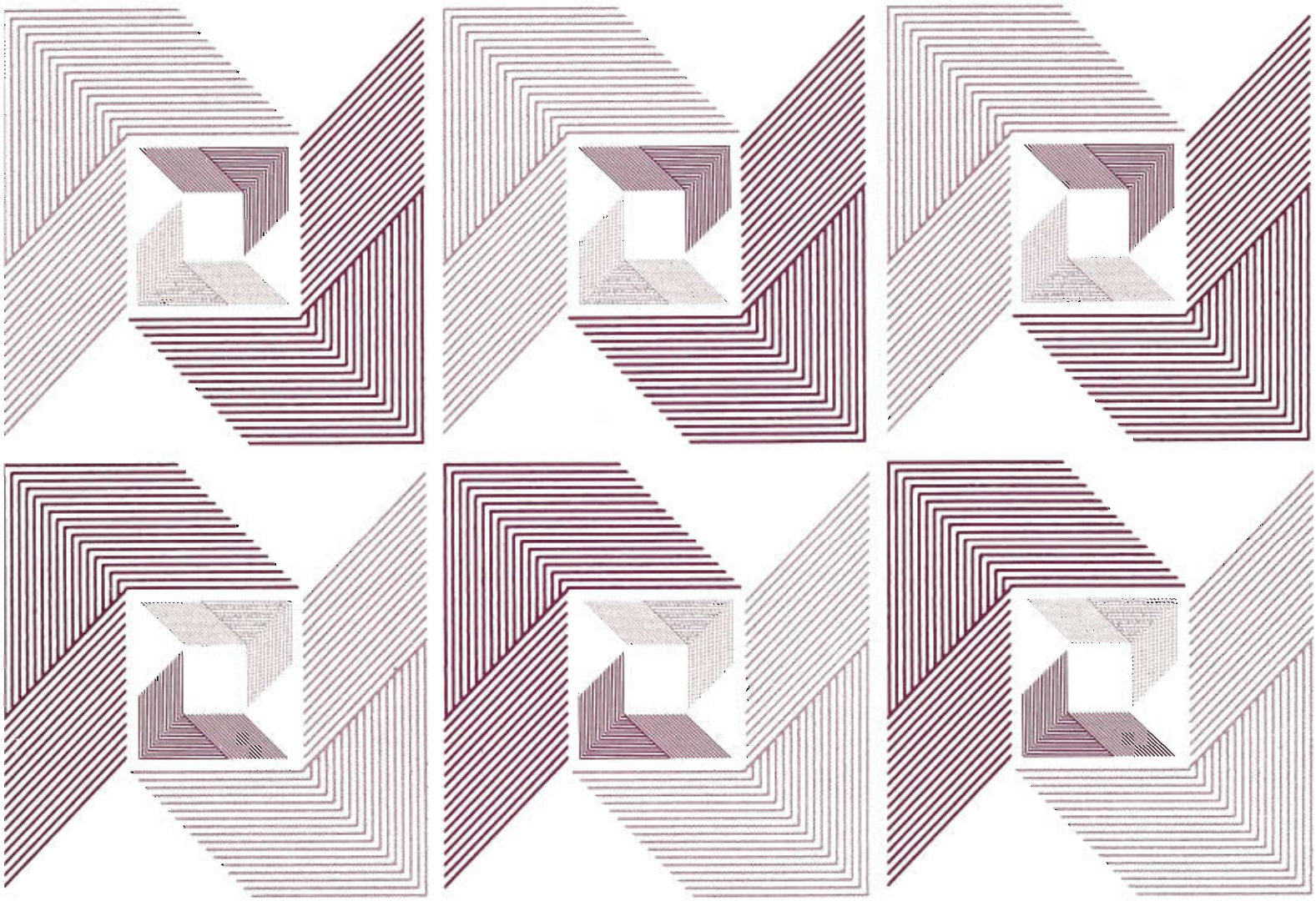
Report No. 89-21
December 1989

SUNSET EVALUATION REPORT
REGULATION OF MIDWIVES

A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAII



SUBMITTED BY THE LEGISLATIVE AUDITOR OF THE STATE OF HAWAII

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OVERVIEW

SUNSET EVALUATION REPORT: REGULATION OF MIDWIVES

Honolulu, Hawaii December 1989

Summary

Most midwives today are nurses with a specialty in nurse-midwifery. They care for women during pregnancy, labor and the postpartum period, and for newborns and infants. Their work may extend to family planning and gynecological services. Although the activities of lay midwives have been circumscribed and even prohibited in some states for many years, the shortage of obstetrical providers has prompted many states to reconsider.

Like all other states, Hawaii permits the practice of nurse-midwifery. The Maternal and Child Health Branch of the Department of Health regulates the practice. To qualify for a license, an applicant must be licensed as a registered nurse in the State of Hawaii, be certified in nurse-midwifery by the American College of Nurse-Midwives, and comply with the college's continuing education requirements.

As of March 1989, there were only five licensed nurse-midwives in the state.

Under Hawaii's Sunset Law, the auditor is responsible for evaluating the licensing programs and recommending whether regulation should continue and under what conditions. This report found that the Department of Health should continue to regulate midwives, but that changes are needed in the statutes and rules.

FINDINGS

Regulation should continue because the practice of midwifery has the potential to harm the public. The current licensing law is not adequate. It does not establish the scope of practice, standards for licensing, prohibited practices, grounds for disciplinary action, and sanctions.

Some of the department's rules are unnecessarily restrictive. They prohibit nurse-midwives from providing gynecological care and using mechanical means in childbirth, and require them to be under the supervision of a physician.

The department's enforcement program is weak. It has not taken action in cases of unlicensed activity and it has not taken advantage of enforcement services of the Department of Commerce and Consumer Affairs.

RECOMMENDATIONS

The licensing program for midwives should remain with the Department of Health, but regulation should continue under new statutes. If the statutes are not repealed, then they should be amended to define the scope of practice, eliminate the health and character requirement, and ensure the proper notification of licensees prior to forfeiture.

In amending its rules, the department should include gynecological care in the practice of midwifery, delete the provision prohibiting artificial or mechanical means of assisting in childbirth, and delete the requirement for physician supervision.

As required by law, the department should collect a compliance resolution fee from each licensee and arrange to have the Department of Commerce and Consumer Affairs handle complaints and cases of unlicensed activity.

RESPONSE

The Department of Health suggests that any new statute regulating midwives should incorporate the standards of the American College of Nurse-Midwives. The department agrees to amend its rules, deleting the requirement for physician supervision and adding rules that recognize continuing education credits approved by the American College of Nurse-Midwives or the department's midwifery committee.

The Department of Commerce and Consumer Affairs believes the referral of cases and the assessment of a compliance resolution fee may be a problem. The director urges that this problem be referred to the Legislature for resolution.

SUNSET EVALUATION REPORT

REGULATION OF MIDWIVES

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

Legislative Auditor of the State of Hawaii
Honolulu, Hawaii

Report No. 89-21
December 1989

FOREWORD

Under the "Sunset Law," licensing boards and commissions and regulated programs are terminated at specific times unless they are reestablished by the Legislature. Hawaii's Sunset Law, or the Hawaii Regulatory Licensing Reform Act of 1977, schedules for termination licensing programs over a six-year period. These programs are repealed unless they are specifically reenacted by the Legislature. In 1979, the Legislature assigned the Office of the Legislative Auditor responsibility for evaluating each program prior to its repeal.

This report evaluates the regulation of midwives under Sections 321-13 to 321-15, Hawaii Revised Statutes. It presents our findings as to whether the program complies with the Sunset Law and whether there is a reasonable need to regulate them to protect public health, safety, or welfare. It includes our recommendation on whether the program should be continued, modified, or repealed. Draft legislation intended to improve the regulatory program is incorporated in this report as Appendix B.

We acknowledge the cooperation and assistance extended to our staff by the Department of Health and other officials contacted during the course of our examination. We also appreciate the assistance of the Legislative Reference Bureau which drafted the recommended legislation.

Newton Sue
Acting Legislative Auditor
State of Hawaii

December 1989

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Chapter 1

INTRODUCTION

The Hawaii Regulatory Licensing Reform Act of 1977, or Sunset Law, repeals statutes concerning 38 occupational licensing programs over a six-year period. Each year, six to eight licensing statutes are scheduled to be repealed unless specifically reenacted by the Legislature.

In 1979, the Legislature amended the law (Chapter 26H, *Hawaii Revised Statutes*) to make the Legislative Auditor responsible for evaluating each licensing program prior to its repeal and to recommend to the Legislature whether the statute should be reenacted, modified, or permitted to expire as scheduled. In 1980, the Legislature further amended the law to require the Legislative Auditor to evaluate the effectiveness and efficiency of the licensing program, even if he determines that the program should not be reenacted.

