

Sunrise Analysis: Regulation of Certified Professional Midwives

A Report to the Governor
and the Legislature of
the State of Hawai'i

Report No. 17-01
January 2017



OFFICE OF THE AUDITOR
STATE OF HAWAII



OFFICE OF THE AUDITOR

STATE OF HAWAII

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Foreword

Our Sunrise Analysis of the Regulation of Certified Professional Midwives was conducted pursuant to House Concurrent Resolution No. 65, House Draft 1, requesting that the Auditor analyze the proposed regulation of CPMs as proposed under House Bill 1899, House Draft 1.

Leslie H. Kondo
State Auditor

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Auditor's Summary

Sunrise Analysis: Regulation of Certified Professional Midwives

Report No. 17-01



Should Certified Professional Midwives Be Regulated?

IN REPORT NO. 17-01, *Sunrise Analysis: Regulation of Certified Professional Midwives*, we found that the State's proposed regulation of Certified Professional Midwives, who comprise just a small segment of the midwifery profession, is insufficient and inconsistent with the State's regulatory policies. The proposed regulation we reviewed applies only to midwives who have obtained the Certified Professional Midwife credential from the North American Registry of Midwives, which is one of several midwifery associations, but the proposed regulation does not require even those individuals to be licensed to provide services as a midwife.

Although the regulation, *as proposed*, is flawed, we found that the Hawai'i Regulatory Licensing Reform Act's criteria supports mandatory licensure of the *entire* midwifery profession. Midwives assist women in home childbirth. They can perform exams



Hawai'i Home Births Increasing

From 1991 through 1996, an average of 171 births occurred at home (or in other out-of-the-hospital settings). In 2015, the number of home births had risen to 339, the State Department of Health reported.

monitoring the pregnant mother’s health as well as the weight, heart rate and position of the baby, provide prenatal care, assist during labor and delivery, and offer guidance about breastfeeding and other newborn care issues. They typically provide such services as an alternative to a medical doctor such as an obstetrician. Their work directly impacts—and can endanger—the health and safety of both mothers and babies. Given the nature of the work performed by midwives, we recommend that the Legislature consider establishing a mandatory licensing framework for all midwives, not just Certified Professional Midwives, to protect the consumers of the services, i.e., the mothers and newborns.

Why did we perform this review?

DURING THE 2016 SESSION, the Legislature considered legislation to regulate Certified Professional Midwives and, by concurrent resolution, asked us to review the appropriateness of the proposed regulation.

The Hawai‘i Regulatory Licensing Reform Act requires us to assess legislative proposals that will create a regulatory scheme for professions and vocations that currently are unregulated. These reviews, which are known as a “Sunrise Analysis,” examine whether regulation is necessary to protect the health, safety, or welfare of consumers of the services and is consistent with other regulatory policies.

The Hawai‘i Regulatory Licensing Reform Act mandates that a profession or vocation be licensed where the nature of services offered may jeopardize the health, safety, or welfare of consumers. At the same time, the Act establishes policies to ensure that the State exercises its power to regulate only where such regulation is reasonably necessary to protect consumers.



Even Barbers are Regulated

THE STATE OF HAWAI‘I, through the Professional and Vocational Licensing Division of the Department of Commerce and Consumer Affairs, regulates 49 professions and vocations. Physicians, dentists, nurses, and pharmacists are regulated by the State, as are barbers, automobile mechanics, massage therapists, and real estate agents. **Midwives, however, are not regulated in Hawai‘i, meaning that the State does not license or otherwise oversee those providing services as a midwife.**

Hawai‘i Regulatory Licensing Reform Act

The Hawai‘i Regulatory Licensing Reform Act requires the Auditor to analyze proposed regulatory measures that, if enacted, would subject unregulated professions and vocations to licensing or other regulatory controls. The policies that the Legislature adopted regarding regulation of professions and vocations are as follows:

The State may regulate professions and vocations only where reasonably necessary to protect the health, safety, or welfare of consumers, and not that of the regulated profession or vocation;

The State must regulate professions or vocations when the health, safety, or welfare of the consumer may be jeopardized by the nature of the service offered by the provider;

Evidence of abuses by providers of the service must be given great weight in determining whether regulation is desirable;

Regulation must be avoided if it will artificially increase the cost of goods and services to consumers, except in cases where this cost is exceeded by the potential danger to the consumer;

Regulation must not unreasonably restrict entry into professions and vocations by all qualified persons; and

Aggregate costs for regulation and licensure must not be less than the full costs of administering that program.



PHOTO: THINKSTOCK.COM

SUNRISE ANALYSIS: Regulation of Certified Professional Midwives

Introduction

Licensure of Certified Professional Midwives (CPMs) as proposed in House Bill No. 1899, House Draft 1 (HB 1899, HD 1), is not consistent with or otherwise supported by the policy criteria for professional licensing in the Hawai‘i Regulatory Licensing Reform Act. In our view, the proposed regulation of CPMs, who are just one type of midwife, is flawed because it: (1) does not require CPMs to obtain a license to perform services as a midwife¹; and (2) applies to only a relatively small segment of the midwifery profession, i.e., CPMs, and therefore, unnecessarily benefits that group.

¹ The term *midwife*, as used herein, refers to non-nurse midwives who assist in planned births outside of hospitals and other medical facilities. Certified Nurse Midwives (CNMs), who are registered nurses, are licensed in Hawai‘i as Advanced Practice Registered Nurses (APRNs). The APRN license requires a license as a registered nurse as well as completion of an accredited graduate-level education program preparing the nurse for one of four practice specialties, which include the CNM specialty. CNMs offer midwifery services in hospitals and other medical facilities and may prescribe prescription drugs and medical devices and equipment.



**...licensure of
the practice
of midwifery
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licensed.**

However, we determined that *the practice of midwifery* meets the Legislature's criteria for professional licensure. Based on that criteria, licensure of the practice of midwifery is necessary, and the State should require *all* midwives to be licensed. We reached a similar conclusion after a sunrise review of proposed legislation in 1999, and, as we did then, we recommend that the Legislature mandate regulation of the midwifery profession through licensure of *all* midwives.²

Objectives of the Study

1. Determine whether the regulation of CPMs, as proposed in HB 1899, HD 1, meets the criteria established by section 26H-2, Hawai'i Revised Statutes (HRS), which limits regulation and licensing of professions to where such regulation and licensing is reasonably necessary to protect the health, safety, or welfare of consumers.³
2. Assess probable effects of proposed regulation.
3. Make recommendations as appropriate.

Summary of Findings

1. The nature of the maternity and prenatal services provided by midwives may endanger the health and safety of women and newborns under the midwife's care. Therefore, the criteria for licensure in the Hawai'i Regulatory Licensing Reform Act requires that the profession of midwifery be regulated and its practitioners be licensed.
2. The regulation of CPMs, as proposed in HB 1899, HD 1, is insufficient. It does not meet the policy criteria for professional licensing because the proposed "licensure" appears optional and primarily benefits one segment of the midwifery profession.
3. Public health and safety concerns substantially outweigh any negative effects arising from regulation, including the resulting restrictions on individuals entering the profession of midwifery and any increase in the cost of midwifery services caused by regulation of the profession.

² Report No. 99-14, *Sunrise Analysis of a Proposal to Regulated Certified Professional Midwives*. Report No. 99-14 is accessible at <http://files.hawaii.gov/auditor/Reports/1999/99-14.pdf>.

³ House Concurrent Resolution No. 65, House Draft 1, requests that the Auditor analyze the proposed regulation of CPMs as proposed under HB 1899, HD 1.

