2011 SENATE HUMAN SERVICES

SB 2315

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2315
2-1-2011
Job Number 13827

☐ Conference Committee

Committee Clerk Signature MMolson

Explanation or reason for introduction of bill/resolution:

Relating to licensing and regulating direct entry or lay midwifery services and to preserve the right of women and families to home delivery of infants.

Minutes: Attached testimony.

Senator Judy Lee opened the hearing on SB 2315. There is a fiscal note.

Sen. J. Lee (District 13) introduced SB 2315 and said it came about because of past concerns of less than adequate care given to mothers and babies at the time of delivery. A lot of medical professionals have concerns about that.

Darlene Bartz, ND Department of Health, provided an overview of the bill. Attachment #1 She explained that a certified nurse midwife is a registered nurse who has gone through advanced training, has taken a certification exam and is licensed by the board of nursing.

Senator Dick Dever asked if a nurse could act as a midwife without being subject to provisions of this bill.

Ms. Bartz deferred that to the Board of Nursing. A registered nurse without advance practice could not be performing as a lay midwife.

Nelson (Buzz) Benson, ND Board of Nursing, provided neutral testimony. Attachment #2 This included an e-mail to Constance Kalanek from the Director of the American College of Nurse Midwives.
In response to a previous question about limiting the certified nurse midwife's participation in the board he said he didn't think the intent would be to limit anybody's participation.

Discussion followed on representation on the board.
The ND Nurse Leadership Council was explained.

Certified nurse midwives don't routinely perform home deliveries mainly because of safety reasons. They typically work within hospital or clinic settings.

Bruce Levi, NDMA, provided neutral testimony. Attachment #3 includes physician statements.

Karen Macdonald, NDNA, provided opposing testimony but agreed with the need to regulate based upon the need for public safety. Attachment #4 included proposed amendments.

Levi Erdmann, Bismarck, testified in opposition. Attachment #5 includes a chart.

Sara Karges, Hazen, testified in opposition. She believes she has the right as a woman to choose the caregiver she wants to preside over her when she is giving birth and the place she does it. She didn't feel it is the states opinion to determine who the caregiver is over her pregnancy and birth. She is familiar with both the risks at home and in the hospital.

Senator Spencer Berry asked if, in the event of difficulties or problems incurred during childbirth, she would want the state to be involved in financing the care that the child may need in the long term.

Ms. Karges replied not unless she came willingly and asked for it. If she doesn't, then she is taking full responsibility for the rest of that child's life. She said she wants to be fully financially responsible in that matter, too. She said she isn't expecting anybody to fix any problems that might occur.

Senator Judy Lee talked about situations that no parent can anticipate that may result in long term services being needed and provided by the state, county, and private providers.

Darrin Karges spoke about the insurance issues. He reported that their doctor said he couldn't do a home birth. There is no guarantee, wherever the birth, that the child will be physically fit to live on his own for the rest of his life.

Marilyn Moen, Upham, spoke in opposition. This bill is supposed to be for the safety of mothers and children. She said the safest place for a baby to be born is at home.

Donna Henderson spoke in opposition. She reported that she had safer home births than hospital births. She talked about the repeal of Obamacare and to her this sounds like typical Obamacare. According to her there is more protection for mothers who want to abort their children.

The hearing was recessed until after the floor session.

Additional testimony submitted – Attachment #6

The hearing on SB 2315 continued.

Andrea Toman, ND Birth Action, testified that while having a bill legalizing and regulating midwifery is acceptable, there were some changes they would like to see. Attachment #7

Senator Dick Dever asked who the ND Birth Action is and what connection their involvement is with the midwifery profession.

Ms.Toman explained the ND Birth Action is an on-line group formed of both certified professional midwives that operate in the state of ND and consumers with an interest in midwifery within the state.

Becky Olson testified against SB 2315. It would eliminate at least one midwife in the western part of the state. Home birth is safe and a hospital birth does not guarantee a healthy baby.

Loyal Karges didn't see a need to certify a midwife. He talked about the freedom to make the decision to have whom they deem to be qualified and suits their needs in a birth. He speculated as to the motivation for the regulation.

Dr. Ben Stegman, Cavalier ND, testified that all of their children were born under midwifery care. He started off opposed to home births but his wife would have been unassisted if they couldn't have midwife services. She couldn't handle a hospital situation due to bad hospital experiences. He cautioned introducing any type of legislation that could limit the services, particularly in rural areas.

The hearing on SB 2315 was closed.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2315
2-2-2011
Job Number 13905

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee re-opened the hearing on SB 2315.

Rafael Ocejo, MD, (Pediatrician) spoke to the committee in support of SB 2315. There is a need to recognize that there are many women who want to have the freedom to have their babies at home. That is a valid point. Delivering at home is a natural process that should be allowed. He believes the bill would be providing a safer environment for those mothers and the children born at home.
The technology in medicine is constantly changing. He believes the mothers wanting to deliver at home want to do so because they don't want a lot of intervention. They want the natural process to be natural. There is plenty of technology now that is not invasive that allows them to do this in a much better way. Problems in babies can be diagnosed ahead of time with the use of ultrasound.
The bill has built in its process the concept of allowing the lay midwives, currently providing services, to enhance their education so they can actually provide better care for these mothers and their babies.
There is no willingness on his part to stop the practice. What he wants is to enhance the education.
He had concerns of talking about how many healthy babies these mothers may have without taking into account those crises when the mother would need to be moved to a hospital to deliver after a very prolonged labor. These would not represent the statistics of a birth at home because they get moved ahead of time.
This bill has a lot of validity because it gives those midwives, currently in practice, the opportunity to become better within two years and then to continue their education so they can provide better care for these mothers and babies.

Senator Judy Lee was concerned that those who should be improving their skills would just go underground and there won't be any regulation or control at all. Those who are directly affected by this don't want it.

Dr. Ocejo replied that the concept in medicine is to advance and move a little bit at a time to gradually improve the care. The problem he sees is they haven't been able to improve that care. This is the beginning to opening a door and allowing them to provide better care.

A short discussion took place on whether this should be under the Board of Nursing.

There was discussion on whether requiring an ultrasound would be necessary to determine if there were any problems. There was speculation as to whether that would make a difference and whether education is enough.

There is a need to work together and there is a need to start somewhere. If the standards are put too high they will just move underground.

Filing birth certificates was talked about and Darlene Bartz, Department of Health, thought they were getting the information on most of the births. It is required by law.

Jan Bury, Obstetrician, asked for support of this bill. Attachment #8 She said that the media portrays the idea that negative things don't commonly happen. She gave examples of negative outcomes in home birth situations.

The topic of abuse and neglect was brought up and discussed. It's a touchy thing.

Senator Dick Dever stated that those who do home births are very passionate about it and take the decision very seriously. He wanted to know if they ask about their midwives credentials.

Dr. Bury said they don't. They just accept it.

Dr. Rhonda Schaefer McLean testified in support of SB 2315. Her perspective was different. She had the opportunity to train in Colorado where midwifery is a very strong constant within those communities and health care systems. She shared her experiences of having been trained by midwives, taking care of patients who were taken care of by lay midwives, and some of the outcomes and transitions surrounding those scenarios. She reiterated that this is a safety choice for the people of ND.
There is a big difference between certified nurse midwives and lay midwives. They understand that but would like to move towards a standard with this group of people who are trying to provide a service.

There are three different tiers: lay midwife with no certification or endorsement, the registered or licensed midwife, the certified nurse midwife.

Darlene Bartz, Department of Health, reflected on the Board of Nursing testimony. She pointed out that basically their approach was neutral. The entity that came in opposing was the Nursing Association which is different than the regulatory body.
She also pointed out that there were 3 lay midwives in ND who would be eligible for training. It would cost about $7500 to train them.

Senator Judy Lee closed the hearing on SB 2315.

Committee discussion followed on possible abuse cases and the gray areas of abuse reporting.

Senator Judy Lee provided some points for the committee to consider – delayed implementation, ideas on how to work together, what the challenge is, who should be on the advisory committee, and who pays for it.

Senator Gerald Uglem was not comfortable with the idea of punishment after the fact. Need to start with education.

Senator Dick Dever referred to various amendments suggested to the committee.

The committee reviewed those suggestions. There was also a suggestion to have just a registry with the health department but to be on that registry certification of education is required. Grants would be available to get the program started.

Senator Judy Lee adjourned the committee.

Attachment #14 – Additional information provided to the committee at a later date.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2315
2-8-2011
Job Number 14212

☐ Conference Committee

Committee Clerk Signature *AMoxon*

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened SB 2315 for committee work and informed the members that she was waiting for written testimony from those physicians who had testified on the afternoon of 2-2-11.

The fiscal note was discussed.

Attachment #9 is information prepared by Marlys Baker, Dept. of Human Services, to answer concerns the committee had about child abuse/neglect.

Attachment #10 is a packet from ND Birth Action of additional information and testimony

Paulette Efimenko, a lay midwife, spoke to the committee. She explained her background, training, continuing education, and experience. She didn't feel certification was necessary for herself. She said she basically does her own continuing education and explained that she makes herself aware of new books, technologies, etc. She keeps in touch with doctors on the latest things that are happening.
She gives out references to prospective home birthing families – from both the families with good outcomes and the families with bad outcomes.

Senator Tim Mathern asked her to explain some of the pre natal preparation that she is involved in with these families.

Ms. Efimenko answered that usually the people are referred to her and contact her by phone. They are mostly seeking a different option for a birth rather than the hospital. She tells them about her history and experiences. They set up an appointment where she does an extensive family history and their own medical history. She checks blood pressure, pulse, weight, hemoglobin check, and urinalysis. She said she is a stickler on exercise and nutrition. She went on to explain how she monitors and checks the baby. She doesn't work with any drugs.

The emotional aspect is very important and it is important that the mother is comfortable with her surroundings.
She said the difference between herself and doctors is that they see the whole process as a medical procedure and she sees it as a beautiful and natural thing.

Senator Spencer Berry asked her about the deaths that occurred with baby's she delivered and she replied they happened once the mother had gone into labor.
She explained the causes of death.

Senator Gerald Uglem asked her if she saw anything wrong with requiring certification so those who are not competent and want to enter the field would need to get that education.

Ms. Efimenko said she did not. She thought licensing and regulation especially for people just getting into it was important but she didn't think it should be required for someone like herself. It should still be the choice of the parents to choose somebody they know whether they are licensed or not.

Senator Judy Lee asked if she encourages her patients to have an initial visit with a physician when they first find out they are pregnant.

Ms. Efimenko said she kind of leaves it up to the parent but they do talk about it. She doesn't require it.

Senator Judy Lee asked how she finds out about the health history of the new mom in case there is something she's predisposed to have as an issue.

Ms. Efimenko replied that in the first pre natal visit they talk extensively about any health problems the mother has had whether in pregnancies or not – even family health problems.

Senator Judy Lee asked how often she sees herself as a primary care provider.

Ms. Efimenko said about 98% of the time. There are a few doctors she can call with any questions that she has.

Senator Judy Lee recessed the committee.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2315
2-9-2011
Job Number 14262

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened SB 2315 for committee work. She explained she had amendments prepared as a result of the previous discussions. Attachment # 11
She asked **Karen Macdonald** to explain some of the background.

Ms. Macdonald reminded the committee that the ND Nurses Association opposed the bill in the methodology that was in the original bill but agreed with the concept in principle. Through a series of conversations with a variety of people, representatives from the Board of Nursing and the Nurses Association sat down to see how they could make it the best they could and came up with these amendments. She then reviewed the points of the amendment .02005.