Objective of the Evaluation

The Legislature in 1988 added certain licensing programs administered by the Department of Health under Sections 321-13 to 321-15, HRS, to the Sunset review schedule. The objective of this evaluation is to determine whether, in light of the policies set forth in the Sunset Law, the public interest is best served by reenactment, modification, or repeal.

Scope of the Evaluation

This report examines the history of the statute on licensing of midwives and the public health, safety, or welfare that the statute was designed to protect. It then assesses the effectiveness of the statute in preventing public injury and the continuing need for regulation.

Organization of the Report

This report consists of three chapters: Chapter 1, this introduction and the framework for evaluating the licensing program; Chapter 2, background information on the regulated industry and the enabling legislation; and Chapter 3, our evaluation and recommendations.

Framework for Evaluation

Hawaii's Regulatory Licensing Reform Act of 1977, or Sunset Law, reflects rising public antipathy toward what is seen as unwarranted government interference in citizens' lives. The Sunset Law sets up a timetable terminating various occupational licensing programs. Unless reestablished, the programs disappear or "sunset" on a prescribed date.

In the Sunset Law, the Legislature established policies on the regulation of professions and vocations. The law requires each occupational licensing program to be assessed against these policies in determining whether the program should be reestablished or permitted to expire as scheduled. These policies, as amended in 1980, are:

1. The regulation and licensing of professions and vocations by the State shall be undertaken only where reasonably necessary to protect the health, safety, or welfare of consumers of the services; the purpose of regulation shall be the protection of the public welfare and not that of the regulated profession or vocation.

2. Where regulation of professions and vocations is reasonably necessary to protect consumers, government regulation in the form

of full licensure or other restrictions on the professions or vocations should be retained or adopted.

3. Professional and vocational regulation shall be imposed where necessary to protect consumers who, because of a variety of circumstances, may be at a disadvantage in choosing or relying on the provider of the services.

4. Evidence of abuses by providers of the services shall be accorded great weight in determining whether government regulation is desirable.

5. Professional and vocational regulation which artificially increases the costs of goods and services to the consumer should be avoided.

6. Professional and vocational regulation should be eliminated where its benefits to consumers are outweighed by its costs to taxpayers.

7. Regulation shall not unreasonably restrict entry into professions and vocations by all qualified persons.

We translated these policy statements into the following framework for evaluating the continuing need for the various occupational licensing statutes.

Licensing of an occupation or profession is warranted if:

1. There exists an identifiable potential danger to public health, safety, or welfare from the operation or conduct of the occupation or profession.

2. The public that is likely to be harmed is the consuming public.

3. The potential harm is one against which the public cannot reasonably be expected to protect itself.

4. There is a reasonable relationship between licensing and protection of the public from potential harm.

5. Licensing is superior to other alternative ways of restricting the profession or vocation to protect the public from the potential harm.

6. The benefits of licensing outweigh its costs.

The potential harm. For each regulatory program under review, the initial task is to identify the purpose of regulation and the dangers from which the public is to be protected.

Not all potential dangers warrant the exercise of the State's licensing powers. The exercise of such powers is justified only when the potential harm is to public health, safety, or welfare. "Health" and "safety" are fairly well understood. "Welfare" means well-being in any respect and includes physical, social, and economic well-being.

This policy that the potential danger be to the public health, safety, or welfare is a restatement of general case law. As a general rule, a state may exercise its police power and impose occupational licensing requirements only if such requirements tend to promote the public health, safety, or welfare. Courts have held that licensing requirements for paperhangers, housepainters, operators of public dancing schools, florists, and private land surveyors could not be justified.[1] In Hawaii, the State Supreme Court ruled in 1935 that legislation requiring photographers to be licensed bore no reasonable relationship to public health, safety, or welfare and constituted an unconstitutional encroachment on the right of individuals to pursue an innocent profession.[2] The court held that mere interest in the practice of photography or in ensuring quality in professional photography did not justify the use of the State's licensing powers.

The public. The Sunset Law further states that for the exercise of the State's licensing powers to be justified, the potential harm must be to the health, safety, or welfare of that segment of the public consisting mainly of consumers of the services provided by the regulated occupation. The law makes it clear that the focus of protection should be the consuming public and not the regulated occupation or profession itself.

Consumers are all those who may be affected by the services provided by the regulated occupation. Consumers do not have to purchase the services directly. The provider of services may have a direct contractual relationship with a third party and not with the consumer, but the criterion is met if the provider's services ultimately flow to and adversely affect the consumer. For example, the services of an automobile mechanic working for a garage or for a U-drive establishment flow directly to the employer, but the mechanic's workmanship ultimately affects the consumer who brings a car in for repairs or who rents a car from the employer.

Consumer disadvantage. The exercise of the State's licensing powers is not warranted if the potential harm is one against which the consumers can reasonably be expected to protect themselves. Consumers are expected to be able to protect themselves unless they are at a disadvantage in selecting or dealing with the providers of services.

Consumer disadvantage can arise from a variety of circumstances. It may result from a characteristic of the consumer or from the nature of the occupation or profession being regulated. Age is an example of a consumer characteristic which may cause the consumer to be at a disadvantage. The highly technical and complex nature of an occupation is an illustration of occupational characteristic that may place the consumer at a disadvantage. Medicine and law fit into the latter illustration. Medicine and law were the first occupations to be licensed on the theory that the general public lacked sufficient knowledge about medicine and law to be able to make judgments about the relative competencies and about the quality of services provided to them by the doctors and lawyers of their choice.

However, unless otherwise indicated, consumers are generally assumed to be knowledgeable and able to make rational choices and to assess the quality of services being provided them.

Relationship between licensing and protection. Occupational licensing cannot be justified unless it reasonably protects the consumers from the identified potential harm. If the potential harm to the consumer is physical injury arising from possible lack of competence on the part of the provider of service, the licensing requirements must ensure the competence of the provider. If, on the other hand, the potential harm is the likelihood of fraud, the licensing requirements must be such as to minimize the opportunities for fraud.

Alternatives. Licensing may not be the most appropriate method for protecting consumers. Instead, prohibiting certain business practices, governmental inspection, or the inclusion of the occupation within another existing business regulatory statute may be preferable, appropriate, or more effective in protecting the consumers. Increasing the powers, duties, or role of the consumer protector is another possibility. For some programs, a nonregulatory approach may be appropriate, such as consumer education.

Benefit-costs. Even when all other criteria set forth in this framework are met, the exercise of the State's licensing powers may not be justified if the costs of doing so outweigh the benefits to be gained. The term "costs" in this regard means more than direct money outlays or expenditure for a licensing program. "Costs" include opportunity costs or all real resources used up by the licensing program; they include indirect, spillover, and secondary costs. Thus, the Sunset Law asserts that regulation which artificially

increases the costs of goods and services to the consumer should be avoided; and regulation should not unreasonably restrict entry into professions and vocations by all qualified persons.

Chapter 2

BACKGROUND

Sections 321-13 to 321-15, *Hawaii Revised Statutes*, regulate the practice of midwifery. This chapter reviews the occupational characteristics of midwives and national and local developments in regulation.

Occupational Characteristics

Most midwives today come from the nursing profession with a specialty in nurse-midwifery. They manage the care of women during pregnancy, labor, and the postpartum period. They also care for newborns and infants. Their work may extend to family planning and gynecological care.

Midwifery began as a respected occupation in the United States. During colonial times, any woman who had given birth and had assisted with the births of her family and friends could be a midwife. Childbirth was viewed as a natural process in which midwives played a central role. They were an important part of community life and held in high esteem. As payment for their services, they received housing, land, food, and salary.

Their status declined, however, as the practices of medicine and nursing developed during the 1700s and 1800s. Without a comparable educational program, midwives were unable to access medical developments and training and did not become part of the emerging health care system. As the medical profession became established, midwives became the subject of controversy.

The occupation was damaged by a 1906 study of maternal and infant mortality in New York City that blamed high death rates primarily on incompetent and ignorant midwives.[1] The city began to regulate midwives by prohibiting them from administering or prescribing drugs and from using artificial or mechanical means of assisting in childbirth. In 1911 it established the first municipally sponsored school for midwives and in 1915, required licensed midwives to be graduates of recognized schools of midwifery.[2] These efforts resulted in a significant decline in the infant mortality rate.

Controversy over midwives reached its height between 1910 and 1920. Physicians who hoped to have obstetrics recognized as a medical specialty sought to eliminate midwives. They contended that obstetrics required the skills of highly trained physicians. Other public health officials did not agree. They believed that the high infant mortality rate could be reduced with properly trained midwives, particularly in rural areas.

After 1920, fewer and fewer births were attended by midwives. This decline was due to the increasing use of forceps, caesarean sections, and pain reducing drugs. More and more childbirths were occurring in hospitals and attended by physicians.

In the 1970s the use of lay midwives reemerged when a variety of organizations began promoting home childbirth. Reacting to the treatment women received from obstetricians and hospitals, these groups questioned the medical domination of childbirth and extoled the benefits of a natural, more woman-centered process. Lay midwives were seen as an alternative to hospital births and their high cost.

