ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

STATE LEGISLATIVE TOOLKIT:

Licensure and Regulation of Certified Professional Midwives (CPMs)

How to use this toolkit:

This toolkit is designed to assist ACOG Fellows to craft their own legislation on certified professional midwives (CPMs), also known variously as LMs, DEMS, and LDEMs. It will also help you to identify and advocate for optimal bill/rule language in your state.

The toolkit is organized by subject according to key concerns: licensure, scope of practice, eligibility criteria for women choosing a home birth, informed consent, transfer & referral to medical care, outcomes reporting, state data collection and oversight, and liability insurance coverage and liability protection.

Each section includes:

- examples of legislative language taken directly from state bills, laws and regulations; these are listed alphabetically by state
- discussion about optimal legislative language and political considerations

The term “legislative language” used throughout includes language in bills, statutes, rules and regulations. If a bill did not pass, that is noted.

TABLE OF CONTENTS

SECTION ONE:
To License, or Not to License?

Discussion

- **CPMs can practice legally doing home births in at least 26 states.** This is the trend. More states are adopting the CPM credential for direct-entry midwives—and not the CM credential which ACOG supports. (The term direct-entry is used to refer to midwives who enter the profession *directly* without earning a nursing degree. Both CPMs and CMs are considered direct-entry midwives.)
- **If CPMs have not succeeded in gaining licensure in your state, your legislative options include:**
  - Continue to oppose CPM-backed licensure bills. This may be an annual battle in your state. Are you worn out, yet?
  - Try to pass legislation that sets a minimum level of education and training for ALL midwives according to the standards set by the American Midwifery Certification Board (AMCB) which ACOG and ACNM both support.
  - For example, try to duplicate what **New York** did over a decade ago. **New York** has one unified framework for licensing ALL midwives—both CNMs and CMs. This is the exception; other states regulate nurse-midwives under one practice act and non-nurse midwives under a different practice act. **New York** is one of only 3 states (including NJ and RI) that recognizes the CM credential and requires all midwives to meet this minimum level of education and training. **New York** midwives must complete an education program that is registered by the Department of Education or deemed equivalent.
  - Another example is **Washington State** whose midwife licensure law, passed in the 1970s, predates the advent of the CPM credential in 1994. **New York's** law also predates the CPM credential. Midwives in **Washington** must complete an educational program at a school of midwifery that is accredited by the state health department. The Seattle Midwifery School has been preparing direct-entry midwives for independent practice since 1978. (see box on page 5)
- **Debate over whether licensure should be voluntary or mandatory has been contentious in some states.** For example, CPMs are actively lobbying to keep licensure *voluntary* in **Missouri** and **Oregon**. In states without a licensure program, women seeking a home birth are not likely to know the education and training qualifications of the midwife delivering their baby and may not think to question whether licensed or unlicensed midwives have different training.

Suggested Legislative Language

1. **Full client disclosure that client is not retaining a nurse-midwife** page 4
2. **One unified framework for licensing ALL midwives** page 4
3. **State laws that predate the CPM credential** page 4

1 *Suggested Legislative Language:* Full client disclosure that client is not retaining a certified nurse-midwife

Colorado SB 88, sunset review of registered direct-entry midwives, enacted 2011

Before accepting a client for care, the direct-entry midwife shall obtain the client's informed consent, which shall be evidenced by a written statement in a form prescribed by the director and signed by both the direct-entry midwife and the client. The form shall certify that full disclosure has been made and acknowledged by the client as to each of the following items… : a description of the available alternatives to direct-entry midwifery care, including a statement that the client understands she is not retaining a certified nurse midwife.

2 *Suggested Legislative Language:* One unified framework for licensing ALL midwives

New York Professional Midwifery Practice Act, Article 40, Sec. 6950, 1992

Practice of midwifery. Only a person licensed or exempt under this title or authorized by any other section of law shall practice midwifery.

Use of title "midwifery". Only a person licensed or exempt under this article shall use the title "midwife". Requirements for a professional license. To qualify for a license as a midwife, an applicant shall fulfill the following requirements: … Education: satisfactorily (a) complete educational preparation (degree or diploma granting) for the practice of nursing, followed by or concurrently with educational preparation for the practice of midwifery in accordance with the commissioner's regulations, or (b) submit evidence of license or certification, the educational preparation for which is determined by the department and in accordance with the commissioner's regulations, or (c) complete a program determined by the department to be equivalent to the foregoing and in accordance with the commissioner's regulations.

3 *Suggested Legislative Language:* Midwife licensure laws that predate the CPM credential

Washington State midwife licensure law, RCW chapter 18.50.040

Candidates for examination—Application—Eligibility—Student midwife permits. … The candidate shall meet the following conditions:

Obtaining a minimum period of midwifery training for at least three years including the study of the basic nursing skills that the department shall prescribe by rule. However, if the applicant is a registered nurse or licensed practical nurse or has had previous nursing education or practical midwifery experience, the required period of training may be reduced depending upon the extent of the candidate's qualifications as determined under rules adopted by the department. In no case shall the training be reduced to a period of less than two years.

Meeting minimum educational requirements which shall include studying obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breast feeding; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization, and aseptic technique; and such other requirements prescribed by rule. … The training required under this section shall include training in either hospitals or alternative birth settings or both with particular emphasis on learning the ability to differentiate between low-risk and high-risk pregnancies.

The Seattle Midwifery School (SMS), founded in 1978, is a 3-year program for direct-entry midwives, accredited by the Midwifery Education Accreditation Council (MEAC) and the State Department of Health. In general, it requires that entering students are at least 18 years old, proficient in English, with a high school diploma or GED, 2 years of college or relevant women's health care experience, completion of a Doulas of North America-approved doula training, and completion of college-level English, human anatomy and physiology, and math with at least a 3.0 grade point average. The SMS curriculum was originally drawn from direct-entry midwifery education in Denmark and The Netherlands and now incorporates the core competencies adopted by the Midwives Alliance of North America (MANA) and the skills required for certification by the North American Registry of Midwives (NARM). The 3-year program includes didactic instruction and 5 quarters of clinical training. In addition to academic requirements, students must participate in 60 births; for 30 of these, the student functions as the primary midwife. Generally, external preceptorships are arranged for clinical training where students work under the supervision of one midwife in a home birth practice or birth center. Students may occasionally work under the supervision of a physician or other health care professional such as a nurse practitioner and may sometimes work in a hospital setting or clinic. Graduates earn a Certificate of Midwifery and are eligible to sit for an examination to become licensed as a midwife in Washington and to become nationally certified as a CPM.

3 Midwife licensure laws that predate the CPM credential

SECTION TWO:
Licensing Standards / Scope of Practice

Discussion

- **In your bill (preferably) or regulations, do not delegate standards for education, licensure, or scope of practice to the Midwives Alliance of North America (MANA) and North American Registry of Midwives (NARM).** Try to incorporate or reference the standards of the American Midwifery Certification Board (AMCB) which ACOG and ACNM both support.
- **However, this may not be achievable** politically in your state. If not, try to:
- **Direct the designated state licensing agency** to establish education and clinical experience requirements for midwives ***in addition to*** MANA's core competencies, but also specify minimum requirements in your bill. It is risky to leave this entirely to the rule-making process as ob-gyns are likely to be under-represented on state midwifery advisory boards. In **Idaho** for example, the governor is *required* only to consider the recommendations of the Idaho Midwifery Council and Idahoans for Midwives when making appointments to the Board of Midwifery.
- **In your bill, cite the World Health Organization (WHO) standards** for high and low-risk pregnancies and mandatory consultation and transfer of patient care. For example, **Utah's** 2008 law defines normal birth and pregnancy according to WHO's definition and standards. ACOG supports the worldwide standards for the education of midwives endorsed by the WHO. Lower standards are unacceptable for the care of women in the US.
- **In your bill, spell-out in detail standards of practice for:**
  - informed consent
  - criteria for initial selection of clients
  - a client care plan including ongoing risk assessment to continuously assess for normalcy; these should be filed with the state licensing agency
  - medical consultation, co-management, referral, elective transfer of care, and emergency transport (for all stages of care including postpartum and newborn management and referral)
  - peer review
  - protocols for medication and equipment use
- **Delineate maternal and newborn conditions** requiring physician consultation, referral and transfer of patient care—for ALL stages of patient care (antepartum, intrapartum, postpartum). Delineate these VERY TIGHTLY. Do not leave this to the subsequent rule-making stage; you want to have clear parameters in your legislation.
- **With peer review requirements, don't let midwife participation in peer review replace state agency investigatory authority.** For example, see