Discussion: There would be voluntary registration for 2 years but required certification after that. It does expire July 30, 2013. Mandatory registered is desired but is costly and in order to make it mandatory, there has to be some funds available.
Preceptorship is when someone works side by side with an individual as they are learning the trade.
Fees were discussed. The board has the ability to set the fees. It is not expected to be costly. Under the Board of Nursing there is already the Unlicensed Assistive Person Registry which this could possibly be under.

Senator Dick Dever referred to the study and stated that the feasibility and desirability of developing a mechanism for mandatory regulation almost sounds like that is the outcome.

Ms. Macdonald responded that they would deal with this in nursing even though it is not a nursing problem. As nurses they are always willing to step up and help with health care issues. They will deal with this in nursing for two years but would like help to come up with a better mechanism. Voluntary registration is not going to do a great deal.

Senator Judy Lee said it is just a small first step to try to assure people who want to know what the background might be of the person whom they want to assist with their home

birth. She said it's not necessarily a predetermined outcome but whether or not it's the right thing to do. She felt the study should be an open ended approach.

Senator Tim Mathern also proposed amendments - .02004 – which he explained.
Attachment # 12
An advisory board would need to be funded therefore a fiscal note would be required.
A structured method where people are on an advisory board clarifies the record about having notice of meetings.
The primary issue is to make sure the system is in place and the parties are there at the table.

Buzz Benson said because the Board of Nursing already has a registry set up with "Unlicensed Assistive Persons" it would be an easy process and at minimal cost.

Senator Tim Mathern asked if his board would take part in the feasibility and desirability of developing a mechanism for mandatory regulation of lay or traditional midwives.

Mr. Benson replied that if it is the wish of the committee they would do it. As the board of nursing they would encourage all parties to be at the table.

Senator Tim Mathern asked how they would pay for that cost – interim committee.

Mr. Benson replied that it is voluntary.

Darlene Bartz, Dept. of Health, said they had studied this for about 6 months and they feel the board of nursing would be the appropriate setting. The nursing board works with the certified nurse midwife so they do have a knowledge base working with the midwife practice. The health department doesn't have that expertise.
She was concerned with making the registry voluntary versus mandatory because if someone doesn't want to be on the registry the information wouldn't be captured even for a study down the road. The reporting piece is very important.
She thought a section on immunity should be included.

Senator Judy Lee pointed out that there is a problem with making it mandatory. There are people who are so strongly committed to home births and resist any kind of regulation at all. She is hopeful that with this very minimal requirement there will be some cooperation.

Senator Tim Mathern was concerned that it is not just the medical folks but the families saying they can't afford health insurance or want a different way of taking part in birth or that are physically in distance areas. He was concerned that the families were not involved in the studies.

Ms. Bartz responded that the workgroup that studied this did visit with the midwives they were aware of at the time.

Discussion: Information that would be included in the registry. The certified lay midwife does not need to be a nurse. The lay midwife is not under the direction of the nurses.

A discussion on the immunity clause indicated that it might be necessary but putting it in the nurse practice act might be the wrong place to put it. It might be in some other chapter.

Senator Tim Mathern appreciated hearing from the Board of Nursing, Nurses Association, and Department of Health and asked to hear input from lay midwives or families about how they view the amendments.

Senator Judy Lee asked if there were comments from any of the home birth people.

Sarah Karges commented that it seems reasonable to ask for a registry. As a citizen who would be concerned about the issues with respect to the study, she would probably be interested in being a part of that process.

Discussion topics included the effective date of required certification and the organizations the certification could be under. The certification would be for "lay" midwives.

Senator Judy Lee encouraged those who were involved to think about how to change the study to do something like a task force where the stakeholders in question actually spend time around the table talking about the details.
There is no way now to collect data about situations in which there has ended up being a hospital delivery but started out as a home birth in which there were problems. The data collection is vital.

Senator Tim Mathern asked Ms. Karges for her comparison of the two amendments.

Ms. Karges saw the main difference was under whom the registry falls and the advisory board. She felt the study would be more appealing to the public than the idea of an advisory board.

Senator Judy Lee asked for collaboration on further amendments to consider a task force and gathering of data and asked Cal Rolfson to help facilitate it.

A short break was taken.

Cal Rolfson, reported back to the committee that there had been participation from all interested parties – nursing, health dept., lawyers, and lay persons. They took the two issues and combined them into one section. Attachment # 13
The only question they had was who should be the convener - Board of Nursing, Dept. of Health, or The Nurses Association.

After committee discussion with those involved there was some consensus that the Department of Health might be the most neutrally perceived and probably the best choice for the convener. The convener would be the one to report to the interim committee.

Senator Tim Mathern showed concern with putting this in the Board of Nursing and preferred working with the Department of Health in moving forward with this study and with the gathering of data and how this would look in the next legislative session.

Senator Judy Lee pointed out that the Department of Health would rather not do it and the Board of Nursing is willing to do. They would all still be at the table in the discussions.

Senator Dick Dever moved the **.02005 amendments with substitution of the new language in the amendment as proposed.**

Seconded by **Senator Gerald Uglem**.

Senator Tim Mathern resisted the amendments.

Roll call vote 4-1-0. **Amendments adopted.**

Senator Gerald Uglem moved a **Do Pass as Amended**.

Seconded by **Senator Spencer Berry**.

Roll call vote 4-1-0. **Motion carried**.

Carrier is **Senator Dick Dever**.

FISCAL NOTE

Requested by Legislative Council
02/11/2011

Amendment to: SB 2315

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$500		$500	
Expenditures			$38,716		$36,716	
Appropriations			$38,216		$36,216	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The lay midwife legislation establishes a registry at the ND Board of Nursing. The number of registrations will determine the workload of board and staff. The registry could not be established without a general fund appropriation.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

If this legislation were enacted without a general fund appropriation, there would be no funds to implement the registry.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Anticipate five applicants for this registry at a biennial fee of $100.00 each.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

EXPENSES PER YEAR

Total Salary & Benefits	15,976	
Legal Expenses (Discipline & Policy Revision)	9,000	
5% Operating Expenses	3,440	
5% Technology Expenses	5,300	
Disciplinary Process (Potential Hearing)	3,000	
*Task Force Meetings	2,000	
TOTAL EXPENSES		38,716

* Task Force would only be needed in the first biennium.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The appropriation requested would be the amount to support the lay midwifery registry. See above.

Name:	Constance B Kalanek	**Agency:**	ND Board of Nursing
Phone Number:	701-328-9781	**Date Prepared:**	02/11/2011

FISCAL NOTE

Requested by Legislative Council
01/26/2011

Bill/Resolution No.: SB 2315

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$500		$500		$500	
Expenditures	$58,916		$56,916		$56,916	
Appropriations	$58,416		$56,416		$56,416	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The lay midwife legislation establishes an advisory board which would meet 1 day quarterly per year. The number of registrations will determine the workload of board and staff. The registry cannot be funded with nurse licensure fees therefore a general fund appropriation is necessary.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

If this legislation were enacted without a general fund appropriation, nurse licensure fees would need to fund a registry of individuals that are not nurses and do not fall under the Nurse Practices Act.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Anticipate five applicants for this registry at a biennial fee of $100.00 each.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

EXPENSES

Total Salary & Benefits	7,988	
Advisory Board Exp (1 Day Quarterly meetings)	10,000	
Legal Expenses (Discipline & Rulemaking)	9,600	
Administrative Rule Promulgation	2,000	
5% Operating Expenses		1,720
5% Technology Expenses		2,650
Disciplinary Process (Potential Hearing)	1,500	
Education Grant		5,000
TOTAL EXPENSES		40,458

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The appropriation requested would be the amount to support the lay midwifery registry without using nurse licensure fees. See above.

Name:	Constance B Kalanek	**Agency:**	ND Board of Nursing
Phone Number:	701-328-9781	**Date Prepared:**	01/31/2011

#11

11.8245.02005
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
February 8, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2315

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-12.1 of the North Dakota Century Code, relating to creation of a lay and traditional midwife registry; to amend and reenact sections 43-12.1-02, 43-12.1-09, and 43-12.1-09.1 of the North Dakota Century Code, relating to the registry of lay and traditional midwives; to provide for a legislative management study; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-12.1-02 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-02. Definitions.

In this chapter, unless the context otherwise requires:

1. "Advanced practice registered nurse" means an individual who holds a current license to practice in this state as an advanced practice registered nurse.

2. "Board" means the North Dakota board of nursing.

3. "Lay or traditional midwife" means an individual who is currently registered as a lay or traditional midwife under this chapter.

4. "Licensed practical nurse" means an individual who holds a current license to practice in this state as a licensed practical nurse.

~~4.~~5. "Nurse" means an individual who is currently licensed as an advanced practice registered nurse, registered nurse, or licensed practical nurse.

~~5.~~6. "Nursing" means the performance of acts utilizing specialized knowledge, skills, and abilities for people in a variety of settings. The term includes the following acts, which may not be deemed to include acts of medical diagnosis or treatment or the practice of medicine as defined in chapter 43-17:

   a. The maintenance of health and prevention of illness.

   b. Diagnosing human responses to actual or potential health problems.

   c. Providing supportive and restorative care and nursing treatment, medication administration, health counseling and teaching, case finding and referral of individuals who are ill, injured, or experiencing changes in the normal health processes.

   d. Administration, teaching, supervision, delegation, and evaluation of health and nursing practices.

e. Collaboration with other health care professionals in the implementation of the total health care regimen and execution of the health care regimen prescribed by a health care practitioner licensed under the laws of this state.

~~6.~~7. "Prescriptive practices" means assessing the need for drugs, immunizing agents, or devices and writing a prescription to be filled by a licensed pharmacist.

~~7.~~8. "Registered nurse" means an individual who holds a current license to practice in this state as a registered nurse.

~~8.~~9. "Specialty practice registered nurse" means an individual who holds a current license to practice in this state as a specialty practice registered nurse.

~~9.~~10. "Unlicensed assistive person" means an assistant to the nurse who regardless of title is authorized by the board to perform nursing interventions delegated and supervised by a nurse.

SECTION 2. AMENDMENT. Section 43-12.1-09 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09. Initial licensure and registration.

1. The board shall license and register nursing, lay or traditional midwife, and unlicensed assistive person applicants. The board shall adopt rules establishing qualifications for initial nursing licensure and unlicensed assistive person registration and for issuing limited licenses and registrations pursuant to subsection 3.

2. Each applicant who successfully meets the requirements of this section is entitled to initial licensure or registration as follows:

   a. An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall:

      (1) Submit a completed application and appropriate fee as established by the board.

      (2) Submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought. The board shall adopt rules establishing standards for the approval of out-of-state nursing education programs. These standards for out-of-state programs must include consideration of whether the program is accredited by the national league for nursing accrediting commission, incorporated, or the commission on collegiate nursing education and whether the program meets the requirements of the state in which the program is provided.

      (3) Pass an examination approved by the board.

   b. An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought.

(3) Submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure.