It is estimated that in 1984, 1 percent of all births occurred outside of hospitals, and lay

midwives attended over 74 percent, or approximately 28,000, of these births.[3]

Development of nurse-midwifery. At the same time that midwifery was declining in the 1920s, the field of nurse-midwifery was emerging. The term "nurse-midwife" was introduced by Fred J. Taussig in 1914, who suggested that only nurses be admitted to schools of midwifery.[4] Both proponents and opponents of midwives supported this concept.

Nurse-midwifery received a strong impetus in 1925 when British-trained American nurses were used to serve remote areas in Kentucky. The Frontier Nursing Service established nursing centers throughout Kentucky which were staffed by nurse-midwives with backup by medical directors in local hospitals. It started its own school of midwifery. The Frontier Nursing Service became legendary for its low infant mortality rates and the comprehensive services it brought to rural Kentucky.[5]

In 1931 the Maternity Center Association in New York City created the first education program for nurse-midwives in the United States. Only registered nurses who had graduated from accredited schools of nursing could enroll. Between 1933 and 1959, the Maternity Center Association School of Nurse-Midwifery graduated 320 nurse-midwives.[6]

In the 1940s and 1950s, nurse-midwives were employed as nursing educators, nursing service staff in hospitals, and consultants in federal and international health organizations. Through the 1960s, most nurse-midwifery graduates entered teaching, supervisory, administrative, or consultative positions in related fields because employment opportunities in clinical nurse-midwifery practice were limited.

In 1955, a committee of nurse-midwives established the American College of Nurse-Midwifery, which later became the American College of Nurse-Midwives (ACNM). Starting with 124 nurse-midwives, the membership increased to 860 by 1975.[7] One factor contributing to this growth was the official recognition of nurse-midwives by the American College of Obstetricians and Gynecologists in 1971.

The ACNM established a certification program for nurse-midwives in 1971. The requirements for certification include completing an accredited education program in nurse-midwifery and passing the ACNM National Certification Examination. By 1987, the ACNM had certified a total of 3,959 nurse-midwives.[8]

The number of educational programs for nurse-midwives proliferated from 9 in 1965 to 26 in 1985.[9] Currently, there are three types of programs: (1) the 9- to 12-month certificate program for registered nurses who have graduated from diploma and associate degree nursing programs or who have graduate degrees; (2) the 18- to 24-month master's degree program for nurses; and (3) the nurse-midwifery program that is part of the requirements leading to a doctor in nursing science. These programs are usually offered in schools or colleges of nursing.

A 1987 ACNM survey of certified nurse-midwives (CNMs) showed that 899 or 59 percent of the CNMs worked in hospitals, 353 or 23 percent were in private practice with physicians, and 63 or 17 percent were in nurse-midwifery practice. CNMs were also employed in public health agencies, prepaid groups, and other work settings.[10] Many worked for more than one organization.

Regulation of Midwives

During the early 1900s, many cities and states enacted or revised laws that defined the activities of midwives and prevented them from attending abnormal births. Massachusetts made it illegal for midwives to attend births unless they were qualified to practice medicine.[11] Since then, many states have passed laws regulating both lay midwives and nurse-midwives. There is considerable diversity among these laws.

Regulation of lay midwives. A 1987 survey of the 50 states found that 10 states have prohibitory laws, 5 states have clauses that allow previously regulated midwives to continue to practice under repealed laws, and 10 states explicitly permit and regulate the practice of lay midwifery.[12] In the remaining states, the status of midwives is legally ambiguous. In some cases, practice is either prohibited or permitted under attorney general opinions.

Each of the 10 states that regulate lay midwifery has a Midwifery Advisory Committee.[13] Generally, the committee is composed of physicians, obstetricians, nurse-midwives, and lay midwives. Most of the laws specify the scope of practice, require midwives to consult with physicians, and limit their practice to "low risk" pregnant women. The statutes also define duties and responsibilities such as reporting requirements for birth certificates. All require applicants to pass an examination, and all states, except Texas, require some clinical experience.

The survey reports that there is a growing grassroots movement among lay midwives to establish a system of voluntary certification with a national examination to test minimum levels of competence. They hope to develop standards of practice and protocols for midwifery care.

The shortage of providers of obstetrical and prenatal care is leading some states to reconsider laws that ban midwives. In 1989, Montana enacted a law exempting midwives attending natural childbirths from the state Medical Practice Act. The intent is to expand the pool of midwives because only 19 of the state's 56 counties have access to a family practice physician or an obstetrician. The statute requires midwives to develop educational criteria and formal standards of care within two years.[14]

Regulation of nurse-midwives. In 1945, New Mexico became the first state to recognize the nurse-midwife.[15] By 1963, the practice of nurse-midwifery was legal in three states and New York City. As a result of the work of the ACNM, nurse-midwives now practice in all 50 states and four jurisdictions (District of Columbia, Guam, Puerto Rico, Virgin Islands). However, the statutes vary considerably in specifying the scope of practice and degree of independence.

The ACNM wants uniform regulation of nurse-midwives. In 1974, the ACNM Legislation Committee stated:

> Separate statutory recognition is recommended as the basis for nurse midwifery practice. To the extent possible, this legislation should be uniform throughout the United States and its jurisdictions. Until such legislation is enacted, nurse-midwives may practice under a variety of legal arrangements.[16]

The variety of legal arrangements include regulation by boards of nursing in a majority of the states or both the board of nursing and board of medicine. In other states nurse-midwives are under the jurisdiction of the board of medicine or department of public health, or a committee of certified nurse-midwives.

Most of the states recognize or require certification by the ACNM for licensing as a nurse-midwife. All states, excluding Rhode Island, require midwives to have a registered nurse license. States issue several different kinds of licenses. Practitioners may be licensed as nurse-midwives, registered nurses, nurse practitioners, midwives, advanced registered nurse practitioners, or advanced nurse practitioners.

Regulation in Hawaii. In 1931, the Territorial Legislature enacted Act 67 requiring midwives to register with the Board of Health. Midwives were also required to file birth certificates for the births they attended.

In 1941, the Hawaii Territorial Legislature passed Act 87 to regulate midwifery along with some other occupations. It authorized the Board of Health to prescribe such rules as may be

necessary to protect the public's health and safety. Act 87 made it illegal to practice midwifery without a certificate of registration or permit. The Senate Committee on Public Health stated that "such regulation is necessary to the safeguarding of public health."[17]

Current Regulation of Midwives in Hawaii

Today, nurse-midwives are regulated by the Maternal and Child Health Branch of the Department of Health (DOH). As of March 1989, there were only five licensed nurse-midwives in Hawaii: one on the island of Oahu, two on the neighbor islands, and two who currently reside in other states.

Section 321-14, HRS, says that it is unlawful to practice as a midwife without a license. Those wishing to practice must apply to DOH for a midwifery license and reregister with DOH every year. DOH is empowered to prescribe rules relating to the practice and to the health, education, training, experience, habits, qualifications, or character of applicants.

In 1976, DOH adopted rules for the licensing program that defined the practice of midwifery as follows:

> The midwife under supervision . . . attends cases of normal childbirth and provides prenatal, intra-partum and post-partum care, including family planning services for the mother, and immediate care for the newborn. All complications are referred to a physician immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.[18]

Only nurses are eligible for licensure. To qualify for a license to practice, an applicant must be licensed as a registered nurse in the State of Hawaii, be certified in nurse-midwifery by ACNM, and comply with continuing education requirements established by ACNM.

The rules require midwives to be supervised by an obstetrician/gynecologist, a physician, or a group of physicians who have a consultative arrangement with an obstetrician/gynecologist. The physical presence of a supervising physician is not required.

DOH may revoke or suspend a certificate of registration or permit for a number of reasons including procuring a license through fraud; professional misconduct, gross carelessness, or manifest incapacity; and practicing midwifery while impaired by alcohol, drugs, physical disability, or mental instability.

According to the rules, DOH may require further education, training, or proof of competency to restore a suspended or revoked license. Instead of revoking or suspending a license, the department may place the licensee on probation.

Chapter 3

EVALUATION OF THE REGULATION OF MIDWIVES

This chapter evaluates the need to regulate midwives and the adequacy of the current regulatory program.