Suggested Legislative Language

Suggested Legislative Language: Detailed definition of midwifery practice 1

Utah SB 93, amending the direct-entry midwife act, enacted 2008

Practice of midwifery means practice 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:

1. *obtaining an informed consent to provide services*
2. *obtaining a health history, including a physical examination*
3. *developing a plan of care for a client*
4. *evaluating the results of client care*
5. *consulting and collaborating with and referring and transferring care to licensed health professionals, as is appropriate, regarding the care of a client*
6. *obtaining medications, as specified in this subsection, to administer to clients, including:*
    a. *Prescription vitamins*
    b. *Rho D immunoglobulin*
    c. *Sterile water*
    d. *One dose of intramuscular oxytocin after the delivery of the placenta to minimize blood loss*
    e. *One dose of intramuscular oxytocin if a hemorrhage occurs, in which case the licensed direct-entry midwife must either consult immediately with a physician…and initiate transfer, if requested, or if the client's condition does not immediately improve, initiate transfer and notify the hospital*
    f. *An additional single dose of oxytocin if a hemorrhage occurs, in which case the licensed direct-entry midwife must initiate transfer if the client's condition does not immediately improve*
    g. *Oxygen*
    h. *Local anesthetics without epinephrine use in accordance with subsection …*
    i. *Vitamin K to prevent hemorrhagic disease of the newborn*
    j. *Eye prophylaxis to prevent opthalmia neonatorum as required by law*
    k. *Any other medication approved by a licensed health care provider with authorith to prescribe that medication*
7. *obtaining food, food extracts, dietary supplements, as defined by the federal Food, Drug and Cosmetic Act, homeopathic remedies, plant substances that are not designed as prescription drugs or controlled substances, and over-the-counter medications to administer to clients*
8. *obtaining and using appropriate equipment and devices such as Doppler, blood pressure cuff, phlebotomy, supplies, instruments, and sutures*
9. *obtaining appropriate screening and testing, including laboratory tests, urinalysis, and ultrasound*
10. *managing the antepartum period*
11. *managing the intrapartum period including: monitoring and evaluating the condition of mother and fetus; performing emergency episiotomy; and delivering in any out-of-hospital setting*
12. *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*
13. *managing the newborn period including: providing care for the newborn, including performing a normal newborn examination*
14. *resuscitating a newborn*
15. *providing limited interconceptual services in order to provide continuity of care including: breastfeeding support and counseling; family planning, limited to natural family planning, cervical caps, and diaphragms; and pap smears, where all clients with abnormal results are to be referred to an appropriate licensed health care provider*
16. *executing the orders of a licensed health care professional, only with the education, knowledge, and skill of the direct-entry midwife.*

1 Detailed definition of midwifery practice

2 *Suggested Legislative Language:* Direct the state agency to set standards in addition to the MANA/NARM standards

Missouri HB 887, introduced but not passed in 2011

The Advisory Committee for Registered Midwives shall develop and recommend midwifery practice guidelines and protocols, including but not limited to: identification of which categories of clients are and are not appropriate for home delivery; which management techniques and interventions are appropriate for a delivery in an out-of-hospital setting.

3 *Suggested Legislative Language:* Incorporate the World Health Organization (WHO) criteria for high/low risk pregnancy, mandatory consultation and transfer of patient care

Utah SB 93, amending the direct-entry midwife act, enacted 2008

"Low risk" means labor, delivery, postpartum, newborn and interconceptual care that does not include a condition that requires a mandatory transfer under administrative rules adopted by the division.

A licensed direct-entry midwife shall:

(a) limit the licensed direct-entry midwife's practice to a normal pregnancy, labor, postpartum, newborn and interconceptual care, which for purposes of this section means a normal labor:

- *that is not pharmacologically induced*
- *that is low risk at the start of labor*
- *that remains low risk throughout the course of labor and delivery*
- *in which the infant is born spontaneously in the vertex position between 37 and 43 completed weeks of pregnancy ; and*
- *except as provided [above], in which after delivery, the mother and infant remain low risk; and*
- *the limitation of [above] does not prohibit a licensed direct-entry midwife from delivering an infant when there is: intrauterine fetal demise or a fetal anomaly incompatible with life; and*

(b) 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 this section and standards established by Division rule.

4 *Suggested Legislative Language:* Client care plan

Missouri HB 2284, introduced but not passed in 2010

Every licensed certified professional midwife shall present an informed consent document to each client which shall include but not be limited to the following: …a written care plan specific to the client to ensure the continuity of care throughout the antepartum, intrapartum, and postpartum periods. The written care plan must incorporate the conditions under which consultation, including transfer of care or transport of the client, may be implemented.

Washington State HB 1130, pending 2011-12 session

Every licensed midwife shall develop a written plan for each patient following the initial patient assessment and before commencement of a regular program of midwifery services. The written plan shall describe…any general risk factors associated with the services to be provided; any specific risk factors pertaining to the individual health and circumstances of the individual patient; a plan to be followed in the event of any emergency, including a plan for transportation … both the midwife and the patient shall acknowledge their consent to the plan.

Suggested Legislative Language: Medical consultation and co-management 5

New Mexico licensed midwife regulations, NMSA Title 16, Chapter 11, Part 3

"Licensed Midwifery" means the provision of health care and management of women in the antepartum, intrapartum, postpartum, and interconceptual periods and infants up to 6 weeks of age. This care occurs within a health care system which provides for midwifery protocols, medical consultation, co-management or referral …

Physician visit: Each woman accepted for care must be referred at least once to a duly licensed physician within four (4) weeks of her initial midwifery visit. The referral must be documented in the chart.

Responsibility to consult: It shall be the responsibility of the midwife to develop a means for consultation with or referral/transfer to a physician or hospital if there are significant deviations from the normal in the health status of either mothers or infants as set out in the Standards and Core Competencies for the practice of Licensed Midwifery in New Mexico.

South Carolina Midwife Regulations, Dept. of Health and Environmental Control, Chapter 61-24

Referral to physician:

Recognition of Problems. The midwife must be able at all times to recognize the warning signs of abnormal or potentially abnormal conditions necessitating referral to a physician. It shall be the midwife's duty to consult with a physician whenever there are significant deviations from the normal. The midwife's training and practice must reflect a particular emphasis on thorough risk assessment.

Continuity of Care. When referring a patient to a physician, the midwife shall remain in consultation with the physician until the resolution of the situation. It is appropriate for the midwife to maintain care of her patient to the greatest degree possible, in accordance with the patient's wishes, remaining present through delivery if possible.

Utah Senate Bill 93, amending the direct-entry midwife act, enacted 2008

The Division shall adopt administrative rules regarding conditions that require mandatory consultation with a physician licensed under the Utah Medical Practice Act or Utah Osteopathic Medical Practice Act, upon:

- *miscarriage after 14 weeks*
- *failure to deliver by 42 completed weeks of gestation*
- *a baby in the breech position after 36 weeks gestation*
- *any sign or symptom of: placenta previa, deep vein thrombosis or pulmonary embolus, or any other condition or symptom that may place the health of the pregnant woman or unborn child at unreasonable risk as determined by the Division by rule.*

Washington State licensed midwife law, RCW chapter 18.50.010

Practicing midwifery defined—gratuitous services—duty to consult with physician. … It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant.

Written plan for consultation, emergency transfer, and transport. Every licensed midwife shall develop a written plan for consultation with other health care providers. …The written plan shall be submitted annually together with the license renewal fee to the department.

Suggested Legislative Language: Participation in peer review & permission for hospitals to release data on home births 6

California Standard of Care for Licensed Midwives, Consensus Document Sept. 2005

The California licensed midwife is also accountable to peers, the regulatory body and to the public for safe, competent, ethical practice, including formal or informal sources of community input. This includes but is not limited to the licensed midwife's participation in the peer review process and any required mortality and morbidity reporting. The results of these individual evaluations can be distributed to influence professional policy development, education, and practice.

Oregon HB 2380, direct-entry midwife law, enacted 2011

[See in section 6, Outcomes Reporting & State Oversight]

Vermont SB 15, licensed midwife private/public health insurance coverage law, enacted 2011

During the peer review process, other health care professionals engaged in the care or treatment of the client may provide written input to the peer review panel related to quality assurance and other matters within or related to the licensed midwife's scope of practice. The written comments shall be filed with the office of professional regulation and subject to the same confidentiality provisions as apply to other documents related to peer reviews. Upon completion of the peer review process, the director shall provide notice of the final disposition of the peer review to all health care professionals who submitted input pursuant to this subdivision.