(4) Submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

(5) Notwithstanding the foregoing requirements of this subdivision, if an applicant for licensure as a licensed practical nurse has been licensed in another state as a licensed practical nurse based upon completion of a registered nurse education program and has had at least twenty-four months of unencumbered practice as a licensed practical nurse in another state within the five-year period preceding the application, then the applicant is not required to meet any additional educational requirements for licensure as a licensed practical nurse.

c. An applicant for licensure as an advanced practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in an advanced nursing role by a national nursing organization meeting criteria as established by the board. An advanced practice registered nurse applicant must have a graduate degree with a nursing focus or must have completed the educational requirements in effect when the applicant was initially licensed.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

d. An applicant for licensure as an advanced practice registered nurse who completed an advanced nursing education program and was licensed or certified in advanced practice by another state before January 1, 2001, or who completed an advanced nursing education program and was licensed or certified as a women's health care nurse practitioner by another state before January 1, 2007, may apply for and receive an advanced practice license if that applicant meets the requirements that were in place in this state at the time the applicant qualified for initial advanced practice licensure in that state.

e. An applicant for unlicensed assistive person registration shall:

(1) Submit a completed application and the appropriate fee as established by the board.

(2) Provide verification of appropriate training or evidence of certification or evaluation in the performance of basic nursing interventions.

f. An applicant for licensure as a specialty practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in a specialty nursing role by a national nursing organization meeting criteria as established by the board. A specialty practice registered nurse applicant must have the educational preparation and national certification within a defined area of nursing practice.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

g. An applicant for registration as a lay or traditional midwife shall:

(1) Submit a completed application and the appropriate fee as established by the board. A qualified applicant may not be licensed as a physician or nurse.

(2) Submit evidence of education related to the practice as a lay midwife; experience, including preceptorship, in the practice of a lay midwife; and effective January 1, 2013, certification by a national organization.

3. For good cause shown, the board may issue a limited license or registration to an applicant.

SECTION 3. A new section to chapter 43-12.1 of the North Dakota Century Code is created and enacted as follows:

Lay or traditional midwife registry.

The board shall administer a voluntary registry for an individual who provides services to women and their newborn children outside of a hospital or clinical setting which is consistent with the individual's training, education, and certification. In order to register as a lay or traditional midwife, an applicant shall submit to a statewide and nationwide criminal history record check under section 43-12.1-09.1.

SECTION 4. AMENDMENT. Section 43-12.1-09.1 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09.1. ~~Nursing licensure~~Licensure or registration - Criminal history record checks.

The board may require each applicant for initial or renewed ~~nursing~~ licensure or registration and any licensee or registrant who is the subject of a disciplinary investigation or proceeding to submit to a statewide and nationwide criminal history record check. The nationwide criminal history record check must be conducted in the manner provided by section 12-60-24. All costs associated with obtaining a background check are the responsibility of the applicant, licensee, or registrant. The board may

grant a nonrenewable temporary permit to an applicant for initial or renewed license or registration who submits to a criminal history record check as required by this chapter if the applicant has met all other licensure or registration requirements in accordance with subsection 2 of section 43-12.1-09.

SECTION 5. LEGISLATIVE MANAGEMENT STUDY - REGULATION OF LAY OR TRADITIONAL MIDWIVES. During the 2011-12 interim, the legislative management shall study the feasibility and desirability of developing a mechanism for mandatory regulation of lay or traditional midwives. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 6. EXPIRATION DATE. This Act is effective through July 30, 2013, and after that date is ineffective."

Renumber accordingly

Date: 2-9-11

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2315

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number Revised .02005

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Dever Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**		✓
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

11.8245.02006
Title.03000

Adopted by the Human Services Committee

February 9, 2011

2-10-11
1 of 5

PROPOSED AMENDMENTS TO SENATE BILL NO. 2315

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-12.1 of the North Dakota Century Code, relating to creation of a lay and traditional midwife registry; to amend and reenact sections 43-12.1-02, 43-12.1-09, and 43-12.1-09.1 of the North Dakota Century Code, relating to the registry of lay and traditional midwives; to provide for a legislative management study; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-12.1-02 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-02. Definitions.

In this chapter, unless the context otherwise requires:

1. "Advanced practice registered nurse" means an individual who holds a current license to practice in this state as an advanced practice registered nurse.

2. "Board" means the North Dakota board of nursing.

3. "Lay or traditional midwife" means an individual who is currently registered as a lay or traditional midwife under this chapter.

4. "Licensed practical nurse" means an individual who holds a current license to practice in this state as a licensed practical nurse.

~~4.~~5. "Nurse" means an individual who is currently licensed as an advanced practice registered nurse, registered nurse, or licensed practical nurse.

~~5.~~6. "Nursing" means the performance of acts utilizing specialized knowledge, skills, and abilities for people in a variety of settings. The term includes the following acts, which may not be deemed to include acts of medical diagnosis or treatment or the practice of medicine as defined in chapter 43-17:

   a. The maintenance of health and prevention of illness.

   b. Diagnosing human responses to actual or potential health problems.

   c. Providing supportive and restorative care and nursing treatment, medication administration, health counseling and teaching, case finding and referral of individuals who are ill, injured, or experiencing changes in the normal health processes.

   d. Administration, teaching, supervision, delegation, and evaluation of health and nursing practices.

e. Collaboration with other health care professionals in the implementation of the total health care regimen and execution of the health care regimen prescribed by a health care practitioner licensed under the laws of this state.

~~6.~~7. "Prescriptive practices" means assessing the need for drugs, immunizing agents, or devices and writing a prescription to be filled by a licensed pharmacist.

~~7.~~8. "Registered nurse" means an individual who holds a current license to practice in this state as a registered nurse.

~~8.~~9. "Specialty practice registered nurse" means an individual who holds a current license to practice in this state as a specialty practice registered nurse.

~~9.~~10. "Unlicensed assistive person" means an assistant to the nurse who regardless of title is authorized by the board to perform nursing interventions delegated and supervised by a nurse.

SECTION 2. AMENDMENT. Section 43-12.1-09 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09. Initial licensure and registration.

1. The board shall license and register nursing, lay or traditional midwife, and unlicensed assistive person applicants. The board shall adopt rules establishing qualifications for initial nursing licensure and unlicensed assistive person registration and for issuing limited licenses and registrations pursuant to subsection 3.

2. Each applicant who successfully meets the requirements of this section is entitled to initial licensure or registration as follows:

   a. An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall:

      (1) Submit a completed application and appropriate fee as established by the board.

      (2) Submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought. The board shall adopt rules establishing standards for the approval of out-of-state nursing education programs. These standards for out-of-state programs must include consideration of whether the program is accredited by the national league for nursing accrediting commission, incorporated, or the commission on collegiate nursing education and whether the program meets the requirements of the state in which the program is provided.

      (3) Pass an examination approved by the board.

   b. An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought.

(3) Submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure.

(4) Submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

(5) Notwithstanding the foregoing requirements of this subdivision, if an applicant for licensure as a licensed practical nurse has been licensed in another state as a licensed practical nurse based upon completion of a registered nurse education program and has had at least twenty-four months of unencumbered practice as a licensed practical nurse in another state within the five-year period preceding the application, then the applicant is not required to meet any additional educational requirements for licensure as a licensed practical nurse.

c. An applicant for licensure as an advanced practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in an advanced nursing role by a national nursing organization meeting criteria as established by the board. An advanced practice registered nurse applicant must have a graduate degree with a nursing focus or must have completed the educational requirements in effect when the applicant was initially licensed.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

d. An applicant for licensure as an advanced practice registered nurse who completed an advanced nursing education program and was licensed or certified in advanced practice by another state before January 1, 2001, or who completed an advanced nursing education program and was licensed or certified as a women's health care nurse practitioner by another state before January 1, 2007, may apply for and receive an advanced practice license if that applicant meets the requirements that were in place in this state at the time the applicant qualified for initial advanced practice licensure in that state.

e. An applicant for unlicensed assistive person registration shall:

(1) Submit a completed application and the appropriate fee as established by the board.

(2) Provide verification of appropriate training or evidence of certification or evaluation in the performance of basic nursing interventions.

f. An applicant for licensure as a specialty practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in a specialty nursing role by a national nursing organization meeting criteria as established by the board. A specialty practice registered nurse applicant must have the educational preparation and national certification within a defined area of nursing practice.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

g. An applicant for registration as a lay or traditional midwife shall:

(1) Submit a completed application and the appropriate fee as established by the board. A qualified applicant may not be licensed as a physician or nurse.

(2) Submit evidence of education related to the practice as a lay midwife; experience, including preceptorship, in the practice of a lay midwife; and effective January 1, 2013, certification by a national organization.

3. For good cause shown, the board may issue a limited license or registration to an applicant.

SECTION 3. AMENDMENT. Section 43-12.1-09.1 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09.1. ~~Nursing licensure~~Licensure or registration - Criminal history record checks.

The board may require each applicant for initial or renewed ~~nursing~~ licensure or registration and any licensee or registrant who is the subject of a disciplinary investigation or proceeding to submit to a statewide and nationwide criminal history record check. The nationwide criminal history record check must be conducted in the manner provided by section 12-60-24. All costs associated with obtaining a background check are the responsibility of the applicant, licensee, or registrant. The board may grant a nonrenewable temporary permit to an applicant for initial or renewed license or registration who submits to a criminal history record check as required by this chapter if the applicant has met all other licensure or registration requirements in accordance with subsection 2 of section 43-12.1-09.

SECTION 4. A new section to chapter 43-12.1 of the North Dakota Century Code is created and enacted as follows:

Lay or traditional midwife registry.

The board shall administer a voluntary registry for an individual who provides services to women and their newborn children outside of a hospital or clinical setting which is consistent with the individual's training, education, and certification. In order to register as a lay or traditional midwife, an applicant shall submit to a statewide and nationwide criminal history record check under section 43-12.1-09.1.

SECTION 5. LEGISLATIVE MANAGEMENT STUDY - REGULATION OF LAY OR TRADITIONAL MIDWIVES. During the 2011-12 interim, the legislative management shall study the feasibility and desirability of developing a mechanism for mandatory regulation of lay or traditional midwives. The state department of health shall convene a task force of interested parties to study the feasibility and desirability of developing a method and source of funding for the regulation of lay or traditional midwives, including the gathering of current and relevant data, and shall report any recommendations to the legislative management. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 6. EXPIRATION DATE. This Act is effective through July 31, 2013, and after that date is ineffective."

Renumber accordingly

Date: 2-9-11

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2315

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8245.02006 Title 03000

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Uglem Seconded By **Sen.** Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**		✓
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen. Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2315: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2315 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-12.1 of the North Dakota Century Code, relating to creation of a lay and traditional midwife registry; to amend and reenact sections 43-12.1-02, 43-12.1-09, and 43-12.1-09.1 of the North Dakota Century Code, relating to the registry of lay and traditional midwives; to provide for a legislative management study; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-12.1-02 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-02. Definitions.

In this chapter, unless the context otherwise requires:

1. "Advanced practice registered nurse" means an individual who holds a current license to practice in this state as an advanced practice registered nurse.
2. "Board" means the North Dakota board of nursing.
3. "Lay or traditional midwife" means an individual who is currently registered as a lay or traditional midwife under this chapter.
4. "Licensed practical nurse" means an individual who holds a current license to practice in this state as a licensed practical nurse.
~~4.~~5. "Nurse" means an individual who is currently licensed as an advanced practice registered nurse, registered nurse, or licensed practical nurse.
~~5.~~6. "Nursing" means the performance of acts utilizing specialized knowledge, skills, and abilities for people in a variety of settings. The term includes the following acts, which may not be deemed to include acts of medical diagnosis or treatment or the practice of medicine as defined in chapter 43-17:
   a. The maintenance of health and prevention of illness.
   b. Diagnosing human responses to actual or potential health problems.
   c. Providing supportive and restorative care and nursing treatment, medication administration, health counseling and teaching, case finding and referral of individuals who are ill, injured, or experiencing changes in the normal health processes.
   d. Administration, teaching, supervision, delegation, and evaluation of health and nursing practices.
   e. Collaboration with other health care professionals in the implementation of the total health care regimen and execution of the health care regimen prescribed by a health care practitioner licensed under the laws of this state.