Summary of Findings

1. *The regulation of midwives should be continued since the practice has a clear potential to harm public health and safety. The regulatory program should remain with the Department of Health (DOH).*

2. *The licensing law for midwives is vague. It does not establish the scope of practice, the standards for licensure, prohibited practices, the grounds for disciplinary action, and the sanctions.*

3. *The DOH rules restrict the practice of licensed midwives. Under the definition of the practice of midwifery, midwives are prohibited from: (1) providing gynecological care; (2) using any artificial, forcible, or mechanical means to assist in childbirth; and (3) practicing except under the supervision of a physician.*

4. *The licensing requirements are not being adequately enforced. In addition, DOH has not assessed a compliance resolution fund fee of the licensed midwives as required by Section 26-9(n), Hawaii Revised Statutes, or taken advantage of compliance resolution services available from the Department of Commerce and Consumer Affairs (DCCA).*

The Need for Regulation

The practice of midwifery poses a clear and significant potential for harm to the health and safety of the public. Nurse-midwives are trained in obstetrics, gynecology, and neonatal pediatrics. They provide prenatal, intra-partum, and post-partum care of normal pregnant women and newborn children. Nurse-midwives also provide family planning services and well-woman gynecological care.

Nurse-midwives work under the supervision of an obstetrician/gynecologist but function relatively independently. They establish professional practice agreements with physicians, who provide medical protocols and backup for consultation, collaboration, and referral.

The practice of nurse-midwifery may injure the mother or newborn. During the maternity cycle, a patient may be exposed to a number of harmful conditions and situations if the practitioner is incompetent or negligent. Medication may be given by the wrong route or in the wrong dosage, an infant may fall during delivery and sustain a fractured skull, a nurse-midwife may fail to consult with a physician when needed, or an abnormal pregnancy may go undetected.

The potential for harm in the field of obstetrics is also seen in the rate of malpractice suits against physicians. The American College of Obstetricians and Gynecologists reports that

delivery problems are the second most common reason for suits against its members. Almost 75 percent of obstetrician/gynecologists had been sued at least once by 1986.[1] Family physicians who practice obstetrics are also named more frequently in malpractice suits.

Nurse-midwives are also sued for malpractice but not to the same extent as physicians. According to a 1987 ACNM survey, a total of 146 out of 1,525, or 9.6 percent of the certified nurse-midwives in clinical practice, reported being named in at least one malpractice suit.[2] The claims of malpractice included cases involving cerebral palsy, negligence, maternal death, mental cruelty, ectopic pregnancy, severe damage resulting from insertion of an intra-uterine device, infant death, and fetal demise.

The lower rate of malpractice suits against nurse-midwives is probably due to the characteristics of their patients and their more limited scope of practice. Nurse-midwives usually care for normal or low-risk women and infants. They consult with physicians and refer to them those patients who are high-risk cases or who develop complications. They are less likely than physicians to prescribe drugs, and unlike physicians, they do not perform major surgery.

In 1987, midwives delivered 71 births out of the total of 18,234 births, or 0.4 percent of the births in Hawaii.[3] These births occurred mostly in hospitals and with women of Hawaiian ancestry.

In the past five years, there has been only one complaint. This related to unlicensed midwifery practice. The Maternal and Child Health Branch filed this complaint with DCCA's Regulated Industries Complaints Office (RICO). No complaints have been filed against licensed midwives partly because very few nurse-midwives are actually practicing.

Currently, the practice of nurse-midwifery is regulated by 49 states but is legal in all 50 states. Colorado does not require nurse-midwives to be licensed but allows them to practice under the Colorado Medical Practice Act.

Regulation is needed to ensure minimum levels of competence and to protect the public from untrained or unqualified practitioners.

Placement of the licensing program. The current licensing program for nurse-midwives is placed administratively with the Maternal and Child Health Branch of DOH. In other states, licensing programs are found in public health departments and under boards of nursing, boards of medicine, or committees of nurse-midwifery.

The midwifery licensing program could be transferred from DOH to a new or existing board in DCCA since DCCA administers the licensing programs for nursing and medicine. However, these alternatives are less desirable than keeping the program with DOH. Current conditions do not justify transferring the program.

In most states, boards of nursing administer the licensing program for nurse-midwives. Generally, they issue a specialty nursing license such as nurse-midwife or as nurse practitioner in the specialty of nurse-midwifery. The Hawaii Board of Nursing is not authorized by statute to issue specialty licenses for nurse-midwives and other specialists. It licenses only registered nurses and practical nurses. To create a separate nursing specialty license for nurse-midwives would set a precedent for licensing other nursing specialties, such as nurse practitioners and other clinical specialists, and it is unclear what the impact and ramifications would be.

An alternative is to place the midwifery licensing program under the Hawaii Board of Medical Examiners. However, this would not be desirable for three reasons. *First*, nurse-midwifery has a nursing orientation rather than a medical one. Nurse-midwives are registered nurses by training and usually receive their basic midwifery education in schools of nursing.

Second, the board does not issue specialty licenses for different areas of medicine. *Third*, regulation of nurse-midwifery by a board of medicine is rarely used in other states.

The midwifery licensing program could be established under a new board or committee of nurse-midwives within DCCA. However, this alternative is not desirable or feasible because there are only five licensed nurse-midwives in the state and only one is now practicing. It would not be cost-effective to create a new regulatory program at DCCA for a small number of licensees.

If the licensing program remains in DOH, the activities of licensed and unlicensed midwives can be monitored more easily. Since midwives are required to file birth certificates with DOH for all births they attend, DOH has access to information about who is practicing midwifery and can readily identify whether they are licensed.

Vague Licensing Law

The current statute is not adequate. A comprehensive licensing law should define the scope of practice, the standards for licensure, prohibited practices, the grounds for disciplinary action, and the sanctions. The licensing law for midwives does not do this.

Instead, broad discretion is given to DOH to determine the scope and nature of regulation. The department is authorized, with the governor's approval, to "prescribe such rules as it deems necessary for the public health or safety." DOH can determine the requirements for licensure, the scope of practice, and the grounds for revoking or suspending licenses. This is unlike the vast majority of occupational licensing programs where the basic requirements are specified by statute.

Since the statute has no specific guidelines, there is no way of determining whether the administrative rules accurately reflect the intent of the law. For example, it is unclear who the law on midwives is intended to cover. The law refers to the practice of midwives but does not define a midwife or the practice of midwifery. The DOH rules cover only nurse-midwives, but the law could regulate lay midwives as well. The two types of midwives have very different educational and experience backgrounds. Without a definition of the practice of midwifery, it is not clear whether the Legislature intended to regulate the practice of nurse-midwifery or lay midwifery.

Inappropriate requirements. Several of the current statutory provisions are inappropriate and should be changed or deleted. The courts have held that a license to practice cannot be taken away without first notifying the licensee in writing. However, Section 321-15, HRS, automatically forfeits a person's license for failing to reregister or pay the required reregistration fee after thirty days of delinquency. If a new law is enacted, DOH should be required to give delinquent licensees proper notice in writing prior to license forfeiture.

The law allows the department to adopt rules on the health, habits, and character of licensees. These kinds of requirements have generally been deleted from occupational licensing statutes because of problems in setting clear and valid standards for health, habits, and character and in enforcing these kinds of standards. The requirements are outdated and irrelevant and should be deleted.

Confusing use of terms. The term "license" means that the State permits an individual to practice an otherwise restricted occupation because that person has met certain minimum requirements. The statutes use the terms "certificates" and "certificates of registration" and "permits" in addition to "license." Certificates, certificates of registration, and permits refer to different, less restrictive forms of regulation. To be accurate and consistent, references to "certificates," and "certificates of registration," and "permits" should be

replaced with the term "license" when license is the proper term.

Need to enact new statutes. If regulation of midwives is continued, new statutes should be enacted which would define the scope of practice and establish specific standards relating to the scope of practice. The statutes should include the definition of the occupation and any exemptions from licensure; the requirements for education, training, and experience together with written examination requirements; and the powers and duties of the department to promulgate rules, and issue, renew, suspend, and revoke licenses. Prohibited acts and practices should be set forth along with penalties and fines.

It should be pointed out that although the concept of creating new statutes is sound, the practical aspects bear consideration. The program currently includes only five licensed midwives, and of these only one is practicing in the state. The desirability of statutory change should be weighed in light of the current participation in the licensing program.

Restrictive Rules

The department's rules define the practice of midwifery as follows:

> The midwife under supervision, as defined below, attends cases of normal childbirth and provides prenatal, intra-partum and post-partum care, including family planning services for the mother, and immediate care for the newborn. All complications are referred to a physician immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version. ["Version" means manually changing the direction of the fetus with reference to the mother.][4]

The definition of the practice of midwifery restricts the practice of licensed midwives. *First*, it does not allow midwives to provide well-woman gynecological care. *Second*, it prohibits the use of any mechanical, artificial, or forcible means to assist in childbirth. *Third*, it does not allow midwives to practice except under the supervision of a physician.

Gynecological care. The current definition of the practice of midwifery prohibits nurse-midwives from providing well-woman gynecological care. It limits the practice of midwifery to the care of pregnant women before, during, and after delivery and allows family planning services for mothers only. It does not include services for women who may not be mothers.

The scope of practice of nurse-midwives today has broadened considerably. Nurse-midwives are trained in the full spectrum of normal obstetrical and gynecological care. They manage the care of pregnant as well as nonpregnant women. They provide well-woman gynecological care for women who may not be in the childbearing cycle.

