviews to the press

Getting your issues covered by the press is usually helpful when lobbying. You may draw in other supporters, and also educate the public about midwifery and home birth. Legislators are very aware of issues that are getting press, and they like to be associated with bills that are getting good press. After all, they are elected by the public and they like to be seen doing good works.

Try to get some media coverage when your bill is being debated. Send press releases to the newspapers in both the capitol city and also in the hometowns of the legislators (especially the legislators who are sponsoring your bill). You can cover more information in a newspaper article than in a television interview, but television reaches more people and allows personalities to shine through.

Find out WHO to send the press release to and talk to them briefly before sending it. A fax is more timely than mail. Call again after the fax has been sent to confirm receipt and answer questions.

These are some suggestions for giving an interview that were shared at a Lobbying Conference by M&R Strategic Services in Washington, DC:

1. You are NEVER off the record. Don't say anything you wouldn't mind being attributed to you in the newspaper the next day. Don't criticize hospitals or doctors.
2. When you are on camera or on the air, assume the tape is rolling at all times.
3. Make your key points early in the interview; your spot may only last a few minutes.
4. Develop the knack for answering questions conclusion first, in short, sound-bite fashion; then elaborate as appropriate for the time and medium.
5. Learn the reporter's name and use it in your response. "You know, Walt, we support that...."
6. Never say "No Comment" or "I can't comment on that." If you don't know, say you don't know but you will find out. Or say "I don't know, but I can assure your viewers (readers) that...."
7. Correct any error immediately, but avoid interrupting the interviewer. "Before I answer that, Katie, let me clarify something you said....Now, you asked...."
8. If you are representing an organization, never speculate, play "what if's" or be led into personal opinions. Readers or viewers seldom distinguish between your personal opinion and that of the organization you represent. "It would be totally inappropriate for me to speculate..." "Let's not venture into the hypothetical..." "What we know is...."

## Online Articles and Blogs

A lot of people, including legislators and reporters, now receive their information from the internet. This can be a useful tool for responding to and providing information.

Most newspapers now have online formats. These include all articles in the print version, and sometimes additional articles about newsworthy topics. Many also include a format for online responses from readers, and a counter to record how many readers “recommend” this article. The number of “hits” an article receives online can determine the newspaper’s continued interest in the issue. Use your e-group to forward the link for any local article to your state supporters (and to the Big Push list). Urge readers to write comments and to click on the “recommend” button if there is one.

Since not everyone reads news online, also send letters to the editor for the print edition of the newspaper. These letters, if chosen for the print version, usually also appear in the online version.

Take note of the reporter who is writing the newspaper articles about midwives or home birth. You may want to designate a particularly articulate and quick responding person to be the media contact who keeps track of which reporters are writing about your issue, and develop a personal relationship with them. At the least, send an e-mail or make a phone call to the author to thank them for the article. Don’t criticize any errors, but provide some follow up information if you think they need to know more about the topic. Urge them to contact your media person if they want information for a future article. Identify the reporters who are best to send press releases to about your issue.

Do some research to determine if there are online political sites in your state. Legislators often read these, or assign their aides to keep up with what is current on them. For example, the Wisconsin legislature has its online media web site ([www.thewheelerreport.com](http://www.thewheelerreport.com)) for news about current legislative issues, and there is another website ([www.wispolitics.com](http://www.wispolitics.com)) for ongoing political news and commentary. Find out if there are similar sites in your state. You can send press releases through these outlets, too.

The legislature may also have an internal system for one-page notices or flyers that are sent directly to the legislators from a press room. Find out if your state does this, and how to tap into it.

Another avenue for disseminating information is through political blogs. Katie Prown, of the Big Push, says this: “Most states have bloggers who focus exclusively on state politics, and many of them consider themselves grassroots activists whose job it is to call attention to under-reported issues or to under-reported angles on issues that are in play at the Capitol. The other benefit to blogs is that your supporters can usually send comments that will be posted without having to be approved by an editor, as is the case for newspapers. Here in WI we’ve recruited highly-read bloggers to offer “exclusives” about legislation we’ve been working on, and they appreciate the increased traffic to their site that always results whenever we direct our grassroots supporters to a post about our issues.”

# Keys to the Art of Persuasion

by Susan Hodges

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The main points in the following article are derived primarily from *The Essence of Political Persuasion*, a three-tape audio program by Michael Cloud, distributed by Advocates for Self Government, a Libertarian organization [www.self-gov.org](http://www.self-gov.org). You can order the tape set in a limited time offer of their project "Operation Persuasion" for only \$5.00 by calling toll-free 1 (800) 932-1776 or by sending \$5 to: Advocates for Self-Government 1202 North Tennessee St., Suite 202, Cartersville, GA 30120. NOTE: At this low price, only one set per address, please. Allow 3-4 weeks for delivery. Shipping costs will be added to foreign orders.

## Introduction

Most Americans are convinced that all women should give birth in the hospital and that childbirth is very dangerous without all the interventions of modern techno-medicine. If we are going to ensure that the Midwives Model of Care and natural childbirth will be widely available in the next millennium, our challenge is to persuade an awful lot of people to think and believe and behave differently about birth and "maternity care."

Since most people won't read printed material that challenges their current knowledge or beliefs on any topic, effective oral communication with individuals and groups is essential. Speaking has advantages: while an article or book is static and written for a predetermined audience, oral communication can be customized for the listener as you go. Oral communication does not replace reading, of course, but persuasive speaking may be the best way to get someone to finally read one of those fliers or articles. And in the political arena, brief oral communication may be your primary means of persuading legislators about your cause.

Good communicating involves the clear and intelligent presentation of ideas, but that is rarely enough to change someone's mind. Persuasion, on the other hand, means getting the other person to change their thinking and accept your idea.

## The Most Basic Elements of Successful Persuasion

### 1. Know the outcome you want

Effective persuaders have a strong sense of purpose. They know just what they want to accomplish (which might be as simple as getting someone to read an article or go to a meeting); they state or think about the desired long-term result in positive terms (they are FOR the Midwives Model of Care, rather than anti-doctor); and they focus on goals that can be realistically accomplished. They identify specific ways in which they will know if they have been successful.

### 2. Refine your sensory awareness to know when you are getting the desired response

An obstacle to effective persuading is our tendency to stay inside our own heads, to make assumptions instead of using our senses to check and verify what is actually happening. As many of us have discovered in childbirth and midwifery, being in the present, in our senses, is mind-altering and empowering; we can lean that this is just as true for the art of persuasion.

If you know the response you seek, then you can analyze if what you are doing is effective. If your approach is not getting the results you want, doing the same thing harder, longer, or louder generally won't get the results you want. You analyze by using your senses to notice how the other person is behaving, what they are doing, how they sound and how they look.

### **3. Be flexible in your method, be able to try many behaviors or methods**

Cloud says, “If you always do what you’ve always done, you’ll always get what you’ve always gotten.” And, “If what you are doing isn’t working, change YOUR behavior!” Doesn’t this sound like working with labor or working with toddlers? If labor has slowed down, you change your activity. If your two-year-old is going bonkers, it is up to you to change the activity and the energy, and you try different tactics till you find the one that works, that results in your toddler being calmer.

As an effective persuader you realize that the meaning of your communication is actually the response you get, and you generate and utilize alternatives in your conversation or presentation as soon as you see that what you were doing is not working. As Cloud points out, there are no stubborn audiences, only incompetent speakers, no closed-minded audiences, only speakers who fail to be resourceful, no resistant people, only inflexible communicators. As he puts it, “You are the variable that controls the equation in the math of life.”

Don’t limit yourself! Limit your options and you lose your edge. For example, you might justify your behavior or tactic because it is “right,” or have a list of things you won’t do based on “principles.” For instance, deciding never to discuss midwifery in terms of choice because choice is associated with abortion, which you oppose, eliminates a persuasive option likely to be especially effective with some audiences. In contrast, the greater the variety of your repertoire, the more choices of action you have and the more ability you have to influence any encounter. Isn’t this true of working with someone in labor, too? And for most other areas of endeavor? So, seek to have a multitude of strategies - look for them, learn them, use them. When you find one is not working, you’ll have others to try.

You will meet people you can’t persuade. Then ask yourself: what did I try? What else did I try? What didn’t I try? What else didn’t I try? This will help you develop your awareness and your repertoire.

## **Essential Skills and Useful Tactics**

Accomplishing persuasion requires more than just the three key elements described above. The following points are essential skills and techniques that will help you be effective with people who are neutral or negative regarding the midwifery issue at hand.

### **1. Build Rapport**

Rapport with your listener is very important, and good speakers do things to get in sync with their audience whether one or many. Rapport means getting into alignment or getting in step with the other person’s reality, meeting them in their place instead of expecting them to meet you in yours. Most of us do some of this all the time with friends and family, but you may have to do it more consciously with someone you want to persuade:

Mirror the other person’s posture and non-verbal behavior - sit how they are sitting, if they lean across the table, you lean across the table, etc. (This includes clothing! Dress similarly to or appropriately for the people you’ll be talking with.)

- Mirror facial expressions - when they smile, you smile back, etc.
- Pace yourself to the other person’s tempo - walk at their speed, talk at their rhythm, etc.
- Match the volume at which they are speaking.

All of this mirroring and matching lets you present yourself non-verbally as a person that resembles your listener; it validates them and helps to establish trust and credibility. Mirroring non-verbal behavior leads to synchrony and often lets you experience the world a little like the other person does. Once you are “in sync” you can lead the other person where you want to them to go. Mirror, pace, match, etc., then lead, and if they don’t follow, go back to more mirroring.

## **2. Ask Questions and Use Reflective Listening**

Another way to build rapport is to sincerely ask questions to elicit the listener's point of view on the subject. Use reflective listening techniques (such as "If I understand you correctly, you are saying that...."), clarifying questions (such as, "Can you explain a little more what you mean by..." or "I'm wondering how you arrived at that conclusion, could you tell me more about what happened?"), and informational questions (such as "I'd like to understand more about your concerns on this issue" or "You mentioned ..., can you tell me some more?"). Everyone likes to be heard and taken seriously. Your listener will feel important, validated and respected and some of that will rub off - the listener in turn will see you as a good person (because you listened to them). The trick is to listen and draw the other person out, without stating your disagreements, opposing position or counter-arguments! You will at the very least learn valuable information about what is important to this individual which you can use in your persuasive efforts, you will have control of the conversation because you are asking the questions, and in the end, the listener usually feels so good about you that they will be willing to hear a little about your point of view on the issue.

## **3. Get to the real issue**

In debates, issues are brought up and responded to, one after another, but no one changes their views. This can happen in individual conversations, too, often because the issue that is truly of concern to the listener is not being addressed (the listener may not even be quite aware of what is really important to them....). Both the content of your remarks and how you are addressing the issues may be the problem. Don't assume you know how your listener thinks! In addition to establishing rapport, here are some steps you can take:

### **Isolate the issue**

State your familiarity (or lack of it) with the situation your listener brings up, such as, that they oppose out-of-hospital birth because it is too dangerous. You can ask your listener something like, "If we looked at the evidence and found the situation was actually NOT as you described, that is, the statistics showed that home birth is NOT dangerous, etc., would you be convinced to change your position on this?" If they answer no, then you can say, "It seems there is something else more important that is of concern to you - can you tell me about that?" and prompt the person to explain (perhaps stemming from a personal experience etc.). After addressing that real issue, you can go on and ask, "In addition to that is there anything else that concerns you?" and then deal with that. This is much more effective than going round and round on "obvious" issues, which aren't really important to that person and won't change their thinking.

### **Identify the criteria for acceptable evidence - the "onus of criteria" principle**

You can ask your listener what they would accept as convincing evidence that your hypothesis or position is valid, and you can ask "what if" questions with hypothetical ideas to help them recognize their criteria. For example, ask "What if you saw..... would that convince you?" or "What if you became convinced that ...?" In other words, generate hypothetical criteria for people to help them realize what their criteria are. Sometimes you will be asking a person to spell this out for the first time, and it can be very enlightening and useful for the listener. Obviously, if there is no criteria for acceptable evidence, the listener is operating on belief, not rational thought about the issue.

### **Use the "falsifiability principle"**

This is similar to the criteria principle above. Ask what demonstration, facts, etc. would convince the listener that their hypothesis (for example, hospitals are the safest place to have a baby) is false or wrong? If a theory cannot be falsified, it cannot be verified either. In that case, it is not a theory but a belief. Since people generally do not know what would convince them, you can ask "what if" and "suppose" questions. For example, "Suppose evidence showed that all women in childbirth did better with a midwife rather than with an OB? Would that convince you that not all women need an OB for childbirth?"

### Use “Mind-Altering” questions

For effective persuasion, you will benefit from spending time looking at HOW people think - the processes, patterns they use. Do not presume that you know how your listener thinks! You can ask questions! However, avoid asking “why” questions; as these lead to justifications, rationalizations, generalizations and denials and do not help you accomplish your purpose. The best questions begin with how, what, when and where.

Here are some examples of the kinds of questions you can ask:

- Specifically, how do you know when an idea is worth considering?
- What information would allow you to know that you had made an error?
- What would get you interested in a new idea?
- Specifically, what are you unsure of in this discussion?
- When would you know if my evidence were valid?
- What would motivate you to get more information?
- How do you know when you are open-minded on an issue?
- Was there ever a time when you did not have this belief?
- What would let you know that you are convinced?
- How do you know when an argument persuades you?
- Have you ever changed your mind on an important issue?
- How did you go about it?
- What would you need to change your mind on this issue?
- Etc.

One of our biggest errors is to assume that the listener thinks the same way we do. Ask questions to find out. Then you can know exactly what you need to do to change this person’s mind.

#### 4. Use language to your advantage

If the law of the jungle is kill or be killed, Cloud says the law of politics is “define or be defined.” Words are both weapons and tools.

History includes many examples of the power of names and words, and currently enormous sums are spent on developing product names and advertising slogans, because word choices greatly influence peoples’ perceptions of products (and people, causes, etc.) and their actions. Words can have powerful connotations, so it is important to be aware and choose names and words that generate positive responses to your cause. The Coalition for Improving Maternity Services, and the Mother Friendly Childbirth Initiative are inspired phrases. Who can be against these? If you are against either one, you must be in favor of making maternity services worse or supporting mother-hostile childbirth! No one would want to be associated with those positions. Use names or words that make it awkward or ridiculous for someone to be in opposition.

#### Find out what your terms really MEAN to others

What are connotations that go with “lay midwife,” “traditional midwife,” “birth attendant,” “certified professional midwife,” “licensed midwife??” What about “home birth” vs. “out-of-hospital birth?” You’ll probably want to choose your terms carefully depending on the background, point of view, and the connotations those terms are likely to have for your listener or audience, rather than the term you like the best for yourself. Let’s look at “Midwives Model of Care.” Because it has similar words and structure to “medical model of care,” the kind of terminology familiar to health care professionals and officials, the term gives midwifery care equal stature and suggests that midwifery is good care in its own right, NOT the absence of medical care, while avoiding words with negative connotations. The key is to find out what the terms you use actually mean to your listeners and audiences.

### **Avoid terms with negative connotations.**

You want to avoid having words or phrases with negative connotations applied to your cause. Here is a strategy to use when someone else uses biased or negative language to describe your position.

- “Unpack” the connotations of the unflattering term used; in other words, describe the negative meanings the term usually implies (but don’t agree that yes, maybe you could think of your cause in that way because of the history or less common definitions of the word - its negative connotations will still stick to you, and that is what you want to avoid.).
- Critique these connotations (briefly explain how they don’t apply to you).
- Define your position with more accurate terms.
- Identify and point out two or three positive implications for outcomes of your position.

For example, someone says that your position supporting midwifery and home birth is just too radical. You could say something like, “Radical usually means extreme or off the wall, even irresponsible, radical at all costs, and that does not describe us. We don’t support extreme or irresponsible practices. We support using proven, evidence-based practices that have been shown to be effective for having healthy mothers and babies. Midwifery care leads to shorter labors with fewer drugs and interventions - safe and healthy for Mom and for Baby!”

### **5. Use “political cross dressing” to reach groups with different perspectives**

We all know that midwives and midwifery advocates include people from the entire political and demographic spectra and many special interest groups. We can use the “political cross dressing” technique to reach many different kinds of people. For midwifery, this really means recognizing the important concerns of each political/philosophical group, and showing how midwifery meets their concerns. For example, for the environmentalists’ midwifery care, especially at home, is “green” - it is “natural,” saves resources and is gentle to life and the earth. For the religious person the midwifery model is family centered, respects birth and the Creator’s plan, and may be compatible with specific religious laws or teachings. For the feminist, the midwifery model is about choice and empowerment. For the capitalist, this approach supports free enterprise. For medical and public health professionals (and many others) the Midwives Model of Care is about proven, evidence-based care for healthy mothers and babies. Etc.

If you want to persuade people with different political and philosophical outlooks, you need to gather some information first:

- “Know their “language” - the key words and phrases used by that group or philosophy, as well as their emotional key words and the basic evidence, arguments and beliefs that support their positions.
- Know the concerns (hopes, fears, wants and needs) that motivate the group and individuals who join it, and what they want to accomplish.
- Show how the Midwives Model of Care addresses their concerns and is part of the solution.

Michael Cloud’s tapes also include some more advanced techniques, which require practice and quick thinking, and are not applicable to all situations. These involve being able to use opposing arguments to make your own points persuasively - the martial arts of persuasion.

Think through these points. Try them out and practice with a friend. Use some of them and analyze the results - you’ll become effective at persuasion!

# Drafting Your Bill

(with input from Susan Hodges and Pam Maurath)

As mentioned earlier, you should review laws in several other states (especially the more recently passed laws), review laws in your state that license other professions, and review any laws that mention midwives, whether direct-entry or nurse-midwives. Start with a basic outline of what you want in the bill, and look at other language that deals with the same issues. Set aside some language for things you don't want in the bill but might have to discuss adding later if passage hinges on that issue. Don't worry about format at first. Once you get a good draft and a sponsor, you will probably take the bill to the in-house attorneys who craft legislation for the legislature. Their job is to see that your bill conforms to the standard bill rules and formulation. They also must identify any other laws that will be affected by your law, and see that appropriate language is recorded there.