Vermont SB 15, amendments proposed—but not passed—to the licensed midwife private/public health insurance coverage law, enacted 2011

Release of clinical data authorized.

A licensed health care professional or facility may release clinical and demographic data concerning home births performed in Vermont to a peer review organization under contract with the Vermont Department of Health.

Vermont Midwives Act, Title 26 VSA Chapter 85, enacted 2001

A licensed midwife shall, within 30 days of a birth or sentinel event, complete any peer review that is both required by rules governing licensed midwives and which is generated due to a death, significant morbidity to client or child, transfer to hospital, or to practice performed outside the standards for midwives as set forth in rules governing licensed midwives. This peer review shall be submitted to the office of professional regulation within 30 days of its completion.

Vermont Administrative Rules for Midwives, Section 3.8

Peer Reviews. A midwife licensed in this state must participate in at least four separate peer review meetings evaluating the midwife's practice during each two-year renewal period as a condition of license renewal. Peer review must be conducted in peer review meetings or in conjunction with professional organization meetings. Each peer review must be conducted by at least two other licensed midwives who have no personal, professional, or financial interest in the birth being reviewed. Peer reviews of the licensed midwife's practice must include but not be limited to process of care, outcome data, referral patterns, and discussion of specific cases and obtaining feedback and suggestions regarding care. Attendance at peer review sessions must be documented in writing on report forms approved by the Director and must be made available to the Director as required.

In addition to the four peer reviews required during each two-year renewal period, a licensed midwife must request and participate in peer review in the following specific situations: (1) when there has been a death, significant morbidity to client or child, or transfer to hospital. (2) When the midwife has acted outside the standards set forth in these rules.

Attendance at any peer review session conducted regarding a specific situation listed above must be documented in writing on report forms approved by the Director and must be filed with the Director within 30 days of the peer review session. Reports filed will be kept confidential by the Director, unless they result in the filing of charges of unprofessional conduct.

7 *Suggested Legislative Language:* Penalties

Wyoming SB 48, certified professional midwife licensure law, enacted 2010

[See in section 5, Transfer & Referral to Medical Care]

SECTION THREE:
Eligibility Criteria for Women Choosing a Home Birth

Discussion

- **The CPM criteria for patients who may be appropriate candidates for home birth** is based on the decision of the individual midwife and patient. This is problematic.
- **Therefore, you will need to:**
  - Define low-risk pregnancy in your bill.
  - Enumerate patient history, conditions and disorders for which the midwife must not assume or continue to take responsibility.
  - Enumerate situations or conditions requiring mandatory consultation and facilitation of transfer.
  - Require midwives to develop written care plans for each client; these should be filed with the state licensing agency. (See in section 2, Licensing Standards/Scope of Practice.)
- **Consider requiring home birth patients to preregister** at the nearest hospital and have a transfer agreement. We are unaware of any state at this time that requires hospital pre-registration by midwife clients. Some states require the midwife to notify the hospital just prior to a transfer; this is not the same as requiring the midwife's client to pre-register early in pregnancy at a nearby hospital.
- **Home birth proponents here in the US often cite the Netherlands,** but the experience of home birth in the Netherlands—where 1 out of 4 women deliver at home—bears little resemblance to the experience for most American women. Dutch midwives train with ob-gyns, follow strict home birth patient selection protocols, do not deliver twins, breech or VBACs at home, are in close proximity to the hospital, and are in contact with the hospital at regular intervals during labor and delivery.
- **Because of eligibility requirements for home birth in the Netherlands,** Dutch mothers who choose a home birth tend to be lower risk from the start than their American counterparts. Dutch women who have had c-sections, for example, are not candidates for home birth.

Suggested Legislative Language

1 **XX**
page 12

1 Suggested Legislative Language

Minnesota birth center licensure bill, 2009

"Low-risk pregnancy" means a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal care, and generally accepted by the health care providers to whom they apply and approved by the commissioner as reasonable.

Wyoming SB 48, certified professional midwife licensure law, enacted 2010

The board shall make, adopt, amend, repeal and enforce reasonable rules and regulations necessary for the proper administration and enforcement of this act. The rules adopted by the board shall, at a minimum:

(A) Prohibit a licensed midwife from providing care for a client with any one or more of the following pregnancy disorders, diagnoses, conditions or symptoms:

- *placental abnormality*
- *multiple gestation*
- *noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first*
- *birth under 37 weeks or after 42 weeks gestational age*
- *a history of more than 1 prior cesarean section with no prior vaginal delivery, a cesarean section within 18 months of the current delivery or any cesarean section that was surgically closed with a classical or vertical incision*
- *rhesus factor or other blood group or platelet sensitization, hematological disorders or coagulation disorders*
- *preeclampsia*
- *cervical insufficiency or a history of cervical insufficiency*

(B) Prohibit a license midwife from providing care for a client with a history of any one or more of the following disorders, diagnoses, conditions or symptoms unless the disorder, diagnosis, condition or symptom is being treated, monitored and managed during the current pregnancy by a physician licensed under the Medical Practice Act:

- *diabetes*
- *thyroid disease*
- *epilepsy*
- *hypertension*
- *cardiac disease*
- *pulmonary disease*
- *renal disease*
- *previous major surgery of the pulmonary system, cardiovascular system, urinary tract or gastrointestinal tract*
- *hepatitis*

(C) Require a licensed midwife to recommend that a client see a physician licensed under the Medical Practice Act and to document and maintain a record if the client has a history of any one or more of the following disorders, diagnoses, conditions or symptoms:

- *previous complicated pregnancy*
- *previous cesarean section*
- *previous pregnancy loss in the second or third trimester*
- *previous spontaneous premature labor*
- *previous preterm rupture of membranes*
- *previous preeclampsia*
- *previous hypertensive disease of pregnancy*
- *prior infection with parvo virus, toxoplasmosis, cytomegalovirus or herpes simplex virus*
- *previous newborn group B streptococcus infection*
- *a body mass index of 35 or higher at the time of conception*
- *underlying family genetic disorders with potential for transmission*
- *psychiatric illness*

SECTION FOUR:
Informed Consent

Discussion

- **With informed consent,** your bill or regulation should be as detailed and specific as politically feasible.
- **Consider informed consent rules** for all stages of patient care:
  - Initial consultation
  - Evaluation of low/high risk
  - Required consultation with a physician; you may want to require evidence of medical evaluation and physician visits in the midwife's client records
  - Referral and transfer of care from the midwife to a physician and from the home setting to a hospital
- **The strongest law/regulation will specify** informed consent requirements for each stage.
- **Consider incorporating the World Health Organization's criteria** for high and low risk pregnancies. (See **Utah** law in section 2, Licensing Standards/Scope of Practice.)
- **Consider separate informed consent** for VBAC. (See in section 9, VBAC.)
- **Consider including client assumption of risk language.** For example, see legislative language proposed in **Colorado**.
- **Consider penalties for failure to provide** the required consent.

Suggested Legislative Language

1. **Informed consent** page 14
2. **Informed consent about physician consultation requirement** page 14
3. **Informed consent about client assumption of risk** page 14

1 *Suggested Legislative Language:* Informed consent

Utah SB 93, amending the direct-entry midwife act, enacted 2008

Prior to providing any services, a licensed direct-entry midwife must obtain an informed consent from a client. The consent must include:

- *the name and license number of the DEM*
- *the client's name, address, telephone number, and primary care provider, if the client has one*
- *the fact, if true, that the DEM is not a certified nurse-midwife or a physician*
- *a description of the DEM's education, training, continuing education, and experience in midwifery*
- *a description of the DEM's peer review process*
- *the DEM's philosophy of practice*
- *a promise to provide the client, upon request, separate documents describing the rules governing DEM practice, including a list of conditions indicating the need for consultation, collaboration, referral, transfer or mandatory transfer, and the DEM's personal written practice guidelines*
- *a medical back-up or transfer plan*
- *a description of the services provided to the client by the DEM*
- *the DEM's current legal status*
- *the availability of a grievance process*
- *client and DEM signatures and the date of signing; and*
- *whether the DEM is covered by a professional liability insurance policy.*

Utah SB 93, amending the direct-entry midwife act, enacted 2008

[See client refusal language in Section 5, Transfer & Referral to Medical Care]

2 *Suggested Legislative Language:* Informed consent about physician consultation requirement

Vermont Midwives Act, Title 26 VSA Chapter 85, enacted 2001

Informed consent must be shown by a written statement, in a form prescribed by the Director and signed by the licensee and the client to whom care is to be given in which the licensee certifies that full disclosure of the following information has been made and acknowledged by the client: …the fact that the client has been advised to consult with a physician at least once during the pregnancy.