For easy reference, these abbreviations are used in this document:

ACOG

American Congress of Obstetricians and Gynecologists

AMCB

American Midwifery Certification Board

APRN

Advanced Practice Registered Nurse

CM

Certified Midwife

CPM

Certified Professional Midwife

DCCA

Hawai'i Department of Commerce and Consumer Affairs

HRS

Hawai'i Revised Statutes

NACPM

National Association of Certified Professional Midwives

NARM

North American Registry of Midwives

NCCA

National Commission for Certifying Agencies

Proposed Regulation of Midwives

House Bill No. 1899, House Draft 1

During the 2016 Session, the Legislature introduced a bill to regulate the practice of midwifery, which was defined as “providing well-woman and maternity care for individuals and their newborns during the antepartum, intrapartum, and postpartum periods.” The stated purpose of House Bill No. 1899 (HB 1899) was “to regulate the practice of midwifery care by establishing licensure requirements, continuing education requirements, and minimum training standards.” HB 1899 was amended by the House Committee on Health to clearly limit the application of the proposed regulation to one class of midwives, CPMs.

If adopted, HB 1899, HD 1, would offer midwives who have received a CPM credential from the North American Registry of Midwives (NARM) the option to obtain a license from the State.⁴ The director of the Department of Commerce and Consumer Affairs (DCCA) would be required to grant a license to practice midwifery to an applicant who meets certain criteria, one of which is a current CPM certification. The proposed legislation, however, would *not* require midwives to have a license to provide maternity care in homes, birthing centers, or elsewhere.

The DCCA director would be required to establish a scope of practice for CPMs who become licensed, including a drug formulary recommended by an advisory committee appointed by the director⁵ and practice standards consistent with standards set by the National Association of Certified Professional Midwives (NACPM). Finally, the DCCA director would be responsible for investigating complaints against licensees and holding disciplinary hearings.

Licensure of midwives is mandated by the policies of the Hawai‘i Regulatory Licensing Reform Act.

The Legislature established policies to ensure that the State exercises its power to regulate a profession or a vocation only where such regulation is reasonably necessary to protect consumers. Where the nature of the services offered by the provider jeopardizes consumers’ health, safety,

⁴ HB 1899, HD 1, defines “licensed midwife” as “an individual who holds a current license issued by the department pursuant to this chapter to engage in the practice of midwifery in Hawaii *and is a certified professional midwife*.” (Emphasis added). Additionally, the bill defines “certified professional midwife” as a person who is certified by NARM or a successor organization.

⁵ The seven-member advisory committee would be composed of the DCCA director, an out-of-hospital birth consumer, four licensed midwives (three CPMs and one CNM), and a physician, who would serve as experts to DCCA in licensing matters; however, only the four midwife members would have voting power.

Certified Professional Midwives

The North American Registry of Midwives (NARM),¹ which is one of a number of professional organizations for midwives, offers a CPM credential to midwives who have completed either an accredited midwifery program or a NARM-approved apprenticeship. CPMs practice according to standards set by state laws, NARM, and the National Association of Certified Professional Midwives. According to NARM, in Hawai‘i, there are 15 CPMs in “good standing”; one other midwife’s CPM credential is “inactive,” and 7 other midwives have allowed their CPM credential to expire.

CPMs are not the only type of midwife; however, the proposed regulation would apply only to CPMs.

¹ NARM is accredited by the National Commission for Certifying Agencies (NCCA), which was created in 1987 to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs and organizations. NCCA-accredited programs certify individuals in a wide range of professions, including nurses, automotive professionals, and respiratory therapists.



PHOTO: THINKSTOCK.COM

Exhibit 1

What a CPM does

The National Association of Certified Professional Midwives outlines practice standards for CPMs. These include working in a partnership with each client; taking actions to optimize health and minimize risk; supporting the woman's right to plan her care according to her needs and desires; concluding caregiving responsibly; documenting health data; and continuously improving the midwife's skills and knowledge. According to two CPMs interviewed, the application of these standards in practice involves the following:



Consultation

A POTENTIAL CLIENT planning a home birth contacts a CPM. The CPM:

- Explains her background, training, and fees;
- States that the CPM will transfer care to a physician if medical conditions or risk factors arise that make the client ineligible for home birth, or if an emergency arises during labor;
- Inquires if the client has medical conditions that make the client ineligible for CPM-assisted homebirth.



Examinations

DURING THE FIRST EXAM, the CPM may gather signed informed consent and patient privacy forms. During subsequent exams, the CPM:

- Checks the client's blood pressure;
- Tests blood and urine;
- Checks the weight, heart rate and position of the baby;
- Monitors the client's psychological and social well-being, such as their job, housing, family, and life in general.

Such exams occur regularly:

- One exam per month for the first 28 weeks of pregnancy;
- One exam every 2 weeks between 28 and 36 weeks;
- Weekly exams after 36 weeks.



Labor

DURING LABOR, the CPM:

- Seeks to keep the client comfortable and safe;
- Checks the client's vital signs;
- Checks the baby's heart rate;
- Allows the client to move around to be comfortable.

If a condition arises that requires the client to be transferred during labor, the CPM arranges for or provides transportation to the hospital. When there's an emergency transfer, the CPM may provide client's records to hospital staff.



Birth

IF THE HOME BIRTH goes as planned, birth may occur in any number of places, including the bed or bathtub. Following birth, the CPM:

- Does a newborn examination;
- Stays until the client and baby are stable;
- Uses sutures to repair a small perineum tear using lidocaine;
- May help clean up;
- Assists the client with breast feeding;
- Follows up with a another visit the next day and several more visits over the next six weeks.

or welfare, the Legislature mandated that those providers be licensed. In relevant part, the Hawai‘i Regulatory Licensing Reform Act specifically states:

The legislature hereby adopts the following policies regarding the regulation of certain professions and vocations:

Regulation *in the form of full licensure* or other restrictions on certain professions or vocations *shall be retained or adopted* when the health, safety, or welfare of the consumer may be jeopardized by the nature of the services offered by the provider.⁶

Examining the proposed regulation according to the above criterion, we initially note that the bill, HB 1899, HD 1, specifically reflects the Legislature’s intent to establish a regulatory process “*for certified professional midwives who practice midwifery care.*” Other types of midwives are not referenced and would remain unregulated. Moreover, as explained more fully above, the bill does not require CPMs to be licensed to practice midwifery.

In accordance with the Hawai‘i Regulatory Licensing Reform Act, our examination starts with whether the midwifery services provided by CPMs may endanger the health, safety, or welfare of the women and newborns under their care. The “[p]ractice of midwifery” is defined in the bill as “providing well-woman and maternity care for individuals and their newborns during the antepartum, intrapartum, and postpartum periods.” If the nature of the midwifery services may jeopardize the health, safety, or welfare of the consumers of the service, i.e., the mothers and newborns, the practice of midwifery “*shall be*” regulated and individuals “*shall be*” licensed to provide services as a midwife.⁷

In our 1999 sunrise review, we determined that “the practice of midwifery poses a clear and significant potential for harm to the health and safety of the public.”⁸ We noted that “[i]f incompetently practiced, lay midwifery can harm the mother or

⁶ Section 26H-2(2), HRS (emphasis added).

⁷ We determined that all midwives, not just CPMs, offer the type of care falling within the bill’s definition of the practice of midwifery. Accordingly, we expanded our initial review to examine whether *the practice of midwifery*, by CPMs and other types of midwives, should be regulated.

⁸ Report No. 99-14, *Sunrise Analysis of a Proposal to Regulated Certified Professional Midwives*, p. 14.

Exhibit 2

Other Types of Midwives

HB 1899, HD 1, proposes licensure only of CPMs. However, there are numerous other types of midwives, including some of whom are certified by organizations other than NARM.

Certified Nurse Midwives (CNMs) are certified nationally by the American Midwifery Certification Board (AMCB). In addition to being licensed registered nurses, CNMs must have a graduate degree in midwifery. CNMs are licensed in Hawai‘i as APRNs (which also include nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists). CNMs are allowed to prescribe drugs and order and dispense medical devices and equipment, among other privileges.