## Overview of a bill:

A regulatory bill has to include sections that address the following:

- Who is being regulated (licensed midwives)
- What is being regulated (practice of midwifery).
- Who has the regulator authority (Board? Dept.? .).
- Eligibility requirements (certification)
- Title protection (usually).
- Regulation: what the Rules and Regulations (created by the regulating authority) will and will not cover.
- The structure and functions of the regulating authority (who, how many, how chosen, compensation, etc. Also, this might include a Midwifery Advisory Board that advises another, already established government Board that actually has the final regulatory authority, depending on your state).
- Responsibilities (reports, issuing licenses, discipline, etc.).
- Any additional issues (disclosure requirements, immunity of other care providers, etc.).
- Penalty for practicing without a license (required by most states, usually a criminal penalty such as misdemeanor or felony). If you can leave this out, there will be more protection for those who remain unlicensed.

Look at other regulatory statutes in your state to get a feeling for the way these sections are usually laid out. Often there is a set format for the different sections, including their order, though that is not always that important. However, you will find that the items in the above list are addressed in the different sections.

A really important point to keep in mind is that the language of the statute sets the parameters for the rules & regulations. The statute authorizes some body (for example a Board) to make any needed rules to carry out the purpose of the statute, but those rules cannot exceed what is mandated by the statute. So, be sure that your bill frames the authority of the regulating entity so that it cannot make rules and regulations that would seriously restrict midwifery practice or make it impossible. One good method is to state that the rules and regs will be consistent with the essential documents, or standards of practice, of the National Association of Certified Professional Midwives. This will really help keep the regs from requiring physician assessments, or from dis-allowing the client to make her own choices regarding her care.

There may be some discussion about making your bill “voluntary”. In other words, the bill affects only licensed midwives and not unlicensed midwives. This is only possible if your bill only lists penalties for claiming to be licensed when you are not, rather than penalties for practicing without a license. This is a long shot, but it has worked in Oregon and Utah. This will really help appease the midwives who don’t want to be licensed. However, most legislatures want to protect the public with a licensure law, and they don’t think allowing the unlicensed practice will protect the public.

If at all possible, leave out any reference to malpractice insurance. If it has to be in there, just say that it will be addressed in the rules and regs. It’s also good to say that medications will be addressed in the rules and regs; that way the legislature doesn’t get to debate what medications you will or will not be allowed to use. However, if you can get approval for specific meds in the law, then your regs will have to allow them.

Be especially careful in referring to the Certified Professional Midwife credential in your law. The CPM is very good for establishing eligibility for licensure, but the CPM does not regulate the practice of midwives, and the state cannot regulate the practice of CPMs. They can, however, regulate the practice of licensed midwives who happen to be CPMs. The CPM should be mentioned in the section establishing eligibility for licensure. Further references should be to Licensed Midwives, indicating that the law applies to CPMs who have received a license.

Even seemingly inconsequential words can have a major impact on the implementation of the law. It is very important to get feedback from others who have worked on midwifery legislation through every step of the way. The joint boards of NARM, MANA, and CfM have a legislative list-serve to review proposed legislation, and offer a conference call between those who have experience advising on midwifery legislation and the midwives and consumers in the state who are working on legislation. To schedule a time for a conference call, call Debbie Pulley at 1-888-842-4784.

You should be aware of which parts of your bill are absolutely essential to the compromise of getting licensed, and which parts you could live without if that were the only way to get the bill passed.

For example, could you live with a bill that required that all midwife clients be evaluated by a physician, or would you kill the bill over that criteria even if that meant staying unlicensed and trying again next year? Or could you live with a compromise that required all clients with specific risk factors to be seen by a physician?

What about medications? Could you live with a bill that did not allow the use of any medications? What about oxygen? Could you compromise with a bill that allowed medications only with the approval of a supervising physician? Some states have successfully gained the ability to carry and administer medications only after the licensed midwife has taken a one-day, state approved course on those medications.

What about malpractice insurance? If a bill requires malpractice, but no one can get it, what does the bill accomplish? What if it becomes available but at a price that only high-volume practitioners can afford, thus driving out the small practice midwife? Requiring malpractice insurance will most likely keep your bill from being implemented, even if it passes. Keep this out.

What about insurance or Medicaid reimbursement? Can you get a bill passed that mandates insurance companies and/or Medicaid to cover a midwife’s services? It is very unlikely to get that coverage without licensure, but even with licensure it may be difficult to get covered unless it is included in the bill. A drawback is that any bill with that kind of language also has to pass through the insurance committee, which increases the opposition to your bill. You might want to take that out in order to get the bill passed, and then get a supplemental bill passed the next year to add it in, thus not multiplying your opponents to the original bill.

You can draft sections that you DON'T want in the bill and keep them aside to offer only if it seems to be the critical element of passage. That way you get to have your wording instead of having the amendment created by the legislative committee as you stand by watching helplessly.

Another good solution is for the law to list issues that will be addressed in your rules and regulations. The legislators are happy that their pet issue will be addressed. Simply using the word "addressed" means that the item may or may not be required as long as it is mentioned. For example, malpractice or physician back-up. Rather than requiring malpractice insurance or physician back-up, your rules can require that your informed consent state whether or not you have malpractice insurance or physician back-up.

Here are some samples of language that addresses specific issues. You can put them into your draft, or hold them out in case the issue comes up and you want to consider adding them to get more support.

# Immunity from Liability:

## From Virginia

Licensed midwives shall be liable for their acts or omissions in the performance of the services that they provide, but no physician, nurse, pre-hospital emergency medical personnel, or health care institution shall be liable for any act or omission resulting from the administration of services by any licensed midwife. A physician, nurse, pre-hospital emergency person, or health care institution shall not be deemed to have established a business relationship solely by providing consultation to or accepting referral from the midwife.

## From Utah:

58-77-602. Immunity and liability.

- (1) If a Direct-entry midwife seeks to consult with, refer, or transfer a client to a licensed health care provider or facility, the responsibility of the provider or facility for the client does not begin until the client is physically within the care of the provider or facility.
- (2) A licensed health care provider who examines a Direct-entry midwife's client is only liable for the actual examination and cannot be held accountable for the client's decision to pursue an out-of-hospital birth or the services of a Direct-entry midwife.
- (3) (a) A licensed health care provider may, upon receiving a briefing data from a Direct-entry midwife, issue a medical order for the Direct-entry midwife's client, without that client being an explicit patient of the provider.
  - (b) Regardless of the advice given or order issued, the responsibility and liability for caring for the client is that of the Direct-entry midwife.
  - (c) The provider giving the order is responsible and liable only for the appropriateness of the order given the data received.
  - (d) The issuing of an order for a Direct-entry midwife's client does not constitute a delegation of duties from the other provider to the Direct-entry midwife.
- (4) A licensed health care provider may not be held civilly liable for rendering emergency medical services that arise from prohibited conduct in Section 57-77-603 , or from care rendered under a waiver as specified in Subsection 58-77-601 (3)(b), unless the emergency medical services constitute gross negligence or reckless disregard for the client.
- (5) A licensed Direct-entry midwife shall be solely responsible for the use of medications under this chapter.

## Malpractice insurance, from Colorado:

“At such time as the director finds that liability insurance is available at an affordable price, the direct-entry midwife shall be required to carry such insurance.”

Insurance and Medicaid coverage, draft from New Hampshire in 2005. Did not pass but is a good example.

Coverage for Certified Midwives. Each insurer that issues or renews any individual policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide to certificate holders of such insurance, who are residents of this state, coverage for expenses arising from the services of midwives certified under RSA 326-D. The benefits included in this section shall not be subject to any greater deductible than any other benefits provided by the insurer. The coinsurance required by the enrolled participant shall not exceed the amount allowed under the contract for the reasonable and customary charge for the service provided. Notwithstanding any provision of law or rule to the contrary, the coverage under this section shall apply to the medical assistance program, pursuant to RSA 161 and RSA 167.

# Medications

There is a difference in prescriptive privileges and permission to obtain and administer medications. It is very difficult to get prescriptive privileges because they are so broad, and they would allow the midwife to write a prescription for the mother to fill. It is possible to get permission to obtain and administer specific medications so that the midwife can get medications from a pharmacy and administer them to the mother according to protocols set in the regulations. If there is enough support for allowing the use of specific medications, then it should be added. Several states require the midwife to take a specific board-approved course in the use of the specific medications allowed in the bill. A one-day course is not unreasonable, and may help gain that component in your bill.

## Sample wording from the Arizona bill:

Authority to purchase and administer certain legend drugs and devices.

- (1) A midwife licensed under ORS 687.405 to 687.495 may purchase and administer authorized scheduled legend drugs and devices that are used in pregnancy, birth, postpartum care, newborn care or resuscitation and that are deemed integral to providing safe care to the public by the State Board of Direct Entry Midwifery by rule.
- (2) Legend drugs authorized under subsection (1) of this section are limited:
  - (a) For neonatal use to prophylactic ophthalmic medications, vitamin K and oxygen; and
  - (b) For maternal use to postpartum antihemorrhagics, Rho(D) immune globulin, epinephrine, intravenous fluids, local anesthetic and oxygen.
- (3) Legend devices authorized under subsection (1) of this section are limited to devices for injection of medications, for the administration of intravenous fluids, for adult and infant resuscitation and for rupturing the amniotic membranes.
- (4) A pharmacist who dispenses drugs and devices to a licensed midwife as authorized by this section and in conformity with the provisions of ORS chapter 689 is not liable for any adverse reactions caused by administration of the legend drugs and devices by the midwife. [2001 c.462 §2]

## Utah:

- (f) obtaining medications, as specified in this Subsection (7)(f), to administer to clients, including:
  - (i) prescription vitamins;
  - (ii) Rho D immunoglobulin;
  - (iii) sterile water;
  - (iv) one dose of intramuscular oxytocin after the delivery of the placenta to minimize blood loss;
  - (v) one dose of intramuscular oxytocin if a hemorrhage occurs, in which case the licensed Direct-entry midwife must either consult immediately with a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, and initiate transfer, if requested, or if the client's condition does not immediately improve, initiate transfer and notify the local hospital;
  - (vi) oxygen;
  - (vii) local anesthetics without epinephrine used in accordance with Subsection (7)(l);
  - (viii) vitamin K to prevent hemorrhagic disease of the newborn;

- (ix) eye prophylaxis to prevent ophthalmia neonatorum as required by law; and
- (x) any other medication approved by a licensed health care provider with authority to prescribe that medication;

**Wording from the proposed Idaho bill:**

- (1) The rules adopted by the board must:
  - (a) allow a midwife to obtain and administer, during the practice of midwifery, oxygen, oxytocin as a postpartum anti-hemorrhagic agent, injectible local anesthetic for the repair of lacerations that are no more extensive than second degree, antibiotics for group b streptococcus prophylaxis consistent with guidelines of the United States centers for disease control and prevention (CDC), epinephrine administered via a metered dose auto-injector, intravenous fluids for stabilization of the woman, Rho(D)Immune Globulin, vitamin K and eye prophylactics to the baby;
  - (b) allow the use of no other legend drugs except those of a similar nature and character as determined by the board to be consistent with the practice of midwifery provided that at least ninety (90) 120 days advance notice of the proposal to allow the use of such drugs is given to the board of pharmacy and the board of medicine and neither board objects to the addition of such drugs to the midwifery formulary;
  - (c) define a protocol for use by licensed midwives of drugs approved by (a) and (b) above which shall include methods of obtaining, storage and disposal of such drugs and indication for use, dosage, route of administration, and duration of treatment;

# Education

Education is always a big issue with legislators, and the apprenticeship education of the direct-entry midwife is a stumbling block for many of them.

There are many explanatory statements about the education of the CPM elsewhere in this booklet (See Facts about the CPM, and the handout section). There ARE educational requirements for the CPM, but there are several routes to getting that education. The term “apprenticeship” is generally avoided in favor of descriptions such as “one-on-one preceptorship,” “competency-based education,” and “adult models of education.”

There is a curriculum for the competency based educational program. The 750 topics in the Knowledge and Skills Checklist are the curriculum for the CPM in training. These topics may be covered in both a didactic and clinical setting, but all must be verified by the instructor/preceptor. The application of the required knowledge and skills must also be evaluated in the clinical setting as the student moves from assisting the supervising midwife to being able to perform all aspects of care as a primary midwife. The knowledge is again verified by the NARM Skills Assessment and the NARM Written Examination.

The competency-based education of the CPM has been accepted as sufficient training for a practicing midwife by 20 of the 24 states that recognize direct-entry midwives to attend births in out-of-hospital settings. Four states require additional formal educational programs. There is no evidence that the additional educational programs result in better outcomes for mothers or babies. NARM supports legislation that recognizes the CPM as the standard for training for direct-entry midwives. However, it is an option for those who cannot get licensure any other way to add formal education to their licensure requirements.

Additional education may be added in several ways:

- 1) Approved courses specific to the scope of practice allowed in the licensure law, such as pharmacology for midwives (if the law allows the use of medications), or well-woman care (if the law allows care beyond the childbearing year)
- 2) Specific midwifery education, such as graduation from a MEAC-accredited educational program. Many MEAC-accredited schools offer distance programs, covering the same requirements as NARM but with frequent evaluation of written work; costs range from around \$5,000 for coursework supplementing the CPM to \$30,000 for full programs.
- 3) Additional higher education such as college degrees or coursework, or credit hours in health related fields

Another option is to list the curriculum of the CPM PEP so that the coursework required for the CPM is more visible to the legislators. This may be done as a handout, and has been added to some proposed laws for clarity. If added to the law, the language should be general enough to cover basic topics.

In 2007, the Illinois midwives proposed additional language to their draft bill listing all of the topics in the NARM knowledge and skills outline, so that the educational requirements of the CPM were clearer to the legislators. The downside is that this list from NARM may change over the years, and the law is stagnant. It is perhaps better to provide this information in a handout than to put it in the law, but it could be useful to cover some basic topics that will be part of the required education. For example, your bill could state that the education of the licensed midwife must include the procurement of knowledge and proficiency in each of the following:

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

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

**Prenatal and intrapartal care, including routine prenatal examinations and risk assessment for:**

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

**Appropriate evaluation of laboratory records, including:**

- CBC
- Hematocrit/hemoglobin
- Blood glucose
- HIV
- Hepatitis
- Rubella screen
- Group B Strep
- VDRL
- Blood type and Rh

- Antibody screen
- Chlamydia
- PAP smear
- Urine culture and analysis

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

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

**Pharmacology:**

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

**Appropriate use and care of equipment, including:**

- Ambu bag and mask
- Medical oxygen tanks
- Suction devices: bulb syringe and DeLee
- Sterilization of birth instruments: hemostats, scissors, and cord clamps
- Lancets
- Suturing equipment
- Urinary catheter
- Ultrasonic Doppler and fetoscope
- Lab equipment: venepuncture supplies and vacuum collection tubes
- Blood pressure cuff
- Stethoscope

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

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

**Daily and weekly assessment of mother and newborn, including:**

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

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

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

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

**See Appendix III for more information about drafting bills.**

# Non-Profit Organizations

If your association of midwives and/or consumers is going to do much fund raising, then you should consider becoming a non-profit organization. There are some strict rules for lobbying for non-profit organizations, so if you are forming just for the purpose of seeking legislation, it may not be worth it to obtain non-profit status. However, if you intend to have an on-going organization to promote education about childbirth options, then you might start by getting non-profit status. The benefit of non-profit status is that you do not have to pay taxes on any money that you raise – all the money can go toward your organization's goals. Depending on the type of non-profit status you acquire, donations to your organization may be tax-deductible to the giver as well.

The first step is to become incorporated as a non-profit by registering with your state, usually through the Attorney General's office. This makes you an organization but does NOT make you tax-exempt, and someone will have to use their social security number and/or taxpayer identification number to pay taxes on any income generated. You ARE allowed to make a profit. Non-profit does not mean that you can't make a profit, it means that a board directs the activities of the organization and is responsible for the finances. While non-profits can have employees and pay salaries, no one "pockets" the profits. Non-profits have by-laws and articles of incorporation that determine how they function and to whom they are responsible. To become tax-exempt (for not paying taxes and for having donations be tax deductible) you must file for tax exempt status with the IRS.

To file for non-profit status and to make your annual IRS reports, you should obtain advice and guidance from a lawyer and, eventually, an accountant. For purposes of consideration, here are some details of which you should be aware.

## Types of Non Profit Organizations

**501 C-3:** public and private non-profit organizations; income is tax exempt and contributions are tax deductible for the giver; grants can be received from private foundations. Lobbying activities are limited. See further info on lobbying.

**501- C- 4,5,6,7:** income is tax exempt but contributions are not tax deductible; lobbying activities are unlimited

**527s:** political organizations, can be a PAC fund connected to a 501 organization, tax exempt but not tax deductible; lobbying activities are rare and taxable but donations can be given to candidates.

The most beneficial non-profit status is 501 C-3, because your income is tax exempt and the donations you receive are tax deductible for the giver, and you are eligible for more grants. However, 501 C-3s have very strict rules for expenditures for lobbying. If you are a 501 C-3 and you are supporting an attempt to pass legislation, you must either spend very little time and money on lobbying (the default test) or you must make a 501 H declaration to the IRS and include detailed proof of your lobbying expenditures.

- 1) **The Default test:** lobbying must be an "insubstantial part" of the overall activities, but the definition of insubstantial is not clearly defined; if you do much lobbying it is a big risk and the penalties are severe. When determining whether the amount of your budget devoted to lobbying is "substantial", the IRS will compute the relative value of in-kind donations and volunteer time, not just paid expenses.
- 2) **The 501 H Expenditure Test:** this is an optional declaration that can be filed with the IRS which requires filing a separate form, but it has clear dollar-based limits, clear definitions of what is lobbying and what isn't, only needs to be filed once, and counts only expenditures rather than including volunteer time in the assessment of value. If you file this form and are found in violation, the penalties are

not as severe and you do not usually lose your tax exempt status. If your total yearly budget is under \$500,000, you can spend up to 20% of your budget on lobbying, but of that 20% only one-fourth can be for grass roots lobbying.

For example, if your total yearly budget is \$10,000, you could spend only \$2,000 on lobbying. Of that amount, \$500 could be for grass roots lobbying and \$1500 could be for direct lobbying. The other \$8,000 of your budget would have to be spent on non-lobbying activities of your organization. But, some of that \$8,000 can be spent on education that is not considered lobbying.

**NO 501 C organizations may make contributions to any political campaign**, so you cannot, for example, use organization money to contribute to the campaign of your primary sponsor when he or she next runs for re-election, nor can you spend money to tell your members to vote for a specific candidate for office. However, you can spend organization money to influence how a legislator votes on a specific issue through direct or grassroots lobbying.