Record Keeping and Report Requirements. Each client's records must contain the following information, as applicable: … evidence of medical evaluation and physician visits, consisting of either a report signed by the physician, a copy of the medical and physician notes, or other documentation received from the physician or medical provider.

3 *Suggested Legislative Language:* Informed consent about client assumption of risk

Colorado SB 88, sunset review of registered direct-entry midwives, enacted 2011.

[NOTE: This language on assumption of risk was deleted in the final bill.]

Assumption of risk. The general assembly hereby finds, determines, and declares that the authority granted in this article for the provision of unlicensed midwifery services does not constitute an endorsement of such practices, and that it is incumbent upon the individual seeking such services to ascertain the qualifications of the registrant direct entry midwife.

SECTION FIVE:
Transfer & Referral to Medical Care

Discussion

- **Don't leave this to the rule-making stage;** in your bill, include specific minimum standards for transfer of care that midwives must follow. (This is different from specifying standards for medical consultation; see the suggested legislative language for medical consultation and co-management in section 2.)
- **Define transfer of care extremely tightly.** Address all stages of care and risk factors including pre-existing conditions and the client's medical /surgery history.
- **Consider client refusal**—specify what the midwife must do in these cases. See Utah's law.
- **Require midwives to participate in peer review for all patient transfers to the hospital.** **Vermont** has required this since 2001. (See suggested legislative language in section 2.) Also, consider requiring peer review reports to be given to the facilities/professionals involved, permit these facilities/professionals to submit an addendum, and require the addendum to be reviewed and acted upon.
- **Consider including a penalty provision—license suspension or revocation**—for failure to facilitate an immediate transfer.
- **Consider mandating the use of standardized forms** as **Vermont** did this year (2011).
- **Consider requiring hospitals to report all transfers of home delivery cases using a standardized form.** We are unaware of any state that has passed this hospital requirement.
- **Consider requiring midwife clients to preregister at the nearest hospital and have a transfer agreement.** We are unaware of any state that requires hospital pre-registration by midwife clients. Some states require the midwife to notify the hospital just prior to a transfer; this is not the same as requiring the midwife's client to pre-register early in pregnancy at a nearby hospital.
- **Watch for exceptions.** For example, **California's** Medical Practice Act includes an exception to the requirements for emergency transport. (See legislative language in this section.)

Suggested Legislative Language

1 *Suggested Legislative Language:* Specify minimum standards for transfer/referral

Utah SB 93, amending the direct-entry midwife act, enacted 2008

The standards for consultation and transfer under Subsection … are the minimum standards that a licensed direct-entry midwife must follow.

2 *Suggested Legislative Language:* Mandatory transfer requirements

California Standard of Care for Licensed Midwives, Consensus Document Sept. 2005

Emergency Transport: If on initial or subsequent assessment during the 1st, 2nd or 3rd stage of labor, one of the following conditions exists, the midwife shall immediately consult with a physician and/or initiate immediate emergency transfer to medical care. Transport via private vehicle is an acceptable method of transport if, in the clinical judgment of the midwife, that is the safest and most expedient method to access medical services.

a. *Prolapsed umbilical cord*
b. *Uncontrolled hemorrhage*
c. *Preeclampsia or eclampsia*
d. *Severe abdominal pain inconsistent with normal labor*
e. *Chorioamnionitis*
f. *Ominous fetal heart rate pattern or other manifestation of fetal distress*
g. *Seizures or unconsciousness in the mother*
h. *Evidence of maternal shock*
i. *Presentation not compatible with spontaneous vaginal delivery*
j. *Laceration requiring repair outside the scope of practice or practice policies of the individual midwife*
k. *Retained placenta or placental fragments*
l. *Neonate with unstable vital signs*
m. *Any other condition or symptom which could threaten the life of the mother, fetus, or neonate as assessed by the midwife exercising ordinary skill and knowledge*

Note: Emergency exceptions clause, California Medical Practice Act, Section 2063

The California licensed midwife may deliver a woman with any of the above complications or conditions, or other bona fide emergencies, if the situation is a verifiable emergency and no physician or other equivalent medical services are available. EMERGENCY is defined as a situation that presents an immediate hazard to the health and safety of the client or entails extraordinary and unnecessary human suffering.

Utah SB 93, amending the direct-entry midwife act, enacted 2008

The Division shall adopt administrative rules regarding conditions that require:

Mandatory transfer of patient care before the onset of labor to a physician upon evidence of:

- *placenta previa after 27 weeks*
- *diagnosed deep vein thrombosis or pulmonaryembolism*
- *multiple gestation*
- *no onset of labor after 43 completed weeks of gestation*
- *more than two prior c-sections, unless restricted by the Division by rule*
- *prior c-section with a known classical or inverted-T or J incision*
- *prior c-section without an ultrasound that rules out placental implantation over the uterine scar*
- *prior c-section without a signed informed consent document detailing the risks of vaginal birth after cesarean*
- *prior c-section with a gestation greater than 42 weeks*
- *Rh isoimmunization with an antibody titre of greater than 1:8 in a mother carrying an Rh positive baby or a baby of unknown Rh type*
- *any other condition that could place the life or long-term health of the pregnant woman or newborn at risk*

Mandatory transfer of care during labor and an immediate transfer in the manner specifically set forth in subsections [above], or upon evidence of:

- *undiagnosed multiple gestation, unless delivery is imminent*
- *prior c-section with cervical dilation progress in the current labor of less than 1 cm in three hours once labor is active*
- *fetus in breech presentation during labor, unless delivery is imminent*
- *inappropriate fetal presentation as determined by the licensed direct-entry midwife*
- *non-reassuring fetal heart pattern indicative of fetal distress that does not immediately respond to*

1 Specify minimum standards for transfer/referral
2 Mandatory transfer requirements

treatment by the direct-entry midwife, unless delivery is imminent

- *moderate thick, or particulate meconium in the amniotic fluid, unless delivery is imminent*
- *any other condition that could place the life or long-term health of the mother or infant at significant risk if not acted upon immediately.*

Wyoming SB 48, certified professional midwife licensure law, enacted 2010

The board shall make, adopt, amend, repeal and enforce reasonable rules and regulations necessary for the proper administration and enforcement of this act. The rules adopted by the board shall, at a minimum:

Require a licensed midwife to facilitate the immediate transfer to a hospital for emergency care, a client with any one or more of the following disorders, diagnoses, conditions or symptoms:

- *maternal fever in labor*
- *suggestion of fetal jeopardy such as significant bleeding, thick meconium or abnormal fetal heart tones without delivery imminent*
- *noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first*
- *second stage of labor longer than 2 hours without adequate progress*
- *current spontaneous premature labor*
- *current preterm rupture of membranes*
- *current preeclampsia*
- *current hypertensive disease of pregnancy*
- *continuous uncontrolled bleeding*
- *bleeding which necessitates the administration of more than 2 doses of oxytocin or other antihemorrhagic agent*
- *delivery injuries to bladder or bowel*
- *seizures*
- *uncontrolled vomiting*
- *coughing or vomiting of blood*
- *severe chest pain*
- *sudden onset of shortness of breath and associated labored breathing*

Suggested Legislative Language: Hospital notification 3

Wyoming SB 48, certified professional midwife licensure law, enacted 2010

The board shall make, adopt, amend, repeal and enforce reasonable rules and regulations necessary for the proper administration and enforcement of this act. The rules adopted by the board shall, at a minimum:

Develop a protocol for written informed consent to treatment, which shall include all of the following:

A written protocol for emergencies that is specific for each individual client, including the following provisions:

- *Transport to a hospital in an emergency*
- *Notification of the hospital to which a client will be transferred upon initiation of the transfer*
- *Accompaniment of the client to the hospital by the midwife, if feasible, or telephone notice to the hospital if the midwife is unable to present personally*
- *Transmission of the client's record to the hospital, including the client's name, address, list of known medical conditions, list of prescription or over the counter medications regularly taken, history of previous allergic reactions to medications, the client's current medical condition and description of the care provided by the midwife*
- *Next of kin contact information.*

Suggested Legislative Language: In case of client refusal 4

Utah SB 93, amending the direct-entry midwife act, enacted 2008

If after 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.