Certified Midwives (CMs) have a graduate degree in midwifery but are not nurses. They are certified by AMCB. *CMs are not regulated by the State.*

Direct Entry Midwives have been educated through self-study, an apprenticeship, a midwifery school, or a program distinct from the training or education for nurses; some may have completed apprenticeship training to be CPMs but have not taken or passed the exam administered by NARM. *Direct Entry Midwives are not regulated by the State.*

Traditional Midwives are not certified. They include Native Hawaiian cultural practitioners who practice midwifery according to cultural traditions. *Traditional Midwives are not regulated by the State.*



WHAT'S IN A TITLE?

Twice since 1998, the Legislature has proposed licensing for midwives. But the proposals have differed significantly on the credentials required for licensure. The current bill would license CPMs credentialed by NARM. By contrast, a 2014 measure proposed licensing CMs and CNMs, both of whom are credentialed by AMCB, as well as naturopathic physicians who had the AMCB credential or training commensurate with that of licensed obstetrician-gynecologists. AMCB's standards for the CM and CNM credentials require a graduate degree in midwifery. NARM's CPM credential, however, does not require any type of degree, only that the person complete a NARM-approved accredited midwifery program or a NARM-approved apprenticeship.

newborn and even result in death.”⁹ Our current review uncovered no data or other information to suggest that our earlier determination was incorrect or that subsequent advancements in the practice of midwifery have rendered that conclusion to be moot. Rather, our examination of the profession continues to lead to the indisputable conclusion that the maternity and newborn care offered by midwives—from the antepartum period to the intrapartum period to the postpartum period—affects the mother's and baby's health and safety. Very simply, CPMs and all other types of midwives including those without formal education or training, are health care providers. Their work has a direct and significant effect on the health and safety of the consumers of their services.

A 2014 study examining planned home births attended by midwives between 2004 and 2009 underscores the public health and safety dimension of midwives' work.¹⁰ That study, which was based on data collected by the Midwives Alliance of North America, found that the rate of fetal deaths occurring after the onset of labor but before birth was 1.3 per 1,000; additionally, the rate of death occurring after a live birth but before 7 completed days of life was 0.88 per 1,000; and the rate of death occurring at 7 to 27 completed days of life was 0.41 per 1,000.¹¹ The death rates might actually be higher: a December 2015 study of planned home births in Oregon, published in *The New England Journal of Medicine*, documented a death rate of 3.9 per 1,000 deliveries when combining fetal deaths and babies that died within the first 28 days.¹²

Given our determination that the nature of the services provided by midwives may endanger the public's health and safety, we conclude that the Hawai'i Regulatory Licensing Reform Act mandates that the profession of midwifery be regulated. Licensure would ensure that midwives, including CPMs, assisting in home births have certain minimum qualifications to mitigate risks associated with those births. We further find that the real and significant possibility of harm to mothers and newborns under the care of a midwife outweighs any increase in the cost of such services. As we

⁹ *Id.* (The report defined the term “lay midwives” to mean non-nurse midwives).

¹⁰ Melissa Cheyney, et al., “Outcomes of Care for 16,924 Planned Homes Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009,” *Journal of Midwifery & Women's Health*, vol. 59, no. 1, January/February 2014, p. 17. The report is available at <http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12172/epdf>. Of the 432 midwives in the study, 336, or 78 percent, were CPMs or otherwise licensed midwives.

¹¹ *Id.* at p. 23.

¹² Jonathan M. Snowden, et al., “Planned Out-of-Hospital Birth and Birth Outcome,” *The New England Journal of Medicine*, vol. 373, no. 27, December 31, 2015, p. 2645 (available at <http://www.nejm.org/toc/nejm/373/27/>).

have previously, we recommend that the Legislature require every individual who provides maternity and prenatal services as a midwife to be subjected to *mandatory* licensing.¹³

The proposed regulation of CPMs is flawed because it does not require licensure and benefits one group of midwives.

The Hawai'i Regulatory Licensing Reform Act explicitly requires "*full licensure*" whenever a profession's services may endanger the health, safety, or welfare of the consumers of the services. The proposed regulation, however, falls short of the statutory requirement that regulation be in the form of *full licensure*. Under HB 1899, HD 1, licensure would only apply to CPMs and is not mandatory to practice midwifery.¹⁴ Furthermore, the proposed regulation does not include enforcement mechanisms or penalties for the unlicensed practice as a midwife.

We understand *full licensure*, as the term is used in the Hawai'i Regulatory Licensing Reform Act, to mean that *all* practitioners *must* be licensed to practice the particular profession or vocation.¹⁵ In the context of HB 1899, HD 1, licensure should be *mandatory* to provide services as a midwife. Based on the optional nature of the "licensure" in HB 1899, HD 1, we find that the proposed regulation does not meet the Hawai'i Regulatory Licensing Reform Act criterion; therefore, the regulation as proposed in HB 1899, HD 1, is insufficient and inconsistent with that criterion.

¹³ We found that the Hawai'i Regulatory Licensing Reform Act's other policies did not weigh against regulation. Because there is no system to regulate midwives, any purported evidence of abuse was anecdotal and impossible to verify; the likely increase in the costs of midwifery services caused by the licensing requirement is outweighed by potential harm to the mothers and newborns; and regulation will not unreasonably restrict entry into the profession.

¹⁴ Although described in the bill as *licensure*, the regulation established by HB 1899, HD 1, appears more like *state certification*, which allows professionals to obtain a certification from the state but does not require certification to practice the occupation. Licensure generally requires professionals to have a license to practice an occupation that is subject to licensure, which is not the case under HB 1899, HD 1.

¹⁵ See Benjamin Shimberg and Doug Roederer, *Questions a Legislator Should Ask*, 2nd ed., Lexington, Ky., The Council on Licensure, Enforcement and Regulation, 1994, p. 1.

Hawai'i Regulatory Licensing Reform Act

The Hawai'i Regulatory Licensing Reform Act requires the Auditor to analyze proposed regulatory measures that, if enacted, would subject unregulated professions and vocations to licensing or other regulatory controls. The policies that the Legislature adopted regarding regulation of professions and vocations are as follows:

The State may regulate

professions and vocations only where reasonably necessary to protect the health, safety, or welfare of consumers, and not that of the regulated profession or vocation;

The State must regulate

professions or vocations when the health, safety, or welfare of the consumer may be jeopardized by the nature of the service offered by the provider;

Evidence of abuses by

providers of the service must be given great weight in determining whether regulation is desirable;

Regulation must be avoided

if it will artificially increase the cost of goods and services to consumers, except in cases where this cost is exceeded by the potential danger to the consumer;

Regulation must not

unreasonably restrict entry into professions and vocations by all qualified persons; and

Aggregate costs for regulation and licensure must not be less than the full costs of administering that program.



Rates of fetal deaths among planned home births

1.3 per 1,000

Rate of fetal deaths occurring after the onset of labor but before birth

.88 per 1,000

Rate of death occurring after a live birth but before 7 completed days of life

.41 per 1,000

Rate of death occurring at 7 to 27 completed days of life

2.59 per 1,000

Rate of death when combining fetal deaths and babies that died within the first 28 days

Source: *Journal of Midwifery & Women's Health*

The proposed regulation benefits only CPMs.

The Hawai'i Regulatory Licensing Reform Act also reflects the Legislature's intent that the purpose of regulation cannot be the protection of the regulated profession or vocation. That intent is expressly stated in the Legislature's policies regarding the regulation of a profession or vocation:

The regulation and licensing of professions and vocations 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[.]*¹⁶

The purpose of the proposed regulation in HB 1899, HD 1, does not appear to protect the profession of midwifery; however, the bill reflects

¹⁶ Section 26H-2(1), HRS (emphasis added).

the intent to establish a regulatory process “*for certified professional midwives*” who practice midwifery care. CPMs are only a segment of the midwifery profession that is currently unlicensed; others assisting in home births and providing services as a midwife include CMs, Direct Entry Midwives, and traditional midwives.