### **Definitions of types of lobbying:**

**Direct Lobbying** is communication with a legislator expressing a view about specific legislation. Legislators include federal, state, and local congressional representatives AND their staff, and any governmental people who participate in the formulation of legislation, such as city council members, governors, mayors, etc. Communication includes phone calls and e-mails as well as in person visits and mailings. Also, if an issue is coming before the general public for a vote, such as a ballot initiative or constitutional amendment, the entire public is considered a “legislator” so any direct mail, etc, in support or against a specific measure is considered direct lobbying.

**Grassroots Lobbying** (on which you can spend ¼ of your total allowed lobbying budget) is any communication to the general public asking them to express a view about specific legislation to a legislator. In this definition, members of your own organization do not count as the general public, and information sent to them is direct, rather than grassroots, lobbying. Example: asking the members of your midwifery association to contact their legislators is direct lobbying; asking your members to urge their clients to contact the legislators is grassroots lobbying.

Amounts considered in assessing the percentage of your budget that is used for direct or grassroots lobbying do not include volunteer labor IF you file the 501 H test, but they do count if you are not filing the 501 H and are hoping that the IRS will consider your amounts insubstantial. As an example, if your group bakes cookies to deliver to legislators with a message in support of your bill, the insubstantial test would include an approximate value of the time each volunteer spent on the cookies, the cost of the ingredients used, and the time to deliver the cookies and speak with the legislators, even if the organization did not pay anything out of its budget for the project. If you have filed for the 501 H test, none of the volunteer cost or donated ingredients would count toward your lobbying budget.

Money spent on your own expenses when you are lobbying, such as travel or meals, does not count as a lobbying expense, but if you buy a meal for a legislator that purchase will count as lobbying.

You can also spend money that doesn't count as lobbying on education about midwifery or related issues as long as there is not a call to action. A call to action is asking your legislator to support a bill, or asking your public to contact their legislators about a bill. Education would be information about midwifery in general or the benefits of home birth, as long as you did not mention a bill (filed or unfiled) and as long as you did not ask the legislator to vote in support of licensing midwives.

Assuming that your midwifery organization has around 50 members and each pays \$25 dues, your organization income would be \$1250. This money might be spent on a newsletter to members and to rent a hall for quarterly meetings. Regardless of whether you incorporate or not, the IRS is not likely to pay any attention to your bank account or your tax status. If you incorporate, you are expected to file tax returns. As your bud-

get grows and/or your visibility grows, you could be taxed on your organizational income. If your organization gets tax exempt status, you do not have to pay taxes on the income.

Assume this organization wants to grow and do more with its money, maybe establish a consumer membership, buy and show videos to the public, establish a lending library for midwives, or any number of activities requiring a larger budget; or even expand in anticipation of needing to be well organized for work toward legislation. With 501 C3 status, clients can donate and take a deduction for their contributions. Local businesses can donate meeting space or food to your activities. If your yearly budget is under \$25,000, you don't even have to file yearly with the IRS (but you must keep good records). But, if you start legislative work, you must pay attention to the amount you spend on lobbying efforts. If you don't file for tax exempt status, you don't have to worry about how much you spend on lobbying, but if you spend all you take in and the IRS asks for its cut, you may owe the government money.

The safest thing is to get 501 C-3 status, file for the 501 H test, keep very good records of all you spend, document whether it is direct or grassroots lobbying, and watch the 20% rule carefully.

The easiest thing is to not incorporate or file for tax exempt status and let everyone pay their own lobbying expenses, but that puts the burden heavily on the few who do all the work. You can ask others to donate to your expenses as long as you accept it personally and don't imply in your solicitation that the organization is tax exempt.

Regardless of your tax status, if you are lobbying for a specific bill at the state capitol you may need to register as a lobbyist. Not everyone who comes to the capitol to talk to their legislator needs to register as a lobbyist, but anyone who will be there often and who might be coordinating the lobbying effort should consider registering. In your early visits with legislators, ask about how to register as a lobbyist. When you find out where or how this is done in your state, go there to clarify whether or not you need to register. It's usually just a formality and there is no cost. In some states you only have to register if you are being paid to lobby, and in other states you need to register if you are representing an organization rather than expressing a personal opinion as a constituent. Just check out the rules in your state.

# Hiring a Professional Lobbyist

A professional lobbyist can be a great help, but is also very expensive. Even if you are raising some money, you won't likely have enough to hire a lobbyist. But you can interview several lobbyists as though you were looking to hire, and then explain that you won't have nearly that much money. Do these interviews well before the session, when they aren't so busy. Most states require the lobbyists to register, so you can get a list and talk to some of them. Some do pro-bono work, and might meet with you several times to give advice before and during the session. Even if you can't officially hire one, you might get a lot of benefit from talking with them. Write thank-you notes, even for a phone call, and ask them to keep your issues in mind even though you can't hire them, and let them know you would welcome any advice any time. Seek contact with lobbyists who have as clients other grass-roots organizations. Also, identify the medical lobbyists. You might not want to seek their advice the same way, but it could be helpful to talk to them once the real lobbying starts. Once the opposition starts to speak, you might want to catch their lobbyist in the halls and have impromptu chats about getting them to back down.

## **Notes from Susan Hodges of Citizens for Midwifery:**

My experience is that a professional lobbyist is similar to a contractor. When you are building a house and hiring a contractor, you are not only hiring his/her experience in construction, you are also hiring his/her relationships with subcontractors. The contractor knows who is good and who isn't, and the subcontractor is more motivated to do good, timely work because future work with this contractor depends on doing a good job. Similarly, when you hire a lobbyist, you are not only hiring his/her expertise in finding the way around the capitol and just spending the time to go talk up your issue with the right people, you are also hiring that person's relationships with the legislators and staff (aides, etc – very important). The legislators and staff are more likely to pay attention to someone they already know, who has provided trustworthy information before, etc, than someone new, coming in green. This may be especially significant for an issue that many will perceive as "fringe". It may be that you can find someone who is already lobbying for similar causes that you can hire part time. It might be worthwhile asking a senator if there is a professional lobbyist they might suggest. Even if you can't afford to hire a professional lobbyist, you might be able to consult some with one who is sympathetic. If you can make friends with one of the regular lobbyists, one or more may keep an eye out for you, give you some useful information, etc.

## **Notes from Steve Cochran of Virginia:**

I believe that it's a simple matter of finding out who all of the registered lobbyists in your state are (most states require lobbyists to register and they provide the public with a directory) and beginning to make phone calls. I'd be very honest that you have limited (or no) funds on hand and that the prospects for raising funds will not be known until you get the ball rolling. Most lobbyists will understand this, and some will be more optimistic about your eventual ability to pay than others. Furthermore, most will understand that you will probably never be able to afford the level of service that larger professions and industries routinely pay. My experience has been that different lobbyists will be more or less willing to offer discount or limited pro-bono help...especially when the legislature is not in session or about to be in session and they have more time on their hands. That makes your prospects better in the summer and less so during the session, when planning and groundwork for the next session are picking up speed . . . but it's never too late to try your luck.

Some lobbyists will see more value grassroots lobbying than others. Some might prefer to do most of the work themselves, perhaps with volunteers in tow, while others will recognize that your budget forces you to rely on volunteers to do as much of the work as possible, and will be glad to serve more as consultants and spend less of their time on the actual legwork of lobbying.

Again, you can learn a whole lot by having initial consultations with as many different lobbyists as you possibly can—preferably over the phone because meetings are more demanding on their time and yours.

# Appendix I, Resources

The following are resources for more information about midwifery

The North American Registry of Midwives  
1-888-353-7089 or 1-888-842-4784  
info@narm.org  
www.narm.org

Midwives Alliance of North America  
info@mana.org  
www.mana.org

Citizens for Midwifery  
1-888-236-4880  
info@cfmidwifery.org  
www.cfmidwifery.org

Midwifery Education Accreditation Council  
360-466-2080  
info@meacschools.org  
www.meacschools.org

Pam Maurath  
New Leaf Strategies  
212-665-4648  
pmaurath@newleafstrategies.net

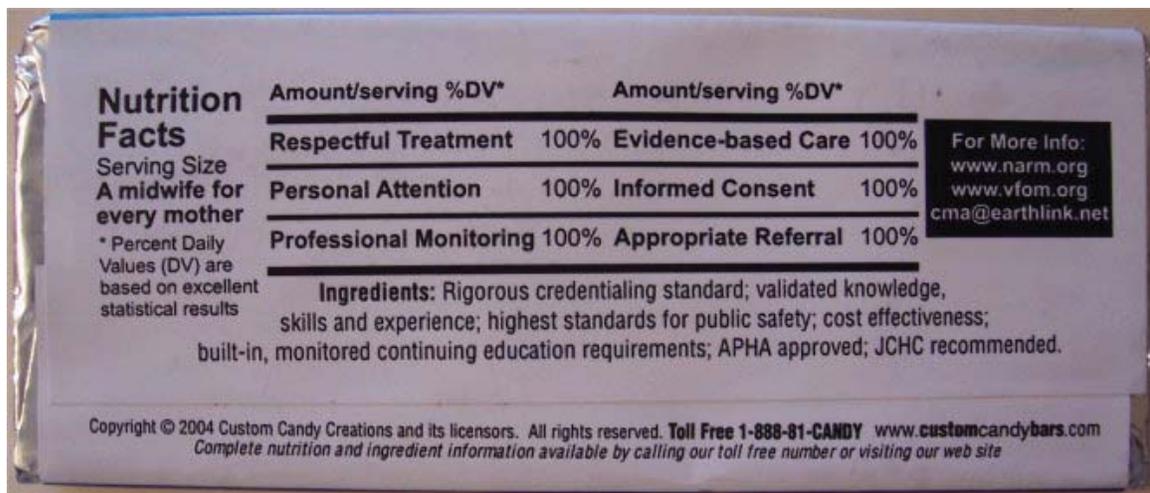
Pam can provide you with Midwife Model of Care folders, postcards, reprints, and brochures to use in lobbying. NARM also has very nice brochures about the CPM at a nominal cost. [www.narm.org](http://www.narm.org)

Representatives from these organizations will review and comment on your legislation. We urge you to seek their input before filing your legislation. There are legislative conference calls where representatives from these organizations will discuss legislative strategy with representatives from your group. Call 1-888-842-4784 to arrange a legislative conference call or to submit your drafts of legislation for feedback.

Contact Brynne Potter at [brynne@mountainviewmidwives.com](mailto:brynne@mountainviewmidwives.com) for a copy of “Midwifery and Civics 101”, a powerpoint presentation for Virginia consumers that can be modified to your state.

# Candy Bar Creations

One good way to keep your name and message in front of the legislators is to give them (or their staff) a treat that is personalized with your name and message. Leave them with small bags of candies or cookies tied with a ribbon and a tag with your message. The Virginia midwives purchased candy bars with a special wrapper that said Listen to Your Mothers on the front and had a “nutritional” chart of midwifery information on the back. Other groups can purchase this candy, edited with their own information, from Custom Candy Creations at 1-888-812-2639 or [www.customcandybars.com](http://www.customcandybars.com). The design below is order number 243139, misc design #55. The price for quantities 42-210 is \$1.30 per bar in multiples of 6. Price decreases with larger quantities.





# Appendix II, Fact Sheets

# Creating Effective Fact Sheets

- Limit fact sheet to one page
- Present one idea or concept per fact sheet
- Organize the primary facts pertaining to your idea in sequential order
- Do not overstate or exaggerate
- Do not make claims that cannot be substantiated
- Include references when presenting quantitative facts, such as statistics, statements by well known persons or researchers
- Avoid generalizations that cannot be substantiated
- Present ideas in clear, grammatically correct English
- Include contact information

Somewhere on each fact sheet, you should list the bill number, the sponsors and co-sponsors of your bill, and any groups who have officially indicated support for the bill (get their permission to list them), such as CfM, NOW, Doula groups, Childbirth Education groups, ICAN, local chapter of ACNM, a chapter of Doctors for Midwives, Perinatal Health groups, your consumer group, your midwife association, etc.

Create a uniform look so that legislators and regulators can quickly identify your materials (a color of paper, for example, used for fact sheets and stickers or buttons to wear)

If you are creating your own fact sheets, it would be wise to check with NARM to be sure you are representing the CPM correctly or to find out if there is other information that might be useful for your fact sheets.

Call 1-888-842-4784 or e-mail [info@narm.org](mailto:info@narm.org)

Many good fact sheets are available from the files section of the Big Push yahoo group web site. Look for the NARM folder.

The following pages contain several useful fact sheets. These fact sheets and others may be found as pdfs at [www.narm.org](http://www.narm.org) and [www.CfMidwifery.org](http://www.CfMidwifery.org). The pdfs on the web site may have better formatting and higher print quality than those reproduced on these pages.

# CPM2000 Study - CfM Press Release

FOR IMMEDIATE RELEASE

From Citizens for Midwifery

June 16, 2005

## Landmark Study Reports Planned Home Births Are Safe

“Outcomes of planned home births with certified professional midwives: large prospective study in North America.” Kenneth C Johnson, senior epidemiologist, Betty-Anne Daviss, project manager. *BMJ* 2005;330:1416 (18 June). Published online at <http://bmj.bmjournals.com/cgi/content/full/330/7505/1416?ehom>

A study published in the June 18 edition of the *British Medical Journal* found that for low risk women in the United States, planned home births are as safe as hospital births, and accomplished with much less medical intervention, compared with low risk hospital births. The researchers used prospective data on more than 5000 planned home births in North America attended by Certified Professional Midwives during the year 2000. This study is the largest yet on this subject, according to author Ken Johnson.

The study results belie the consistent claim of U.S. medical professionals and their organizations that “home birth is dangerous,” a belief that is not supported by the weight of scientific evidence.

“We challenge U.S. physician organizations to acknowledge the findings of this study and others like it, and to actively support legislative and regulatory changes that will promote access to out-of-hospital maternity care provided by professional (independent) midwives, such as Certified Professional Midwives,” said Susan Hodges, President of Citizens for Midwifery, a U.S. grassroots organization.

The researchers analyzed outcomes and medical interventions for planned home births, including transports to hospital care. According to the *British Medical Journal* press release, they found:

- Planned home births “had a low mortality rate during labor and delivery, similar to rates found in most studies of low risk hospital births in North America.”
- “Rates of medical intervention, such as epidural, forceps and caesarean section, were lower for planned home births than for low risk hospital births.”
- “A high degree of safety and maternal satisfaction were reported, and over 87% of mothers and babies did not require transfer to hospital” care.

These outcomes indicate that, despite many of the midwives in the study not being well-integrated into the healthcare system, appropriate transports were accomplished, and mothers and babies who needed hospital-based medical care received that care. Imagine the benefit to women and their families if these maternity care providers were welcomed and integrated into the American health care system. In addition, the results suggest that low risk women giving birth in hospitals may be subject to overuse of interventions that are not necessary for good outcomes.

Citizens for Midwifery expects this study to be a wake-up call that refocuses U.S. maternity care on evidence-based practice including access to professional midwives and out-of-hospital birth.

## Fact Sheet

### **Advantages of Using the Certified Professional Midwife (CPM) for State Licensure and Certification**

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

For more information on the CPM credential, contact  
North American Registry of Midwives (NARM) at [www.narm.org](http://www.narm.org) or 888-842-4784 or  
e-mail: [info@narm.org](mailto:info@narm.org).

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## Fact Sheet

### How Can the CPM Save Government Agencies Money?

When the Certified Professional Midwife (CPM) is used as the state credential for midwives practicing in out-of-hospital settings, government agencies can:

- Avoid spending valuable staff time to validate the education of direct-entry midwives who practice in primarily out-of-hospital settings;
- Avoid test construction and maintenance costs associated with the creation of an examination;
- Save the cost of test administration;
- Save the cost of monitoring continuing education for re-licensure;
- Provide a standard for reciprocity for midwives moving to your state.

**It's a good deal for midwives! It's a money saver for the state!**

For more information on the CPM credential, contact  
North American Registry of Midwives (NARM) at [www.narm.org](http://www.narm.org) or 888-842-4784 or  
e-mail: [info@narm.org](mailto:info@narm.org).

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## Fact Sheet

### Midwives

#### Essential for Affordable and Effective Maternity Care

Standard U.S. maternity care is big business, with many unnecessary interventions:

- About 4 million births per year.
- About 6 million obstetrical procedures, primarily on healthy women in normal labor.
- Includes 4 of the 8 most common surgical procedures in the U.S.

Midwives are key to affordable and effective maternity care in universal health care systems, as many countries have discovered including: England, France, Germany, Netherlands, Denmark, Sweden, Norway, Finland, Spain, New Zealand, Australia, Japan, Chile, Thailand.

Every country in the world with maternal and infant mortality rates lower than the U.S. has universal health care AND midwives attending the majority of births.

Midwifery care is cost effective compared to physician care:

- Midwifery training costs less.
- More full term, full weight, and healthy babies not needing special care.
- Fewer costly and risky interventions.

Pregnancy and childbirth are normal processes, not diseases. Contrary to widespread beliefs, expensive and interventive doctor care and hospitalization are rarely needed.

The US cesarean rate is now a staggering 26%. Hospital-based midwives have a documented 10% cesarean rate in comparison. Unnecessary cesarean sections increase health care costs and contribute toward increased maternal and infant morbidity and mortality.

The Midwives Model of Care is health-promoting – an evidence-based wellness model that improves birth outcomes and is mother-friendly and baby-friendly.

The American Public Health Association supports “increased access to midwifery services,” and “efforts to increase access to out-of-hospital maternity services ... through recognition that legally-regulated and nationally certified direct-entry midwives can serve clients desiring safe, planned, out-of-hospital maternity care services.” (APHA Resolution Increasing Access To Out-Of-Hospital Maternity Care Services Through State-Regulated and Nationally-Certified Direct-Entry Midwife,” October 24, 2001)

## Fact Sheet

### Overview of Maternity Care in the US by Carolyn Keefe, MLS

With four million births each year<sup>1</sup> and three-quarters of American women becoming mothers, maternity care affects large numbers of women. It is also big business. The United States has the highest per capita spending on health care in the world, with care for mothers and newborns combined as the fourth largest category of hospital expenses,<sup>2</sup> and childbirth as the most common reason for the hospitalization of women in the United States.