If after 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 *Suggested Legislative Language:* Mandatory participation in peer review

Vermont SB 15, amendments proposed—but not passed—to the licensed midwife private/public health insurance coverage law, enacted 2011

Peer review reports in cases where care is transferred shall be provided to facilities and professionals involved in the case who may submit a supporting or dissenting addendum to the peer review report. Any peer review report or addendum identifying areas for improvement shall be reviewed by the three OPR advisors for licensed midwives who shall design a peer review plan for improvement and follow-up in appropriate cases. Facilities and professionals who have submitted information or addenda through the peer review process may review and comment on the peer review report and follow-up plan.

Vermont Midwives Act, Title 26 VSA Chapter 85, enacted 2001

[See in section 2, Licensing Standards/Scope of Practice]

6 *Suggested Legislative Language:* Penalties for failure to transfer

Wyoming SB 48, certified professional midwife licensure law, enacted 2010

The board may revoke, suspend or condition the license of a midwife or require the midwife to practice for a time under the supervision of a person licensed under the Medical Practice Act, a certified nurse-midwife or another midwife as appropriate if the board finds the midwife has committed any one or more of the following:

…..Failed to refer women or newborn children in need of care or at risk of needing care beyond the abilities of the midwife to an appropriate health care professional in accord with standards of the national association of certified professional midwives or other national midwife certifying agency established for such purpose which has been reviewed and approved by the board.

SECTION SIX:
Outcomes Reporting & State Oversight

Discussion

- **Accurate collection and reporting of safety statistics and birth outcomes** in different birth settings is critical. These data must differentiate between the different types of midwives. With the birth certificate, accurate recording of (1) intended place of delivery and (2) birth attendant are essential.

Midwife reporting is critical.

- **Require midwives to file with the state** a notice of intent to home deliver. Ideally, the state licensing agency should develop the standard notice form and all notices should be available to the public. We are unaware of any state laws that require this. ACOG-backed legislation in **Missouri** did not pass.
- **Require midwives to keep and file client summary reports;** consider quarterly, biannual or yearly filing requirements.
- **Require midwives to report, within a specified time period, any death or morbidity** including stillbirths. Ideally, these should be filed with the state licensing agency or board of midwifery AND with the state public health officer.
- **Consider a penalty provision for failure to report.** Be specific. At minimum, specify that failure to comply is unprofessional conduct and cite a fine penalty. For example, see **Montana's** rules. This may be difficult to achieve if your state does not have similar penalties for other practitioners, namely physicians.

Hospital reporting is critical.

- **Hospitals are a critical ally.** You'll need their support for state oversight goals.
- **Consider requiring hospitals to report all midwife patient transfers and referrals** using a standardized form. We are unable to identify any state laws that require this. It may be necessary to include specific authority in your bill for hospitals to release clinical and demographic data on home birth transfers. For example, see legislative language proposed in **Vermont**.
- **Hospital reporting of out-of-hospital transfers could help** in the collection of accurate home birth statistics. Birth certificates may not accurately record the *intended* place of birth or the birth attendant.

State government oversight is critical.

- **Your bill should specify the responsibilities of the state licensing agency and/or midwifery advisory board** including:
  - verify that all licensed midwives meet annual reporting requirements
  - collect & report safety measures and outcomes of out-of-hospital births
  - aggregate this information and report annually to the Legislature

Suggested Legislative Language

1 *Suggested Legislative Language:* Notice of intent to home deliver

Missouri HB 2284, ACOG-backed CPM licensure introduced but did not pass in 2010

Every licensed certified professional midwife who intends to provide midwife services for any client shall, within ten days of entering into any agreement to provide such services, file with the department of health and senior services a notice of intent to home deliver.

The forms for filing the notice of intent to home deliver shall be promulgated by rule and made available by the department. The department shall maintain a permanent database, which shall be made available to the public, of all home deliveries done under the care of a licensed certified professional midwife.

2 *Suggested Legislative Language:* Client summary reports, record keeping & reporting

California 2007-8 law mandating annual reporting, beginning March 2008

Each licensed midwife who assists, or supervises a person acting under the midwife's orders to assist, in normal childbirth shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted in March, for the prior calendar year, shall be in writing, and shall contain all of the following:

1. *The midwife's name and license number.*
2. *The calendar year being reported.*

The following information with regard to cases in which the midwife, or someone supervised by the midwife, assisted in the previous year:

1. *The total number of clients served as primary care giver.*
2. *The total number of clients served with collaborative care by, or backup from, a physician or surgeon.*
3. *The number and county of live births attended as primary care giver.*
4. *The number and county of stillbirths attended as primary care giver.*
5. *The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.*
6. *The number, reason, and outcome for each elective hospital transfer.*
7. *The number, reason, and outcome for each urgent or emergency transport of an expectant mother prior to labor.*
8. *The number, reason, and outcome for each urgent or emergency transport of an infant or mother during or after labor or birth.*
9. *A brief description of any complications resulting in the mortality of a mother or an infant.*
10. *he number of student supervised births.*
11. *Any other information prescribed by the board in regulations.*

Idaho HB 185, amending certified professional midwife licensure act, enacted 2009

Disclosure and Record Keeping- License Renewal. Any licensed midwife submitting an application to renew a license shall compile and submit to the board complete practice data for the 12 months immediately preceding the date of the application. Such information shall be provided in form and content as prescribed by rule of the board and shall include, but not be limited to: the number of clients to whom care has been provided by the licensed midwife; the number of deliveries performed by the licensed midwife; the apgar score of the infants delivered by the licensed midwife; the number of prenatal transfers; the number of transfers during labor, delivery and immediately following birth; any perinatal deaths; and other morbidity statistics as required by the board.

Montana direct-entry midwife regulations, ARM section 24.111.613

Required Reports. A licensed direct-entry midwife shall submit semiannual summary reports on each client, covering the six month period of January 1 through July 1, or July 1 through January 1 as appropriate. The reports are due on or before January 15 and July 15 of each year. If a licensed direct-entry midwife does not have any clients during a reporting period, the licensee shall notify the board in writing by the reporting date.

New Mexico Licensed Midwife Quarterly Report Form

1. Name _____ Date _____
2. Circle the quarter: **1st** (Jan-Mar) **2nd** (Apr-Jun) **3rd** (Jul-Sep) **4th** (Oct-Dec)
3. Circle the year: **2008 2009 2010 2011 2012 2013**
4. Were you a primary midwife to one or more women in NM in the quarter? **YES NO**
5. If YES, then
   A. Answer the questions below for the quarter, and
   B. Sign the certification of participation in MANA Statistics Project

Women in Your Care:

1. How many well woman clients in your care this quarter? ____
2. How many pregnant women in your care at the beginning of the quarter? ____
3. How many pregnant women in your care at the end of the quarter? ____
4. How many births did you attend this quarter? ____
5. How many clients' care did you complete this quarter? ____

Transfers:

1. How many women transferred from your care AP for non-medical reasons? Reasons
2. How many women transferred from your care AP for medical reasons? Reasons
3. How many women transferred from your care in labor? Reasons
4. How many women transferred from your care postpartum? Reasons
5. How many babies transferred from your care? Reasons

I certify that I participate in the MANA statistics project (www.manastats.org) and am in compliance with their data reporting requirements.

Suggested Legislative Language: Filing the birth certificate 3

New Mexico licensed midwife regulations, NMSA Title 16, Chapter 11, Part 3

Birth Registration: The licensed midwife must complete a New Mexico Certificate of Live Birth Registration and file it with the Bureau of Vital Records and Health Statistics of the Department of Health within 10 days of the birth of any child in the State of New Mexico. No licensed midwife shall register nor enable any other party to register as a New Mexico birth any child not born in the state. Failure to meet the Vital Records regulations shall be grounds for disciplinary action.

Suggested Legislative Language: Mandatory reporting of mortality and morbidity including stillbirth 4

Montana direct-entry midwife rules, ARM section 37-27-320

A licensed direct-entry midwife shall report within 72 hours to the board and to the department of public health and human services any maternal, fetal, or neonatal mortality or morbidity in patients for whom care has been given.

South Carolina midwife regulations, Dept of Health and Environmental Control, Chap 61-24

Reporting Requirements.

Reporting Mortalities. The midwife shall report any maternal or infant death on a Report of Fetal Death form (DHEC 665) to the Department, Attn: Vital Records and Public Health Statistics, within 48 hours. This report requires information concerning the death to include sex, weight, date and place of delivery, method of delivery, congenital anomalies of the fetus, and cause of death.