As explained above, based on and consistent with the Hawai‘i Regulatory Licensing Reform Act’s policies, we found that the *entire* midwifery profession should be subject to mandatory licensure. It is our conclusion that the proposed licensure of only practitioners who have obtained a designation from a private trade organization, i.e., CPMs, may create an unfair and unnecessary competitive advantage for that segment of the midwifery profession. Only a CPM would be able to be a “licensed midwife.” Other midwives, even those with graduate and other professional degrees or other significant qualifications, could not obtain that status. The proposed licensure of only CPMs promotes and protects that one group of midwives; protecting the health and safety of those being assisted by *all* midwives does not appear to be the primary and overriding purpose of the proposed regulation of only CPMs.

Recommendations

1. The Legislature should not “license” midwives where such regulation is not mandatory and benefits one segment of the midwifery profession. Rather, consistent with policies articulated in the Hawai‘i Regulatory Licensing Reform Act, section 26H-2, HRS, the Legislature should consider requiring *mandatory* licensure of the *entire* midwifery profession.
2. If mandatory licensure of the profession is considered, the Legislature should examine whether it is appropriate to create requirements for licensure that are independent from and do not require applicants to be credentialed or otherwise a member of NARM or any other private midwifery association. (Twenty-eight states currently regulate midwives. Those states have taken diverse approaches to regulation. *See* Appendix E – Regulation of Midwives in Other States.)



REGULATION AND LICENSING

Regulation is the act of subjecting something to governing principles or laws. **The most stringent form of government regulation is licensure**, defined as a “process by which a government agency grants individuals permission to engage in a specified profession or occupation upon finding that an individual has attained the minimal degree of competency required to ensure that the public’s health, safety, and welfare will be reasonably well-protected.” Once a profession obtains licensure status, it is illegal for anyone who does not hold a valid license to practice the profession or occupation.

Source: *Questions a Legislator Should Ask*



Planned Home Births on the Rise

WOMEN IN THE U.S. are increasingly choosing to give birth outside of hospitals, usually at home or at free-standing birth centers. The rate of planned out-of-hospital births nationally increased 20 percent between 2004 and 2008, to 0.67 percent of the total number of births from 0.56 percent, and by approximately 60 percent between 2008 and 2012, reaching nearly 1 percent of all births.¹ In Hawai'i, the rates of home births are even higher; according to the Hawai'i Department of Health, 339 of approximately 18,000 children born in 2015, or 1.8 percent, were born at home.

Women planning for home birth may do so for a variety of reasons, often to avoid the hospital setting and medical interventions. When compared with home births, hospital births involve a strikingly higher rate of medical interventions, such as induced labor, cesarean surgery, and vaginal

deliveries using forceps or a vacuum device. For example, citing a December 2015 study published in *The New England Journal of Medicine*, the American Congress of Obstetricians and Gynecologists reported a rate of cesarean sections associated with out-of-hospital births in the U.S. to be 53 in 1,000, or 5.3 percent, versus a rate of 247 in 1,000, or 24.7 percent, associated with planned hospital births.² The report said the increased interest in home births may be associated with the fact that U.S. hospitals often do not allow vaginal birth after a woman has undergone a cesarean section.

Some women choose home birth assisted by a midwife for other reasons. The project coordinator for a Native Hawaiian organization, for example, testified that birthing choice is a central issue in terms of women's empowerment, reproductive freedom, cultural perpetuation, and self-determination.

As women increasingly choose home birth, more states have moved to regulate the midwifery profession. Twenty-eight states regulate non-nurse midwives. (See Appendix E for a discussion of the regulation of midwives in other states.)

¹ Jonathan M. Snowden, et al., "Planned Out-of-Hospital Birth and Birth Outcome," *The New England Journal of Medicine*, vol. 373, no. 27, December 31, 2015, p.2643 (available at <http://www.nejm.org/toc/nejm/373/27/>).

² The study cited by the American Congress of Obstetricians and Gynecologists shows that, while planned home birth is associated with fewer maternal interventions than planned hospital birth, planned home birth is associated with a more than twofold increased risk of perinatal death.

Appendices

Appendix A – House Concurrent Resolution 65, House Draft 1

Appendix B – House Bill 1899, House Draft 1

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Appendix A

House Concurrent Resolution 65, House Draft 1

HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

H.C.R. NO. 65
H.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE AUDITOR TO PERFORM A SUNRISE ANALYSIS OF THE
REGULATION OF CERTIFIED PROFESSIONAL MIDWIVES.

1 WHEREAS, in Hawaii, the only licensed professionals
2 regulated by the State to provide prenatal care and assist with
3 childbirth are medical licensees such as doctors and advanced
4 practice registered nurses; and

5
6 WHEREAS, for women with complications, medical intervention
7 is invaluable, but many women have relatively uncomplicated
8 births in which the services of a trained midwife could be of
9 value in providing an out-of-hospital childbirth; and

10
11 WHEREAS, reproductive choice includes choice of
12 practitioner and treatment modality and midwifery should be
13 available to any woman who chooses to pursue home birth; and

14
15 WHEREAS, a Certified Professional Midwife is a
16 knowledgeable, skilled, and professional independent midwifery
17 practitioner who has met the standards for certification set by
18 the North American Registry of Midwives and is qualified to
19 provide the Midwives Model of Care; and

20
21 WHEREAS, over 200 women and their families across the State
22 each calendar year utilize the services of Certified
23 Professional Midwives; and

24
25 WHEREAS, Certified Professional Midwives are regulated and
26 authorized to practice in 30 states and, as of 2016, legislation
27 is pending in 11 more states to regulate Certified Professional
28 Midwives; and

1 WHEREAS, the lack of licensure for Certified Professional
2 Midwives may harm the public while causing confusion among
3 Certified Professional Midwives who are licensed in another
4 state and move to this State; and
5

6 WHEREAS, the establishment of a licensing program for
7 currently unregulated Certified Professional Midwives in the
8 State under the Department of Commerce and Consumer Affairs will
9 provide necessary oversight; and
10

11 WHEREAS, under section 26H-6, Hawaii Revised Statutes, a
12 sunrise analysis by the Auditor must occur prior to initiating
13 the regulation of a previously unregulated profession; and
14

15 WHEREAS, in March 1999, a sunrise analysis was conducted by
16 the Auditor pursuant to section 26H-6 and concluded that
17 regulation of Certified Professional Midwives was warranted; and
18

19 WHEREAS, the Legislature finds that it has been 17 years
20 since the last sunrise analysis was conducted by the Auditor and
21 since 1990, 26 other states have adopted regulatory programs
22 governing Certified Professional Midwives; now, therefore,
23

24 BE IT RESOLVED by the House of Representatives of the
25 Twenty-eighth Legislature of the State of Hawaii, Regular
26 Session of 2016, the Senate concurring, that the Auditor is
27 requested to perform an analysis of the proposed regulation of
28 the profession of Certified Professional Midwife, as proposed in
29 House Bill No. 1899, House Draft 1 (2016); and
30

31 BE IT FURTHER RESOLVED that the Auditor is requested to set
32 forth the probable effects of the proposed regulation and to
33 assess whether the proposed regulation is consistent with the
34 policies set forth in section 26H-2, Hawaii Revised Statutes,
35 and whether there are alternative appropriate forms of
36 regulation; and
37

38 BE IT FURTHER RESOLVED that the Auditor is requested to
39 submit findings of the sunrise analysis to the Legislature no
40 later than twenty days prior to the convening of the Regular
41 Session of 2017; and

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1 BE IT FURTHER RESOLVED that certified copies of this
2 Concurrent Resolution be transmitted to the Governor, Director
3 of Commerce and Consumer Affairs, Auditor, and President of the
4 Midwives Alliance of Hawaii.