Women are subjected to an ever-increasing array of interventions and technologies, many of which are highly invasive, with little or no evidence of their effectiveness. In fact, the medical evidence shows that the routine use of unnecessary interventions put mothers and babies at risk. Medical interventions are also expensive and often used not for the benefit of women and babies, but for the convenience or legal protection of doctors and hospitals.

All of this would be acceptable if we had better outcomes to show for it. Unfortunately, our outcomes are not nearly as good as those of developed countries that rely more heavily on midwifery care. Some of the clear problems with our maternity care system include:

- A high infant mortality rate compared to other developed countries – 27th in the world.<sup>3</sup> Infant mortality rates are higher for African American, Latina and Native American babies – with the rate for African American babies twice that of white babies.<sup>4</sup>
- A maternal mortality rate that has not improved in 20 years — 15th in the world.<sup>5</sup> Maternal mortality is higher for women of color than for white women, nearly 4 times higher for African American women.<sup>6</sup>
- A cesarean birth rate of 24.4% — among the highest in the world. Cesarean birth rates are highest for African American women, followed by white women, Latina women, Asian women, and Native American women.<sup>7</sup>
- A 20% drop in vaginal births after cesarean (VBAC) from 2000 to 2001 to 16.4% – access to VBAC is disappearing requiring many women who have cesarean scars to undergo surgery.<sup>8</sup>
- An induction rate of 20.5% — which has more than doubled since 1989 and continues to rise.<sup>9</sup>
- Many mothers traumatized by their treatment during birth, with as many as 30% exhibiting some signs of post-traumatic stress disorder<sup>10</sup> and 50% experiencing some aspect of postpartum depression (the highest such rate in the world).<sup>11</sup>

Moreover:

Of the eight most common surgical procedures in the US, four are obstetric in nature – episiotomy, repair of obstetric laceration, cesarean birth, artificial rupture of membranes. These are in also the top four surgeries performed on women in the US.<sup>12</sup> Obstetric procedures are the most common type of surgical procedures performed in the US (6,209,000), slightly higher than cardiac procedures (5,939,000). Consider the following:

- obstetric procedures are only performed on women – more obstetric procedures are performed on women than the next two categories (cardiac and digestive) combined;

- there are over six million obstetric procedures, but just over four million births;
- these procedures are primarily performed on healthy women during a normal physiological process.

The problem has steadily gotten worse over the last two decades. All obstetric procedures combined have nearly doubled since 1980, while certain procedures, such as medical induction of labor, vacuum extraction, and manually assisted delivery increased more than tenfold in that time.<sup>13</sup> Each procedure carries with it risks to mothers and babies, and less invasive techniques exist for most of them. Furthermore, they are usually not medically necessary and are avoidable for the majority of women.

The Midwives Model of Care<sup>14</sup> and the evidence-based Mother-Friendly Childbirth Initiative<sup>15</sup> recognize birth as a normal, natural process and support the use of less invasive techniques, such as position changes, waiting, hydrotherapy, and perineal support, that carry fewer risks to mothers and babies and are usually more effective.

Research shows that midwives are the safest birth attendants for most women, with lower infant and maternal mortality rates and fewer invasive interventions such as episiotomies and surgical births (cesareans). In developed countries where midwives are the primary care providers for pregnant women, mortality and surgical birth rates are much lower than in the United States. However, legal, regulatory, and financial barriers to the practicing the Midwives Model of Care and Mother-Friendly care make it difficult for women to access either in the US.

## References:

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13. IBID, p. 46.
14. Developed in 1996 by Midwifery Task Force, [www.midwiferytaskforce.org](http://www.midwiferytaskforce.org).
15. Developed in 1996 by the Coalition for Improving Maternity Services, [www.mother-friendly.org](http://www.mother-friendly.org).

Information reflects 2001 data. Reprinted with permission from BirthNet.

## Fact Sheet

### **Planned Home Birth is Safe for Most Mothers and Babies**

**Healthy women with qualified care providers, usually midwives, can have safe home births.**

#### **Home birth reduces:**

- risk of infection
- risks from unnecessary interventions
- maternal morbidity rates from complications and interventions
- risks from errors in hospitals
- interference in bonding and breastfeeding from hospital policies
- risks from poor staffing levels in hospitals
- risks of tampering with the baby

#### **Home birth provides:**

- safe, familiar and private surroundings for labor and birth
- woman-centered care during pregnancy, labor, and birth
- family-oriented birth with no strangers present
- an opportunity for immediate bonding and breastfeeding
- less disruption and stress for the whole family
- affirmation that birth is a normal and profound life event

**Research shows that planned home birth with a qualified attendant is safe for most mothers and babies.**



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## Fact Sheet

### **Safety in Birth Begins with Midwifery Care**

**“In terms of quality, satisfaction, and costs, the midwifery model for pregnancy and maternity care has been found to be beneficial to women and families, resulting in good outcomes and cost savings. ... With its focus on pregnancy as a normal life event and health promotion for women of all ages, the midwifery model of care is an appropriate alternative or complement to the medical approach to childbirth.”**

*American Public Health Association, “Supporting Access to Midwifery Services in the United States (Position Paper)”, American Journal of Public Health, Vol. 91, No. 3, March 2001.*

**“It is inherently unwise, and perhaps unsafe, for women with normal pregnancies to be cared for by an obstetric specialist. ... Midwives and general practitioners, on the other hand, are primarily oriented to the care of women with normal pregnancies, and are likely to have more detailed knowledge of individual women.”**

*Murray Enkin, et al, A Guide to Effective Care in Pregnancy and Childbirth. Oxford University Press, 2000.*

**“It is the finding and vision of the Taskforce that the midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women.”**

*Dower CM, Miller JE, O’Neil EH and the Taskforce on Midwifery, Charting a Course for the 21st Century: The Future of Midwifery. San Francisco, CA: Pew Health Professions Commission and the UCSF Center for the Health Professions. April 1999.*

**“Midwives are the most appropriate primary health care provider to be assigned to the care of normal birth.”**

*Maternal and Newborn Health/Safe Motherhood Unit of the World Health Organization, Care in Normal Birth: A practical guide. World Health Organization, 1996.*

**“Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes...”**

*Coalition for Improving Maternity Services, The Mother-Friendly Childbirth Initiative, 1996*

## Fact Sheet

### The Safety of Home Birth

#### The evidence is overwhelming – planned home birth is safe for healthy women

**“Recognizing the evidence that births to healthy mothers, who are not considered at medical risk after comprehensive screening by trained professionals, can occur safely in various settings, including out-of-hospital birth centers and homes. ...Therefore, APHA supports efforts to increase access to out-of-hospital maternity care services...”**

*American Public Health Association, “Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives (Policy Statement)”.*  
*American Journal of Public Health, Vol 92, No. 3, March 2002.*

**“Several methodologically sound observational studies have compared the outcomes of planned home-births (irrespective of the eventual place of birth) with planned hospital-births for women with similar characteristics. A meta-analysis of these studies showed no maternal mortality, and no statistically significant differences in perinatal mortality risk in either direction.”**

*Murray Enkin, et al, A Guide to Effective Care in Pregnancy and Childbirth. Oxford University Press, 2000.*

**“It is safe to say that a woman should give birth in a place where feels is safe, and at the most peripheral level at which appropriate care is feasible and safe. For a low-risk pregnant woman this can be at home, at a small maternity clinic or birth centre, in town or perhaps at the maternity unit of a larger hospital. However, it must be a place where all the attention and care are focused on her needs and safety, as close to home and her own culture as possible.**

*Maternal and Newborn Health/Safe Motherhood Unit of the World Health Organization, Care in Normal Birth: A practical guide. World Health Organization, 1996.*

**“Excellent outcomes with much lower intervention rates are achieved at home births. This may be because the overuse of interventions in hospital births introduces risks or the home environment promotes problem-free labors.”**

*Henci Goer, Obstetric Myths versus Research Realities: A Guide to the Medical Literature. Bergin & Garvey, 1995.*

**“This study supports previous research indicating that planned home birth with qualified care providers can be a safe alternative for healthy lower risk women.”**

*Anderson RE, Murphy PA. “Outcomes Of 11,788 Planned Home Births Attended By Certified Nurse-Midwives. A Retrospective Descriptive Study.” Journal of Nurse Midwifery, 1995 Nov-Dec;40(6):483-92. (Abst)*



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## **Fact Sheet**

### **Safety in Birth Begins with Midwives**

- Respectful Treatment
- Personal Attention
- Emotional Support
- Confidence in our Bodies
- Education and Information

**Midwives are specialists in normal birth.**

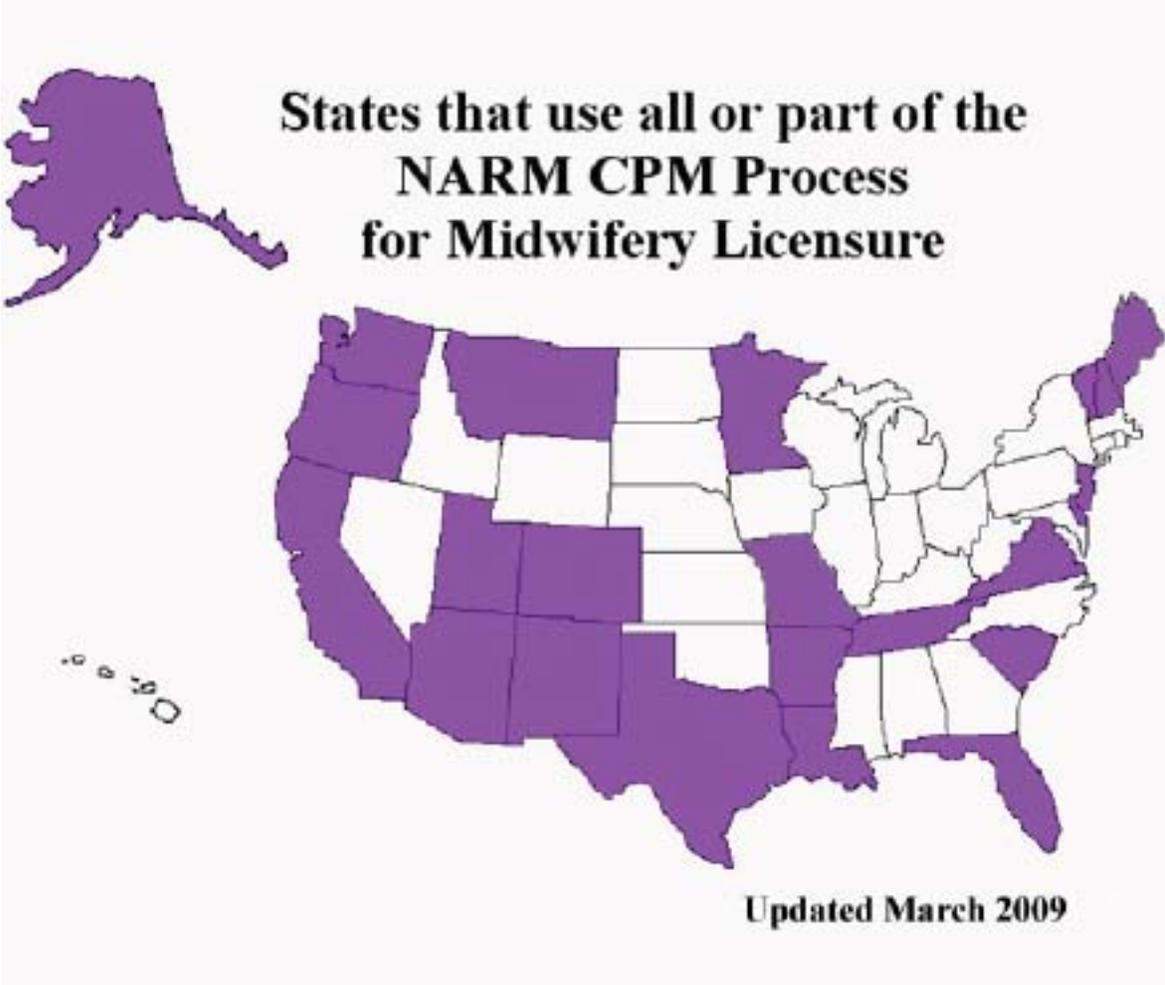
**Midwives recognize that birth is a normal, healthy process.**

**Midwives focus more on women and babies as individuals and less on technology.**

**A thorough knowledge of birth allows midwives to minimize the use of technology and medical interventions.**

**Midwives do not expose women and babies unnecessarily to potentially harmful interventions.**

**Research shows that midwives are the safest care.**



# Educational Requirements for the Certified Professional Midwife

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

The certification program provides a complete and thorough incorporation of knowledge, skills, and abilities defined by the NARM Job Analyses into the education, training, and testing required for certification. This process is designed and implemented in accordance with the standards set by the National Commission on Certifying Agencies (NCCA), to identify core topics that must be mastered for the performance of midwifery skills in an out-of-hospital setting.

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

- The instructor verifies that the student has demonstrated knowledge and proficiency of all didactic components, including definitions, signs and symptoms, differential diagnosis for Risk Assessment, stabilization and treatment, follow-up, referral, and transport, in over 750 core competencies.
- The instructor determines that the student has undergone complete and thorough preparation as an assistant midwife prior to assuming responsibility as primary midwife. Clinical care performed under supervision during training include, at a minimum:
  - 75 prenatal exams
  - 20 births as an assistant midwife
  - 20 births as primary midwife from the onset of labor to the delivery of the placenta and the stabilization of mother and newborn
  - 20 newborn exams
  - 40 postpartum exams
- The instructor assesses and verifies performance of skills during an intensive, hands-on Skills Assessment, a demonstration exam performed for and scored by a NARM-trained Qualified Evaluator.
- The student must pass a 350 item, 8-hour written national board exam that covers all aspects of midwifery care as identified by the NARM Job Analysis.

# The Didactic Component of the Educational Process for Certified Professional Midwives

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

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

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

## **Prenatal and intrapartal care, including routine prenatal examinations and risk assessment for:**

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

## **Appropriate evaluation of laboratory records, including:**

- CBC
- Hematocrit/hemoglobin
- Blood glucose
- HIV

- Hepatitis
- Rubella screen
- Group B Strep
- VDRL
- Blood type and Rh
- Antibody screen
- Chlamydia
- PAP smear
- Urine culture and analysis

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

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

## **Pharmacology:**

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

## **Appropriate use and care of equipment, including:**

- Ambu bag and mask
- Medical oxygen tanks
- Suction devices: bulb syringe and DeLee
- Sterilization of birth instruments: hemostats, scissors, and cord clamps
- Lancets
- Suturing equipment
- Urinary catheter
- Ultrasonic Doppler and fetoscope
- Lab equipment: venepuncture supplies and vacuum collection tubes
- Blood pressure cuff
- Stethoscope

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

- Respirations

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

**Daily and weekly assessment of mother and newborn, including:**

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

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

- Informed Consent
- Confidentiality

- Childbirth education
- Physical and emotional aspects of pregnancy and birth
- Diet, nutrition, and supplements
- Prenatal testing and lab work
- Female reproductive anatomy and physiology
- Prenatal exercise
- Breast self-exam
- Environmental and teratogenic hazards to pregnancy
- Benefits and risks of birth site options
- Preparing for birth at home or birth center
- Emergency protocol

# The Clinical Component of the Educational Process for Certified Professional Midwives

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

- The student must provide prenatal, intrapartal, and postpartal care as well as newborn assessment, equivalent to a minimum of 1,350 clinical contact hours under the direct supervision of one or more instructors approved by the North American Registry of Midwives.
- The student must receive an assessment of skilled proficiency as an assistant midwife in order to assume responsibility as primary midwife. Supervised training includes:
  - 75 prenatal exams as primary midwife
  - 20 births as an assistant midwife
  - 20 births as primary midwife from the onset of labor to the delivery of the placenta and the stabilization of mother and newborn
  - 20 newborn exams as primary midwife
  - 40 postpartum exams as primary midwife
- The student must provide all aspects of care as a primary midwife while under the physical, on-site supervision of the instructor.
- The instructor must verify that the student has demonstrated skilled proficiency in providing care to clients in out-of-hospital clinical settings.
- The student must be trained in adult CPR and infant/neonatal resuscitation
- The student must pass written and practical skills national board exams for the practice of midwifery developed and implemented following the standards set by the National Commission for Certifying Agencies and administered by the North American Registry of Midwives.

# 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.

Other healthcare credentials accredited by the NCCA include:

- Certified Nurse-Midwife
- Certified Midwife
- Certified Critical Care Nurse
- Certified Women's Health Care Nurse Practitioner
- Certified Neonatal Nurse Practitioner
- Certified Pediatric Nurse
- Certified Perinatal Nurse

For a complete list of NCCA accredited healthcare credentials, see [www.noca.org](http://www.noca.org).