~~6.~~ 7. "Prescriptive practices" means assessing the need for drugs, immunizing agents, or devices and writing a prescription to be filled by a licensed pharmacist.

~~7.~~ 8. "Registered nurse" means an individual who holds a current license to practice in this state as a registered nurse.

~~8.~~ 9. "Specialty practice registered nurse" means an individual who holds a current license to practice in this state as a specialty practice registered nurse.

~~9.~~ 10. "Unlicensed assistive person" means an assistant to the nurse who regardless of title is authorized by the board to perform nursing interventions delegated and supervised by a nurse.

SECTION 2. AMENDMENT. Section 43-12.1-09 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09. Initial licensure and registration.

1. The board shall license and register nursing, lay or traditional midwife, and unlicensed assistive person applicants. The board shall adopt rules establishing qualifications for initial nursing licensure and unlicensed assistive person registration and for issuing limited licenses and registrations pursuant to subsection 3.

2. Each applicant who successfully meets the requirements of this section is entitled to initial licensure or registration as follows:

   a. An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall:

      (1) Submit a completed application and appropriate fee as established by the board.

      (2) Submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought. The board shall adopt rules establishing standards for the approval of out-of-state nursing education programs. These standards for out-of-state programs must include consideration of whether the program is accredited by the national league for nursing accrediting commission, incorporated, or the commission on collegiate nursing education and whether the program meets the requirements of the state in which the program is provided.

      (3) Pass an examination approved by the board.

   b. An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall:

      (1) Submit a completed application and appropriate fee as established by the board.

      (2) Submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought.

      (3) Submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure.

(4) Submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

(5) Notwithstanding the foregoing requirements of this subdivision, if an applicant for licensure as a licensed practical nurse has been licensed in another state as a licensed practical nurse based upon completion of a registered nurse education program and has had at least twenty-four months of unencumbered practice as a licensed practical nurse in another state within the five-year period preceding the application, then the applicant is not required to meet any additional educational requirements for licensure as a licensed practical nurse.

c. An applicant for licensure as an advanced practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in an advanced nursing role by a national nursing organization meeting criteria as established by the board. An advanced practice registered nurse applicant must have a graduate degree with a nursing focus or must have completed the educational requirements in effect when the applicant was initially licensed.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

d. An applicant for licensure as an advanced practice registered nurse who completed an advanced nursing education program and was licensed or certified in advanced practice by another state before January 1, 2001, or who completed an advanced nursing education program and was licensed or certified as a women's health care nurse practitioner by another state before January 1, 2007, may apply for and receive an advanced practice license if that applicant meets the requirements that were in place in this state at the time the applicant qualified for initial advanced practice licensure in that state.

e. An applicant for unlicensed assistive person registration shall:

(1) Submit a completed application and the appropriate fee as established by the board.

(2) Provide verification of appropriate training or evidence of certification or evaluation in the performance of basic nursing interventions.

f. An applicant for licensure as a specialty practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in a specialty nursing role by a national nursing organization meeting criteria as established by the board. A specialty practice registered nurse applicant must have the educational preparation and national certification within a defined area of nursing practice.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

g. An applicant for registration as a lay or traditional midwife shall:

(1) Submit a completed application and the appropriate fee as established by the board. A qualified applicant may not be licensed as a physician or nurse.

(2) Submit evidence of education related to the practice as a lay midwife; experience, including preceptorship, in the practice of a lay midwife; and effective January 1, 2013, certification by a national organization.

3. For good cause shown, the board may issue a limited license or registration to an applicant.

SECTION 3. AMENDMENT. Section 43-12.1-09.1 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09.1. ~~Nursing licensure~~Licensure or registration - Criminal history record checks.

The board may require each applicant for initial or renewed ~~nursing~~-licensure or registration and any licensee or registrant who is the subject of a disciplinary investigation or proceeding to submit to a statewide and nationwide criminal history record check. The nationwide criminal history record check must be conducted in the manner provided by section 12-60-24. All costs associated with obtaining a background check are the responsibility of the applicant, licensee, or registrant. The board may grant a nonrenewable temporary permit to an applicant for initial or renewed license or registration who submits to a criminal history record check as required by this chapter if the applicant has met all other licensure or registration requirements in accordance with subsection 2 of section 43-12.1-09.

SECTION 4. A new section to chapter 43-12.1 of the North Dakota Century Code is created and enacted as follows:

Lay or traditional midwife registry.

The board shall administer a voluntary registry for an individual who provides services to women and their newborn children outside of a hospital or clinical setting which is consistent with the individual's training, education, and certification. In order to register as a lay or traditional midwife, an applicant shall submit to a statewide and nationwide criminal history record check under section 43-12.1-09.1.

SECTION 5. LEGISLATIVE MANAGEMENT STUDY - REGULATION OF LAY OR TRADITIONAL MIDWIVES. During the 2011-12 interim, the legislative management shall study the feasibility and desirability of developing a mechanism for mandatory regulation of lay or traditional midwives. The state department of health shall convene a task force of interested parties to study the feasibility and desirability of developing a method and source of funding for the regulation of lay or traditional midwives, including the gathering of current and relevant data, and shall report any recommendations to the legislative management. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 6. EXPIRATION DATE. This Act is effective through July 31, 2013, and after that date is ineffective."

Renumber accordingly

2011 TESTIMONY

SB 2315

Darlene Bartz

#1

2011 Legislation SB 2315 Explanation

This bill would establish a system for licensing and regulating lay midwife services. At the present time lay midwives are not licensed or subject to any regulation by any professional body in North Dakota. The regulation of lay midwives varies from state to state. For example, judicial decisions in one state concluded that because childbirth is a natural process, lay midwives assisting pregnant women during childbirth are not engaged in the practice of medicine or the practice of nursing.

See State Board of Nursing v. Ruebke, 259 Kan. 599, 913 P.2d 142 (1996) ("the terms... used to define healing arts clearly and unequivocally focus... on pathologies, i.e., diseases) and abnormal human conditions (i.e., ailments...). Pregnancy and childbirth are neither pathologies nor abnormalities").

Not much is heard about the practice of lay midwives or direct entry midwives, until something goes wrong with either the baby or mother. The department of health received a phone call from a hospital after they had received a patient when something had gone wrong in the home delivery. The department received the concern because we regulate hospitals and the hospital wanted to know who to go to with their concerns. As lay midwives in our state are not licensed or subject to regulation by any professional body in North Dakota, there was nowhere to refer the hospital with their concerns. The decision was made to pull together a group to look at this issue and to pull together members representing the professional boards for nursing and medicine, the department of health, and the North Dakota Hospital Association, the North Dakota Medical Association, a Certified Nurse Midwife, Hospital Medical Director, Obstetrician, and Neonatologist participated in the discussions. In addition, information was sought from the lay midwives practicing in North Dakota as well as the Certified Nurse

Midwives in our state. All agreed that safety of the mother and infant was of key importance.

Statutes from several other states were reviewed, as well as discussion with the North American Registry of Midwives related to the competency evaluation of lay or direct entry midwives. In many states, the regulation of lay midwives comes under the purview of the Board of Medicine or Board of Nursing. After discussion, the best fit for North Dakota was identified to be the Board of Nursing.

The review of the bill section by section is as follows:

Section 1 of the bill amends section 43-12.1-05 relating to the composition of the board of nursing. It provides that a certified nurse midwife appointed to the midwife advisory board, which is established by this legislation, may participate in board of nursing matters relating to the licensure and practice of licensed midwives.

Section 2 of the bill (page 1, beginning at line 18) -- would establish a new chapter to title 43 of the North Dakota century code for the licensing and regulation of lay midwives.

Definitions -- the definitions included a definition of an advisory board on lay midwives and a definition of a "licensed midwife" (which is found at page 2, lines 2-4)

> A licensed midwife is defined as an individual who is not licensed as a physician [M.D.] or nurse [R.N.] and who holds a current license issued by the board of nursing pursuant to the provisions of this chapter "to engage in the practice of midwifery, who must be designated LM."

"Midwifery" or the "practice of midwifery" (page 2, lines 5-9) -- means providing maternity care outside a hospital or clinic setting which is consistent with the midwife training education and experience to women and their newborn children throughout the childbearing cycle, and it includes identifying and referring pregnant women or their newborn children who require additional health care to a qualified health care professional.

Licensure Requirements (page 2, beginning at line 10) -- This section of the new chapter specifies the licensure requirements for a lay midwife. Basically, any individual providing midwifery services in North Dakota, regardless of whether for consideration or pay must be licensed. The licensure requirements require an individual to file a board-approved application; provide proof of current certification as a certified professional midwife or CPM by the North American Registry of midwives; and other requirements that are spelled out on page 2 of the bill.

The licensure requirements also include a grandfather clause -- so that a midwife who has been continuously practicing midwifery in North Dakota for at least five years before July 31, 2011 is exempt the qualifications for an initial license for a period of two years, if such midwife provides documentation to the board of nursing.

The licensing section also provides that the board may license a midwife who provides evidence of current licensure or certification by another state with requirements that are at least as stringent as those set forth in this new chapter -- if the applicant is in good standing in that state, and has not been sanctioned by another state without resolution satisfactory to the board of nursing.

Regulation of the Practice of Midwifery (Page 4, Lines 16-26.) The next section provides that the Board of Nursing may adopt rules governing the practice of midwifery upon consultation with the midwifery advisory board. In general, these rules may be consistent with the North American Registry of midwives current job description and the national Association of certified professional midwives standards of practice.

(As a practical matter, there are too few lay midwives in North Dakota to justify a separate board to regulate lay midwives.)

Education grants (page 4, beginning at line 27) -- the board of nursing is required to establish a grant program for midwives who have been continuously practicing midwifery in North Dakota for at least five years before July 31, 2011.

Advisory Board on Midwifery (page 5, beginning at line 8) -- an advisory board on midwifery is established consisting of five members. The section spells out the terms of office of the board members, the appointment of a Chairman, etc.

Requirements for Disclosure and Written Agreement (page 5, lines 29-31 and page 6, many lines *1-25*) -- this section requires a midwife, **before initiating care**, to obtain a signed written agreement from each client that the client has received certain documents of, including a description of the midwife's qualifications, a written protocol for medical emergencies, a description of the midwives model of care, a copy of the regulations governing the practice of midwifery, a statement concerning the licensed midwife's malpractice liability insurance coverage; and "a statement of informed consent."

Subsection 2 of this section (page 6, lines 26-27) -- requires a licensed midwife to have a signed written agreement form on file for each client.

Limitations of Practice (Page 7, Lines 2-4) -- subsection 1 of this section provides the licensed midwife may not prescribe, dispense, or administer prescription drugs except as permitted by the board of nursing specific to the maternity care, labor, delivery, and post partum care of the mother and newborn infant. And, a midwife may not prescribe or administer any controlled substances as defined by DEA (page 7, lines 9-10, subsection 1(c)).

The section also provides (page 7, lines 6-9, subsection 1(d)) -- that a licensed midwife may not prescribe, administer, *sign for*, dispense, or procure pharmaceutical samples.