The American College of Nurse-Midwives (ACNM) recognizes gynecological care as an important component of nurse-midwifery practice. Graduates in nurse-midwifery must acquire skills in gynecological care as part of ACNM's core competencies. The practice of nurse-midwifery is defined by ACNM as "the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally, and/or gynecologically."[5]

A 1987 survey conducted by ACNM shows that 1,200 out of 1,526 nurse-midwives or 78.6 percent, were providing gynecological care.[6] The nurse-midwives' activities included well-woman gynecologic histories and physical exams, breast cancer screening, and cervical cancer screening.

Use of mechanical means. Hawaii rules prohibit the use of any artificial, forcible, or mechanical means, and any manual changing of the direction of the fetus in attending childbirth. Nurse-midwives may not use instruments such as forceps and vacuum extractors to assist in delivery. They must refer the case to a physician. This restriction may delay care and place undue stress on the patient.

The situation on Molokai illustrates the dangers of this restrictive rule. Women on Molokai have been cared for by nurse-midwives since family physicians stopped their practice of obstetrics and gynecology about four years ago. Since nurse-midwives cannot deliver babies using forceps or vacuum extractors, all patients needing such help must be transported to Oahu. It usually takes over two hours before the mother receives care, and the delay may cause irreparable harm.

Nurse-midwives in other states have used instruments such as forceps and vacuum extractors to assist in deliveries. According to a 1987 ACNM survey, 80 nurse-midwives performed forceps deliveries and vacuum extractions.[7]

DOH should review the restriction in light of the situation on Molokai and other areas in Hawaii where a physician is not available.

Physician supervision. The rules require a licensed midwife to be under the supervision of a physician. "Supervision" is defined as:

> Formal association by a midwife with an obstetrician/gynecologist or a physician or group of physicians who has/have a formal consultative arrangement with an obstetrician/gynecologist. This includes written protocols which describe the association in terms of functions and responsibilities of the participants. Supervision does not require the physical presence of the supervising physician.[8]

This regulation restricts entry into the profession by qualified persons. It is a major reason for the low number of licensed midwives in Hawaii. Midwives have had difficulty finding physicians who are willing to be their supervising physician and without a supervising physician, nurse-midwives cannot practice.

The number of licensed midwives has been consistently low. A total of 16 nurse-midwives have been licensed since DOH began licensing nurse-midwives in 1976. As of March 1989, Hawaii had only five licensed midwives. Three midwives live in Hawaii and the other two live on the mainland. Of the three nurse-midwives living in Hawaii, only one was practicing nurse-midwifery at the time of our study.

Although nurse-midwives have the formal support of the American College of Obstetricians and Gynecologists, they have a difficult time finding supervising physicians. The main factors contributing to this problem are: (1) obstetricians and gynecologists may see nurse-midwives as competitors in providing obstetrical and gynecological care, and (2) physicians cannot afford the increased cost of liability insurance when they sponsor a nurse-midwife.

Physician supervision may not be necessary. Nurse-midwives have a low rate of malpractice suits in comparison with obstetrician/gynecologists. Studies show that nurse-midwives manage normal pregnancies as well as or better than physicians and recognize conditions which require medical consultation.[9]

Other programs allow nurse-midwives to practice without physician supervision. For example, Medicaid reimburses nurse-midwife services independent of physician referral or supervision. Independent nurse-midwives are also eligible for reimbursements under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which provides medical benefits for dependents of military personnel and retirees.

Although physician supervision may not be required, nurse-midwives should still practice in consultation and collaboration with a physician. Nurse-midwives must be able to refer to a physician any high-risk patient or any patient who develops complications.

Professional standards for nurse-midwives say that they should practice under certain guidelines. The ACNM standards state that the practice of nurse-midwifery occurs *interdependently* within a health care delivery system and provides for physician consultation, collaboration, and referral.[10] The guidelines establish an interdependent relationship rather than a supervisory one between a nurse-midwife and a physician.

The American College of Obstetricians and Gynecologists and ACNM issued a joint statement on the practice relationships between obstetrician/gynecologists and nurse-midwives. They recommend that the clinical relationship between the obstetrician/gynecologist and the certified nurse-midwife should provide for mutually agreed upon written medical guidelines or protocols, informed consent about the involvement of the physician and nurse-midwife, periodic and joint evaluation of services provided, and review and updating of the written medical guidelines or protocols. They further recommend that there be interdependent practice of the obstetrician/gynecologist and the nurse-midwife without requiring the physical presence of the physician when care is being provided by the nurse-midwife.

Weaknesses in Enforcement

The department's enforcement program has not actively taken action against unlicensed midwifery activity, and although required by law, it has not assessed a fee for compliance resolution that would enable it to take greater advantage of the services available from DCCA's Regulated Industries Complaints Office.

Need for better enforcement. Under Sections 321-13(b) and 321-14, it is unlawful for any person to practice midwifery without a certificate or license. Although DOH is aware of instances of illegal practice, it has not actively enforced this requirement.

The Maternal and Child Health Branch receives a copy of the birth certificates from the DOH Research and Statistics Office which indicates if a midwife attended the birth. If the branch finds that the midwife is not licensed, then it attempts to contact the midwife by sending a letter to the parents listed on the birth certificate. In most cases, no response is received from the parents or the midwife, and the branch does not investigate further.

In 1981, DOH developed a plan for preventing the unlicensed practice of midwifery. The branch would send letters warning unlicensed persons that they are practicing illegally and request that they stop. The name of the unlicensed midwife who appears a second time on a birth certificate would be sent to the attorney general for investigation and prosecution.

Since 1981, a number of unlicensed midwives have appeared on birth certificates. The names of nine individuals appeared on more than one birth certificate. One individual attended 10 births between 1981 and 1986. When the branch received no response to the letters it had sent to the parents, it did not pursue these cases further.

DOH has taken action against only one unlicensed midwife in the past five years. In 1985, the branch received a complaint about an unlicensed midwife. The branch notified the person of the requirements of the midwifery licensing law. It subsequently received a report that the individual was still providing midwifery services but did not refer the case to the attorney general. Instead, in 1986 it filed a complaint with DCCA. In 1987, DCCA and DOH filed a joint civil suit for violations of the nursing and

midwife licensing laws. However, in 1988 the case was dismissed since the individual could not be located.

Compliance resolution fee. Act 60 in 1982, created a compliance resolution special fund to enable DCCA to pursue complaints and to hire investigators, attorneys, and other personnel who would determine whether licensees or applicants have complied with occupational licensing laws.

Section 26-9(n), *Hawaii Revised Statutes*, states that every person licensed under any law subject to Hawaii's Sunset Law must pay an annual fee which will be deposited into the compliance resolution special fund. Midwives were required to pay such a fee for their licenses when Sections 321-13 to 321-15 were placed on the sunset review schedule in Section 26H-4 in 1988. DOH has not complied with this requirement nor has it taken advantage of the services provided under DCCA's compliance resolution program.

If the regulation of midwives continues to be on the Sunset schedule, the department should assess a compliance resolution fund fee of licensed midwives and refer all cases of unlicensed practice to DCCA for investigation. It should arrange formally with DCCA how cases involving licensed and unlicensed midwives should be handled. The complaint handling process between the agencies should be made clear to ensure that the referral and disposition of complaints are handled in a consistent and expeditious manner.

Recommendations

1. *The regulation of midwives should be continued but under new statutes. The Legislature should delete "midwives" from Section 321-13 and establish new statutes for midwives which define the scope of practice, the standards for licensure, prohibited practices, the grounds for disciplinary action, and the sanctions.*

2. *The licensing program for midwives should remain with the Department of Health.*

3. *If regulation of midwives is continued under the current statutes, the statutes should be amended to:*

   - *define the scope of practice;*
   - *eliminate the health, character, and habit requirement of applicants;*
   - *require proper notification of licensees prior to forfeiture; and*
   - *replace the terms "certificates," "certificates of registration" and "permit" with the term "license," whenever "license" is the proper term.*

4. *The Department of Health should amend its rules to:*

   - *include gynecological care for women in the definition of the practice of midwifery;*
   - *delete the provision prohibiting the use of artificial, forcible, or mechanical means to assist childbirth; and*
   - *delete the requirement for physician supervision and allow midwives to practice in a collaborative, interdependent relationship with physicians.*

5. *The Department of Health should assess each licensee a compliance resolution fee if the regulation of midwives continues to be on the Sunset schedule and establish an agreement with the Department of Commerce and Consumer Affairs on the handling of complaints and cases of unlicensed activity.*

NOTES

Chapter 1

1. See discussion in *51 American Jurisprudence*, 2d., "Licenses and Permits," Section 14.

2. *Terr. v. Fritz Kraft*, 33 HAW. 397.