# Important Facts Addressing Concerns about Licensing Midwives

Information Provided by the North American Registry of Midwives

## Safety

**The largest study of home births attended by Certified Professional Midwives has found that home birth is safe for low risk women and involves far fewer interventions, such as cesarean sections and inductions, than similar births in hospitals.**

*“Outcomes of planned home births with certified professional midwives: large prospective study in North America.” Kenneth C Johnson and Betty-Anne Daviss. *BMJ* 2005;330:1416 (18 June).*

**“Recognizing the evidence that births to healthy mothers, who are not considered at medical risk after comprehensive screening by trained professionals, can occur safely in various settings, including out-of-hospital birth centers and homes. ...Therefore, APHA supports efforts to increase access to out-of-hospital maternity care services...”**

*American Public Health Association, “Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives (Policy Statement)”. *American Journal of Public Health, Vol 92, No. 3, March 2002.**

**“The low CPM rates of intervention are benchmarks for what the majority of childbearing women and babies who are in good health might achieve.”**

*The Milbank Memorial Fund, a nonpartisan institute devoted to health policy analysis, issued a new report titled “Evidence-Based Maternity Care: What It Is and What It Can Achieve.” October, 2008*

## Economic Benefits

**An economic analysis of the cost benefits of a licensed midwife program indicate that “The cost savings to the health care system (public and private) is estimated to be ten times the cost of the program.”**

*Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits, (A report to the Washington Department of Health), Health Management Associates, October, 2007*

## Other Endorsements

**A certified nurse-midwife (CNM) and a certified professional midwife (CPM) specialize in prenatal care, labor, and delivery. Both can be a good option for healthy women at low-risk for problems during pregnancy, labor, or delivery. A CNM does not need experience delivering babies in home settings and most practice in hospitals and birth centers. A CPM is required to have experience delivering babies in home settings because most practice in homes and birthing centers.**

*From [www.womenshealth.gov](http://www.womenshealth.gov), the Federal Government Source for Womens’ Health Information*

# Important Facts about the Education of the Certified Professional Midwife

- The education of the CPM follows an extensive curriculum of over 750 topics. All educational routes to the CPM must follow the same curriculum, which may be verified through diplomas from accredited midwifery schools, licenses from states with equivalent requirements, or an extensive evaluation of alternative pathways through the Portfolio Evaluation. Students from all routes to certification must meet the SAME extensive educational goals, follow the same curriculum, and pass the same nationally standardized examinations. These are equivalent routes to the same education.
- Instructors and preceptors are responsible for the education and supervision of student CPMs, which may occur in classroom, private, and clinical settings. Instructors must verify that the student has mastered all knowledge and skills and has demonstrated competency in the clinical setting before proceeding through the testing process. Students then must pass a hands-on Skills Assessment and an 8-hour Written Examination.
- The clinical training for CPM certification must cover a minimum of at least one year of supervised clinical work, which is equivalent to 1350 hours of supervision. The average length of clinical training is 3-5 years. All students must document this supervised clinical work, regardless of route of education.
- The excellent outcomes documented in the CPM 2000 study were a result of over 5,000 births attended by CPMs, 99% of which were attended by midwives who received the CPM credential through the NARM Portfolio Evaluation Process. The results of this study attest to the safety of births attended by CPM and the significant cost savings of reduced intervention in birth.
- The process used to create and administer the CPM has been evaluated and accredited by the National Commission for Certifying Agencies, the same organization that accredits the credentials for the Certified Nurse-Midwife and many other advanced practice nursing credentials.
- All states that license direct-entry midwives to provide home birth services accept the CPM credential as meeting all or part of their licensure requirements, and all of these states use the NARM exam as the state licensure examination. States with older program that precede the establishment of the CPM credential may have some state-specific additional requirements, but all states with licensure programs established after 1993 have accepted the CPM credential as the eligibility criteria for licensure. This saves the state the administrative expense of evaluating varied educational pathways, assures reciprocity with other licensed states, and follows the national standards for midwifery education and training.
- Twenty-four states license direct entry midwives to attend home births using the CPM credential or equivalent. Many programs have been in existence for over 20 years, and no state has sought to terminate the licensure program. This is testimony to the excellence of midwifery care by the Certified Professional Midwife.

# **Appendix III, Guidelines for Drafting Legislation**

Each state will have specific requirements for how bills are drafted in terms of format, language, grammar, punctuation, numbering, etc. Most state legislatures have a staff of attorneys whose primary job is to assist legislators in writing legislation so that it does not contain major errors that would require re-writing after submission. It may be required that every bill be submitted for review to these attorneys prior to filing.

Midwives should draft the content of their legislation and then ask the legislative staff for assistance in reviewing the bill for standardization. The legislature may have a handbook on drafting legislation, and that handbook may be on their web site. If your state does not have a handbook, you might look at other state websites for examples.

The Arkansas legislature has a very thorough (100 page) handbook on drafting legislation. Not all of it will be relevant to midwifery legislation, and not all of it will be relevant in other states. For purposes of education and familiarity, some general information on writing bills from the Arkansas handbook is included here.

## **How a Draft Bill is Prepared**

Typically, the process of preparing general legislation begins when a legislator contacts a Bureau attorney and presents an idea for a bill or a problem that he or she wants to address. The attorney will research the issue and work with the legislator to develop legislation. At other times, the legislator may direct the bill drafter to work with an interested party or to prepare legislation based on legislation in another state or a model bill or may provide a draft prepared by a constituent or interest group.

Arkansas Code § 10-2-501 prohibits Bureau staff from starting work on a bill, resolution, or amendment based on instructions conveyed by a registered lobbyist without prior direct approval of a member of the General Assembly. The Bureau has extended this requirement to non-lobbyists because it is difficult for staff to quickly determine who is a registered lobbyist.

“Prior direct approval” is met when the Senator or Representative communicates the approval to a Bureau employee by telephone, email, fax, or other written document.

## **Legislation Drafted Outside the Bureau**

All bills, resolutions, and amendments must be processed by the Bureau. A draft by an outside bill drafter is reviewed and edited by Bureau staff, and, if necessary, the staff alerts the sponsor of unresolved problems in the draft. Bureau review includes the following elements:

- If it amends current law, whether the legislation accurately shows present law and the additions and deletions being made to the present law.
- Whether the legislation conforms to style and numbering requirements.
- Whether the provisions are clear and complete.
- Whether the legislation raises legal issues of which the sponsor should be made aware, e.g., a conflict with federal or state constitutional law, other federal law, or Arkansas law.

It is to the advantage of the outside drafter for the Bureau staff to make the technical changes because this allows the outside drafter to still have input into the process. Even if the Bureau fails to conform a draft, the Arkansas Code Revision Commission is also charged with conforming new laws to the style of Arkansas Code.

## **Format Requirements for Outside Bill Drafters who Submit an Electronic Copy of the Bill**

Staff should encourage outside bill drafters to provide their drafts to us in electronic format. Having the drafts in electronic format helps expedite the bill because it keeps us from having to completely retype the bill. Unfortunately, sometimes the document format keeps us from using the electronic version.

If possible, provide the Bureau with a copy of the draft bill on a computer disk or as an attachment to an email message. For the file to be useful to Bureau staff, the document must be prepared using the following guidelines:

- (1) Use Microsoft Word.
- (2) Keep the Word document simple.
  - Do not try to duplicate the appearance of an official bill. Almost all formatting you add must be removed by the Bureau. Problems frequently arise from formatting inserted by outside drafters and results in significant delays in bill preparation and filing.
  - Do not change fonts or the size of fonts. Use one font throughout the draft – preferably the “Courier New” font.
  - Do not use italics or bold font attributes.
  - Do not use “indent”. Instead use “tabs”.
  - Use “left alignment”. Do not use “justify”, “center alignment”, or “right alignment”.
  - Do not use features such as headers, footers, footnotes, margin changes, tab changes, or other word processing features that will have to be removed when the bill is processed.
  - Do not use “styles” to alter the appearance of your document. Use of “styles” will prevent the Bureau from using your electronic document.
  - If a “symbol” must be inserted into the document, use only those listed in Microsoft Word under Symbols - Font (normal text).
- (3) If the bill amends existing law, it must show the law as it existed prior to the current session of the General Assembly and how the bill would change the law as shown in the official hard copy of the Arkansas Code. (An exception would be those instances in which the bill amends the existing law that has been amended by an act of the current legislative session.)
  - Use the font attribute “underline” to indicate new language.
  - Use the font attribute “strikethrough” to show language that will be deleted from present law.
  - Do not use the “track changes” or “highlight changes” function in Microsoft Word as a way of showing additions and deletions to the law. A mark-up document created by using the “track changes” or “highlight changes” function cannot be used by Bureau staff and the Bureau will have to retype the entire document.
  - Do not use “styles” function in Microsoft Word as a way of showing additions and deletions to the law. A document using “styles” may cause the Bureau to have to retype the entire document.
- (4) The document must be free of viruses. Virus infected documents cause significant delays and may result in the bill and other bills being lost.
- (5) If possible, also provide a hard copy of the draft with the electronic version.

**Further information outlines how to draft sections of a bill and how to number. Also, these points on grammar:**

a) Clarity

Arkansas Code § 1-2-121 says: “No bill shall be considered or law is written in clear, unambiguous language.”

b) Run-on Sentences

Do not use long, complicated sentences. Shorter sentences provisos” and “exceptions” can usually become separate sentences related topics together using the classification system to show provisions. A section divided into subsections sets the order, and respective subsections clarify the relationships.

c) Present Tense

Statutes are regarded as speaking in the present, as of the Therefore, draft in the present tense.

d) Active Verb

Generally, use the active rather than the passive verb.

(e) Singular and Plural

Draft using the singular unless the plural is exclusively intended.

(f) Dangling Modifiers

Dangling modifiers are phrases that do not clearly and logically modify a word or phrase in a sentence. The words in a sentence should be rearranged to make the modifier refer clearly to the right word or new words should be added to make the meaning clear and logical.

## Capitalization

(a) PROPER NAMES.

Capitalize first letters of proper names. Do not capitalize “department”, “board”, “commission”, etc., if not used as part of the full name.

In general, do not capitalize short versions of officers’ titles.

### Examples:

The Secretary of the Department of Aeronautics  
the secretary

(b) Capitalization of Particular Words

(1) “Act”

The word “act” when referring to a law is written in lower case unless the reference includes the act number and year.

### Examples:

Act 12 of 1999  
section 1 of this act  
this act

## Numbers

(a) in General

- (1) Write numbers as both words and numerals. The numerals should be surrounded by parentheses.

### Examples:

two (2) years  
twenty-four (24) hours  
one hundred feet (100’)  
five percent (5%)  
three-fourths (3/4)  
zero dollars (\$0.00)

- (2) A number in a hyphenated term does not use numerals.

### Examples:

four-year term  
thirty-day period  
twenty-four-hour-a-day care

- (3) Avoid using the words “once”, “twice”, and “thrice”.

### Example:

In the order, the court shall specify the requirement of judicial review of the case, either formal or informal, at least one (1) time [not “once”] a year.

There are many more examples of punctuation and grammar that are suggested for writing bills at this web site. Look first for a similar document on your state web site. If there is not one specific to your state, review this one for ideas.

<http://www.arkleg.state.ar.us/data/Legislative-DraftingDec04.pdf>

or [www.arkleg.state.ar.us](http://www.arkleg.state.ar.us), click on resources, then on Legislative Drafting Manual

# **Appendix IV, Sample Legislation**

Text of legislation passed in Utah and Virginia in 2005  
Tennessee in 2003 and Wisconsin in 2006

# Utah

## DIRECT-ENTRY MIDWIFE ACT 2005 GENERAL SESSION STATE OF UTAH

**Chief Sponsor: Jackie Biskupski**  
**Senate Sponsor: Parley G. Hellewell**

### CHAPTER 77. DIRECT-ENTRY MIDWIFE ACT

#### Part 1. General Provisions

##### **58-77-101. Title.**

This chapter is known as the “Direct-entry Midwife Act.”

Section 4. Section 58-77-102 is enacted to read:

##### **58-77-102. Definitions.**

In addition to the definitions in Section 58-1-102 , as used in this chapter:

- (1) “Board” means the Licensed Direct-entry Midwife Board created in Section

##### **58-77-201 .**

- (2) “Certified nurse-midwife” means a person licensed under Title 58, Chapter 44a, Nurse Midwife Practice Act.
- (3) “Client” means a woman under the care of a Direct-entry midwife and her fetus or newborn.
- (4) “Direct-entry Midwife” means an individual who is engaging in the practice of Direct-entry midwifery.
- (5) “Licensed Direct-entry midwife” means a person licensed under this chapter.
- (6) “Physician” means an individual licensed as a physician and surgeon, osteopathic physician, or naturopathic physician.
- (7) “Practice of Direct-entry midwifery” means practice of providing the necessary supervision, care, and advice to a client during essentially normal pregnancy, labor, delivery, postpartum, and newborn periods that is consistent with national professional midwifery standards and that is based upon the acquisition of clinical skills necessary for the care of pregnant women and newborns, including antepartum, intrapartum, postpartum, newborn, and limited interconceptual care and includes:
  - (a) obtaining an informed consent to provide services;
  - (b) obtaining a health history, including a physical examination;
  - (c) developing a plan of care for a client;
  - (d) evaluating the results of client care;
  - (e) consulting and collaborating with and referring and transferring care to licensed health care professionals, as is appropriate, regarding the care of a client;
  - (f) obtaining medications, as specified in this Subsection (7)(f), to administer to clients, including:
    - (i) prescription vitamins;
    - (ii) Rho D immunoglobulin;
    - (iii) sterile water;
    - (iv) one dose of intramuscular oxytocin after the delivery of the placenta to minimize blood loss;
    - (v) one dose of intramuscular oxytocin if a hemorrhage occurs, in which case the licensed Direct-entry midwife must either consult immediately with a physician licensed under Title 58,

Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, and initiate transfer, if requested, or if the client's condition does not immediately improve, initiate transfer and notify the local hospital;

- (vi) oxygen;
  - (vii) local anesthetics without epinephrine used in accordance with Subsection (7)(l);
  - (viii) vitamin K to prevent hemorrhagic disease of the newborn;
  - (ix) eye prophylaxis to prevent ophthalmia neonatorum as required by law; and
  - (x) any other medication approved by a licensed health care provider with authority to prescribe that medication;
- (g) obtaining food, food extracts, dietary supplements, as defined by the Federal Food, Drug, and Cosmetic Act, homeopathic remedies, plant substances that are not designated as prescription drugs or controlled substances, and over-the-counter medications to administer to clients;
  - (h) obtaining and using appropriate equipment and devices such as Doppler, blood pressure cuff, phlebotomy supplies, instruments, and sutures;
  - (i) obtaining appropriate screening and testing, including laboratory tests, urinalysis, and ultrasound;
  - (j) managing the antepartum period;
  - (k) managing the intrapartum period including:
    - (i) monitoring and evaluating the condition of mother and fetus;
    - (ii) performing emergency episiotomy; and
    - (iii) delivering in any out-of-hospital setting;
  - (l) managing the postpartum period including suturing of episiotomy or first and second degree natural perineal and labial lacerations, including the administration of a local anesthetic;
  - (m) managing the newborn period including:
    - (i) providing care for the newborn, including performing a normal newborn examination; and
    - (ii) resuscitating a newborn;
  - (n) providing limited interconceptual services in order to provide continuity of care including:
    - (i) breastfeeding support and counseling;
    - (ii) family planning, limited to natural family planning, cervical caps, and diaphragms; and
    - (iii) pap smears, where all clients with abnormal results are to be referred to an appropriate licensed health care provider; and
  - (o) executing the orders of a licensed health care professional, only within the education, knowledge, and skill of the Direct-entry midwife.
- (8) "Unlawful conduct" is as defined in Sections 58-1-501 and 58-77-501 .
- (9) "Unprofessional conduct" is as defined in Sections 58-1-501 and 58-77-502 and as may be further defined by rule.

**Section 5. Section 58-77-201 is enacted to read:**

**Part 2. Board**

**58-77-201. Board.**

- (1) There is created the Licensed Direct-entry Midwife Board consisting of four licensed Direct-entry midwives and one member of the general public.
- (2) The board shall be appointed and serve in accordance with Section 58-1-201 .
- (3) (a) The duties and responsibilities of the board shall be in accordance with Sections 58-1-202 and 58-1-203 .
- (b) The board shall designate one of its members on a permanent or rotating basis to:
  - (i) assist the division in reviewing complaints concerning the unlawful or unprofessional conduct of a licensed Direct-entry midwife; and

- (ii) advise the division in its investigation of these complaints.
- (c) (i) For the years 2006 through 2011, the board shall present an annual report to the Legislature's Health and Human Services Interim Committee describing the outcome data of licensed Direct-entry midwives practicing in Utah.
- (ii) The board shall base its report on data provided in large part from the Midwives' Alliance of North America.
- (4) A board member who has, under Subsection (3), reviewed a complaint or advised in its investigation may be disqualified from participating with the board when the board serves as a presiding officer in an adjudicative proceeding concerning the complaint.
- (5) Qualified faculty, board members, and other staff of Direct-entry midwifery learning institutions may serve as one or more of the licensed Directed-entry midwives on the board.

**Section 6. Section 58-77-202 is enacted to read:**

**58-77-202. Licensed Direct-entry Midwife Formulary Committee—Adoption of licensed Direct-entry midwife formulary.**

- (1) The division shall establish a Licensed Direct-entry Midwife Formulary Committee under Subsection 58-1-203 (1)(f) to make recommendations to the board and the division regarding which additional prescription drugs are appropriate for the scope of practice of licensed Direct-entry midwives and guidelines for their use.
- (2) The committee shall consist of five members as follows:
  - (a) two licensed Direct-entry midwives;
  - (b) one licensed physician who has professional experience consulting for and collaborating with Direct-entry midwives;
  - (c) one certified nurse midwife who has professional experience consulting for and collaborating with Direct-entry midwives; and
  - (d) one licensed pharmacist.
- (3) The committee members shall:
  - (a) be appointed by the director of the division; and
  - (b) serve without compensation, travel costs, or per diem for their services.
- (4) In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the division shall adopt by rule a licensed Direct-entry midwife formulary which includes:
  - (a) those additional prescription drugs which may be obtained and administered by licensed Direct-entry midwives as defined in Subsection 58-77-102 (7)(f)(xi); and
  - (b) standards, conditions, and guidelines for use of the prescription drugs included in the formulary.

**Section 7. Section 58-77-203 is enacted to read:**

**58-77-203. Licensed Direct-entry Midwife Temporary Rules Committee—Rules recommendations.**

- (1) The division shall establish a Licensed Direct-entry Midwife Temporary Rules Committee under this section to make recommendations to the board and division regarding the condition types listed in Subsection 58-77-601 (2).
- (2) The committee shall consist of the following six members appointed by the director of the division:
  - (a) three Direct-entry midwives;
  - (b) one licensed physician who has professional experience consulting for and collaborating with Direct-entry midwives;
  - (c) one certified nurse midwife who has professional experience consulting for and collaborating with Direct-entry midwives; and
  - (d) a licensed physician or certified nurse midwife who has practiced obstetrics or midwifery in an out-of-hospital setting.

- (3) The director of the division shall appoint one of the three Direct-entry midwives to serve as committee chair.
- (4) Committee members shall serve without compensation and may not receive travel costs or per diem for their services on the committee.
- (5) Qualified committee members may also serve on the Licensed Direct-entry Midwife Formulary Committee and the Licensed Direct-entry Midwife Board established under this chapter.
- (6) The director shall make appointments to the committee by July 1, 2005, and the committee shall cease to function after March 31, 2006.
- (7)
  - (a) The committee shall recommend rules under Subsection (1) based on convincing evidence presented to the committee.
  - (b) At least four members must vote in the affirmative on any recommendation made by the committee to the board or the division.
  - (c) If the committee is unable to complete its recommendations by March 31, 2006, it shall develop a recommended plan of action which, along with its work product and responsibilities, shall be transferred to the board on April 1, 2006.