Subsection 2 (page 7-lines 18-19) also provides that a licensed midwife may not perform any operative or surgical procedures except for suture repair of first-degree or second-degree **perineal** lacerations (*of the mucosa of the perineal area, the Vulva, vagina).*

Immunity from Liability (page 7, beginning at line 20) -- A physician, nurse, hospital, emergency medical technician, or ambulance personnel is not liable in any civil action for damages for any injury resulting from an act or omission of a licensed midwife in the treatment of a mother or infant, or a pregnant woman whose delivery was attempted under the care of a licensed midwife, even if the health care provider has consulted with or received a referral from a licensed midwife.

But a physician, nurse, emergency medical technician, ambulance personnel, or hospital is liable for the provider's own subsequent independent negligent acts or

omissions, or if the provider has a business relationship with a licensed midwife who provided care to the patient. But a health care provider is not considered to have established a business relationship a relationship of agency, employment, partnership, or joint venture with the licensed midwife solely by providing consultation or accepting a referral from a licensed midwife. (Pages 7, lines 25-30, and page 8, lines 1 and 2.)

Reporting (page 8, lines 3-16) This section provides that -- a licensed midwife must complete a record of birth in accordance with requirements of the vital records act, section North Dakota century code 23-02.1-13; a midwife must compile a summary report on each client; a licensed midwife must promptly report to the board of nursing any maternal, fetal, or neonatal mortality or morbidity. And, a midwife must report to the board termination, revocation, or suspension of the licensed midwife's certification or disciplinary action taken against the midwife by the North American Registry of midwives or by another jurisdiction.

Protected titles and licensure & penalty (page 8, lines 17-27) This section provides that "it is unlawful for any person to assume or use the title or designation licensed midwife or LM, or other titles words or abbreviations -- unless the person is licensed as a midwife under the new chapter or is exempt from the requirement to be licensed until July 31, 2012. A violation of this section is a class A misdemeanor. (A class ***A*** misdemeanor is punishable by imprisonment for up to one year or a fine of up to $2,000, or both.)

# # #

#2

Senate Human Services Committee

Nelson (Buzz) Benson CRNA, MMGT
Board Member
President
North Dakota Board of Nursing

Chairman Lee and members of the Committee, thank you for the opportunity to provide information regarding the SB 2315 related to licensing and regulating direct entry or lay midwifery services. I am Buzz Benson CRNA and President of the Board of Nursing. The Board currently licenses approximately: RNs 10,736; LPN 3,611; APRN 753; UAPs and Medication Assistants 4,591. The Board of Nursing is currently a nine member board appointed by the governor. The Board is a member of the Nurse Licensure Compact which encompasses 24 states.

The Board of Nursing was represented by Dr. Kalanek and me on the Lay Midwife Workgroup established by the ND Department of Health. The Board surveyed the Certified Nurse Midwives (CNM) on the regulation of lay midwifes and the respondents unanimously agreed that the practice of lay midwifery in ND should be regulated. None of the CNM performs home deliveries.

As a point of reference, the Certified Nurse Midwife is a masters prepared registered nurse who has completed nurse midwifery program and passed a the national certification examination for nurse midwifery. There are 11 CNMs licensed in North Dakota by the Board of Nursing.

AMENDMENT:

The Board of Nursing would like to offer an amendment to the proposed bill:

1. Eliminate "Education Grants" section; Page 4, lines 27-31 and Page 5, lines 1-7; or
2. Replace the word **"board"** on page 4, line 27 with **"legislature"**.

RATIONALE:

The NDBON is board funded by licensure and renewal fees. The small number of potential licensed midwives would not generate the revenue to support an education grant.

At the January 20, 2011 ND Board of Nursing Meeting the Board voted unanimously to take no position on this bill.

Thank you for your time. I am now open to questions.

A survey was sent to the eleven Certified Nurse Midwives CNM licensed by the ND Board of Nursing. The survey was sent using Survey Monkey the first time and sent by regular email the second time. Six of the CNM responded to the survey. A summary of the responses is provided below.

1. Four of the six indicated they did not work with lay midwives (LM) in their practice.

2. One CNM that worked with the LM stated "they brought a patient to the hospital after an unsuccessful home birth attempt for me to assume care—I had to refer on to an MD for a needed C/S.

   A second CNM stated the following: "I have cared for three patients in the last year that planned home births, but chose to have me provide joint prenatal care. They wanted a relationship with a hospital midwife in the event that a hospital transport was needed. They also completed routine labs, such as the initial OB panel, and a screening US at our clinic. These were not available through the home-birth midwife. However, I have had no contact whatsoever with any of the home-birth midwives. Everything has been communicated verbally by the pt".

3. Would you be willing to provide prenatal and neonatal care (i.e. metabolic screening) to an expectant mother who has chosen a lay midwife and a home birth?

   Four of the six indicated they are currently doing this and are willing to provide care.
   - One responded "We discourage the use of LM but sometimes a patient see us for antenatal care and then tell us at 36 weeks they plan a home birth.
   - Another responded "One of the issues with participating in joint care is that if patients require hospital transport, midwifery care is usually not appropriate. They generally come in because of stalled labor, or require emergent delivery, etc and require surgical intervention. In this case, they need to be cared for by a physician, not a midwife".

4. In your opinion, why do you think expectant parents choose a lay midwife for a home birth?
   - Cost.
   - Lack of knowledge about potential complications; misinformation; fear of hospitals, finances.
   - In search of a "perfect birth"; "natural delivery".
   - Everyone has different reasons, some are religious.
   - Unhappy with local hospital birthing services.
   - Do not have a CNM in the area.
   - Women want a natural process and hospitals require too much intervention.
   - No control in a hospital setting.
   - Time constraints that hospitals place on labors.

5. Would you support ND legislation to require Lay Midwives to be licensed or registered?
   - All six said yes;
   - Two commented they need to show evidence of certified training and must be licensed.
   - One stated it would assure that continuing education was received.

6. What would you expect to be included in the minimum requirements for becoming licensed or registered?
    - Two –Successful completion of an academic program with internship;
    - Two-Licensing examination.
    - Awareness of public of difference between lay midwife and CNM.
    - Do not want to be affiliated or associated with LM.
    - CPR, PALS, etc
    - Same as CNMs
    - CME
    - One- not sure
    - Certification

Other comments of interest:

- I have "shared" care for one patient who is a Type I diabetic with an insulin pump and intends to VBAC at home (which she has already done once successfully). This pt is obviously NOT a candidate for a home birth, however, a lay midwife has agreed to provide care and attend her at home. There is absolutely no way to regulate or prevent this under the current lack of regulation. I have counseled her and documented, but that is all I can do.
- I do not agree with "grandfathering" current lay midwives. I believe that a minimum standard should be set and that only those who meet the standard should be licensed. We don't want to grandfather substandard practitioners.

Connie Kalanek

[redacted]

nt: Joanna King [JKing@acnm.org]
Monday, January 31, 2011 4:21 PM
To: Connie Kalanek
Subject: ACNM feedback on ND SB 2315

Ms. Constance B. Kalanek, RN,
Executive Director, North Dakota Board of Nursing

Dear Ms. Kalanek,

At the recent NCSBN APRN Summit in San Diego, Elaine Germano and Sally Tom who work on midwifery education issues involving certified nurse-midwives and certified midwives mentioned that you had been interested in our feedback on a bill to license direct-entry midwives under the regulation of the BON.

Unfortunately, Senate Bill 2315 is not a bill that ACNM could support in its current form.

First, the bill seeks to license midwives regardless of whether a formal accredited course of education has been completed. That is, it does not draw any distinction, as our policy position does, between the primary route to the certified professional midwife (CPM) credential that is apprenticeship-only (PEP) and the route that includes a formal education component approved by the US Dept. of Education (MEAC). The bill explicitly acknowledges an intent to license apprenticeship-route midwives. You may wish to consider the direct-entry regulatory framework chosen by New Jersey, a state that has adopted midwifery regulation that licenses only formally educated CPMs. It also licenses [redacted]d midwives.

...nother problem with the bill is that it envisions granting "prescriptive authority" to licensed midwives which is plainly not within the training and education of CPMs. A bill that confers prescriptive authority upon such licensed midwives would be unprecedented and plainly insupportable. Some states have, however, authorized CPMs to legally obtain and administer certain medications, such as *vitamin K and eye prophylaxis,* precisely because prescriptive authority is inappropriate.

Additionally, while we would applaud the addition to the Board membership of a dedicated CNM position, we would prefer to see that allow full functioning on all aspects of Board business and not solely in respect to DEM licensure and practice.

There is another bill under consideration in North Dakota this year that we are supporting—SB 2148—to eliminate the collaborative practice agreement requirement for APRNs. I hope that this important legislation will win approval.

Please let me know if I can provide any further information.

Thank you very much,

Joanna M. King,
Director, Government Relations
American College of Nurse-Midwives

[redacted]

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#3

Testimony on SB 2315
Senate Human Services Committee
February 1, 2011

Madam Chairman Lee, Members of the Senate Human Services Committee, I'm Bruce Levi representing the North Dakota Medical Association. NDMA is the professional membership organization for physicians, residents and medical students.

In 2007, the North Dakota Medical Association and others asked the ND Legislative Assembly to consider legislation to clarify the standards relating to the provision of obstetrical services, allowing only those individuals licensed and in compliance with current professional medical and nursing standards to provide obstetrical services. That bill was defeated.

The bill in 2007 was introduced as a result of a review of circumstances surrounding some home births assisted by lay midwives, and the subsequent care of newborns at the hospital at which it was concluded that the welfare and safety of newborns and mothers had been placed at an unnecessary level of risk. Recognizing that there are individuals in North Dakota who may prefer home birth and that there are unlicensed and unsupervised individuals who assist with home births, NDMA participated in discussions this past year with the ND Department of Health, the ND Board of Nursing, several Bismarck physicians, and the ND Hospital Association on possible approaches to addressing these concerns.

The public should expect that an individual who holds themselves out as someone who can provide medical services, including obstetrical services, is competent and practices safely within a defined and appropriate standard of care. SB 2315 is one approach at attempting to ensure that home births are provided in a manner that provide safeguards beyond the unregulated environment that now exists. The purpose of this bill is to maximize potential health outcomes and safety for newborns and their mothers. However, NDMA has reservations that this regulatory approach can achieve the desired result or diminish the level of risk.

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Physician 1 (FM) Bismarck

My opinion … This is a REALLY, REALLY, REALLY, REALLY, REALLY, REALLY, REALLY, REALLY, REALLY, REALLY dangerous practice. Every month without fail we (the residents and faculty) have at least one delivery where the mother and/or infant would have likely died had they not been in the hospital.

I think trained midwives delivering babies in hospitals or attached birthing centers is great, but lay midwives endanger lives.

The next question though, should they be regulated, I am not so sure of. We still let people drive Corvairs and we do not make people immunize their kids, so how can we force people to not do something stupid?

Physician 2 (FM) Bismarck

I was involved in two cases in the 1980s that led to me refusing to be involved in any care that involved lay midwives:

#1 I saw for initial prenatal visit and never saw her again. She showed up at term with ruptured membranes, prolapsed cord and dead child. She had been attended by a lay midwife. It was one of the hardest things I have done in medicine to deliver a healthy looking term boy that was dead.

#2 I saw this lady for intermittent prenatal care. About 3 weeks before her due date she called to say her membranes had been ruptured for 48 hour and she was being attended by a midwife. She was told to go immediately to the hospital where we tried to induce labor. Because of infant distress c-section was done and the uterus and baby were infected both needing prolonged hospital stays. Thankfully both did okay but I standard of care is to try to deliver a mother before membranes are ruptured 24 hours.