Chapter 2

1. Helen Varney, *Nurse-Midwifery*, 2nd ed., Boston, Blackwell Scientific Publications, 1987, p. 21.

2. Judy Barrett Litoff, *American Midwives: 1860 to the Present*, Westport, Conn., Greenwood Press, 1978, p. 55.

3. Irene H. Butter and Bonnie J. Kay, "State Laws and the Practice of Lay Midwifery," *American Journal of Public Health*, vol. 78, no. 9, September 1988, p. 1167.

4. Litoff, *American Midwives*, p. 122.

5. Varney, *Nurse-Midwifery*, p. 24.

6. *Ibid.*, p. 26.

7. *Ibid.*, p. 11.

8. American College of Nurse-Midwives, *American Nurse-Midwifery 1987*, Washington, D.C., American College of Nurse-Midwives, 1989, p. 1.

9. Varney, *Nurse-Midwifery*, p. 32.

10. American College of Nurse-Midwives, *American Nurse-Midwifery 1987*, p. 44.

11. Litoff, *American Midwives*, p. 56.

12. Butter and Kay, "State Laws and the Practice of Lay Midwifery," p. 1161.

13. The states are Alaska, Arizona, Arkansas, Florida, Louisiana, New Mexico, New Hampshire, South Carolina, Texas, and Washington.

14. "Montana Law Allows Midwife Practice After Five Hours of Training," *Professional Regulation News*, vol. 9, No. 7, July 1989.

15. Litoff, *American Midwives*, p. 128.

16. S. Cohn, et al., "Legislation and Nurse-Midwifery Practice in the U.S.A.," *Journal of Nurse-Midwifery*, vol. 29, no. 2, March/April 1984, p. 172.

17. Senate Standing Committee Report No. 208 on Senate Bill 256, Regular Session of 1941.

18. Section 11-141-2, *Hawaii Administrative Rules*.

Chapter 3

1. Gail Sinquefield, et al., *Risk Management in Action*, Washington, D.C., American College of Nurse-Midwives, 1988, p. 2.

2. American College of Nurse-Midwives, *American Nurse-Midwifery 1987*, pp. 70-71.

3. Hawaii, Department of Health, *Statistical Supplement*, Honolulu, 1987, p. 11.

4. Section 11-141-2, *Hawaii Administrative Rules*.

5. The American College of Nurse-Midwives, "What Is a Nurse-Midwife?," Washington, D.C. (pamphlet).

6. American College of Nurse-Midwives, *American Nurse-Midwifery 1987*, p. 32.

7. *Ibid.*, p. 36.

8. Section 11-141-2, *Hawaii Administrative Rules.*

9. U.S. Congress, Office of Technology Assessment, *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis*, Washington, D.C., December 1986, p. 23.

10. American College of Nurse-Midwives, *Standards for the Practice of Nurse-Midwifery*, 1987, p. 4.

APPENDIXES

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APPENDIX A

COMMENTS ON AGENCY RESPONSES

We transmitted a draft of this report to the Department of Health on October 12, 1989. A copy of the transmittal letter to the department is included as Attachment 1 of this Appendix. The response from the department is included as Attachment 2. A response from the Department of Commerce and Consumer Affairs is Attachment 3.

The Department of Health suggests that any new statute regulating midwives should incorporate the standards of the American College of Nurse Midwives. The department agrees to amend its rules to delete the requirement for physician supervision of midwives and proposes to add rules to recognize continuing education credits approved by the American College of Nurse Midwives or the department's midwifery committee.

The Department of Commerce and Consumer Affairs (DCCA) responds that the recommendation for the Department of Health to assess a compliance resolution fund fee and to refer all cases to DCCA's Regulated Industries Complaints Office for investigation and prosecution might be a problem. The director believes that only DCCA, not the Department of Health, has the authority to collect the fees, but it cannot raise fees from a group over which it has no regulatory authority. The director urges that this problem be referred to the Legislature for resolution.

ATTACHMENT 1

THE OFFICE OF THE AUDITOR
STATE OF HAWAII
465 S. KING STREET, RM. 500
HONOLULU, HAWAII 96813

COPY

October 12, 1989

The Honorable John C. Lewin, M.D.
Director of Health
Department of Health
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Lewin:

Enclosed are three preliminary copies, numbered 4 through 6 of our *Sunset Evaluation Report, Regulation of Midwives.*

The report contains our recommendations relating to the regulation of the three occupations. If you have any comments on our recommendations, we would appreciate receiving them by November 13, 1989. Any comments we receive will be included as part of the final report which will be submitted to the Legislature.

Since the report is not in final form and changes may possibly be made to it, we request that you limit access to the report to those officials whom you wish to call upon for assistance in your response. Please do not reproduce the report. Should you require additional copies, please contact our office. Public release of the report will be made solely by our office and only after the report is published in its final form.

We appreciate the assistance and cooperation extended to us.

Sincerely,

Newton Sue
Acting Auditor

Enclosures

ATTACHMENT 2

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

November 15, 1989

Mr. Newton Sue
Acting Auditor
The Office of the Auditor
State of Hawaii
465 S. King St., Rm. 500
Honolulu, HI 96813

Dear Mr. Sue:

Thank you for the opportunity to review a draft copy of the "Sunset Evaluation Report, Regulation of Midwives". Overall, we think that the report is solid, but did want to make several comments on both the recommendations and text.

Starting with the recommendations, we would propose that the first recommendation be amended so that any new statute would be promulgated to reference the standards established by the American College of Nurse Midwives (ACNM). It is important that state requirements for scope of practice, licensure and disciplinary actions do not conflict with those set by the ACNM and create any additional barriers to future practice by nurse midwives in Hawaii.

In addition, we would propose that the fourth recommendation include another bullet clarifying that the Department would recognize continuing education credits preapproved by either the ACNM or the DOH midwifery committee. This flexibility is important in assuring acceptance of CME credits and its inclusion will send a positive message to the nurse midwife community.

Since the report was prepared, the department has more current data on the number of nurse midwives in Hawaii. As of October, 1989, there were ten nurse midwives: one on Kauai (in the process of obtaining licensure), four on Oahu (one licensed, one applying), two on Molokai (both licensed), one on Maui (licensed) and two on the Big Island (one licensed, one applying). A licensed nurse midwife will be arriving on the Big Island in January, 1990. The report refers to one nurse midwife currently practicing while there are actually two in practice.

We would also like to clarify that while the report describes the need to continue regulation of nurse midwives, the dangers of the practice of nurse midwifery as described on page 9 are not unique or exclusive to midwives; the potential for injury is not unlike that for other practitioners.

With regard to the report's discussion of lower rates of malpractice suits against nurse midwives on page 10, we see the low number of suits to be due to the intensive prenatal care and education provided to the patients and the unlikely use of invasive techniques on a routine basis by nurse midwives. We also do not see the number of complaints (none) against licensed nurse midwives to be tied to the number in practice.

We are concerned that the wording on page 12 regarding transport of women from Molokai implies that these patients do not receive ongoing obstetric support while awaiting transport, which is not the case.

Finally, we agree with the report's recommendation to delete any requirement for physician supervision of nurse midwives as this restriction does inhibit recruitment and retention of nurse midwives in Hawaii.

Many thanks for the opportunity to comment.

Yours very truly,

JOHN C. LEWIN, M.D.
Director of Health

ATTACHMENT 3

JOHN WAIHEE
GOVERNOR

ROBERT A. ALM
DIRECTOR
COMMISSIONER OF SECURITIES

SUSAN DOYLE
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

November 24, 1989

Mr. Newton Sue
Acting Legislative Auditor
Office of the Legislative Auditor
State of Hawaii
465 S. King Street, Room 500
Honolulu, Hawaii 96813

Dear Mr. Sue:

I appreciate the opportunity to review Sunset Evaluation Report: Regulation of Midwives. The report essentially discusses the activities of the Department of Health (DOH), and I believe that DOH's response has already been submitted. I would, however, want to comment on one section of the report.

On page 15 and 16 of the Report, DOH is urged to assess a Compliance Resolution Fund fee and to refer all cases (and presumably the fees collected) to the Department of Commerce and Consumer Affairs' (DCCA) Regulated Industries Complaints Office (RICO) for investigation and prosecution. While the provisions of Hawaii Revised Statutes (HRS) Section 26-9 and Chapter 26H can be read to produce such a situation, a more likely reading leaves a conflict which cannot be settled except by the Legislature. Specifically, I do not believe that the Director of Health may collect fees using the provisions of HRS Sec. 26-9, which is solely the province of DCCA. On the other hand, I do not believe that that section gives me the authority to raise fees from a group over which I have no regulatory authority, i.e. nurse midwives.

Therefore, rather than suggest that DOH attempt to use the authority of HRS Sec. 26-9, I would urge that this statutory anamoly be referred to the Legislature for resolution without any suggestion as to what DOH can or should be doing with the existing language.