**Section 8. Section 58-77-301 is enacted to read:**

**Part 3. Licensure**

**58-77-301. Licensure.**

The division shall issue to a person who qualifies under this chapter a license as a licensed Direct-entry midwife.

**Section 9. Section 58-77-302 is enacted to read:**

**58-77-302. Qualifications for licensure.**

Each applicant for licensure as a licensed Direct-entry midwife shall:

- (1) submit an application in a form prescribed by the division;
- (2) pay a fee as determined by the department under Section 63-38-3.2 ;
- (3) be of good moral character;
- (4) hold a Certified Professional Midwife certificate in good standing with the North American Registry of Midwives or equivalent certification approved by the division in collaboration with the board;
- (5) hold current adult and infant CPR and newborn resuscitation certifications through an organization approved by the division in collaboration with the board; and
- (6) provide documentation of successful completion of an approved pharmacology course as defined by division rule.

**Section 10. Section 58-77-303 is enacted to read:**

**58-77-303. Term of license—Expiration—Renewal.**

- (1)
  - (a) The division shall issue each license under this chapter in accordance with a two-year renewal cycle established by rule.
  - (b) The division may by rule extend or shorten a renewal period by as much as one year to stagger the renewal cycles it administers.
- (2) Each license automatically expires on the expiration date shown on the license unless the individual renews it in accordance with Section 58-1-308 .
- (3) At the time of renewal, the licensed Direct-entry midwife shall be in current compliance with the requirements of Section 58-77-302 .

**Section 11. Section 58-77-304 is enacted to read:**

**58-77-304. Parents' rights.**

Nothing in this chapter abridges, limits, or changes in any way the right of parents to deliver their baby where, when, how, and with whom they choose, regardless of licensure under this chapter.

**Section 12. Section 58-77-401 is enacted to read:**

**Part 4. Licensure Denial and Discipline**

**58-77-401. Grounds for denial of license—Disciplinary proceedings.**

Grounds for refusing to issue a license to an applicant, for refusing to renew a license, for revoking, suspending, restricting, or placing on probation a license, for issuing a public or private reprimand, and for issuing a cease and desist order shall be in accordance with Section 58-1-401 .

**Section 13. Section 58-77-501 is enacted to read:**

**Part 5. Unlawful and Unprofessional Conduct—Penalties**

**58-77-501. Unlawful conduct.**

- (1) In addition to the definition in Subsection 58-1-501 (1), “unlawful conduct” includes:
  - (a) representing or holding oneself out as a licensed Direct-entry midwife when not licensed under this chapter; and
  - (b) using prescription medications, except oxygen, while engaged in the practice of Direct-entry midwifery when not licensed under this chapter.
- (2)
  - (a) Except as provided in Subsections (1)(a) and (b), it is lawful to practice Direct-entry midwifery in the state without being licensed under this chapter.
  - (b) The practice of Direct-entry midwifery is not considered the practice of medicine, nursing, or nurse-midwifery.

**Section 14. Section 58-77-502 is enacted to read:**

**58-77-502. Unprofessional conduct.**

In addition to the definition in Subsection 58-1-501 (2), “unprofessional conduct” includes:

- (1) failing to obtain informed consent as described in Subsection 58-77-601
- (2) disregarding a client’s dignity or right to privacy as to her person, condition, possessions, or medical record;
- (3) failing to file or record any medical report as required by law, impeding, or obstructing the filing or recording of the report, or inducing another to fail to file or record the report;
- (4) breaching a statutory, common law, regulatory, or ethical requirement of confidentiality with respect to a person who is a client, unless ordered by the court;
- (5) inappropriately delegating Direct-entry midwifery duties;
- (6) using advertising or an identification statement that is false, misleading, or deceptive;
- (7) using in combination with the term “midwife” the term “nurse” or another title, initial, or designation that falsely implies that the Direct-entry midwife is licensed as a certified nurse midwife, registered nurse, or licensed practical nurse; and
- (8) submitting a birth certificate known by the person to be false or fraudulent.

**Section 15. Section 58-77-503 is enacted to read:**

**58-77-503. Penalty for unlawful conduct.**

A person who violates the unlawful conduct provisions defined in this chapter is guilty of a class A misdemeanor.

**Section 16. Section 58-77-601 is enacted to read:**

**Part 6. Standards of Practice**

**58-77-601. Standards of practice.**

- (1)
  - (a) Prior to providing any services, a licensed Direct-entry midwife must obtain an informed consent from a client.

- (b) The consent must include:
  - (i) the name and license number of the Direct-entry midwife;
  - (ii) the client's name, address, telephone number, and primary care provider, if the client has one;
  - (iii) the fact, if true, that the licensed Direct-entry midwife is not a certified nurse midwife or a physician;
  - (iv) all sections required by the North American Registry of Midwives in its informed consent guidelines, including:
    - (A) a description of the licensed Direct-entry midwife's education, training, continuing education, and experience in midwifery;
    - (B) a description of the licensed Direct-entry midwife's peer review process;
    - (C) the licensed Direct-entry midwife's philosophy of practice;
    - (D) a promise to provide the client, upon request, separate documents describing the rules governing licensed Direct-entry midwifery practice, including a list of conditions indicating the need for consultation, collaboration, referral, transfer or mandatory transfer, and the licensed Direct-entry midwife's personal written practice guidelines;
    - (E) a medical back-up or transfer plan;
    - (F) a description of the services provided to the client by the licensed Direct-entry midwife;
    - (G) the licensed Direct-entry midwife's current legal status;
    - (H) the availability of a grievance process; and
    - (I) client and licensed Direct-entry midwife signatures and the date of signing; and
  - (v) whether the licensed Direct-entry midwife is covered by a professional liability insurance policy.
- (2) A licensed Direct-entry midwife shall appropriately recommend and facilitate consultation with, collaboration with, referral to, or transfer or mandatory transfer of care to a licensed health care professional when the circumstances require that action in accordance with standards established by division rule.
- (3) If after a client has been informed that she has or may have a condition indicating the need for medical consultation, collaboration, referral, or transfer and the client chooses to decline, then the licensed Direct-entry midwife shall:
  - (a) terminate care in accordance with procedures established by division rule; or
  - (b) continue to provide care for the client if the client signs a waiver of medical consultation, collaboration, referral, or transfer.
- (4) If after a client has been informed that she has or may have a condition indicating the need for mandatory transfer, the licensed Direct-entry midwife shall, in accordance with procedures established by division rule, terminate the care or initiate transfer by:
  - (a) calling 911 and reporting the need for immediate transfer;
  - (b) immediately transporting the client by private vehicle to the receiving provider; or
  - (c) contacting the physician to whom the client will be transferred and following that physician's orders.
- (5) For the period from 2006 through 2011, a licensed Direct-entry midwife must submit outcome data to the Midwives' Alliance of North America's Division of Research on the form and in the manner prescribed by rule.
- (6) This chapter does not mandate health insurance coverage for midwifery services.

**Section 17. Section 58-77-602 is enacted to read:**

**58-77-602. Immunity and liability.**

- (1) If a Direct-entry midwife seeks to consult with, refer, or transfer a client to a licensed health care provider or facility, the responsibility of the provider or facility for the client does not begin until the client is physically within the care of the provider or facility.
- (2) A licensed health care provider who examines a Direct-entry midwife's client is only liable for the actual examination and cannot be held accountable for the client's decision to pursue an out-of-hospital birth or the services of a Direct-entry midwife.
- (3)
  - (a) A licensed health care provider may, upon receiving a briefing data from a Direct-entry midwife, issue a medical order for the Direct-entry midwife's client, without that client being an explicit patient of the provider.
  - (b) Regardless of the advice given or order issued, the responsibility and liability for caring for the client is that of the Direct-entry midwife.
  - (c) The provider giving the order is responsible and liable only for the appropriateness of the order given the data received.
  - (d) The issuing of an order for a Direct-entry midwife's client does not constitute a delegation of duties from the other provider to the Direct-entry midwife.
- (4) A licensed health care provider may not be held civilly liable for rendering emergency medical services that arise from prohibited conduct in Section 57-77-603 , or from care rendered under a waiver as specified in Subsection 58-77-601 (3)(b), unless the emergency medical services constitute gross negligence or reckless disregard for the client.
- (5) A licensed Direct-entry midwife shall be solely responsible for the use of medications under this chapter.

# Virginia

## Acts of Assembly — Chapter

An Act to amend the Code of Virginia by adding in Article 4 of Chapter 29 of Title 54.1 sections numbered 54.1-2957.7 through 54.1-2957.13, relating to licensure of midwives.

[H 2038]

Approved

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 4 of Chapter 29 of Title 54.1 sections numbered 54.1-2957.7 through 54.1-2957.13 as follows:

**§ 54.1-2957.7. Licensed midwife and practice of midwifery; definitions.**

“Midwife” means any person who provides primary maternity care by affirmative act or conduct immediately prior to, during, and subsequent to childbirth, and who is not licensed as a doctor of medicine or osteopathy or certified nurse midwife.

“Practicing midwifery” means providing primary maternity care that is consistent with a midwife’s training, education, and experience to women and their newborns throughout the childbearing cycle, and identifying and referring women or their newborns who require medical care to an appropriate practitioner.

**§ 54.1-2957.8. Licensure of midwives; requisite training and educational requirements; fees.**

A. It shall be unlawful for any person to practice midwifery in the Commonwealth or use the title of licensed midwife unless he holds a license issued by the Board. The Board may license an applicant as a midwife after such applicant has submitted evidence satisfactory to the Board that he has obtained the Certified Professional Midwife (CPM) credential pursuant to regulations adopted by the Board and in accordance with the provisions of §§ 54.1-2915 and 54.1-2916.

B. Persons seeking licensure as a midwife shall submit such information as required in the form and manner determined by the Board.

C. Persons seeking licensure shall pay the required license fee as determined by the Board.

**§ 54.1-2957.9. Regulation of the practice of midwifery.**

The Board shall adopt regulations governing the practice of midwifery, upon consultation with the Advisory Board on Midwifery. The regulations shall (i) address the requirements for licensure to practice midwifery, (ii) be consistent with the North American Registry of Midwives’ current job description for the profession and the National Association of Certified Professional Midwives’ standards of practice, except that prescriptive authority and the possession and administration of controlled substances shall be prohibited, (iii) ensure independent practice, (iv) provide for an appropriate license fee, and (v) include requirements for licensure renewal and continuing education. Such regulations shall not (a) require any agreement, written or otherwise, with another health care professional or (b) require the assessment of a woman who is seeking midwifery services by another health care professional.

License renewal shall be contingent upon maintaining a Certified Professional Midwife certification.

**§ 54.1-2957.10. Advisory Board on Midwifery established; membership; duties; terms; sunset.**

A. The Advisory Board on Midwifery is established as an advisory board in the executive branch of state government. The purpose of the Advisory Board is to assist the Board of Medicine in formulating regulations pertaining to the practice of midwifery. The Advisory Board shall also assist in such other matters relating to the practice of midwifery as the Board may require.

B. The Advisory Board shall consist of five nonlegislative citizen members to be appointed by the Governor, subject to confirmation by the General Assembly, including three Certified Professional Midwives, one doctor of medicine or osteopathy or certified nurse midwife who is licensed to practice in the Commonwealth and who has experience in out-of-hospital birth settings, and one citizen who has used out-of-hospital midwifery services. Nonlegislative citizen members of the Advisory Board shall be citizens of the Commonwealth of Virginia.

The initial appointments shall provide for staggered terms with two members being appointed for two-year terms, two members being appointed for three-year terms, and one member being appointed for a four-year term. Thereafter, nonlegislative citizen members shall be appointed for a term of four years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. All members may be reappointed. However, no nonlegislative citizen member shall serve more than two consecutive four-year terms. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment. Vacancies shall be filled in the same manner as the original appointments.

C. The Advisory Board shall elect a chairman and vice chairman from among its membership. A majority of the members shall constitute a quorum. The meetings of the Advisory Board shall be held at the call of the chairman or whenever the majority of the members so request.

D. Members shall receive such compensation for the discharge of their duties as provided in § 2.2-2813. All members shall be reimbursed for reasonable and necessary expenses incurred in the discharge of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the costs of compensation and expenses of the members shall be provided by the Board of Medicine.

E. The Department of Health Professions shall provide staff support to the Advisory Board. All agencies of the Commonwealth shall provide assistance to the Advisory Board, upon request.

F. This section shall expire on July 1, 2008.

**§ 54.1-2957.11. Requirements for disclosure.**

Any person practicing as a licensed midwife shall provide disclosure of specific information in writing to any client to whom midwifery care is provided. Such disclosure shall include (i) a description of the midwife's qualifications, experience, and training; (ii) a written protocol for medical emergencies, including hospital transport, particular to each client; (iii) a description of the midwives model of care; (iv) a copy of the regulations governing the practice of midwifery; (v) a statement concerning the licensed midwife's malpractice or liability insurance coverage; (vi) a description of the right to file a complaint with the Board of Medicine and the procedures for filing such complaint; and (vii) such other information as the Board of Medicine determines is appropriate to allow the client to make an informed choice to select midwifery care.

**§ 54.1-2957.12. Immunity.**

No person other than the licensed midwife who provided care to the patient shall be liable for the midwife's negligent, grossly negligent or willful and wanton acts or omissions. Except as otherwise provided by law, no other licensed midwife, doctor of medicine or osteopathy, nurse, prehospital emergency medical personnel, or hospital as defined in § 32.1-123, or agents thereof, shall be exempt from liability (i) for their own subsequent and independent negligent, grossly negligent or willful and wanton acts or omissions or (ii) if such person has a business relationship with the licensed midwife who provided care to the patient. A doctor of medicine or osteopathy, nurse, prehospital emergency medical person, or hospital as defined in § 32.1-123, or agents thereof, shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with the licensed midwife solely by providing consultation to or accepting referral from the midwife.

**§ 54.1-2957.13. Exceptions.**

The provisions of §§ 54.1-2957.7 through 54.1-2957.12 shall not prevent or prohibit:

1. Any licensed midwife from delegating to an apprentice or personnel in his personal employ and supervised by him such activities or functions that are nondiscretionary and that do not require the exercise of professional judgment for their performance, if such activities or functions are authorized by and performed for the licensed midwife and responsibility for such activities or functions is assumed by the licensed midwife; or
2. Any person from performing tasks related to the practice of midwifery under the direct and immediate supervision of a licensed doctor of medicine or osteopathy, a certified nurse midwife, or a licensed midwife during completion of the North American Registry of Midwifery Portfolio Evaluation Process Program within a time period specified in regulations adopted by the Board.
2. That, notwithstanding the provisions of § 54.1-2902, the practice of midwifery in Virginia prior to the effective date of this act shall not constitute grounds for disciplinary action by the Board of Medicine. The Board may issue a license to a person who has so practiced midwifery in the Commonwealth upon application and compliance with the provisions of this act.
3. That the Board of Medicine shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

# Tennessee

## Code: Title 63 Professions of the Healing Arts:

### CHAPTER 29 MIDWIFERY

#### **63-29-101. Findings of general assembly.**

The general assembly recognizes the need for a person to have the freedom to choose the manner, cost, and setting for giving birth. The general assembly finds that access to prenatal care and delivery services is limited by the inadequate number of providers of such services and that the practice of midwifery may help to reduce this shortage. The general assembly also recognizes the need for the safe and effective delivery of newborn babies and the health, safety, and welfare of their mothers in the delivery process. The general assembly, in the interest of public health, promotes the regulation of the practice of midwifery in this state for the purpose of protecting the health and welfare of women and infants. The general assembly recognizes that midwifery is a profession in its own right and that it is not the practice of medicine.

#### **63-29-102. Chapter definitions.**

As used in this chapter, unless the context requires otherwise:

- (1) “Antepartal” means occurring during pregnancy;
- (2) “Board” means the board of osteopathic examiners of the department of health to which the council of certified professional midwifery reports;
- (3) “Certified professional midwife (CPM)” means a person who has obtained national certification from the North American Registry of Midwives;
- (4) “Consultation” means exchange of information and advice regarding the client condition and indicated treatment with a physician;
- (5) “Council” means the council of certified professional midwifery;
- (6) “CPM-TN” means certified professional midwife in Tennessee. A “CPM-TN” must be certified to practice midwifery by the North American Registry of Midwives;
- (7) “Department” means the department of health;
- (8) “Intrapartal” means occurring during the process of giving birth;
- (9) “Midwife” means a person who is trained to give the necessary care and advice to women during pregnancy, labor, and the post-birth period, to conduct normal deliveries on the midwife’s own responsibility and to care for the newly born infant. The midwife is able to recognize the warning signs of abnormal conditions requiring referral to and/or collaboration with a physician;
- (10) “Midwifery” means the practice of attending low-risk women during pregnancy, labor and the post-birth period with the informed consent of the mother. The scope of midwifery shall include comprehensive care of the pregnant woman during the antepartal phase, intrapartal phase, and postpartal phase, and application of emergency care when necessary;
- (11) “NARM” means the North American Registry of Midwives;
- (12) “Physician” means a person who is duly licensed in the state of Tennessee to practice medicine by the state board of medical examiners or to practice osteopathy by the board; and
- (13) “Postpartal” means occurring subsequent to birth.

#### **63-29-103. Council established.**

- (a) There is hereby established a council of certified professional midwifery, which shall serve as a subcommittee of and report to the board. The council members shall be appointed by the commissioner of health. The council shall consist of nine (9) members.
- (b) Members shall be residents of Tennessee.

- (c) Members shall consist of four (4) certified professional midwives, one (1) consumer, one (1) certified nurse midwife, one (1) obstetrician, one (1) family physician and one (1) pediatrician. At least one (1) of the obstetrician, pediatrician or family physician members shall be a doctor of osteopathy.
- (d) Members of the council shall serve without pay. Members shall be entitled to reimbursement for per diem and travel expenses.

**63-29-104. Members - Terms of office.**

The terms of office of the members of the council shall be staggered four-year terms. In making the initial appointments, the commissioner shall appoint four (4) members to four-year terms, three (3) members to three-year terms and two (2) members to two-year terms. All subsequent terms shall be for a period of four (4) years. No member shall be appointed for more than two (2) consecutive terms.