I turned down several requests to help care for someone that was pregnant and planning a home delivery.

Physician 3 (OB-Gyn) Fargo

I have been with _____ in Fargo for about 15 years. We are rarely going to get involved with lay midwives unless we have complications. I have seen those situations over the years not in a high statistical number but in higher level of acuity requiring both obstetrical emergency, neonatal emergency, or both. I have long had a concern for this practice in North Dakota. Although I could never speak for all my colleagues, I'm sure you will find concerns across the board.

Physician 4 (FM) Fargo

Home delivery w/ lay midwife should be outlawed.

Physician 5 (FM) Western ND

I have had a couple experiences I would like to share with you.

1) 44 yr old mother with pre-existing anemia, who refused to take iron supplementation. She had an obvious macrosomic infant. I saw her about 6 times during the pregnancy, because she was concerned that she was "high risk", but not concerned enough to deliver in a hospital. I advised her against home delivery because of the size of her baby and the risk of postpartum hemorrhage. She said her lay midwife had no concerns. She delivered at home and called to tell me about her postpartum hemorrhage, which the lay midwife controlled with TWO HOURS of uterine massage. She was feeling quite lightheaded when I spoke with her and she did go to a local clinic to have a hemoglobin, which was 4.0 (normal > 8 or9 postpartum). I believe her postpartum hemorrhage stopped because she went into shock and her blood pressure could not longer support uterine blood flow. She recovered after a 4 unit blood transfusion. She did not give the name of the midwife, but it is a woman who was working in NW North Dakota in the late '90s or early'00s.

2) 20 something year old woman who came in after attempting a home delivery with a lay midwife (whom she and her husband declined to name). They reported that they thought the baby wasn't doing well. It is unclear whether the midwife told them that there had been a cord accident. She presented to Hettinger, unannounced, stating that she thought her baby was dead. No fetal heart tones were auscultated and she was taken to emergent C-section for probable prolapsed cord and delivered a stillborn infant. Dr. _____ in our practice has more intimate knowledge of this case, but it prompted a sentinel event evaluation in our facility.

Physician 6 (Ped) Grand Forks

I am a pediatrician in Grand Forks. I have occasionally had patients who have been delivered by lay midwives in MN, but not so much here in ND. I have been working as a civilian in ND for the past 3 years and 4 months, so not a long stretch of time.

One of our family friends works is a lay midwife and works with members of the Amish and conservative Mennonite communities. For these plain people, she represents the only access to care for delivering babies.

The issue of safe deliveries by lay midwives has come up recently in the literature. I will forward a comment I sent to the author of a large study looking at this issue.

I think it would be useful if you would consider creating a real survey for physicians in ND - and NPs and PAs - to learn what the global experience is.

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I think it would be useful if you would consider creating a real survey for physicians in ND - and NPs and PAs - to learn what the global experience is.

I have no experience with adverse outcomes of infants/mothers delivered by lay midwives in ND.

Physician 7 (FM) (Central ND)
I have had an experience where a home birth was done and the mother sustained a complex vaginal laceration. The midwife did not have her even ice it, and then I had to try and repair this the following day. Another baby I took care of had some complications, I believe because they did not cut the umbilical cord for about an hour. He got pretty polycythemic and had trouble with jaundice. I have, however, had good experiences with the certified midwives in Minot who deliver in the hospital.

Physician 8 (Ped) Jamestown

See front page article in *Jamestown Sun* shortly after Christmas about a lay midwife doing a VBAC without physician backup, then didn't make it to delivery due to weather...unfortunately the *Sun* published it as a "warm fuzzy story" and forgot to mention anything about lay midwifery being unregulated, unmonitored, etc....

Also had a distressed baby born at Jamestown Hospital a couple of years ago after a lay midwife had a mom push for 2 hrs against a closed cervix, then drove her 45 min to Carrington hospital (which didn't do OB) , then by ambulance to Jamestown. Don't know how the child is now.

Physician 9 (OB-Gyn) Williston

I do know of a few cases that were quite concerning—one in particular was a mother who was a type I diabetic, started care with our practice, but switched to a lay midwife, because of course she was looking for a more natural birth plan. She continued her care with this woman (were sugars being monitored, baby being monitored, high risk pregnancy from our standpoint) delivered at home and baby presented to the ER two days after birth with I believe a fractured humerus. The lay midwife did not request records, did not work with any physicians, did not consult during labor/delivery. In addition, we recently had another patient who was a high risk pregnancy from our standards, who came to L&D with a lay midwife (at least she did get this patient to L&D) after receiving Prenatal care from this lay midwife. Can get specifics if you need them, both of these occurred in the past year.

Testimony – Senate Bill 2315

For the record, my name is Karen Macdonald. I am a registered nurse, and a family nurse practitioner. I am a member of the North Dakota Nurses Association (NDNA) and a lobbyist for that organization. I appear today on their behalf. NDNA opposes the passage of Senate Bill 2315 – yet, we agree in principle with the need to regulate based upon the need for public safety.

Our opposition is focused on these three areas:

1. Legislative Intent
2. Credibility of the Nursing Profession
3. Fiscal responsibility

First, historical background. NDNA was organized by a group of trained nurses in 1912 and was championed by Bertha Erdman, a Registered Nurse who had been recruited by UND to be the director of a nursing program to be established at UND. She came to ND from Minnesota where nurses had achieved licensure in 1907. The major concerns according to the historical documents were – there were over 36 training schools in ND, mostly in small hospitals, most did not have trained faculty or a course of study, the programs basically were an attempt to provide workers for the institution.. The students were not assured of graduation or jobs, the length of study was indeterminate, and in some institutions the students did not even have their own beds. When the student did complete the program, as a graduate, she could register with the local courthouse and thus be available to provide nursing care if needed in the home. The courageous group of nurses that formed NDNA did so in order to assure the public that indeed a trained nurse had in fact completed a proscribed course of study and would undergo an examination to verify her capability of practicing as a trained nurse. This group of women approached the ND Legislature in 1915 at a time when women did not have a vote, and convinced the Legislature that in order to protect the public a state board of nursing should be established and that training schools should be reviewed, and that graduates of approved nursing programs should be "registered" by the board of nursing, thus assuring the public that the registered nurse was appropriately trained and competent to provide care to the ND citizens. The ND Board of Nursing will celebrate its 100th anniversary in 2015 and continues this mission to protect the public through its' due diligence in approval of

nursing programs, licensing of qualified applicants, and discipline of those individuals. who do not practice safely.

As a student of history I give you this background for a very important reason. Organized nursing, through the American Nurses Association, and the North Dakota Nurses Association believes that the individual states have delegated the regulation of nursing to nursing boards as exemplified by Nursing's Social Policy Statement - which states that society has allowed nursing to self-regulate as long as it does so in the public's interest. The individual state legislatures do formulate the practice act and determine the parameters of nursing's scope of practice but the regulation is in the public's interest. Paraphrased further, nurses themselves sought regulation, to provide for safe practitioners, to protect the public from the incompetent practitioner or person who seeks to provide nursing care but is not licensed.

Contrast that with the premise of this bill – individuals referred to as direct-entry midwives did not bring forth this bill; in fact they are not interested in being licensed. The regulation is sought by other health care providers, most notably members of health care professions that object to the practice of the lay midwife. The recipients of this care have not petitioned the state for regulation of the direct entry midwife, and in fact seem to be seeking the services of these individuals because they are not regulated. What in fact is the legislative intent? If the Legislature feels these individuals should be regulated, is professional licensure the only vehicle or avenue you have open to you? The Department of Health in another bill heard on the house side, seeks to regulate unlicensed nursing assistants, why not fold the direct-entry midwife into that registry. If in fact the legislative intent is to know where these individuals are, that seems to be a very reasonable option. Another option might be a business license. This is provided so the state knows who is doing business. I have investigated this personally as if I ever do get to retire; I hope to open a home sewing business. This license is basically a registration with the Secretary of State.

In addition, the proposed language provides very proscriptive criteria for direct entry licensure of midwives that in fact is problematic and may in fact serve to prevent the state from identifying and regulating these individuals. Citing specific organizations that are voluntary in nature and incorporating their criteria into bill language would in fact seem to set up a conflict that most likely only can be decided by the courts - if a direct-entry midwife who did not meet these qualifications, could not be licensed and felt this was a restraint of trade. Or another direct entry midwifery group has different education, skills, and testing criteria. An example of this would be the American College of Nurse Midwives recognizes direct entry midwives, but the definition is much different then that contained in this bill – ie. Direct entry means the individual comes into the midwifery educational program with an education in another discipline but does achieve the graduate education program in midwifery.

In summary of the legislative intent, is it safe to say these individuals do not want to be regulated? That the recipients of their care do not seek to have the individuals regulated and in fact, are searching for something they feel is not provided within the current context of the present health care arena? What protection of the public is afforded when the individuals who were reviewed did not see the need for proscribed education or regulation? Will they continue to practice as the bill does not seem to be mandatory in nature?

The second premise of opposition by NDNA is the nursing credibility and resultant confusion to the public. Currently Certified Nurse Midwives are regulated by the Board of Nursing as one of four advanced practice registered nurses. They are highly educated and respected in the nursing community and provide a much sought after type of care of mothers and babes. Nursing itself is highly regarded by the public, recent Gallup Polls have shown that nursing is one of the highest esteemed professions by the public, there is generally a public feeling that nurses will not do harm, nurses can be trusted, nurses care for individuals, groups and families without regard to creed, race, nationality, sexual orientation, gender. The Board of Nursing is very cognizant of the need to protect the public and their disciplinary process and record is notably consistent with that social

policy statement I referred to earlier – the profession of nursing is allowed by the state to self-regulate because it does so in the public's interest.

If this bill becomes law – there will be both a "certified nurse midwife" and a "certified professional midwife". What – is the certified nurse midwife not a professional? Of course he/she is. Is the certified professional midwife a professional? Not by my standards – and simply calling one a professional does not make it so. One of my favorite sayings is – a person completing an ethics course is not an ethical person; a person carrying a diploma is not necessarily an educated person.

Do we think this will be confusing to the public? Of course it will. Or will the public say "We trust nurses and if they (in the form of board of nursing) license these individuals, it must be okay. "

The third premise regards the fiscal note. This will be a costly venture; those who serve on the advisory board must be reimbursed as provided by the state; the Board of Nursing I would hope be reimbursed for administrative services – do I want my licensure fee to increase to pay for this? And with just four or five individuals involved, would the advisory board ever become self-funded? Or would this be a biennial exercise requiring board staff to submit requests, appear before the appropriations committee; defend the need for continued funding. And if the state gets in a budget crunch and does not fund this for the next biennium, what has been achieved?

Prior to 1985, the Board of Nursing administered a nursing scholarship loan program funded through the state's general funds for aspiring nursing students. The program was enacted by the Legislature in the 60"s to support nursing students with a monetary award that could be repaid in work within the state after graduation. This program in 1985 was under scrutiny by the appropriations legislative committee, things were a little tough with the economy then, other programs were felt to be more deserving. The Board of Nursing determined at that time that this was a very worthwhile venture; some of you may remember there was a forecast of a dire nursing shortage that in fact did occur, so the

Board of Nursing determined that the program would continue but would be funded by licensure fees. Today my license as a registered nurse does include money that goes to the program and is awarded to aspiring nursing students, graduate nursing students, and returned nurses who seek assistance with refresher courses. I applaud that and wholeheartedly support that. Contrast that with provisions of this bill, providing a grant of $2500 to an individual to assist the individual with meeting the licensure requirements. Where do those funds come from? This current proposed appropriation? I suspect that there is the expectation that will also be administered by the Board of Nursing – a more costly process then you might see on the surface, and who would subsidize that? I sincerely believe that it is appropriate that my licensure fees assist the upcoming nursing generation, but I would not agree that my fees should assist someone to achieve licensure as a direct entry midwife.