For the record, I do have concerns about having RICO's personnel reporting to other departments directly. And while the small size of the licensee population may render these concerns to be relatively minor in this case, once we start down this path it may be hard to get off of it. Among the concerns, are the potential for competing demands on staff resources and the unfamiliarity our personnel will have with DOH's procedures and practices on an ongoing basis. RICO already has a very full workload just handling DCCA's regulatory programs and it is difficult to justify adding these types of workload to its mandate.

Very truly yours,

ROBERT A. ALM
Director

RAA:kh

cc: Honorable John C. Lewin
Honorable Warren Price, III

APPENDIX B

G0185

DIGEST: RELATING TO MIDWIVES

Establishes new statutes governing the licensing and regulation of midwives. Continues regulation of midwives by the department of health until 12/31/96. Defines the scope of the practice of midwifery, the standards for licensure, prohibited practices, grounds for disciplinary action, and penalties.

THE SENATE
FIFTEENTH LEGISLATURE, 1990
STATE OF HAWAII

S.B. NO.

A BILL FOR AN ACT

RELATING TO MIDWIVES.

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

SECTION 1. The purpose of this Act is to implement the recommendations of the legislative auditor in the auditor's sunset evaluation report on the regulation of midwives which reviewed state laws that authorize the licensing of midwives by the department of health. The legislature agrees with the auditor's findings that the regulation of midwives should be continued since the practice poses a clear and significant potential to harm public health and safety, and that the regulatory program should remain with the department of health.

SECTION 2. Section 26H-4, Hawaii Revised Statutes, is amended to read as follows:

"**§26H-4 Repeal dates.** (a) The following chapter and sections are hereby repealed effective December 31, 1990:

(1) Chapter 466J (Board of Radiologic Technology)

(2) Sections 321-13 to 321-15 ([midwives,] laboratory directors, laboratory technologists, laboratory supervisors, laboratory technicians, tattoo artists, electrologists, and sanitarians)

(b) The following chapters are hereby repealed effective December 31, 1991:

(1) Chapter 447 (Dental Hygienists)

(2) Chapter 453 (Board of Medical Examiners)

(3) Chapter 457 (Board of Nursing)

(4) Chapter 458 (Board of Dispensing Opticians)

(5) Chapter 460J (Pest Control Board)

(6) Chapter 462A (Pilotage)

(7) Chapter 438 (Board of Barbers)

(8) Chapter 468K (Travel Agencies)

(c) The following chapters are hereby repealed effective December 31, 1992:

(1) Chapter 448H (Elevator Mechanics Licensing Board)

(2) Chapter 451A (Board of Hearing Aid Dealers and Fitters)

(3) Chapter 457B (Board of Examiners of Nursing Home Administrators)

(4) Chapter 460 (Board of Osteopathic Examiners)

(5) Chapter 461 (Board of Pharmacy)

(6) Chapter 461J (Board of Physical Therapy)

(7) Chapter 463E (Podiatry)

(8) Chapter 467D (Social Workers)

(d) The following chapters are hereby repealed effective

December 31, 1993:

(1) Chapter 437 (Motor Vehicle Industry Licensing Board)

(2) Chapter 437B (Motor Vehicle Repair Industry Board)

(3) Chapter 440 (Boxing Commission)

(4) Chapter 446 (Debt Adjusters)

(5) Chapter 436E (Board of Acupuncture)

(e) The following sections are hereby repealed effective December 31, 1993:

(1) Sections 445-21 to 38 (Auctions)

(2) Sections 445-131 to 136 (Pawnbrokers)

(3) Sections 445-171 to 172 (Secondhand Dealers)

(4) Sections 445-231 to 235 (Scrap Dealers)

(f) The following chapters are hereby repealed effective December 31, 1994:

(1) Chapter 441 (Cemetery and Funeral Trusts)

(2) Chapter 443B (Collection Agencies)

(3) Chapter 452 (Board of Massage)

(4) Chapter 455 (Board of Examiners in Naturopathy)

(5) Chapter 459 (Board of Examiners in Optometry)

(6) Chapter 442 (Board of Chiropractic Examiners)

(7) Chapter 373 (Commercial Employment Agencies)

(8) Chapter 448 (Board of Dental Examiners)

(9) Chapter 465 (Board of Psychology)

(10) Chapter 468E (Speech Pathology and Audiology)

(g) The following chapters are hereby repealed effective December 31, 1995:

(1) Chapter 439 (Board of Cosmetology)

(2) Chapter 444 (Contractors License Board)

(3) Chapter 448E (Board of Electricians and Plumbers)

(4) Chapter 454 (Mortgage Brokers and Solicitors)

(5) Chapter 454D (Real Estate Collection Servicing Agents)

(6) Chapter 464 (Professional Engineers, Architects, Surveyors and Landscape Architects)

(7) Chapter 466 (Board of Public Accountancy)

(8) Chapter 467 (Real Estate Commission)

(h) The following laws are hereby repealed effective December 31, 1996:

Part , chapter 321 (Midwives)

[(h)] (i) The following chapters are hereby repealed effective December 31, 1997:

(1) Chapter 463 (Board of Private Detectives and Guards)

(2) Chapter 471 (Board of Veterinary Examiners)."

SECTION 3. Chapter 321, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read

as follows:

"PART . MIDWIVES

§321- Findings and purpose. The legislature 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 legislature finds that the interests of public health require the regulation of the practice of midwifery in this State for the purpose of protecting the health and welfare of mothers and infants.

§321- Definitions. As used in this part:

"Department" means the department of health.

"Director" means the director of health.

"Midwife" means a person who is licensed under this part to practice midwifery.

"Midwifery" means the care and management of essentially normal newborns and women before, during, and after pregnancy and childbirth, and includes the provision of normal obstetrical and gynecological services and the rendering, undertaking, or providing of such care, management, or services, regardless of whether compensation or profit is received.

"Normal" means without significant medical complications or injury to the mother or child.

"Physician" means a person licensed to practice medicine as authorized in chapter 453.

§321- License required. Except as otherwise provided by law, no person, other than a physician, shall engage or hold themselves out as practicing midwifery without first obtaining and holding a valid unrevoked license to do so in accordance with this part and any rules adopted by the department.

§321- Qualifications for licensing. A person shall meet the following requirements in order to qualify for a license to practice as a midwife:

(1) Licensure as a registered nurse under chapter 457; and

(2) Certification to practice midwifery by the American College of Nurse-Midwives.

§321- Fees. No license shall be issued unless all fees as required by the director have been paid.

§321- Regulation of midwives. (a) The director shall adopt rules in accordance with this part and pursuant to chapter 91 to implement the purposes of this part and as may be necessary to safeguard the health and safety of the mother and child. The rules shall include, but shall not be limited to:

(1) Procedures for maintaining a safe and hygienic environment, monitoring the progress of labor and the

status of the fetus, recognizing early signs of distress or complications, referring complications to a physician, and preparing an emergency care plan to ensure continuity of medical care throughout labor and delivery and to provide for immediate medical care if an emergency arises;

(2) Providing that midwives shall practice in consultation and collaboration with a physician who specializes in the field of gynecology or obstetrics, or a physician or group of physicians who have a formal consultative arrangement with a gynecologist or obstetrician;

(3) The allowable scope of midwifery practice regarding use of equipment, procedures, and medication; and

(4) Procedures for the issuance and renewal of licenses.

§321- Disciplinary actions; penalties. (a) The following acts shall be grounds for disciplinary action as set forth in this section:

(1) Procuring or attempting to procure a license to practice midwifery by fraud, misrepresentation, deceit,

or bribery;

(2) Engaging in unprofessional conduct, which includes, but is not limited to, any departure from, or the failure to conform to, the standards of practice of midwifery as established by the director, or as provided by the statement of functions, standards, and qualification by the American College of Nurse-Midwives;

(3) Advertising falsely, fraudulently, or deceptively;

(4) Being unable to practice midwifery with reasonable skill and safety to patients by reason of illness, drunkenness, or use of drugs, narcotics, chemicals, or other materials or as a result of any mental or physical condition;

(5) Failing to report to the department any person who the licensee knows is in violation of this part or of the rules of the department;

(6) Wilfully or repeatedly violating any provision of this part, any rule of the department, or any lawful order of the department previously entered in a disciplinary proceeding;

(7) Loss of licensure, for any reason, to practice as a registered nurse in the State of Hawaii; and

(8) Having a license to practice midwifery revoked, suspended, or otherwise acted against, including being denied licensure, by the licensing authority of another state, territory, or country.

(b) When the department finds any person guilty of any of the grounds set forth in subsection (a), it may enter an order imposing one or more of the following penalties:

(1) Refusal to approve an application for licensure;

(2) Revocation or suspension of a license;

(3) Imposition of an administrative fine not to exceed $1,000 for each separate offense;

(4) Issuance of a reprimand; or

(5) Placement of the licensee on probation for a period of time and subject to those conditions as the department may specify, including, but not limited to, requiring the midwife to undertake further relevant education or training, or observation of the licensee by a physician.