5 *Suggested Legislative Language:* Failure to report

Montana direct-entry midwife rules, ARM section 37-27-320

Reports—failure to report. (1) A licensed direct-entry midwife shall submit semiannually to the board, on forms supplied by the board, a summary report on each patient who was given care. The report must include vital statistics on each patient and information on the procedures and scope of care administered, including transport of the patient to a hospital and physician referrals, but may not include information disclosing the identity of the patient. (2) A licensed direct-entry midwife shall report within 72 hours to the board and to the department of public health and human services any maternal, fetal, or neonatal mortality of morbidity in patients for whom care has been given. (3) Failure of a direct-entry midwife to submit required reports constitutes grounds to deny renewal of a license.

6 *Suggested Legislative Language:* State oversight function: Data collection

California law mandating annual reporting, commencing March 2008

Each licensed midwife… shall annually report to the Office of Statewide Health Planning and Development. … The office shall verify that all licensed midwives have met the requirements of subdivision (a). The office shall report to the Board of Licensing of the Medical Board, by April, those licensees who have not met the requirements for that year. The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement. …The office shall report the aggregate information in its annual report to the Legislature.

Missouri HB 2284, ACOG-backed CPM licensure bill, introduced but did not pass in 2010

The department shall maintain a permanent database, which shall be made available to the public, of all home deliveries done under the care of a licensed certified professional midwife.

Oregon HB 2380, direct-entry midwife law, enacted 2011

The Center for Health Statistics established under ORS 432.010 shall collect and report data on birth and fetal death outcomes occurring in this state, including intrapartum and neonatal transfers to hospital care from another birthing facility, hospital or other location. The center shall report the data by attendant type. The report shall distinguish outcomes between licensed direct-entry midwives and direct-entry midwives who are not licensed.

Utah SB 93, amending the direct-entry midwife act, enacted 2008

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. The board shall base its report on data provided in large part from the Midwives' Alliance of North America.

Vermont SB 15, licensed midwife private/public health insurance coverage law, enacted 2011

Department of Health; Reporting Requirement. The department of health shall access the database maintained by the Division of Research of the Midwives Alliance of North America to obtain information relating to care provided in Vermont by midwives licensed pursuant to chapter 85 of Title 26 and by advanced practice registered nurses licensed pursuant to chapter 28 of Title 26 who are certified as nurse midwives.

7 *Suggested Legislative Language:* State oversight function: Investigatory authority

Missouri HB 2284, ACOG-backed CPM licensure bill introduced but did not pass in 2010

The board shall investigate all complaints concerning alleged violations…or if there are grounds for the suspension, revocation, or refusal to issue a license. The board may employ investigators who shall investigate complaints and make inspections and any inquiries as, in the judgment of the board, are appropriate to enforce [these] sections …..may issue subpoenas… may[ask] a court to issue a restraining order, an injunction, or a writ of mandamus…may cause a complaint to be filed with the administrative hearing commission…may refuse to issue or renew any license for one or any combination of causes stated in subsection 2 [including]engaging in conduct detrimental to the health or safety of either the mother or the infant, or both, as determined by the board… .

Oregon HB 2380, direct-entry midwife law, enacted 2011

Peer review that is conducted outside of the Oregon Health Licensing Agency may not be used to replace agency regulatory investigations of complaints against licensed direct entry midwives.

South Carolina Midwife Regulations, Dept of Health and Environmental Control, Chap 61-24

Midwifery Advisory Council. The Council shall establish a committee for peer review to consult with

midwives in questions of ethics, competency and performance, and to serve as an appeal committee when disciplinary action has been taken. The committee may recommend denying, suspending, or revoking a license, or may recommend specific educational objectives, apprenticeship or other improvement measures as necessary.

Monitoring Outcomes. As part of the monitoring process, the Department shall evaluate consumer feedback forms issued through midwives to all consumers of midwifery care. The Department shall also issue to, collect, and evaluate quarterly forms from midwives regarding their practices.

Washington licensed midwife regulations, WAC section 246-834-340

The department requests the assistance of executive officers of any state or federal program operating in state of Washington, under which a midwife is employed to provide patient care services, to report to the department whenever such a midwife has been judged to have demonstrated his/her incompetency or negligence in the practice of midwifery, or has otherwise committed unprofessional conduct, or is a mentally or physically disabled midwife. These requirements do not supersede any federal or state law.

Suggested Legislative Language: Hospital reporting 8

Vermont SB 15, amendments proposed—but not passed—to the licensed midwife private/public health insurance coverage law, enacted 2011

Release of clinical data authorized.

(a) Hospitals licensed under section 1905 of Title 18 may release clinical data to the Vermont Program for Quality in Health Care, Inc., for use in a statewide quality assurance system.

(b) A licensed health care professional or facility may release clinical and demographic data concerning home births performed in Vermont to a peer review organization under contract with the Vermont Department of Health.

Suggested Legislative Language: Funding for State oversight 9

Oregon HB 2380, direct-entry midwife law, enacted 2011

The Oregon Health Authority may accept gifts, grants and contributions from any public or private source for the purpose of carrying out the provisions of this section.

Wyoming SB 48, certified professional midwife licensure law, enacted 2010

Fees. The board shall establish fees …as necessary to provide for the administration of this act, including establishment of a working capital fund. The board may establish fees for licensure, renewal of licenses, late applications, provisional licensure and ***per delivery fees for midwives conducting deliveries****. Any per delivery fee established by the board shall not exceed fifty dollars and shall be forwarded to the board at the interval specified by board rules and regulations. The fees shall be deposited and managed in the same manner as other fees collected pursuant to this act.*

SECTION SEVEN:
Liability Insurance Coverage

Discussion

- **Requiring midwives to carry liability insurance can be tricky,** politically, as only a minority of states require (by law) physicians to carry professional liability insurance. If there are no statutory requirements on physicians in your state, it may be difficult to pass mandatory liability insurance coverage requirements for midwives.
- **Be careful.** In 1993, the legislature in **Washington State**, where midwives have been licensed since the late 1970s, stepped-in to provide liability coverage for CPMS, CNMs and birth centers *as a last resort*. This "state" coverage (provided thru a Joint Underwriting Association) is, in fact, subsidized by assessments on health care companies licensed to operate in **Washington State**. The program accepts only Washington midwives; no other state has a similar program.
- **Consider requiring companies providing professional liability coverage for midwives to report any malpractice settlement, award, payment in excess of a certain amount, and payment of 3 or more claims in a 12-month period.** **Washington State** requires this.
- **Consider requiring insured midwives to participate in annual professional liability reviews (PLR)** that focus on risk management and quality of care. In **Washington State**, PLR is conducted annually and is required of all midwives who purchase professional liability insurance. The results of this review are used by the JUA in determining eligibility for continued coverage. The cost of the basic PLR is paid for from the midwife's annual premium.

Suggested Legislative Language

1. **Requirement for midwife to have liability coverage**
page 25
2. **Disclosure to client about midwife's liability coverage status**
page 25
3. **Mandatory reporting of awards, settlements & claims payments**
page 25

Suggested Legislative Language: Requirement for midwife to have liability coverage 1

Wisconsin certified professional midwife licensure law, Act 292, enacted 2006

[Note: Wisconsin lawmakers rejected the below amendment during debate on the licensure law.]

Senate amendment 5: The rules shall require that a licensed midwife have in effect a malpractice insurance policy in an amount identical to the amount of malpractice liability insurance required of a nurse-midwife by the board of nursing.

Suggested Legislative Language: Disclosure to client about midwife's liability coverage status 2

Florida midwife licensure law, enacted 2001

A licensed midwife shall include in the informed consent plan presented to the parents the status of the midwife's malpractice insurance, including the amount of malpractice insurance, if any.

Idaho HB 185, amending certified professional midwife licensure law, enacted 2009

Disclosure and record keeping—license renewal. Before initiating care, a licensed midwife shall obtain a signed informed consent agreement from each client, acknowledging receipt, at minimum of the following: … notice of whether or not the licensed midwife has professional liability coverage.

Missouri HB 887, ACOG-backed CPM licensure bill, introduced but not passed in 2011

Every registered midwife shall present an informed consent document to each client which shall include but not be limited to the following: a statement specifying whether malpractice or other similar liability insurance is maintained by the registered midwife and if maintained, a description of the liability conditions and limits of such insurance, and a description of the limitation on liability by a health care professional under subsection 3 of this section if a transfer to a health care facility becomes necessary.

Suggested Legislative Language: Mandatory reporting of awards, settlements & claims payments 3

Washington licensed midwife regulations, WAC section 246-834-320

Professional liability carriers. Every institution or organization providing professional liability insurance directly or indirectly to midwives shall send a complete report to the department of any malpractice settlement, award, or payment in excess of twenty thousand dollars as a result of a claim or action for damages alleged to have been caused by an insured midwife's incompetency or negligence in the practice of midwifery. Such institution or organization shall also report the award, settlement, or payment of three or more claims during a twelve-month period as a result of the midwife's alleged incompetence or negligence in the practice of midwifery.