House Bill 1899, House Draft 1

H.B. NO. 1899
H.D. 1

A BILL FOR AN ACT

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

17 § -1 Definitions. As used in this chapter:

1 "Certified professional midwife" means a person who is
2 certified by the North American Registry of Midwives or any
3 successor organization.

4 "Client" means a person under the care of a licensed
5 midwife, as well as the person's fetus and newborn child.

6 "Department" means the department of commerce and consumer
7 affairs.

8 "Director" means the director of commerce and consumer
9 affairs.

10 "Licensed midwife" means an individual who holds a current
11 license issued by the department pursuant to this chapter to
12 engage in the practice of midwifery in Hawaii and is a certified
13 professional midwife.

14 "Midwifery Education Accreditation Council" means the
15 organization established in 1991 and recognized by the United
16 States Department of Education as an accrediting agency for
17 midwifery education programs and institutions.

18 "Midwives Alliance of North America" means a professional
19 organization representing out-of-hospital birth midwives.

1 "National Association of Certified Professional Midwives"
2 means the membership organization that specifically represents
3 certified professional midwives in the United States.

4 "North American Registry of Midwives" means the
5 organization that sets standards for competency based
6 certification for certified professional midwives.

7 "Out-of-hospital" means taking place in a birth center or
8 home.

9 "Postpartum period" means the period not exceeding six
10 weeks from the date of delivery.

11 "Practice of midwifery" means providing well-woman and
12 maternity care for individuals and their newborns during the
13 antepartum, intrapartum, and postpartum periods.

14 "United States Midwifery Education, Regulation, and
15 Association" means a coalition comprising representatives of the
16 following national midwifery associations, credentialing bodies,
17 and education accreditation bodies: Accreditation Commission for
18 Midwifery Education, American College of Nurse Midwives,
19 American Midwifery Certification Board, Midwifery Education
20 Accreditation Council, Midwives Alliance of North America,

1 National Association of Certified Professional Midwives, and
2 North American Registry of Midwives.

3 § -2 Powers and duties. In addition to any other powers
4 and duties authorized by law, the director shall:

- 5 (1) Receive applications for licensure;
- 6 (2) Determine the qualifications of persons applying for
7 licensure;
- 8 (3) Grant licenses to qualified applicants;
- 9 (4) Establish procedures to renew, suspend, revoke, and
10 reinstate licenses;
- 11 (5) Establish and collect fees for the examination of
12 applicants for licensure and license renewal;
- 13 (6) Establish the minimum educational and continuing
14 educational requirements for licensure;
- 15 (7) Investigate complaints against licensed midwives;
- 16 (8) Undertake, when appropriate, disciplinary hearings;
17 and
- 18 (9) Subject to chapter 91, adopt, amend, or repeal rules,
19 as necessary to effectuate this chapter.

20 § -3 Advisory committee; appointment; term. (a) The
21 director shall appoint an advisory committee to serve as experts

1 to the department in licensing matters. The advisory committee
2 shall consist of seven members as follows:

3 (1) The director or the director's designee, who shall be
4 a nonvoting member;

5 (2) Four licensed midwives who shall be in current and
6 active practice of midwifery in the State for the
7 duration of their appointment and who shall have
8 actively practiced as licensed midwives in the State
9 for at least three years immediately preceding their
10 appointment, who shall be voting members; provided
11 that the initial members appointed pursuant to this
12 paragraph shall be three certified professional
13 midwives and one certified nurse midwife who each have
14 at least three years of experience in the practice of
15 midwifery and who are eligible to become licensed
16 pursuant to this chapter;

17 (3) One licensed physician, who has provided primary
18 maternity care for at least twenty births in the
19 twelve-month period prior to appointment, maintains
20 current hospital privileges, and has attended at least
21 one home birth, who shall be a nonvoting member; and

(4) One out-of-hospital birth consumer, who is either currently under midwifery care and planning an out-of-hospital birth or has had an out-of hospital-birth in the past, who shall be a nonvoting member.

(b) Members of the committee shall serve four year terms.

(c) In the event of the death, resignation, or removal of any committee member before the expiration of the member's term, the vacancy shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(d) The committee shall elect a chairperson from among its members. The committee shall meet at least annually to make recommendations to the director and may hold additional meetings at the call of the chairperson or at the written request of any two members of the committee. Three voting members shall constitute a quorum. The vote of the majority of members present at a meeting in which a quorum is present shall determine the action of the committee.

§ -4 Scope of practice; formulary. (a) The director shall establish scope of practice standards for the practice of midwifery.

(b) The scope of practice standards shall include:

- 1 (1) Adoption of a drug formulary recommended by the
- 2 advisory committee and approved by the director; and
- 3 (2) Practice standards for antepartum, intrapartum,
- 4 postpartum, and newborn care that prohibit a licensed
- 5 midwife from providing care for a client with a
- 6 history of disorders, diagnoses, conditions, or
- 7 symptoms outside of the scope of practice recommended
- 8 by the advisory committee and approved by the director
- 9 pursuant to the standards of the National Association
- 10 of Certified Professional Midwives.
- 11 (c) The scope of practice standards:
- 12 (1) Shall not require a licensed midwife to practice under
- 13 the supervision of another health care provider,
- 14 except as a condition imposed as a result of
- 15 discipline by the department;
- 16 (2) Shall not require a licensed midwife to enter into an
- 17 agreement with another health care provider, except as
- 18 a condition imposed as a result of discipline by the
- 19 department;
- 20 (3) Shall not impose distance or time restrictions on
- 21 where a licensed midwife may practice;

(4) Shall not grant a licensed midwife prescriptive privileges outside of the privilege of ordering, obtaining, and administering medications on the approved formulary; and

(5) Shall not allow a licensed midwife to perform abortions.

§ -5 License; qualifications. (a) A license to practice midwifery pursuant to this chapter shall be granted to an applicant who files a department-approved application for licensure, pays the required application fees, and provides evidence to the department of the following:

(1) Current certification as a certified professional midwife by the North American Registry of Midwives or a successor organization;

(2) Completion of an educational program or pathway accredited by the Midwifery Education Accreditation Council or having obtained the midwifery bridge certificate issued by North American Registry of Midwives;

(3) Documentation of a graduate letter from a Midwifery Education Accreditation Council accredited school or

1 letter of completion of portfolio evaluation process;
2 and

3 (4) Successful completion of continuing education
4 requirements.

5 (b) All licenses issued under this chapter shall be valid
6 for two years from the date of issuance.

7 § -6 Fees; penalties. (a) Each applicant shall pay a
8 licensing fee of \$250 upon application for a new or renewal
9 license. Fees collected pursuant to this section shall be
10 deposited into the compliance resolution fund established
11 pursuant to section 26-9(o).

12 (b) Any fine imposed by the department after a hearing
13 conducted pursuant to this chapter shall be no less than \$100
14 and no more than \$1,000 for the first violation. A second or
15 subsequent violation of this chapter shall be referred to the
16 office of the attorney general for criminal prosecution. Any
17 person who pleads guilty to or is found guilty of a second or
18 subsequent violation of this chapter shall be guilty of a
19 misdemeanor.

20 § -7 Hearings. (a) Unless otherwise provided by law,
21 in every case in which the department refuses to issue, renew,

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1 restore, or reinstate a license under this chapter, or proposes
2 to take disciplinary action or other licensing sanctions against
3 a licensee, the department shall conduct an administrative
4 proceeding in accordance with chapter 91.

5 (b) In all proceedings before it, the department and each
6 member thereof shall have the same powers respecting
7 administering oaths, compelling the attendance of witnesses and
8 the production of documentary evidence, and examining witnesses
9 as are possessed by circuit courts. In case of disobedience by
10 any person of any order of the department or of a member
11 thereof, or of any subpoena issued by it or a member, or the
12 refusal of any witness to testify to any matter regarding which
13 the witness may be questioned lawfully, any circuit judge, on
14 application by the department or a member thereof, shall compel
15 obedience as in the case of disobedience of the requirements of
16 a subpoena issued by a circuit court, or a refusal to testify
17 therein.