(c) All actions under this section shall be taken only after notice and opportunity for hearing as provided in chapter 91.

§321- Violations; penalties. It shall be a misdemeanor for

any person to:

(1) Practice midwifery, unless holding an active license to do so;

(2) Use or attempt to use a license which has been suspended or revoked;

(3) Use in connection with the person's name any designation tending to imply that the person is a licensed midwife unless licensed to practice under this part;

(4) Knowingly permit or assist an unlicensed person to practice midwifery;

(5) Knowingly conceal information relating to the enforcement of this part or rules adopted pursuant thereto; or

(6) Otherwise violate any provisions of this part."

SECTION 4. Section 321-13, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) The department of health with the approval of the governor, may prescribe such rules as it deems necessary for the public health or safety respecting:

(1) The occupations or practices of [midwives,] laboratory directors, laboratory technologists, laboratory

supervisors, laboratory technicians, tattoo artists, electrologists, sanitarians, asbestos inspectors, asbestos management planners, and asbestos abatement project designers;

(2) The health, education, training, experience, habits, qualifications, or character of persons to whom certificates of registration or permits for [such] those occupations or practices may be issued;

(3) The health, habits, character, practices, standards, or conduct of persons holding [such] those certificates or permits; or

(4) The grounds or causes for revoking or suspending [such] those certificates or permits.

[Such] The rules shall have the force and effect of law."

SECTION 5. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun, before its effective date.

SECTION 6. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 7. This Act shall take effect upon its approval.

INTRODUCED BY: _____

G0185(a)

DIGEST: RELATING TO MIDWIVES

Continues the regulation and licensing of midwives by the department of health until 12/31/96. Amends current statutes to define the scope of practice, eliminate the health, character, and habit requirement of applicants and to require notice and hearing prior to forfeiture of licenses.

THE SENATE
FIFTEENTH LEGISLATURE, 1990
STATE OF HAWAII

S.B. NO.

A BILL FOR AN ACT

RELATING TO MIDWIVES.

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

SECTION 1. The purpose of this Act is to implement the recommendations of the legislative auditor in the auditor's sunset evaluation report on the regulation of midwives, which reviewed state laws which authorize the licensing of midwives by the department of health. The legislature agrees with the auditor's findings that the regulation of midwives should be continued since the practice poses a clear and significant potential to harm public health and safety and that the regulatory program should remain with the department of health.

SECTION 2. Section 26H-4, Hawaii Revised Statutes, is amended to read as follows:

"**§26H-4 Repeal dates.** (a) The following chapter and sections are hereby repealed effective December 31, 1990:

(1) Chapter 466J (Board of Radiologic Technology)

(2) Sections 321-13 to 321-15 ([midwives,] laboratory directors, laboratory technologists, laboratory supervisors, laboratory technicians, tattoo artists, electrologists, and sanitarians)

(b) The following chapters are hereby repealed effective December 31, 1991:

(1) Chapter 447 (Dental Hygienists)

(2) Chapter 453 (Board of Medical Examiners)

(3) Chapter 457 (Board of Nursing)

(4) Chapter 458 (Board of Dispensing Opticians)

(5) Chapter 460J (Pest Control Board)

(6) Chapter 462A (Pilotage)

(7) Chapter 438 (Board of Barbers)

(8) Chapter 468K (Travel Agencies)

(c) The following chapters are hereby repealed effective December 31, 1992:

(1) Chapter 448H (Elevator Mechanics Licensing Board)

(2) Chapter 451A (Board of Hearing Aid Dealers and Fitters)

(3) Chapter 457B (Board of Examiners of Nursing Home Administrators)

(4) Chapter 460 (Board of Osteopathic Examiners)

(5) Chapter 461 (Board of Pharmacy)

(6) Chapter 461J (Board of Physical Therapy)

(7) Chapter 463E (Podiatry)

(8) Chapter 467D (Social Workers)

(d) The following chapters are hereby repealed effective

December 31, 1993:

(1) Chapter 437 (Motor Vehicle Industry Licensing Board)

(2) Chapter 437B (Motor Vehicle Repair Industry Board)

(3) Chapter 440 (Boxing Commission)

(4) Chapter 446 (Debt Adjusters)

(5) Chapter 436E (Board of Acupuncture)

(e) The following sections are hereby repealed effective December 31, 1993:

(1) Sections 445-21 to 38 (Auctions)

(2) Sections 445-131 to 136 (Pawnbrokers)

(3) Sections 445-171 to 172 (Secondhand Dealers)

(4) Sections 445-231 to 235 (Scrap Dealers)

(f) The following chapters are hereby repealed effective December 31, 1994:

(1) Chapter 441 (Cemetery and Funeral Trusts)

(2) Chapter 443B (Collection Agencies)

(3) Chapter 452 (Board of Massage)

(4) Chapter 455 (Board of Examiners in Naturopathy)

(5) Chapter 459 (Board of Examiners in Optometry)

(6) Chapter 442 (Board of Chiropractic Examiners)

(7) Chapter 373 (Commercial Employment Agencies)

(8) Chapter 448 (Board of Dental Examiners)

(9) Chapter 465 (Board of Psychology)

(10) Chapter 468E (Speech Pathology and Audiology)

(g) The following chapters are hereby repealed effective December 31, 1995:

(1) Chapter 439 (Board of Cosmetology)

(2) Chapter 444 (Contractors License Board)

(3) Chapter 448E (Board of Electricians and Plumbers)

(4) Chapter 454 (Mortgage Brokers and Solicitors)

(5) Chapter 454D (Real Estate Collection Servicing Agents)

(6) Chapter 464 (Professional Engineers, Architects, Surveyors and Landscape Architects)

(7) Chapter 466 (Board of Public Accountancy)

(8) Chapter 467 (Real Estate Commission)

(h) The following sections are hereby repealed effective December 31, 1996: sections 321-13 to 321-15 (midwives)

[(h)] (i) The following chapters are hereby repealed effective December 31, 1997:

(1) Chapter 463 (Board of Private Detectives and Guards)

(2) Chapter 471 (Board of Veterinary Examiners)."

SECTION 3. Section 321-13, Hawaii Revised Statutes, is amended to read as follows:

"**§321-13 Regulation of certain other occupations.** (a) The

department of health [with the approval of the governor, may] pursuant to chapter 91, shall prescribe such rules as it deems necessary for the public health or safety respecting:

(1) The occupations or practices of midwives, as defined in subsection (d), laboratory directors, laboratory technologists, laboratory supervisors, laboratory technicians, tattoo artists, electrologists, sanitarians, asbestos inspectors, asbestos management planners, and asbestos abatement project designers;

(2) The [health,] education, training, experience, [habits,] or qualifications[, or character] of persons to whom [certificates of registration or permits] licenses for [such] those occupations or practices may be issued;

(3) The [health, habits, character,] practices, standards, or conduct of persons holding [such certificates or permits;] those licenses; or

(4) The grounds or causes for revoking or suspending [such certificates or permits.] those licenses.

[Such] The rules shall have the force and effect of law.

(b) It shall be unlawful for any person to engage in or to attempt to engage in or to follow any of the occupations or

practices referred to in this section, unless the person first obtains and holds a valid unrevoked [certificate of registration or permit] license under [such] rules or regulations as the department shall prescribe.

(c) The department may revoke or suspend any [certificate of registration or permit] license issued under this section or issued prior to April 23, 1941, upon proof to its satisfaction of a violation of any rule or regulation of the department on the part of any person holding a [certificate or permit;] license; provided that no [such certificate or permit] license shall be revoked or suspended except upon due notice to the person holding the same and the person shall be given an opportunity to be heard and present evidence in the person's own defense.

(d) As used in this chapter, "midwife" means a person who is licensed as a registered nurse under chapter 457, and who is certified to practice midwifery by the American College of Nurse Midwives."

SECTION 4. Section 321-15, Hawaii Revised Statutes, is amended to read as follows:

"**§321-15 Annual registration; fees, failure to register.** Every person holding a license to practice any occupation specified in section 321-13(a)(1) shall reregister with the

department of health, in accordance with the rules of the department, [on or] before [January 31] February 1 of each year and shall pay a reregistration fee. [The] Upon the failure[, neglect, or refusal] of any person holding [such] a license to reregister or to pay the reregistration fee, [after thirty days of delinquency, shall constitute a forfeiture of the person's license;] the department shall notify the person in writing within ten days that failure to reregister or pay the fee after thirty days of delinquency shall constitute a forfeiture of the person's license; provided that the license shall be restored upon written application therefor together with a payment of all delinquent fees and an additional late reregistration fee that may be established by the director of health. Hearings on license forfeitures shall be held under chapter 91."

SECTION 5. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 6. This Act shall take effect upon its approval.

INTRODUCED BY: _____