In summary NDNA opposes Senate Bill 2315. Our opposition is focused on these three areas:

1. Legislative Intent: Does this legislation accomplish the need to supervise the direct entry midwife? NO

2. Credibility of the Nursing Profession: Should the direct entry midwives piggy back onto the nursing profession for public acceptance and value? NO

3. Fiscal responsibility: Does the legislation provide a neutral fiscal note? NO

I propose a series of amendments to SB 2315 as follows:

1. I'm not sure if you can hog house a bill before it goes to the other side. But if so, I would recommend that everything after A Bill be struck and legislative council asked to draft language to require those seeking to practice as direct entry or lay midwives be required to register as a business entity with the Secretary of State. A criminal penalty for failure to register could be added.

2. Failing that, I would recommend the following:

Section 1. Amendment be struck in its' entirety.

Section 2. Substitute language to enact a new chapter to title 23 regarding regulation of lay nurse midwives. That chapter would include

a. definition of a direct entry or lay midwife
b. definition of the department
c. definition of a registry of direct entry midwives

The chapter would further allow the department to promulgate rules for the establishment of the registry to enable the department to register an individual who holds him/her self out to assist in the care of the pregnant woman, assist in the delivery of the infant(s), and assist in the care of the infant(s) who is not licensed or regulated by any professional board under Chapter 43-12. Further language would allow the department to establish penalties for those who provide this care who are not registered. This could mirror language of the provisions for penalties for other entities such as restaurants, day care establishments, etc. who offer services to the public but do not follow the regulations set by the department.

Rationale for this approach: The Department of Health proposes in HB 1041 to establish a registry for nurse assistants. The numbers of these individuals could be in the thousands. Surely the Department could handle the numbers of direct entry midwives through a very small subset of that registry.

On behalf of the North Dakota Nurses Association, thank for the opportunity to provide testimony on this bill. I would be happy to respond to any questions or comments you might have.

AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime

POSITION STATEMENT

MIDWIFERY EDUCATION

The American College of Nurse-Midwives (ACNM) is the professional organization that sets national educational and practice standards for Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs). Standards for education and certification in midwifery* are identical for CNMs and CMs. The difference between the two credentials reflects the background of the individual prior to entering professional midwifery[1]. Both enter the profession with degrees in a variety fields and complete course work in the sciences and social sciences. Additionally, CNMs enter midwifery as Registered Nurses (RNs).

Entry-level competencies that must be mastered in all education programs are standardized in the ACNM document *Core Competencies for Basic Midwifery Practice*[2].
This document was developed by ACNM and is revised every 5 years. Curricular standards for programs have been set by the ACNM since 1962[3,4,5].

All midwifery education programs are located in or affiliated with an institution of higher learning that is accredited by an agency recognized by the US Department of Education[6]. Beginning in 2010, a graduate degree will be required for entry into midwifery practice[7]. All education programs accredited by the Accreditation Commission for Midwifery Education (ACME), (formerly the ACNM Division of Accreditation) either grant a master's degree or higher or are affiliated with a school that offers a master's completion option.

The Accreditation Commission for Midwifery Education (ACME) is an autonomous accrediting agency, and has been recognized continuously by the US Department of Education since 1982. It accredits both midwifery education programs and institutions. Standardized criteria developed by ACME[6] are used to assess the quality and content of midwifery education. A complete list of currently accredited programs and institutions can be found at http://www.midwife.org/map.cfm.

The American Midwifery Certification Board (AMCB) is an autonomous certifying organization accredited by the National Commission for Certifying Agencies (NCCA). The functions of the AMCB include initial certification of CNMs/CMs for entry to clinical practice, recertification and discipline. Candidates must have graduated from a DOA accredited program in order to be eligible to sit for the national certification exam administered by the AMCB. Individuals who successfully complete AMCB certification requirements are granted a certificate as a certified nurse-midwife (CNM) or certified midwife (CM).[8]

[1] *The Knowledge, Skills And Behaviors Prerequisite To Midwifery Coursework (Nov. 2005)* http://midwife.org/careers.cfm?id=904

[2]*Core Competencies for Basic Midwifery Practice (May 31, 2002)*
http://www.midwife.org/display.cfm?id=484

[3]Avery, M. D. The history and evolution of the Core Competencies for basic midwifery practice. J Midwifery Women's Health 2005 Mar-Apr; 50(2):102-107.

[4]Education Committee, ACNM. Core competencies in nurse-midwifery: expected outcomes of nurse-midwifery education. Journal of Nurse-Midwifery 1979; 24(1):32-36.

[5]Roberts, Joyce and Sedler, Kay D. The Core Competencies for Basic Midwifery Practice: critical ACNM document revised. Journal of Nurse-Midwifery 1997; 42(5):371-372.

[6]*Criteria for Programmatic Accreditation of Education Programs in Nurse-Midwifery and Midwifery with Guidelines for Elaboration and Documentation of Programmatic Accreditation Criteria* (October 2003)
http://www.midwife.org/siteFiles/career/Criteria_for_Programmatic_Accreditation.pdf

[7]*Mandatory Degree Requirements for Entry into Midwifery Practice Position Statement* (March 2006)
http://www.midwife.org/siteFiles/position/Mandatory_Degree_Requirements_3.06.pdf

[8]AMCB website
www.amcbmidwife.org

* Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC).

Replaces: Nursing as a Base of Midwifery Education (1990); Midwifery and the Title Midwife (1991); Nurse-Midwifery Education (1992).
Source: ACNM Board of Directors
Approved: June 1996
Revised: August 1997, December 2005, December 2006, July 2009

#5

Testimony to Senate Human Services Committee regarding SB 2315

February 1, 2011

Levi Erdmann
1942 N 7th ST
Bismarck, ND 58501
(701) 214-0569

Senator Lee and members of the committee:

My name is Levi Erdmann. I live in Bismarck, and I am before you today to testify against Senate Bill 2315.

My wife Michelle and I have had two children at home, utilizing the services of a direct entry midwife (Paulette Efimenko) for both of them. Though initially my wife was the one desiring a home birth, I found the experience to be safe and very personally rewarding, and I strongly believe that the option should be preserved for citizens of North Dakota. I very much disagree, however, that this bill will preserve the "right of women and families to home delivery of infants" or the practice of midwifery in North Dakota. The introduction of fines and criminal penalties, as well as restrictive and costly certification requirements will do more to damage midwifery than to preserve it, as this bill cunningly states.

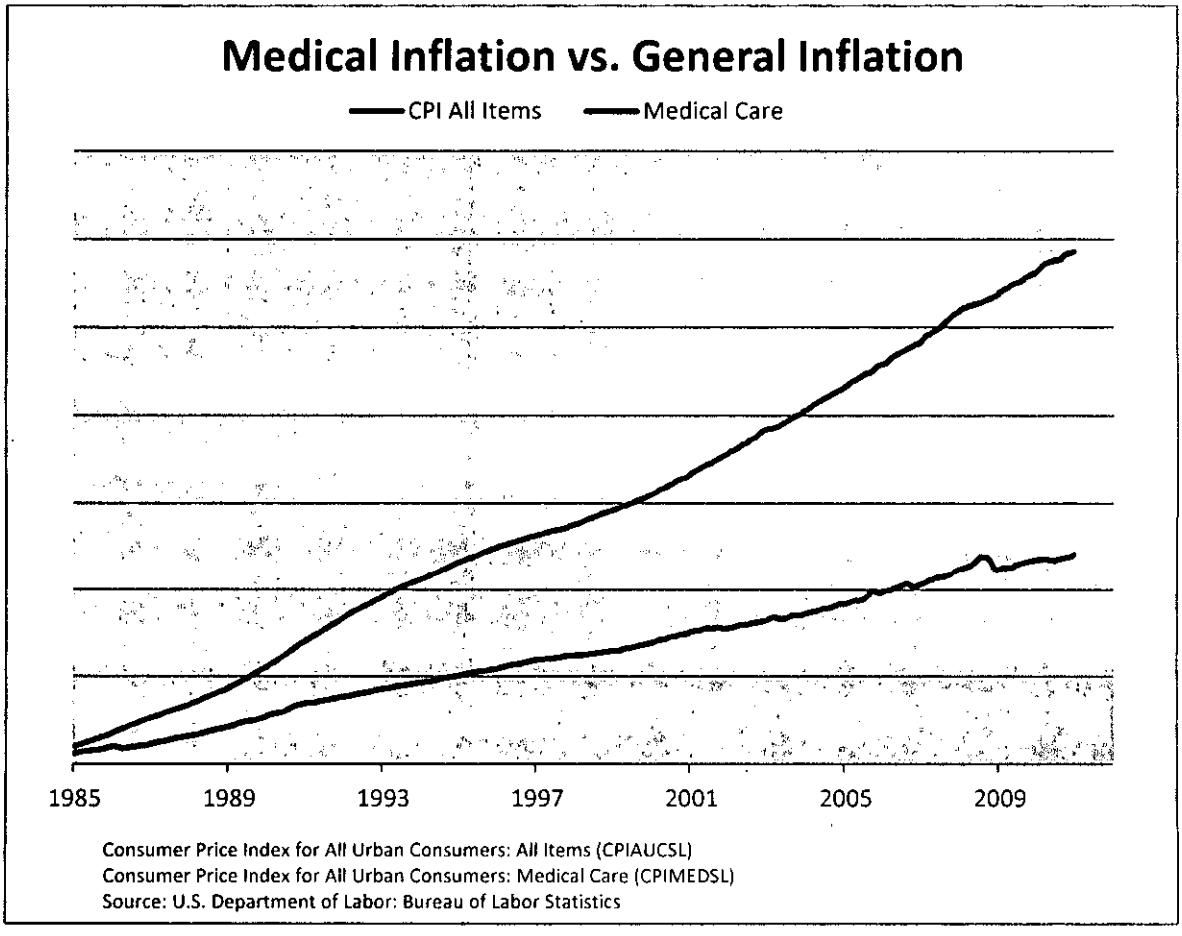
From an economic perspective, this bill raises steep barriers to entry and does more to help the medical establishment than any supposed benefit it may provide to consumers. Though the primary argument in support of licensure requirements such as this is to assure consumers that practitioners are qualified experts in their field, this can be accomplished without persecuting what little competition the medical industry encounters in matters of childbirth. If a midwife has been certified by the nursing board, then he or she can use that as a selling point without having the state label other practitioners as criminals.

Though removal of the criminal penalties and fines would be an improvement of this bill, I must state that I don't believe a trade certification deserves government subsidy. The medical industry is capable of setting their own certification standards without taking $58,916 of the taxpayer rolls. The North American Registry of Midwifes already certifies midwives, as you know since this bill mandates the certification. Pursuit of this certification is already an option for anyone desiring their Certified Professional Midwife (CPM) endorsement.