18 § -8 Exemptions. This chapter shall not apply to the
19 following:

20 (1) Certified nurse midwives authorized by the board of
21 nursing to practice in Hawaii, unless the certified

- 1 nurse midwife chooses to become concurrently licensed
2 under this chapter. Certified nurse midwives with
3 concurrent licensure shall be subject to chapter 457,
4 as well as this chapter;
- 5 (2) Student midwives in training under the direct
6 supervision of licensed midwives as required by North
7 American Registry of Midwives;
- 8 (3) A person administering care to a spouse or parent;
- 9 (4) A person rendering aid in an emergency where no fee
10 for the service is contemplated, charged, or received;
11 and
- 12 (5) Other than as provided in paragraph (1), the practice
13 of a profession by persons who are licensed,
14 certified, or registered under other laws of this
15 State and are performing services within their
16 authorized scope of practice.
- 17 § -9 Client protection. A licensed midwife shall not:
- 18 (1) Disregard a client's dignity or right to privacy as to
19 the client's person, condition, possessions, or
20 medical record;

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- 1 (2) Breach any legal requirement of confidentiality with
2 respect to a client, unless ordered by a court of law;
3 (3) Submit a birth certificate known by the licensed
4 midwife to be false or fraudulent, or willfully make
5 or file false or incomplete reports or records in the
6 practice of midwifery;
7 (4) Fail to provide information sufficient to allow a
8 client to give fully informed consent;
9 (5) Engage in the practice of midwifery while impaired
10 because of the use of alcoholic beverages or drugs; or
11 (6) Violate any other standards of conduct as determined
12 by the department.
- 13 § -10 Disclosure; record keeping. (a) Before
14 initiating care, a licensed midwife shall obtain a signed
15 informed consent agreement from each client, acknowledging
16 receipt, at minimum, of the current North American Registry of
17 Midwives required Informed Disclosure for Midwifery Care.
- 18 (b) All licensed midwives shall maintain a record of
19 signed informed consent agreements for each client pursuant to
20 section 622-58.

1 § -11 Immunity from vicarious liability. No licensed
2 medical provider or facility providing medical care or treatment
3 to a person due to an emergency arising during childbirth as a
4 consequence of care received by a licensed midwife shall be held
5 liable for any civil damages as a result of such medical care or
6 treatment unless the damages result from the licensed medical
7 provider or facility's provision of or failure to provide
8 medical care or treatment under circumstances demonstrating a
9 reckless disregard for the consequences so as to affect the life
10 or health of another. A physician who consults with a licensed
11 midwife but who does not examine or treat a client of the
12 midwife shall not be deemed to have created a physician-patient
13 relationship with the client."

14 SECTION 3. If any provision of this Act, or the
15 application thereof to any person or circumstance, is held
16 invalid, the invalidity does not affect other provisions or
17 applications of the Act that can be given effect without the
18 invalid provision or application, and to this end the provisions
19 of this Act are severable.

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1 SECTION 4. This Act does not affect rights and duties that
2 matured, penalties that were incurred, and proceedings that were
3 begun before its effective date.

4 SECTION 5. This Act shall take effect on July 1, 2070.

H.B. NO. 1899 H.D. 1

Report Title:
Licensure; Midwife

Description:
Regulates certified professional midwives. (HB1899 HD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

Appendix C

Prior Attempts to Regulate Midwives

The Legislature twice before, in 1998 and 2014, considered legislation to license and regulate health care professionals who attend out-of-hospital births, including midwives. Both efforts failed.

Senate Bill No. 2569 (2014)

During the 2014 Session, the Legislature considered creating a home birth safety board with authority to issue licenses to qualified applicants as home birth providers, which included certain types of midwives such as CNMs, CMs, and naturopathic physicians who had completed training commensurate with that of a licensed obstetrician-gynecologist or were certified by the AMCB. Standards for CNMs and CMs, which are set by AMCB, require a graduate degree in midwifery; CPMs, who can receive their certification merely by completing an apprenticeship under NARM standards, were not eligible for licensure.

After much public debate, the bill was significantly amended: The proposed home birth safety board was eliminated; instead, the amended bill created a home birth task force to address a number of issues, including licensure requirements and home birth standards of care based on successful models in other states. The bill, however, died. We did not conduct a sunrise analysis of the 2014 bill.

House Bill No. 3123 (1998)

Legislation introduced during the 1998 Session called for establishing a midwifery committee within DCCA. Like the current bill, the measure would have licensed only CPMs.

Although the bill died in committee, the Legislature asked the Auditor to examine whether, based on criteria in the Hawai'i Regulatory Licensing Reform Act, CPMs should be regulated. We concluded that the regulation of CPMs and other non-nurse midwives was warranted because regulation would help protect consumers and because other public benefits were possible. However, our report also recommended that the proposed regulation should not be enacted until lawmakers resolved key issues, including a lack of consensus that could lead to fragmented regulation and the establishment of sufficient occupational qualifications and practice standards.

Appendix D

Methodology, Probable Effects, and Other Work Performed

Methodology

We reviewed midwife licensure statutes and administrative rules in other states. We contacted stakeholders in the proposed licensure, including midwives, physician and midwifery organizations, and health insurers. We reviewed literature on midwifery and home birth. We inquired about enforcement actions filed by the State Office of Consumer Protection and complaints made to DCCA's Regulated Industries Complaints Office. We attempted to identify the costs and possible impacts of the proposed regulation.

Probable Effects of Licensure

There are a number of currently unknown variables that will affect the practice of midwifery if licensure is required. Most of the effects of licensure will depend on the specific requirements to obtain and maintain a license to practice midwifery. For instance, we expect that a certain level of education may be one requirement for licensure; if so, some midwives may be unwilling or unable to satisfy those requirements. Whatever the licensing requirements, it is also likely that a number of midwives will decline to seek licensure for religious, personal, or philosophical reasons, or because they are unwilling to pay the licensing fees or costs. We expect that regulation of the practice of midwifery will likely reduce options for mothers interested in a midwife-assisted home birth.

However, licensure also may increase demand for midwifery services. One effect of licensure is that health insurers will likely provide coverage for all or part of the services provided by a licensed midwife. As a result, more mothers may opt for home birth because of reduced out-of-pocket costs for those types of services.

Given the nature of the services offered by midwives, any potential negative effects of licensure seem to be greatly outweighed by the greater protection of mothers' and newborns' health and safety.

Assessment of Other Forms of Regulation

In addition to assessing whether the proposed regulation of CPMs is consistent with the Hawai'i Regulatory Licensing Reform Act's policies, the Legislature requested that we examine whether there are alternative appropriate forms of regulation.¹⁷ We assessed other forms of regulation with the understanding that it is the State's

¹⁷ See Section 26H-6, HRS.

policy, as reflected in the Hawai‘i Regulatory Licensing Reform Act, that government should provide only the minimal level of regulation necessary to protect the public.¹⁸

Licensure is the most stringent form of regulation; it restricts a profession so that it may become illegal for individuals to provide specific services without a license. For that reason, licensure should be used only as a last resort.

Registration is a less stringent, rigorous form of regulation that typically requires professionals to provide their names and addresses to a designated agency; there is usually no screening and few minimum practice standards. Registration is appropriate where the threat to life, health, safety, and economic well-being is low.

State certification grants recognition to persons who have met predetermined qualifications set by the government. Non-state certified practitioners may still practice their profession, but simply may not represent that they are “state certified.” One factor is whether a non-governmental certification program has been established to assist the public in identifying qualified practitioners.¹⁹ In the case of midwives, there are already two types of non-nurse midwife certifications: CPMs and CMs. Because nongovernmental certifications already exist for midwives, creating government certifications would have minimal effects on enhancing public health, safety, and welfare.