SECTION EIGHT:
Liability Protection for Consulting & On-call Physician

Discussion

- **Physicians are concerned about their liability exposure for the actions of midwives** from whom they have accepted a referral or with whom they have no clinical or supervisory relationship.
- **Two legislative approaches are suggested here:** Good Samaritan protection and non-vicarious liability.
- **Legislative option #1:** try to extend your state's Good Samaritan laws to include physicians and hospitals handling midwife patient transfers, so-called "drop-in" deliveries.
- **There are various ways to do this legislatively** and this will be a strategic decision based on political realities in your state. For example: You can try to pass drop-in delivery immunity as a separate stand-alone bill, as part of a larger medical liability reform law as in **Georgia** and **South Carolina**, or as part of your midwife licensure law.
- **Be forewarned.** These measures are very difficult to pass. Lawmakers have been reluctant to grant this immunity and many patient rights groups oppose it outright.
- **Be careful to avoid what happened in California in 1988** when the legislature passed a drop-in delivery immunity law that specifically excluded physicians required to serve on-call as part of their regular hospital privileges. **California's** law provides immunity only if the medical care is both voluntary and without expectation of compensation. This is problematic as most hospitals either require mandatory emergency coverage or else pay physicians to cover, thus negating the Good Samaritan protection. This unfortunate requirement disqualified the majority of physicians handling drop-in deliveries.
- **Legislative option #2:** include a non-vicarious liability provision in your midwife licensure law. These provisions have been successfully included in recently enacted midwife licensure laws. Try to word this so it protects the consulting physician and physicians who accept referrals. For example, see **Wisconsin's** 2006 law.

Suggested Legislative Language

1. **Extend Good Samaritan laws to "drop-in" deliveries**
page 27

2. **AVOID this Good Samaritan language!**
page 28

2. **Non-vicarious liability**
page 28

Suggested Legislative Language: Extend Good Samaritan laws to "drop-in" deliveries

1

Georgia SB 3, caps noneconomic awards in medical liability cases including immunity for drop-in deliveries, enacted 2005

Section 10. Gross negligence standard for emergency care—In a medical liability cause of action arising out of the provision of emergency medical care in a hospital emergency department, obstetrical unit, or surgical suite immediately following the evaluation of the patient in a hospital emergency department, the court shall instruct the jury to consider whether the physician had the patient's medical history, whether there was a pre-existing patient-physician relationship, the circumstances constituting the emergency, and the circumstances surrounding the delivery of the emergency medical care. No physician or health care provider can be held liable for a medical liability cause of action arising from such care, unless it is proven by clear and convincing evidence that the provider's actions constitute gross negligence.

Maine HB 1275, midwife licensure bill, failed to pass in 2007

A health care provider…is immune from civil liability for any injuries resulting from the acts or omissions of a licensed midwife. Licensed physicians are immune from civil liability when consulting or collaborating with a licensed midwife or accepting transfer of care of clients who are outside of the scope of practice of the licensed midwife.

Montana HB 342, stand-alone immunity bill, failed to pass in 2009

Limits on liability of health care provider in emergency situations. A physician licensed under [STATE CODE], a nurse licensed under [STATE CODE], or a hospital licensed under [STATE CODE], rendering care or assistance in good faith in an emergency situation to a patient who has intentionally attempted a delivery outside of a hospital setting, whether or not assisted by a birth attendant, is liable for civil damages for acts or omissions committed in providing such emergency obstetrical care or assistance only to the extent those damages are caused by gross negligence or by willful or wanton acts or omissions. For purposes of this section, the term "birth attendant" means a midwife, a nurse-midwife, a physician, a relative or any other person.

New Mexico licensed midwife regulations, NMSA Title 16, Chapter 11, Part 3

Limitation of physician liability: Any consultative relationship with a physician shall not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife.

South Carolina SB 83, caps noneconomic awards in medical liability cases including immunity for drop-in deliveries, enacted 2005

Section 15-32-330. (A) In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation involving an immediate threat of death or serious bodily injury to the patient receiving care in an emergency department or in an obstetrical or surgical suite, no physician may be held liable unless it is proven that the physician was grossly negligent. This exception does not apply when a patient is medically stable, is not in immediate threat of death or serious bodily injury or has been discharged from the hospital.

(B) In an action involving a medical malpractice claim arising out of care rendered by an obstetrician on an emergency basis when there is no previous doctor/patient relationship between the obstetrician or a member of his practice with a patient or the patient has not received prenatal care, an obstetrician is not liable unless it is proven the obstetrician is grossly negligent.

Utah direct-entry midwife licensure law, Chapter 299, Sec 58-77-102, enacted 2005

Immunity and liability. 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. 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. 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. Regardless of the advice given or order issued, the responsibility and liability for caring for the client is that of the direct-entry midwife. The provider giving the order is responsible and liable only for the appropriateness of the order given the data received. 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. 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. A licensed direct-entry midwife shall be solely responsible for the use of medications under this chapter.

Wyoming SB 477, certified professional midwife licensure law, enacted 2010

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.

1 Extend Good Samaritan laws to "drop-in" deliveries

No hospital, person licensed under the Medical Practice Act, person licensed under the Nurse Practice Act, prehospital emergency medical personnel or any of their agents shall be liable for care provided to a woman or newborn child subsequent to care provided by a midwife, except that any hospital, person licensed under the Medical Practice Act, person licensed under the Nurse Practice Act, prehospital emergency medical personnel or any of their agents shall remain liable as otherwise provided by law for his or its own actions which are independent of the actions and omissions of the midwife.

No person licensed under the Medical Practice Act, person licensed under the Nurse Practice Act or hospital in which they practice shall be liable for any failures of a midwife to meet any standard of care for patients on which they provide consultation to a midwife or accept a referral from the midwife but shall remain liable as otherwise provided by law for his or its own actions.

For purposes of this section, "midwife" means the licensed midwife who provided care to the patient and any employer under whose authority the midwife provided that care.

2 *Suggested Legislative Language:* AVOID this Good Samaritan language!

California AB 3473, "on-call" physician immunity: obstetrical services, adding section 2395.5 to the Business and Professions Code, enacted 1988

A licensee who serves on an on-call basis to a hospital emergency room, who in good faith renders emergency obstetrical services to a person while serving on-call, shall not be liable for any civil damages as a result of any negligent act or omission by the licensee in rendering the emergency obstetrical services. The immunity granted by this section shall not apply to acts or omissions constituting gross negligence, recklessness, or willful misconduct.

The protections shall not apply to the licensee in any of the following cases: (1) Consideration in any form was provided to the licensee for serving, or the licensee was required to serve, on an on-call basis to the hospital emergency room. In either event, the protections shall not apply unless the hospital expressly, in writing, accepts liability for the licensee's negligent acts or omissions. (2) The licensee had provided prior medical diagnosis or treatment to the same patient for a condition having a bearing on or relevance to the treatment of the obstetrical condition which required emergency services. (3) Before rendering emergency obstetrical services, the licensee had a contractual obligation or agreement with the patient, another licensee, or a third-party payer on the patient's behalf to provide obstetrical care for the patient, or the licensee had a reasonable expectation of payment for the emergency services provided to the patient.

3 *Suggested Legislative Language:* Non-vicarious liability

Colorado SB 88, sunset review of registered direct-entry midwives, enacted 2011

Assumption of risk—nonvicarious liability—legislative declaration. It is the policy of this state that registrants shall be liable for their acts or omissions in the performance of the services that they provide, and that no licensed physician, nurse, prehospital emergency medical personnel, or health care institution shall be liable for any act or omission resulting from the administration of services by any registrant. This subsection does not relieve any physician, nurse, prehospital emergency medical personnel, or health care institution from liability for any willful and wanton act or omission or any act or omission constituting gross negligence, or under circumstances where a registrant has a business or supervised relationship with any such physician, nurse, prehospital emergency medical personnel, or health care institution. A physician, nurse, prehospital emergency medical personnel, or health care institution may provide consultation or education to the registrant without establishing a business or supervisory relationship, and is encouraged to accept referrals from registrants pursuant to this article.

Idaho HB 185, amending certified professional midwife licensure law, enacted 2009

Immune from vicarious liability. No physician, hospital, emergency room personnel, emergency medical technician or ambulance personnel shall be liable in any civil action arising out of any injury resulting from an act or omission of a licensed midwife, even if the health care provider has consulted with or accepted a referral from the licensed midwife. A physician who consults with a licensed midwife but who does not examine or treat a client of the midwife shall not be deemed to have created a physician-patient relationship with such client.