**63-29-105. Removal of council member for absenteeism.**

When a council member is absent from three (3) consecutive meetings without excuse, that member shall be removed from office, and a new member shall be appointed by the commissioner of health. An absence shall be deemed excused if caused by a health problem or condition verified in writing by a physician, or by an accident or similar unforeseeable tragedy or event prior to or at the time of the next council meeting.

**63-29-106. Election of chairpersons - Quorum - Meetings - Notice - Records.**

- (a) The council members shall elect annually from their membership a chair and vice chair.
- (b) A quorum shall consist of two thirds (2/3) of the members.
- (c) No final action shall be taken on any matter without a quorum and majority vote of the members present.
- (d) The council shall meet at least every six (6) months.
- (e) Emergency meetings may be called by the chair with written notice to all members.
- (f) Public notice shall be given for all meetings.
- (g) All meetings are open to the public.
- (h) All records are available to the public. Persons wishing to obtain copies of such records may request the same in writing from the council.

**63-29-107. Responsibilities of council.**

The council shall:

- (1) Assist and advise the board and the department in developing rules with guidance from the Midwives Alliance of North America's Core Competencies and not inconsistent with the law. The rules shall include, but not be limited to, the allowable scope of midwifery practice regarding use of equipment, procedures, and administration of medication as prescribed by a physician.
- (2) Make recommendations to the board and the department regarding:
  - (A) Certified professional midwifery;
  - (B) Applications and renewals;
  - (C) Development of forms for reporting and receiving certified professional midwifery forms as set forth herein;
  - (D) Up-to-date files on all active CPM-TN in Tennessee including emergency plan guidelines; and
  - (E) Compilation of annual statistics on CPM-TN deliveries.
- (3) Educate the public and other providers of obstetrical care about the role of the CPM-TN.

**63-29-108. Certification.**

- (a) A midwife who has met the standards set forth in this chapter may apply to the board for Tennessee certification. An application for Tennessee certification shall provide information as required by this section and as may be required by the board. Except for the American College of Nurse Midwives certified midwives and certified nurse midwives, a certificate under this chapter is required to practice midwifery for monetary compensation in which service has been offered for a fee. A certificate under

this chapter is not required for certified nurse midwives who maintain their licensure as registered nurses pursuant to title 63, chapter 7.

- (b) In order to receive certification as a CPM-TN, an applicant shall:
  - (1) Obtain certification from NARM and currently hold the title of CPM;
  - (2) Read, understand, and agree to practice under the guidelines set forth herein and any rules promulgated pursuant to this chapter; and
  - (3) Have proof of current CPR certification including infant or neonatal resuscitation.

**63-29-109. Title - Term of initial certificate - Renewal - Denial of applications - Third party payment.**

- (a) A midwife who is certified under the standard found in § 63-29-108 may use the initials “CPM-TN.”
- (b) An initial certificate is available for a three-year period.
- (c) The certificate is renewable every two (2) years after the initial three-year period.
- (d) Renewal is available to the CPM who maintains current certification from NARM by complying with the continuing education requirement applicable to the CPM.
- (e) Renewal is available to the CPM-TN whose certification from NARM remains in good standing and who has current CPR certification.
- (f) The board may deny an application for certification only if the applicant is not in compliance with the standards herein.
- (g) A CPM-TN may receive third party payment from private agencies that provide coverage for maternity and obstetrical care. No managed care organization or insurance company shall require a patient to be served by a CPM-TN instead of a medical doctor or a nurse practitioner.

**63-29-110. Status.**

Any CPM who is not practicing midwifery in Tennessee may be placed in inactive status by requesting such status in writing and submitting it to the council. Active status may be renewable by requesting a change of status from inactive to active in writing to the council and by fulfilling the requirements for renewal set forth in this chapter.

**63-29-111. Reapplication after expiration of certificate.**

Any CPM who does not seek inactive status and allows the certificate to expire after a sixty (60) day grace period must apply for a new certificate as prescribed in this chapter.

**63-29-112. Fees.**

The application and renewal fees are to be set by the commissioner of health and shall not be less than that sum necessary to permit the council to recover its costs of operation.

**63-29-113. Display of certificate.**

The certificate shall be displayed at all times in a conspicuous place where the CPM-TN is practicing, when applicable.

**63-29-114. Revocation or suspension of license - Appeals.**

- (a) (1) A CPM-TN’s license may be revoked or suspended for any of the grounds set forth in subdivision (2), or for failing to follow the standards set forth in this section. Such action may occur only after investigations by the department. Any action on the certification shall be made by the council, subject to approval by the board.
- (2) The board has the power to deny, revoke or suspend any certificate or to otherwise discipline a certificate holder upon proof that the person:
  - (A) Is guilty of fraud or deceit in procuring or attempting to procure a certificate to practice midwifery;
  - (B) Is guilty of a crime;
  - (C) Is unfit or incompetent by reason of negligence, habits or other cause;
  - (D) Is addicted to alcohol or drugs to the degree of interfering with midwifery duties;
  - (E) Is mentally incompetent;

- (F) Is guilty of unprofessional conduct; or
  - (G) Has violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of, or conspired to violate, any provision of this chapter or any lawful order of the board issued pursuant thereto.
- (b) If the council decides to consider discipline of a certificate holder, the same organization shall notify the CPM in writing of the reasons for such consideration. The notice shall set forth the time, place, and date of the meeting at which the council shall take action. Such meeting shall not be set less than thirty (30) days from the mailing of the notice.
  - (c) If the CPM desires a hearing by the council, the CPM shall notify the chair of the council in writing within fifteen (15) days after receipt of notice. The council shall then set a hearing to occur within no less than fifteen (15) days and no more than forty-five (45) days. The council shall then notify the CPM in writing of the findings and grounds for the decision. The decision shall take effect immediately upon being reduced to writing and signed by the chair of the council.
  - (d) All notification required by this section shall be in writing and shall be sent by certified, return receipt requested mail or by personal delivery.
  - (e) The following procedure shall govern the conduct of appeals hearings before the council:
    - (1) The appellant shall have the right, but not be required, to be represented by counsel.
    - (2) The council shall arrange for a notary public or other officer empowered to administer oaths to be in attendance at every hearing, and all evidence offered shall be under oath.
    - (3) All proceedings of all hearings before the council shall be recorded.

**63-29-115. Responsibilities of midwife.**

- (a) The CPM-TN may provide care for the low-risk client who is expected to have a normal pregnancy, labor, birth and postpartal phase in the setting of the mother's choice. The CPM-TN shall form a collaborative care plan with a physician for all clients.
- (b) The CPM-TN shall ensure that the client has signed an informed consent form. This form shall include information to inform the client of the qualifications of the CPM-TN.
- (c) For screening purposes only, the CPM-TN may order routine antepartal and postpartal laboratory analysis to be performed by a licensed laboratory. Abnormal findings would require a consultation with a physician.
- (d) The CPM-TN shall develop an emergency plan that shall be signed by the client and placed in the client chart at the initial visit. The emergency plan shall include documentation of the initial consultation with the physician previously referenced in subsection (a). The documentation shall also include referral and transfer plans for the patient in the event of an emergency. A copy of the plan shall be sent to the named physicians.
- (e) The CPM-TN shall determine the progress of labor and, when birth is imminent, shall be available until delivery is accomplished.
- (f) The CPM-TN shall remain with the postpartal mother during the postpartal period until the conditions of the mother and newborn are stabilized.
- (g) The CPM-TN shall instruct the parents regarding the requirements of § 68-5-202.
- (h) The CPM-TN shall instruct the parents regarding the requirement of § 68-5-401.
- (i) The CPM-TN shall maintain a birth certificate for each birth in accordance with the requirements of title 68. A copy of the birth certificate shall be filed with the department.
- (j) The CPM-TN shall practice in compliance with the rules and regulations promulgated pursuant to this chapter.

**63-29-116. Rules and regulations.**

The board and department, with assistance and advice from the council, are authorized to promulgate rules and regulations to effectuate the purposes of this chapter. All such rules and regulations shall be promul-

gated in accordance with the provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

## **General Rules Governing Certified Professional Midwives**

### **1050-5-.01 DEFINITIONS.**

As used in this chapter, the following terms and acronyms shall have the following meaning ascribed to them:

- (1) Administrative Office - The office of the administrator assigned to the Board and Council located on the First Floor, Cordell Hull Building, 425 5th Avenue North, Nashville, Tennessee 37247-1010.
- (2) CPR - Cardiopulmonary resuscitation.
- (3) Division - The Division of Health Related Boards, Tennessee Department of Health, from which the Council receives administrative support.
- (4) NARM - The North American Registry of Midwives.

Authority: T.C.A. §§4-5-202, 4-5-204, 63-9-101, 63-29-101 et seq., and 63-29-116. Administrative History: Original rule filed February 4, 2002; effective April 20, 2002. Amendment filed April 8, 2003; effective June 22, 2003.

### **1050-5-.02 SCOPE OF PRACTICE.**

The scope of midwifery practice shall be as set forth in Tennessee Code Annotated, Sections 63-29-102 (9) and (10) and 63-29-115. As an aid to interpretation and application of that scope of practice, the Council adopts, as if fully set out herein, and as it may from time to time be amended, the “Practice Guidelines” issued by the Tennessee Midwives Association. In the event that the “Practice Guidelines are in conflict with any portion of Tennessee Code Annotated §§ 63-29-101, et seq. (Midwifery Practice Act) the “Midwifery Practice Act” shall govern. Information on how to acquire a copy of the “Practice Guidelines” may be obtained by contacting the Board’s administrative office.

### **1050-5-.05 CERTIFICATION PROCESS.**

- (1) Applications
  - (a) Any individual who desires to practice as a certified professional midwife in Tennessee shall apply for certification to the Council on forms provided by the Council, and shall submit the fees required by rule 1050-5-.06.
  - (b) It is the intent of this rule that all steps necessary to accomplish the filing of the required documentation be completed prior to filing an application and that all documentation be filed simultaneously.
  - (c) Application review and certification decisions shall be governed by rule 1050-2-.05, where applicable.
- (2) Requirements
  - (a) An applicant shall have current certification from the North American Registry of Midwives. It is the applicant’s responsibility to request verification of current NARM certification be submitted directly from NARM to the Council’s administrative office.
  - (b) An applicant shall have current certification in CPR, including infant or neonatal resuscitation. The applicant shall submit a notarized photocopy of current certification in CPR with his/her application for certification as a CPM-TN.
  - (c) An applicant shall submit a clear and recognizable, recently taken, bust photograph which shows the full head, face forward from at least the top of the shoulders up.
  - (d) An applicant shall submit evidence of good moral character. Such evidence shall include at least two (2) letters attesting to the applicant’s character. One (1) of the required letters shall be sub-

mitted from a health care professional on the signator's letterhead. No letters from family members or relatives shall be accepted.

- (e) If an applicant has ever been authorized to practice as a professional midwife in any other state or country, the applicant shall cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from each such licensing agency which indicates the applicant either holds a current or active authorization to practice as a professional midwife and whether it is in good standing, or has held an authorization to practice as a professional midwife which is currently inactive and whether it was in good standing at the time it became inactive. It is the applicant's responsibility to request this information be submitted directly from each such licensing agency to the Council's administrative office.
- (f) An applicant shall disclose the circumstances surrounding any of the following:
  - 1. Conviction of any criminal law violation of any country, state or municipality, except minor traffic violations.
  - 2. The denial of professional licensure/certification application by any other state or the discipline of any professional licensure/certification in any state.
  - 3. Loss or restriction of professional licensure/certification.
  - 4. Any civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract, antitrust activity or any other civil action remedy recognized under the country's or state's statutory common or case law.
  - 5. Failure of any professional licensure or certification examination.

#### **1050-5-.06 FEES.**

- (1) Application fee \$ 500.00
- (2) Biennial renewal fee \$ 500.00
- (3) Late renewal fee \$ 15.00
- (4) Reinstatement fee \$ 50.00
- (5) Duplicate certificate fee \$ 5.00
- (6) Biennial state regulatory fee \$ 10.00
- (7) All fees may be paid in person, by mail or electronically by cash, check, money order, or by credit and/or debit cards accepted by the Division. If the fees are paid by certified, personal or corporate check they must be drawn against an account in a United States Bank, and made payable to the Tennessee Council of Certified Professional Midwifery.

#### **1050-5-.07 APPLICATION REVIEW, APPROVAL, AND DENIAL.**

Review, approval and denial of all applications under this chapter of rules shall be governed by rule 1050-2-.05

#### **1050-5-.09 CERTIFICATION RENEWAL.**

All Professional midwives certified by the Council must renew their certification to be able to continue in practice. Certification renewal is governed by the following:

- (1) The due date for renewal is the last day of the month in which a certificate holder's birth date falls pursuant to the Division of Health Related Board's biennial birth date renewal system.
- (2) Methods of Renewal - Certificate holders may accomplish renewal by one of the following methods:
  - (a) Internet Renewals - Individuals may apply for renewal and pay the necessary fees via the Internet. The application to renew can be accessed at: [www.tennesseeanytime.org](http://www.tennesseeanytime.org)
  - (b) Paper Renewals - Certificate holders who have not renewed their authorization online via the Internet, will have a renewal application form mailed to them at the last address provided by them to the Board. Failure to receive such notification does not relieve the individual of the responsibility of timely meeting all requirements for renewal. To be eligible for renewal a certificate

holder must submit to the Division of Health Related Boards on or before the certificate holder's expiration date the following:

1. A completed and signed renewal application form.
  2. The renewal and state regulatory fees as provided in Rule 1050-5-.06.
  3. Attestation of compliance with NARM continuing education requirements so that current NARM certification in good standing is maintained.
  4. Attestation of maintaining current CPR certification, as provided in rule 1050-5-.05.
- (3) Any renewal application received after the expiration date but before the last day of the month following the expiration date must be accompanied by the late renewal fee provided in Rule 1050-5-.06.
- (4) Any certificate holder who receives notice of failure to timely renew pursuant to rule 1200-10-1-.10, and who, on or before the last day of the second (2nd) month following the month in which the certificate expires, executes and files in the Council's administrative office an affidavit of retirement pursuant to Rule 1050-5-.11 may have their certificate retired effective on their certification expiration date.
- (5) Anyone submitting a signed renewal form, electronically or otherwise, which is found to be fraudulent or untrue may be subject to disciplinary action.
- (6) Any individual who fails to comply with the certificate renewal rules and/or notifications sent to them concerning failure to timely renew shall have their certificate processed pursuant to rule 1200-10-1-.10.
- (7) Certificates processed pursuant to rule 1200-10-1-.10 for failure to renew may be reinstated upon meeting the following conditions:
- (a) Submit a written request for a Renewal/Reinstatement/Reactivation Application to the Council's Administrative Office; and
  - (b) Complete and submit to the Council's Administrative Office the Renewal/ Reinstatement/Reactivation Application along with the payment of all past due renewal fees; state regulatory fee and the reinstatement fee provided in rule 1050-5-.06; and
  - (c) Submit any documentation which may be required by the form to the Council's Administrative Office; and
  - (d) If requested, after review by the Council or its duly authorized representative, appear before either the Council for an interview regarding continued competence in the event expiration of certification was in excess of two (2) years or there was receipt of derogatory information or communication during the reinstatement process, and/or be prepared to meet or accept other conditions or restrictions as the Council may deem necessary to protect the public.
  - (e) If certification expiration was in excess of five (5) years, the certificate holder may be required to successfully complete requirements the Council feels necessary to establish current levels of competency.
- (8) Renewal issuance and reinstatement decisions pursuant to this Rule may be made administratively subject to review by the Council, any Council member, or the Council's Designee.

#### **1050-5-.11 INACTIVE STATUS AND REACTIVATION.**

- (1) Certificate holders who wish to retain their certification but not actively practice as a professional midwife may avoid compliance with the certification renewal process by doing the following:
  - (a) Obtain from, complete and submit to the Council's administrative office an inactive status affidavit form.
  - (b) Submit any documentation which may be required by the form to the Council's administrative office.
  - (c) Upon successful application for inactive status with completion and receipt of all proper documentation to the Council's satisfaction, the Council shall register the Certificate as inactive. Any person who has an inactive certificate may not practice as a CPM-TN.

- (2) Reactivation - Any certificate holder whose certification has been placed in inactive status may reenter active practice by doing the following:
  - (a) Submit a written request for a Renewal/Reinstatement/Reactivation Application to the Council's administrative office; and
  - (b) Complete and submit the Council's Renewal/Reinstatement/Reactivation Application along with payment of the certification renewal fee as provided in Rule 1050-5-.06 to the Council's administrative office. If reactivation was requested prior to the expiration of one (1) year from the date of acquiring inactive status, the Council may require payment of the reinstatement fee and past due renewal fees as provided in Rule 1050-5-.06; and
  - (c) Submit any documentation which may be required by the form to the Council's Administrative Office; and
  - (d) If requested, after review by the Council or its duly authorized representative, appear before either the Council for an interview regarding continued competence in the event of inactivation of certification in excess of two (2) years or the receipt of derogatory information or communication during the reactivation process and/or be prepared to meet or accept other conditions or restrictions as the Council may deem necessary to protect the public.
  - (e) If certification inactivation was in excess of five (5) years, the certificate holder may be required to successfully complete requirements the Council feels necessary to establish current levels of competency.

#### **1050-5-.12 CONTINUING EDUCATION.**

- (1) To be eligible for renewal of certification the continuing education requirements imposed by NARM must be complied with and attestation of compliance submitted at renewal time.
- (2) Having successfully completed the certification requirements of NARM as provided in rule .05 of this chapter shall be considered proof of sufficient education to constitute compliance with continuing education requirements for the initial three (3) year certification period for individuals who are certified by the Council during their first three years of certification with NARM.
- (3) All certificate holders must retain independent documentation acceptable to NARM of completion of all continuing education hours. This documentation must be retained for a period of four (4) years from the end of the renewal period in which the continuing education was acquired. This documentation must be produced for inspection and verification, if requested in writing by the Division during its verification process.
- (4) Anyone who falsely attests to completion of the required hours of continuing education may be subject to disciplinary action pursuant to Rule 1050-5-.15.
- (5) Anyone who fails to obtain the required continuing education hours may be subject to disciplinary action pursuant to Rule 1050-5-.15 and may not be allowed to renew certification.
- (6) Education hours obtained as a result of compliance with the terms of Council and/or Board Orders in any disciplinary action shall not be credited toward the continuing education hours required to be obtained in any renewal period.