We found no alternative form of regulation that would be appropriate for the midwifery profession. In our opinion, based on the nature of the services provided by midwives, more specifically our determination that those services may endanger the health and safety of mothers and newborns under their care, full licensure is mandated under the Hawai‘i Regulatory Licensing Reform Act.

¹⁸ Benjamin Shimberg and Doug Roederer, *Questions a Legislator Should Ask*, 2nd ed., Lexington, Ky., The Council on Licensure, Enforcement and Regulation, 1994, p. 6.

¹⁹*Id.* at p. 26.

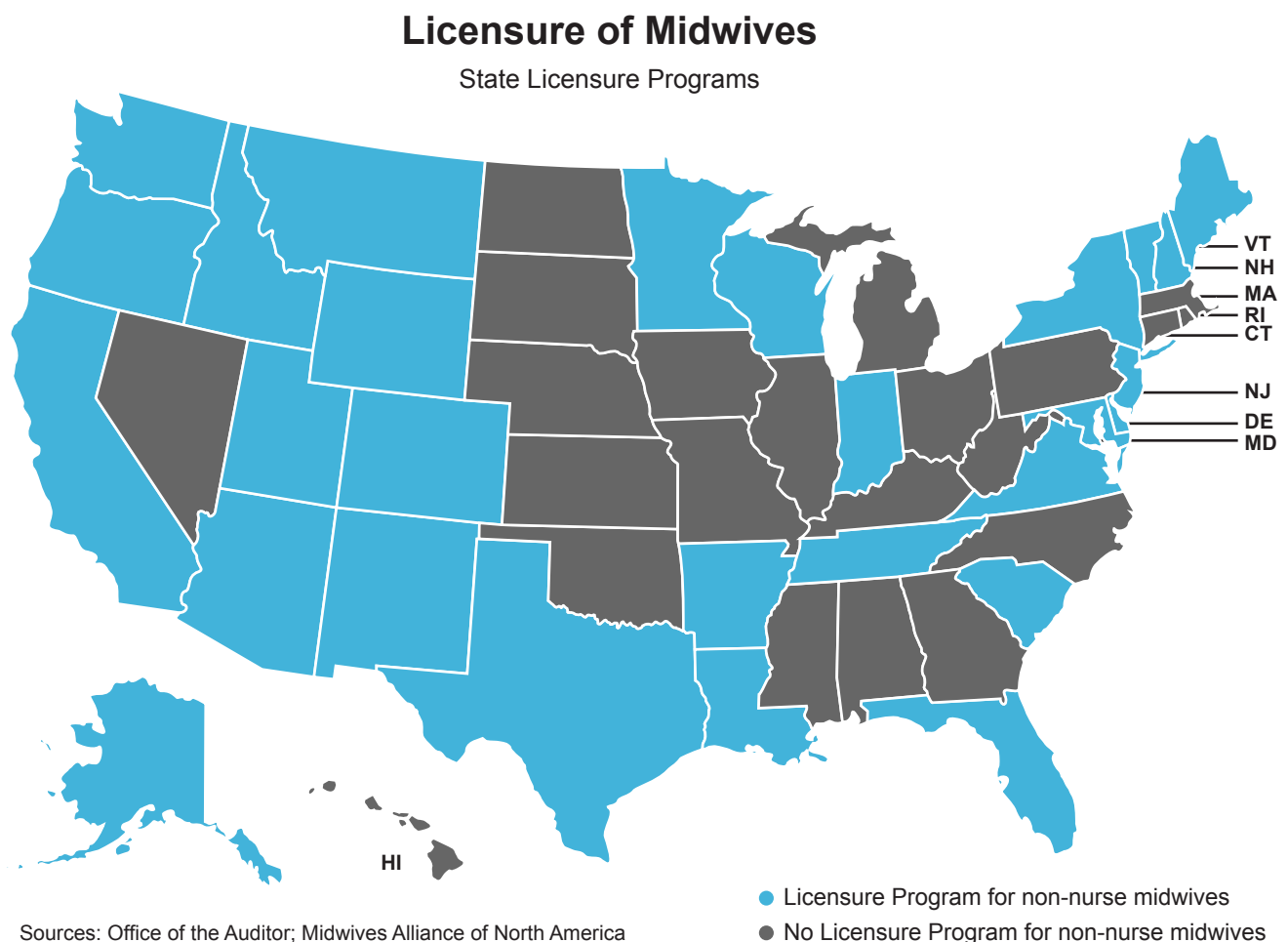
Appendix E

Regulation of Midwives in Other States

We examined licensure requirements for midwives in several states. We focused on issues frequently raised by stakeholders during testimony on HB 1899, HD 1²⁰, including questions regarding its optional nature and whether it should regulate only CPMs; how the State would establish a scope of practice and drug formulary for licensed midwives; and the composition of the regulatory entities overseeing licensed midwives. The examples below show a variety of policies that states have adopted to address those issues.

Twenty-eight other states license non-nurse midwives.

As outlined below, 28 states provide licensure for non-nurse midwives. Hawai'i is one of 22 states without such licensure.

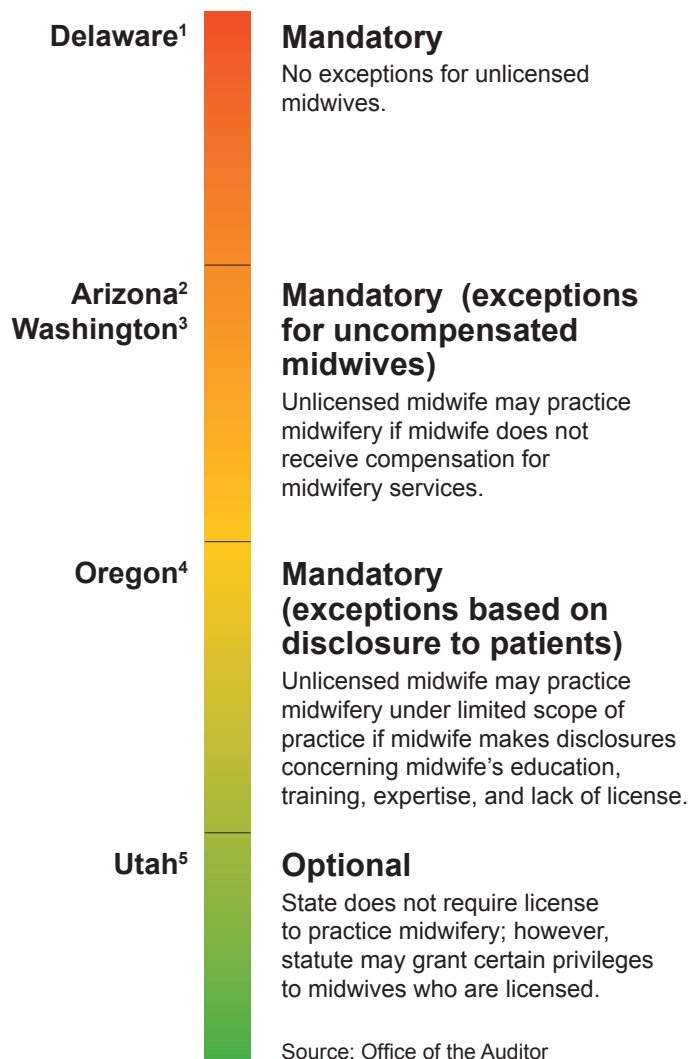


²⁰ Testimony available at http://www.capitol.hawaii.gov/Session2016/Testimony/HB1899_HD1_TESTIMONY_CPC_02-17-16_.PDF

States vary in how strictly they regulate midwives.