Wisconsin SB 477, certified professional midwife licensure law, enacted 2006

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 NINE:
Vaginal Birth after Cesarean (VBAC)

Discussion

- **In states where home VBAC with a midwife is permitted,** most of the political negotiation has occurred after the bill has passed, during the rule-making stage. But you'll want to try to make the bill permitting VBAC as detailed as possible. Clear parameters going into the rule-drafting stage are the goal here.
- **Don't leave it to the CPMs.** Require midwives to use a state-prescribed informed consent form for VBAC.
- **Enumerate ALL requirements.** If it's not listed, it's not regulated.
- **Consider requiring the state licensure agency to review the rules for VBAC** within one year from their effective date, and regularly thereafter.

Suggested Legislative Language

1. **Client informed consent for VBAC** page 30
2. **Strict requirements for VBAC** page 30
3. **Required review of VBAC rules** page 31

1 *Suggested legislative language:* Client informed consent for VBAC

California licensed midwife rules, CAC Title 16, Section 1379.19

With respect to care of a client who has previously had a cesarean section but who meets the criteria set forth in the Standard of Care for California Licensed Midwives (SCCLM), the licensed midwife shall provide the client with written informed consent (and document that written consent in the client's midwifery record) that includes but is not limited to all of the following:

1. *The current statements by the American College of Obstetricians and Gynecologists regarding its recommendations for vaginal birth after cesarean section (VBAC).*
2. *A description of the licensed midwife's level of clinical experience and history with VBACs and any advanced training or education in the clinical management of VBACs.*
3. *A list of educational materials provided to the client.*
4. *The client's agreement to: provide a copy of the dictated operative report regarding prior C-section; permit increased monitoring; and, upon request of the midwife, transfer to a hospital at any time or if labor does not unfold in a normal manner.*
5. *A detailed description of the material risks and benefits of VBAC and elective repeat C-section.*

Montana direct-entry midwife rules, ARM section 24.111.612

Vaginal Birth after Cesarean (VBAC) Deliveries. A licensed direct-entry midwife shall not assume primary responsibility for prenatal care and/or birth attendance for women who have had a previous cesarean section, unless all of the following conditions are met:

An informed consent statement, on a form furnished by the board, shall be signed by all prospective VBAC parents and the licensee, and retained in the licensee's records. The form shall include:

- *VBAC educational information, including history of VBAC and client's own personal information;*
- *associated risks and benefits of VBAC at home;*
- *a workable hospital transport plan;*
- *alternatives to VBAC at home;*
- *other information as required by the board.*

2 *Suggested legislative language:* Strict requirements for VBAC

Montana direct-entry midwife rules, ARM section 24.111.612

A workable hospital transport plan must be established for home VBAC. The plan shall include:

- *provision for physician/hospital backup, e.g., through the physician/hospital policy on backup;*
- *place of birth within 30 minutes of transport to the nearest hospital able to perform an emergency cesarean;*
- *readily available phone numbers for physician backup and nearest hospital, in writing, in client's records;*
- *phone contact with nearest hospital at onset of labor and prior to any transport to notify that transport is in progress; and at conclusion of home birth if no transport is necessary.*

Licensee shall obtain prior doctor/hospital cesarean records, in writing, prior to acceptance of the woman as a client, and shall analyze the indication for the previous cesarean, and retain the records and a written assessment of the physical and emotional considerations in licensee's files. Records which show a previous classical uterine/vertical incision, any other uterine scars into the endometrium, or less than 18 months between the last surgery to the next delivery are contraindications to VBAC at home, and shall require immediate transfer of care of the client. If a licensee is unable to obtain written records, the licensee shall not retain the woman as a client.

VBAC deliveries shall be performed by a fully licensed midwife (not an apprentice licensee), skilled with VBAC support, able to assess true complications and emergencies, to be present from the onset of active labor, throughout the immediate postpartum period.

Utah SB 93, amending the direct-entry midwife act, enacted 2008

[See in section 5, Transfer & Referral to Medical Care]

Vermont Midwives Act, Title 26, VSA Chapter 85; Vermont Administrative Rules for Midwives

The following requirements must be met for vaginal birth after cesarean (VBAC). In addition, prenatal consultation is advised when available.

1. *The midwife must consult with a licensed MD or DO to ascertain that the client had only one documented previous lower uterine segment cesarean section with uterine closure of more than one layer.*
2. *There must be at least 18 months from the client's cesarean to the due date of the current pregnancy.*

3. *The client must obtain ultrasound documentation to determine that the location of the placenta is not previa or is not low and anterior.*
4. *Signed informed consent must be present in the client's chart. See Appendix A.*
5. *The midwife must perform fetal auscultation at least every 15 minutes during active labor and more frequently if necessary and at least every five minutes during the second stage of labor and more frequently if necessary.*
6. *The birth site must be located within 30 minutes' transport time from a hospital emergency room.*
7. *Two licensed midwives must be present during the birth.*
8. *No labor induction or augmentation of any kind must be done, including use of any chemical or herbal medication or nipple stimulation.*
9. *Pre-admission forms must be completed for the client before labor, for the hospital to which the client may possibly be transferred.*
10. *Prenatal records for the client must be sent before labor to the back-up system for the birth (hospital, labor and delivery unit, or physician practice).*

Suggested legislative language: Required review of VBAC rules 3

Montana direct-entry midwife rules, ARM section 24.111.612

The board shall conduct a "sunset" review, including the necessity for and safety of the VBAC rule, on or about May, 2011, or five years from the effective date of this rule.

Vermont Midwives Act, Title 26, VSA Chapter 85; Vermont Administrative Rules for Midwives

No later than one year from the effective date of these rules or earlier upon written request, the Director, in consultation with the advisor appointees and the Commissioner of Health, will review current scientific research on vaginal birth after cesarean (VBAC), for the purpose of seeking amendment of this rule to reflect current scientific research findings, provided the Director concludes after consultation that amendment is necessary.

2 Strict requirements for VBAC

3 Required review of VBAC rules

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Overset

from Section 1, page 3

- If CPMs are legalized in your state but unregulated (this is the situation in **Hawaii**, **Missouri**, Oregon, and previously in **Idaho**), you'll want to try to bring them under the State Medical or Nursing Board, and set scope of practice requirements including informed consent, strict patient eligibility criteria, and outcomes reporting. This may be an uphill battle. Midwives in your state may be opposed to any state or physician oversight.
- Another legislative option is to consider registration—rather than full licensure—as **Colorado** has currently. Registration does not confer the same status as licensure. It may be less objectionable to the state medical society and other physician specialty groups in your state whose support may be critical. A registration system can be helpful in addressing drop-in deliveries and mortality and morbidity associated with independent midwives who practice "underground" and are not integrated into the maternity care system. For example, a registration program gives state health officials critical oversight tools and authority, including the authority to collect, review and act on outcomes data.
- You can also work to amend—and strengthen—CPM-backed scope of practice expansions using this toolkit, or introduce your own version of CPM licensure using this toolkit.

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from Section 2, page 6

the **Oregon** legislation. Also, it may be necessary to include in your bill explicit permission for health care professionals and hospitals to submit clinical and demographic data concerning home birth transfers to the state licensing agency or contracted peer review entity. For example, see legislative language proposed in **Vermont**.

- Consider including a penalty provision—license suspension or revocation—for failure to facilitate an immediate transfer.
- Watch for midwife proponents to pursue legislation that would waive physician consultation through a client disclosure/refusal process. Watch for—and avoid—language specifying that practice regulations shall not require assessment by another health care professional.
- Based on the experience of several states, you can expect midwives to attempt to expand their scope of practice *after* gaining registration or licensure. This includes twins, breeches and vaginal birth after cesarean. Again, it will be important to tightly define scope of practice in your bill and limit midwife practice to normal, low-risk pregnancies. This will help later on during rules development as well as ongoing oversight by the state agency or midwifery advisory board.
- Specify record keeping and reporting requirements—for midwives, hospitals and the state. (See in section 6.)

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from Section 6, page 19

- monitor consumer complaints, conduct investigations & oversee the disciplinary process.

- Don't let midwife participation in peer review replace state agency investigatory authority of complaints against midwives. You may want to spell this out in your legislation. For example, see **Oregon's** legislation.
- Don't overlook funding for state oversight activities. A dedicated funding source is critical especially where state government agencies are under-resourced.
- Consider giving the state licensing agency or midwifery advisory board subpoena power.