#### **1050-5-.13 PROFESSIONAL ETHICS.**

All certificate holders shall comply with the codes of ethics adopted by the Midwives Alliance of North America except to the extent that they conflict with the laws of the state of Tennessee or the rules of the Council and/or Board. If the codes of ethics conflict with state law or rules, the state law or rules govern the matter. Violation of the codes of ethics or state law or rules may subject a certificate holder to disciplinary action.

#### **1050-5-.15 DISCIPLINARY GROUNDS, ACTIONS, AND CIVIL PENALTIES.**

- (1) Upon a finding by the Council and Board that a certificate holder has violated any provision of the T.C.A. § 63-29-114 or the rules promulgated pursuant thereto, the Council and Board may take any of the following actions separately or in any combination which is deemed appropriate to the offense;

- (a) Warning Letter - This is a written action issued for minor or near infractions. It is informal and advisory in nature and does not constitute a formal disciplinary action.
  - (b) Reprimand - This is a written action issued for one time and less severe violations. It is a formal disciplinary action.
  - (c) Probation - This is a formal disciplinary action which places a certificate holder on close scrutiny for a fixed period of time. This action may be combined with conditions that must be met before probation will be lifted and/or which restrict the individual's activities during the probationary period.
  - (d) Certificate Suspension - This is a formal disciplinary action that suspends the right to practice for a fixed period of time. It contemplates the re-entry into practice under the certificate previously issued.
  - (e) Revocation For Cause - This is the most severe form of disciplinary action which removes an individual from the practice of the profession and terminates the certificate previously issued. The Council and Board, in their discretion, may allow reinstatement of a revoked certificate upon conditions and after a period of time which they deem appropriate. No petition for reinstatement and no new application for certification from a person whose certificate was revoked for cause shall be considered prior to the expiration of at least six (6) months from the effective date of the revocation order.
  - (f) Conditions - Any action deemed appropriate by the Council and Board to be required of a disciplined certificate holder during any period of probation or suspension or as a pre-requisite to the lifting of probation or suspension or the reinstatement of a revoked certificate.
  - (g) Civil Penalty - A monetary disciplinary action assessed by the Council and Board pursuant to the procedures and schedules contained in paragraph (2).
- (2) Civil Penalties
- (a) Purpose - The purpose of this rule is to set out a schedule designating the minimum and maximum civil penalties which may be assessed pursuant to T.C.A. § 63-1-134.
  - (b) Schedule of Civil Penalties.
    1. A "Type A" Civil Penalty may be imposed whenever the Council and Board find a person who is required to be licensed, certified, permitted, or authorized by the Council and Board, guilty of a willful and knowing violation of T.C.A. §§ 63-29-101, et seq., or regulations promulgated pursuant thereto, to such an extent that there is, or is likely to be, an imminent, substantial threat to the health, safety and welfare of an individual patient or the public. For purposes of this section, willfully and knowingly practicing without a certificate is one of the violations for which a "Type A" Civil Penalty is assessable.
    2. A "Type B" Civil Penalty may be imposed whenever the Council and Board find the person required to be licensed, certified, permitted, or authorized by the Council and Board is guilty of a violation T.C.A. §§ 63-29-101, et seq., or regulations promulgated pursuant thereto in such manner as to impact directly on the care of patients or the public.
    3. A "Type C" Civil Penalty may be imposed whenever the Council and Board find the person required to be licensed, certified, permitted, or authorized by the Council and Board is guilty of a violation of T.C.A. §§ 63-29-101, et seq., or regulations promulgated pursuant thereto, which are neither directly detrimental to the patients or public, nor directly impact their care, but have only an indirect relationship to patient care or the public.
  - (c) Amount of Civil Penalties.
    1. "Type A" Civil Penalties shall be assessed in the amount of not less than \$500 nor more than \$1000.
    2. "Type B" Civil Penalties shall be assessed in the amount of not less than \$100 and not more than \$500.

3. "Type C" Civil Penalties shall be assessed in the amount of not less than \$50 and not more than \$100.
- (d) Procedures for Assessing Civil Penalties.
1. The Division of Health Related Boards may initiate a civil penalty assessment by filing a Memorandum of Assessment of Civil Penalty. The Division shall state in the memorandum the facts and law upon which it relies in alleging a violation, the proposed amount of the civil penalty and the basis for such penalty. The Division may incorporate the Memorandum of Assessment of Civil Penalty with a Notice of Charges which may be issued attendant thereto.
  2. Civil Penalties may also be initiated and assessed by the Council and Board during consideration of any Notice of Charges. In addition, the Council and Board may, upon good cause shown, assess a type and amount of civil penalty which was not recommended by the Division.
  3. In assessing the civil penalties pursuant to these rules the Council and Board may consider the following factors:
    - (i) Whether the amount imposed will be a substantial economic deterrent to the violator;
    - (ii) The circumstances leading to the violation;
    - (iii) The severity of the violation and the risk of harm to the public;
    - (iv) The economic benefits gained by the violator as a result of non-compliance; and
    - (v) The interest of the public.
  4. All proceedings for the assessment of civil penalties shall be governed by the contested case provisions of Title 4, Chapter 5, T.C.A.

**1050-5-.16 REPLACEMENT CERTIFICATES.**

A Certificate holder whose "artistically designed" Certificate has been lost or destroyed may be issued a replacement document upon receipt of a written request in the Administrative Office. Such request shall be accompanied by an affidavit (signed and notarized) stating the facts concerning the loss or destruction of the original document and the fee required pursuant to Rule 1050-5-.06.

**1050-5-.17 CHANGE OF NAME AND/OR ADDRESS.**

- (1) Change of Name - Any certificate holder shall notify the Administrative Office in writing within thirty (30) days of a name change and must provide both the old and new names. A name change notification must also include a copy of the official document involved and reference the individual's profession, council/board, social security number, and certificate numbers.
- (2) Change of Address - Each person holding a certificate who has had a change of address shall file in writing with the Administrative Office his/her current address providing both the old and new addresses. Such requests must be received in the Administrative Office no later than thirty (30) days after such change is effective and must reference the individual's name, profession, social security number, and certificate number.

**1050-5-.19 COUNCIL OFFICERS, CONSULTANTS, RECORDS, AND DECLARATORY ORDERS.**

- (1) The Council shall annually elect from its members the following officers:
  - (a) Chairperson - who shall preside at all meetings of the Council; and
  - (b) Vice-Chairperson - who shall preside at meetings in the absence of the Chairperson and who along with the Council Administrator shall be responsible for correspondence from the Council.
- (2) The Council has the authority to select a Council consultant who shall serve as a consultant to the Division and who is vested with the authority to do the following acts:
  - (a) Review complaints and recommend whether and what type of disciplinary actions should be instituted as the result of complaints received or investigations conducted by the Division.

- (b) Recommend whether and upon what terms a complaint, case or disciplinary action might be settled. Any matter proposed for settlement must be subsequently reviewed, evaluated and ratified by the Council and Board before it becomes effective.
  - (c) Undertake any other matter authorized by a majority vote of the Council and/or Board.
- (3) Records and Complaints
- (a) Minutes of the Council meetings and all records, documents, applications and correspondence will be maintained in the Administrative Offices.
  - (b) All requests, applications, notices, other communications and correspondence shall be directed to the Administrative Office. Any requests or inquiries requiring a Council decision or official Council action except documents relating to disciplinary actions, or hearing requests must be received fourteen (14) days prior to a scheduled meeting and will be retained in the Administrative Office and presented to the Council at the Council meeting. Such documents not timely received shall be set over to the next Council meeting.
  - (c) All records of the Council, except those made confidential by law, are open for inspection and examination, under the supervision of an employee of the Division at the Administrative Office during normal business hours.
  - (d) Copies of public records shall be provided to any person upon payment of a fee.
  - (e) All complaints should be directed to the Division's Investigations Section.
- (4) The Council members or the Consultant are individually vested with the authority to do the following acts:
- (a) Review and make determination on certification, renewal and reactivation of applications subject to the rules governing those respective applications and subject to the subsequent ratification by the Council and Board.
  - (b) Serve as Consultant to the Division to decide the following:
    1. Whether and what type disciplinary actions should be instituted upon complaints received or investigations conducted by the Division.
    2. Whether and under what terms a complaint, case or disciplinary action might be settled. Any proposed settlement must be subsequently ratified by the Council and Board.
- (5) The Council shall designate one (1) of its members or the Consultant to make determinations pursuant to Rule 1360-4-1-.18.
- (6) Requests for Verification of Licensure for a certified midwife desiring to practice in another state must be made in writing to the Administrative Office.
- (7) Declaratory Orders - The Council adopts, as if fully set out herein, rule 1200-10-1-.11, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the declaratory order process. All declaratory order petitions involving statutes, rules or orders within the jurisdiction of the Council shall be addressed by the Council pursuant to that rule and not by the Division. Declaratory Order Petition forms can be obtained from the Administrative Office.

# Wisconsin

Date of enactment: April 10, 2006

2005 Senate Bill 477 Date of publication\*: April 20, 2006

2005 WISCONSIN ACT 292

AN ACT to amend 440.042 (1), 441.15 (2) (intro.) and 448.03 (2) (a); and to create 440.08 (2) (a) 46w., subchapter XI of chapter 440 [precedes 440.980] and 441.15 (2m) of the statutes; relating to: licensing midwives, granting rule-making authority, and providing a penalty.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

**SECTION 1. 440.042 (1) of the statutes is amended to read:**

440.042 (1) The secretary may appoint persons or advisory committees to advise the department and the boards, examining boards, and affiliated credentialing boards in the department on matters relating to the regulation of credential holders. The secretary shall appoint an advisory committee to advise the department on matters relating to and making investigations, conducting hearings, and taking disciplinary action under s. 440.986. A person or an advisory committee member appointed under this subsection shall serve without compensation, but may be reimbursed for his or her actual and necessary expenses incurred in the performance of his or her duties.

**SECTION 1m. 440.08 (2) (a) 46w. of the statutes is created to read:**

440.08 (2) (a) 46w. Midwife, licensed: July 1 of each even-numbered year; \$56.

**SECTION 2. Subchapter XI of chapter 440 [precedes 440.980] of the statutes is created to read:**

CHAPTER 440

SUBCHAPTER XI

LICENSED MIDWIVES

**440.980 Definitions. In this subchapter:**

- (1) “Health care provider” means a health care provider, as defined in s. 146.81 (1), a person licensed or issued a training permit as an emergency medical technician under s. 146.50, or a person certified as a first responder under s. 146.50 (8).
- (2) “Licensed midwife” means a person who has been granted a license under this subchapter to engage in the practice of midwifery.
- (3) “Practice of midwifery” means providing maternity care during the antepartum, intrapartum, and postpartum periods.

**440.981 Use of title; penalty.**

- (1) No person may use the title “licensed midwife,” describe or imply that he or she is a licensed midwife, or represent himself or herself as a licensed midwife unless the person is granted a license under this subchapter or is licensed as a nurse-midwife under s. 441.15.
- (2) Any person who violates sub. (1) may be fined not more than \$250, imprisoned not more than 3 months, or both.

**440.982 Licensure.**

- (1) No person may engage in the practice of midwifery unless the person is granted a license under this subchapter, is granted a temporary permit pursuant to a rule promulgated under s. 440.984 (2m), or is licensed as a nurse-midwife under s. 441.15.

Section 991.11, WISCONSIN STATUTES 2003-04 : Effective date of acts. “Every act and every portion of an act enacted by the legislature over the governor’s partial veto which does not expressly prescribe the time

when it takes effect shall take effect on the day after its date of publication as designated” by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

- (1m) Except as provided in sub. (2), the department may grant a license to a person under this subchapter if all of the following apply:
- (a) The person submits an application for the license to the department on a form provided by the department.
  - (b) The person pays the fee specified in s. 440.05 (1).
  - (c) The person submits evidence satisfactory to the department of one of the following:
    1. The person holds a valid certified professional midwife credential granted by the North American Registry of Midwives or a successor organization.
    2. The person holds a valid certified nurse–midwife credential granted by the American College of Nurse Midwives or a successor organization.
- (2) The department may not grant a license under this subchapter to any person who has been convicted of an offense under s. 940.22, 940.225, 944.06, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.06, 948.07, 948.075, 948.08, 948.09, 948.095, 948.10, 948.11, or 948.12.

#### **440.983 Renewal of licensure.**

- (1) The renewal date for licenses granted under this subchapter is specified in s. 440.08 (2) (a). Renewal applications shall be submitted to the department on a form provided by the department and shall include the renewal fee specified in s. 440.08 (2) (a).
- (2) A licensed midwife shall, at the time that he or she applies for renewal of a license under sub. (1), submit proof satisfactory to the department that he or she holds a valid certified professional midwife credential from the North American Registry of Midwives or a successor organization or a valid certified nurse–midwife credential from the American College of Nurse Midwives or a successor organization.

#### **440.984 Rule making.**

- (1) The department shall promulgate rules necessary to administer this subchapter. Except as provided in subs. (2), (2m), and (3), any rules regarding the practice of midwifery shall be consistent with standards regarding the practice of midwifery established by the National Association of Certified Professional Midwives or a successor organization.
- (2) The rules shall allow a licensed midwife to administer oxygen during the practice of midwifery.
- (2m) The rules shall provide for the granting of temporary permits to practice midwifery pending qualification for licensure.
- (3) The rules may allow a midwife to administer, during the practice of midwifery, oxytocin (Pitocin) as a postpartum antihemorrhagic agent, intravenous fluids for stabilization, vitamin K, eye prophylactics, and other drugs or procedures as determined by the department.
- (4) The rules may not do any of the following:
  - (a) Require a licensed midwife to have a nursing degree or diploma.
  - (b) Require a licensed midwife to practice midwifery under the supervision of, or in collaboration with, another health care provider.
  - (c) Require a licensed midwife to enter into an agreement, written or otherwise, with another health care provider.
  - (d) Limit the location where a licensed midwife may practice midwifery.
  - (e) Permit a licensed midwife to use forceps or vacuum extraction.

**440.985 Informed consent.**

A licensed midwife shall, at an initial consultation with a client, provide a copy of the rules promulgated by the department under this subchapter and disclose to the client orally and in writing all of the following:

- (1) The licensed midwife's experience and training.
- (2) Whether the licensed midwife has malpractice liability insurance coverage and the policy limits of any such coverage.
- (3) A protocol for medical emergencies, including transportation to a hospital, particular to each client.
- (4) Any other information required by department rule.

**440.986 Disciplinary proceedings and actions.**

- (1) Subject to the rules promulgated under s. 440.03 (1), the department may conduct investigations and hearings to determine whether a violation of this subchapter or any rule promulgated under this subchapter has occurred.
- (2) Subject to the rules promulgated under s. 440.03 (1), the department may reprimand a licensed midwife or deny, limit, suspend, or revoke a license granted under this subchapter if the department finds that the applicant or the licensed midwife has done any of the following:
  - (a) Intentionally made a material misstatement in an application for a license or for renewal of a license.
  - (b) Subject to ss. 111.321, 111.322, and 111.34, practiced midwifery while his or her ability to engage in the practice was impaired by alcohol or other drugs.
  - (c) Advertised in a manner that is false or misleading.
  - (d) In the course of the practice of midwifery, made a substantial misrepresentation that was relied upon by a client.
  - (e) In the course of the practice of midwifery, engaged in conduct that evidences an inability to apply the principles or skills of midwifery.
  - (f) Obtained or attempted to obtain compensation through fraud or deceit.
  - (g) Allowed another person to use a license granted under this subchapter.
  - (h) Violated any law of this state or federal law that substantially relates to the practice of midwifery, violated this subchapter, or violated any rule promulgated under this subchapter.
- (3) Subject to the rules promulgated under s. 440.03(1), the department shall revoke a license granted under this subchapter if the licensed midwife is convicted of any of the offenses specified in 440.982 (2).

**440.987 Advisory committee.**

If the department appoints an advisory committee under s. 440.042 to advise the department on matters relating to the regulation of licensed midwives, the committee shall consist of only the following:

- (1) Two members who are licensed midwives.
- (2) One member who is licensed as a nurse-midwife under s. 441.15 and who practices in an out-of-hospital setting.
- (3) One member who is a physician specializing in obstetrics and gynecology.
- (4) One public member who has received midwifery care in an out-of-hospital setting.

**440.988 Vicarious liability.**

No health care provider shall be liable for an injury resulting from an act or omission by a licensed midwife, even if the health care provider has consulted with or accepted a referral from the licensed midwife.

**SECTION 3. 441.15 (2) (intro.) of the statutes is amended to read:**

441.15 (2) (intro.) Except as provided in sub.(2m), no person may engage in the practice of nurse–midwifery unless each of the following conditions is satisfied:

**SECTION 4. 441.15 (2m) of the statutes is created to read:**

441.15 (2m) Subsection (2) does not apply to a person granted a license to practice midwifery under subch. XI of ch. 440.

**SECTION 5. 448.03 (2) (a) of the statutes is amended to read:**

448.03 (2) (a) Any person lawfully practicing within the scope of a license, permit, registration, certificate or certification granted to practice midwifery under subch.

XI of ch. 440, to practice professional or practical nursing or nurse–midwifery under ch. 441, to practice chiropractic under ch. 446, to practice dentistry or dental hygiene under ch. 447, to practice optometry under ch. 449, to practice acupuncture under ch. 451 or under any other statutory provision, or as otherwise provided by statute.

**SECTION 6.0 Nonstatutory provisions.**

- (1) Notwithstanding section 440.987 (1) of the statutes, as created by this act, an initial member of an advisory committee appointed under section 440.987 (1) of the statutes is not required to be a licensed midwife under section 440.982 of the statutes, as created by this act, if the appointment occurs before the first day of the 13th month beginning after publication and at the time of the appointment the individual holds a valid certified professional midwife credential granted by the North American Registry of Midwives or a successor organization.

**SECTION 7.0 Effective dates.**

This act takes effect on the first day of the 13th month beginning after publication, except as follows:

- (1) The treatment of section 440.987 of the statutes and SECTION 6 of this act take effect on the day after publication.

## Note:

This workbook is an ongoing project. It will be updated yearly, and new information will be added based on what is working in other states. Please contact NARM with your ideas.

It is very valuable to keep a written history of your legislative work. Almost like a journal, the daily activities, successes, and frustrations will be an important part of your history, and will be helpful to others who walk this path after you.

Please let us include your history and your ideas in the future editions of this workbook.

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