State midwifery licensing statutes vary: some require licensure with certain exceptions; others allow broad exceptions for unlicensed midwives provided their scopes of practice are restricted and they obtain informed consent from clients. Among the states we examined, only Utah's licensure program is optional, similar to the proposed regulation under HB 1899, HD 1.

Degrees of Regulation



¹ Delaware Code, Title 24 § 1799FF.

² Arizona Revised Statutes § 36-752, -760.

³ Revised Code of Washington § 18.50.005-020.

⁴ Oregon Revised Statutes § 687.415.

⁵ Utah Code § 58-77-501.

Regardless of how strictly they regulate the practice of midwifery, the midwifery statutes we examined typically exempt various persons who attend births, including licensed physicians, licensed CNMs, midwifery students training with a licensed midwife, parents delivering their own baby, and people delivering babies in emergencies. Beyond these standard exceptions, however, state regulations vary.

At one end of the range are two states which recently adopted licensure: **Maine**, which passed legislation in 2016, and **Delaware**, which adopted licensure in 2015. Both require a license to practice midwifery with few exceptions: Delaware exempts CNMs and persons licensed to practice medicine, while Maine exempts licensed professionals, midwifery students, and religious or cultural practitioners following traditions that include birth attendants.²¹

Other states, such as **Arizona** and **Washington**, allow unlicensed midwives to practice as long as they do not receive compensation for midwifery services; Arizona expressly prohibits unlicensed midwives from advertising midwifery services.

Other states generally require a license but carve out exceptions allowing unlicensed midwives to practice with restrictions. **Oregon**, for example, allows unlicensed “traditional midwives” to practice without a license as long as the midwives adhere to certain practice restrictions and make a number of disclosures about their training and expertise, including statements that the midwives are not licensed. Oregon also requires unlicensed traditional midwives to inform potential clients of the types of midwives who are actually licensed by the state.

Oregon requires unlicensed midwives to use a “Traditional Midwife Information Disclosure” form when obtaining informed consent from clients. The form includes statements that the midwife is not licensed, that the client may face a greater risk of death by using a midwife whose qualifications were not reviewed by the state, and that the unlicensed midwife is not authorized to carry and administer potentially life-saving medications.

Scope of practice and drug formularies vary.

Licensed midwives’ scopes of practice and drugs they are allowed to administer also vary by state.

Some statutes define the scopes of practice for licensed midwives. For example, Delaware’s statute states explicitly that only low-risk patients are eligible for home birth or birth assisted by a licensed midwife.²²

²¹ Maine Revised Statutes §32-12501 *et seq.*

²² Delaware Code, Title 24 § 1799JJ.



INFORMED CONSENT

Informed consent is a standard element of midwifery licensing statutes, requiring licensed practitioners to provide certain information to clients. For example, California’s statute requires licensed midwives to make a list of disclosures, including statements that the licensed midwife is not a CNM and that the midwife practices in out-of-hospital settings and does not have hospital privileges; California also requires midwives to disclose whether they have liability insurance. Arizona’s statute requires the midwife to inform the client orally and in writing of the midwife’s scope of practice, educational background, and credentials and potential risks, including the risk of death. Arizona midwives also must create an emergency care plan.

Delaware's statutory low-risk standards include pregnancies in which there is a single fetus; no significant disease arising from the pregnancy; and no pre-existing maternal disease or condition likely to affect the pregnancy, such as uterine surgeries including cesarean procedures. Likewise, Maine requires CPMs to transfer care and not conduct a home birth under certain conditions, such as when the client is carrying twins or has previously had a cesarean section.²³ By contrast, California's statute does not prohibit midwives from attending births when the client previously had a cesarean section; however, the statute requires approval by a physician trained in obstetrics and gynecology before a midwife provides midwifery services if the client has "any preexisting condition likely to affect the pregnancy."²⁴

Arizona limits the scope of practice through administrative rules, which list conditions that render a client ineligible for midwifery services, such as patients with multiple fetuses, hypertension, or an abnormal fetal heart rate.²⁵

States also vary on the extent to which they allow midwives to administer drugs. Arizona generally prohibits midwives from administering prescription drugs or medications but allows midwives to do so under a physician's orders in limited situations.²⁶ California, by contrast, allows licensed midwives to obtain supplies and devices, obtain and administer drugs and diagnostic tests, and order testing and receive reports that are necessary to the practice of midwifery and consistent with the midwife's scope of practice.²⁷

Midwifery governing bodies vary.

The composition of boards governing licensed midwives varies.

Arizona's midwife licensure is administered by the Arizona Department of Health Services, which defines the scope of practice by rule. An advisory committee recommends administrative rule changes, among other duties. The committee is composed of four licensed midwives, a member of the public experienced with midwife services, a licensed physician, and a licensed CNM.

California's midwife licensure is administered by the 15-member Medical Board of California, which consists of seven members of the public and eight licensed physicians. A midwifery advisory council makes

²³ Maine Revised Statutes § 32-12536 *et seq.*

²⁴ California Business and Professions Code § 2507(a)(b).

²⁵ Arizona Administrative Code § R9-16-111.

²⁶ *Id.* at R9-16-111(H), R9-16-108 (I)(5)(f), (K)(1)(g), (K)(2)(c), R9-16-113.

²⁷ California Business and Professions Code § 2507(f).

recommendations to the board on matters specified by the board. At least one half of council members must be California-licensed midwives.

Delaware's medical board also administers licensure of midwives in collaboration with an advisory panel. Delaware's licensure statute calls for the state Board of Medical Licensure and Discipline to appoint a seven-member Midwifery Advisory Council whose voting members include two CPMs, two CMs, one CNM, one practicing obstetrician with hospital admitting privileges who is a member of the American Congress of Obstetricians and Gynecologists and certified by the American Board of Obstetrics and Gynecology, and one practicing pediatrician with hospital admitting privileges and certification from the American Board of Pediatrics. The council is in charge of promulgating rules and a scope of practice subject to the approval of the Board of Medical Licensure and Discipline.

In **Maine**, midwives are regulated by a Board of Complementary Health Care Providers, which also regulates acupuncture and naturopathic medicine. The nine-member board consists of two licensed acupuncturists, two licensed naturopathic doctors, one CPM, one other licensed midwife, one licensed physician who is board certified in obstetrics and gynecology, and a physician or nurse practitioner specializing in pediatrics. However, initial rules relating to scope of practice limitations, drug formulary, informed consent, reporting, and pre-existing conditions that render a pregnancy ineligible for out-of-hospital birth must be adopted by this board in joint rulemaking with the Board of Licensure in Medicine.

In **Oregon**, a seven-member Board of Direct Entry Midwifery is appointed by the governor and consists of four licensed direct entry midwives, one CNM, one licensed physician involved in obstetrical care or education, and a member of the public. The board is responsible for adopting administrative rules specifying practice standards, patient health risks that preclude out-of-hospital care, and a list of drugs and medical devices approved for use by licensed midwives.

Washington's midwifery licensure is administered by the state Department of Health. Washington's licensure statute also establishes a midwifery advisory committee consisting of one physician who is a practicing obstetrician, one practicing physician, one CNM, three licensed midwives, and a member of the public. The committee is required to make recommendations on issues including continuing education, mandatory reexamination, and peer review.

Appendix F

Births, By Midwife and Place of Delivery: United States (2015)

Place of delivery	Certified nurse midwife	Other midwife	Total
Total	338,663	32,841	371,504
In-hospital ¹	318,936	7,660	326,596
Not in hospital	19,714	25,159	44,873
Freestanding birthing center	10,161	7,390	17,551
Clinic or doctor's office	181	14	195
Residence	9,191	17,200	26,391
Other	181	555	736
Not specified	13	22	35

Source: National Vital Statistics Reports, Vol. 66, No. 1, January 5, 2017

¹ Includes births occurring en route to or on arrival at hospital.