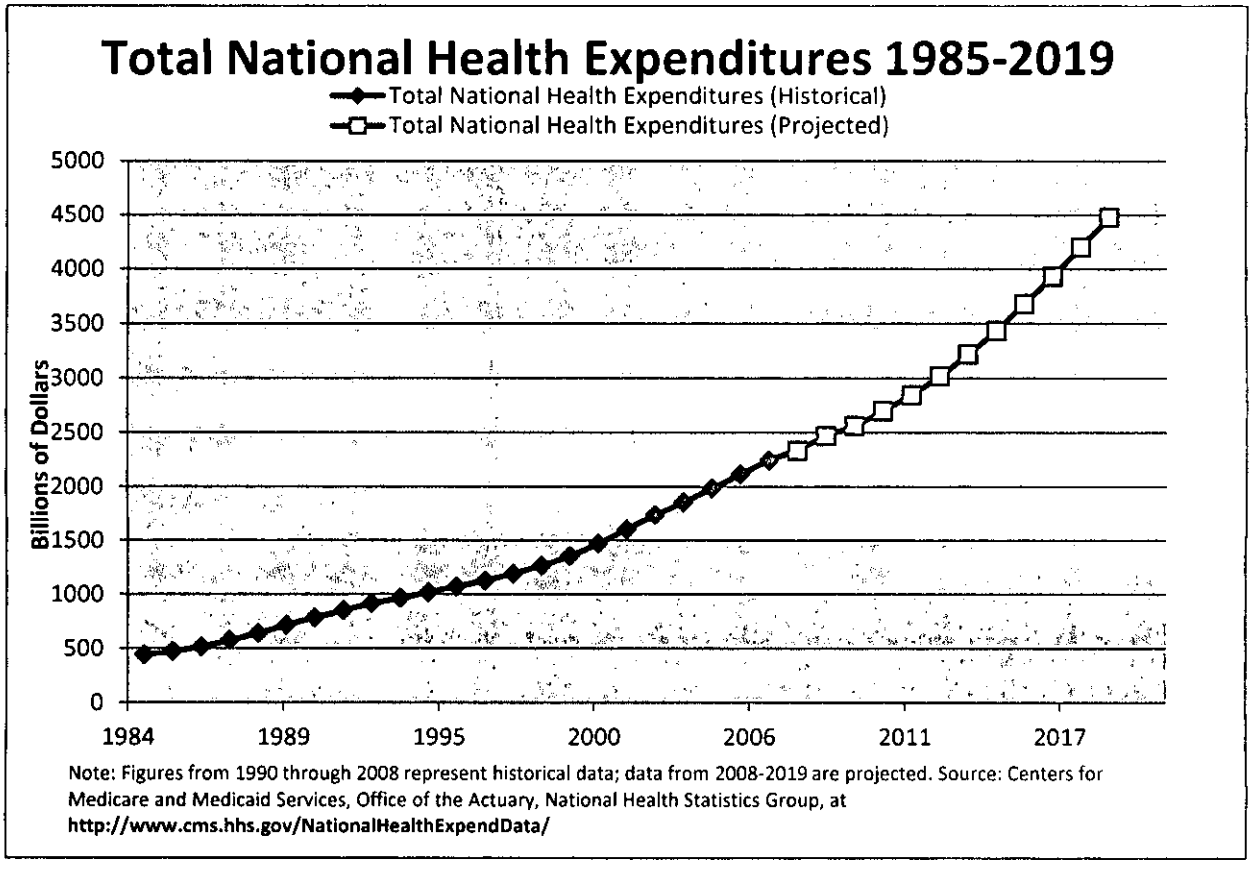
Of note, in a rural state like ND, the requirements to become a Certified Professional Midwife (CPM) are difficult to satisfy. To my knowledge there are no programs accredited by the "Midwifery Education Accreditation Council" in ND. In addition, the experience requirements are difficult to fulfill in such a large, sparsely populated state. I have been told anecdotally that many people need to travel overseas to places like Africa to fulfill the experience necessary for these certifications.

The cost of medical care in this country has become a serious issue, as evidenced by a controversial national health care debate. Seldom do you ever hear discussion of lightening the licensing requirements that maintain the stranglehold on supply that shelters this industry from meaning forces of supply and demand. Passage of this bill will add to the problem.

Home birth has been free of government control in North Dakota since 1889. Nothing has changed that now requires we regulate the practice. Senator Lee and members of the committee, thank you for your consideration.



Consumer Price Index for All Urban Consumers: All Items (CPIAUCSL)
Consumer Price Index for All Urban Consumers: Medical Care (CPIMEDSL)
Source: U.S. Department of Labor: Bureau of Labor Statistics



Note: Figures from 1990 through 2008 represent historical data; data from 2008-2019 are projected. Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at **http://www.cms.hhs.gov/NationalHealthExpendData/**

#10

Madam Chairman, Members of the Committee,

Thank you for the privilege of appearing before you. I would like to state that the licensing requirements as put forth in SB 2315 are overly restrictive and remove from the prospective parents their right to deliver their baby in the place and with the health provider that they choose. Licensure doesn't guarantee quality of care or competency of the health care provider. As individuals, the right to make these decisions and the results and consequences of those decisions belong to them alone and is one of our guaranteed freedoms.

One could take this bill and detail problems with each requirement but in the interest of time there are only a couple of points I would like to specifically address. First, having the state board of nurses oversee the licensure, governing and regulation of midwifery is a conflict of interest because how can they regulate something they have no experience in? Having my BS degree in nursing I know that they are not trained in midwifery. Second, under the regulation of the practice of midwifery this board is given the right to add any requirements they want to this licensure. There are no definitions and no limitations upon them. That is too much power in a governing body.

This bill, as written, adds onerous requirements and unduly regulates a profession that has an excellent history in this state. Its end result and aim doesn't appear to provide better service for families or make birth safer but to eliminate midwifery and home birth altogether.

Thank you

Janice Karges

Janice Karges
4630 15th St SW
Stanton, ND 58571
701-748-2976.

Vote No to SB 2315

From the Office of the

Jonathan Bartlett Family

1854 107th St NE, Bottineau, ND 58318

bartlett@srt.com **701-263-4574**

February 1, 2011

Dear Senators of the Human Services Committee,

Senate Bill 2315 is very important to me. As a 19-year-old young man with the vision of some day leading a wife and family, I am concerned about how this legislation will prevent us from securing the assistance of an unlicensed lay midwife for the delivery of my future children. The bill states that it is designed to *"preserve the right of women and families to home delivery of infants,"* but this right to home delivery already exists in its entirety; it will be severely restricted and nearly abrogated by the provisions contained therein.

Many, many families I know have had all their children safely delivered at home by unlicensed midwives. To me, it is such a blessing to have the option of avoiding hospitals and their attendant financial burdens, unhealthy pharmaceutical drugs, unfriendly environment, and scripturally unsound practices. To implement the new policy will require lay midwives and parents to be grafted into the very medical establishment they have sought to avoid by home birthing. Every mother I know who has had a child born at home under the care of such a midwife will readily testify to the benefits of such an experience, and it will be a sad day if such an option is ever denied the people of North Dakota. SB 2315 sets the stage for this result.

My objection to this bill rests fundamentally on the fact that as a future father, I have the God-given responsibility to lead, provide for, and protect my family. Interference with the exercise of these rights through the forced imposition of licensed midwives strikes a wedge between my duty to God and my lawful ability to exercise that duty in what my wife and I deem the best option for our children.

Although I strongly object to every portion of this bill, these two particulars are most grievous to me:

1. Midwives will be required to undergo a process of licensure supervised by the conventional medical establishment in order to continue their practice. The definition of a midwife in SB 2315 is written as *"providing primary maternity care outside a hospital or clinical setting which is consistent with the midwife's training, education, and experience to women and their newborn children throughout the childbearing cycle, and includes identifying and referring women or their newborn children who require health care to a qualified health care professional."* As mentioned above, there are many families who choose to avoid the medical establishment and use alternative natural health practices instead. This bill classifies the use or recommendation of such treatments as a Class A Misdemeanor when done by an unlicensed practitioner even in the earliest stages of pregnancy, though this person may have already proved to the satisfaction of my wife and I that she is competent, experienced, and knowledgeable in the exercise of midwifery. State licensing cannot compete with the quality achieved when a husband and wife embark upon a diligent, caring, and informed decision making process. Whether the decision is made in favor of either conventional or home birthing, the initials L.M. after someone's name are ultimately meaningless. The responsibility and liability lies solely on the shoulders of the parents to discern the options from all angles and decide

accordingly. To me, the licensing of a midwife would suggest she adheres to the modern unnatural medical practices which I attempt to avoid.

2. The new midwifery advisory board is given autonomous authority to *"impose any additional reasonable and necessary requirements for licensure to practice midwifery."* This is nothing less than government without representation. The advisory board can make literally any regulation they deem "reasonable and necessary" without the approval of any elected official and without the consent of the people.

I firmly believe home birthing under the supervision of an experienced unlicensed lay midwife is the best option for my family. Lord willing, my future wife and I will one day stand side by side with our children and thankfully acknowledge the blessing of God in the preservation of the right for unlicensed, experienced, knowledgeable, and capable midwifes to continue their loving assistance of home birthing families in North Dakota as a result of this committee hearing. Please vote "No" to SB 2315.

Sincerely,

Jonathan Bartlett

Jonathan J. Bartlett

To Senate Human Services Committee Members:

My name is Summer Joy Peterson. I am a constituent of District 31 in southern Grant County, North Dakota. I am writing to urge you to put a recommendation of Do Not Pass on SB 2315. I would have attended the hearing in person, but due to the weather conditions, and the home birth of my third child six days ago, I am unable to do so.

First of all, let me say that protecting the right of ND families to home birth is very important to me for many reasons. I have had three births, the last two of which occurred in my home. I have a background in traditional medicine, and have therefore personally experienced the breakdown of our medical system. Not only as an employee, but also as a patient in a traditional medical model, I have been subjected to breach of patient/provider confidentiality, lab test mix-ups, and hospital infection. Therefore, I feel I was rightly justified in seeking an alternative for the birth of my children. What I learned was a way of giving birth that avoiding several of the aforementioned challenges of traditional hospital maternity care. What I gained was a life changing experience!

I would like to quickly highlight my objections to SB 2315. My first issue with this bill is that by regulating midwifery through the board of nursing, midwives would be subject to a set of standards that is directly contrary to the art and theory of midwifery to begin with! It seems to me that using board members holding degrees of RN, PN, and CNM, would be a kin to asking the M & M Mars Company to police a nutrition program for children!! Midwives, if policed at all, should be policed by their own!

Secondly, this bill is highlighted as regulating direct entry or lay midwifery service, and yet, as stated specifically in the bill, the means of "regulation" is to require these women to certification through a minimum of CPM, or "certified professional midwife".. Certification automatically defeats the purpose of the term "lay" midwifery!

My third major issue with this bill is with the advisory board for midwifery. Once again, why is a physician sitting on this board? The way midwives and physicians provide maternity care is polar opposite! Not only that, but this advisory board has the authority to make changes to the requirements in the future of midwives that apply for licensure through the board. These "ambiguous" powers leave a whole host of regulations that can be applied at any given moment!

Finally, both during the process of application and during the course of practice, this bill requires that midwives submit sensitive information regarding their clients to the advisory board. Has it ever occurred to anyone that those clients may object to their information being shared with such a board?

My husband and I live in the very southwestern part of North Dakota. Our access to qualified health care is very scarce. In fact, the closest hospital we have in our vicinity is over an hour away! The medical profession has a way of dealing with women like me. It is called induction, scheduled cesarean section, and convenient birthing plans. My husband and I also have a way of dealing with women like me. It is by having a support

team who have stayed in my home, helping me prepare physically, emotionally, mentally, helping me labor and deliver, rejoicing and praying with me. I have avoided infection, episiotomy, tearing, pharmaceuticals, and pain because of the team of dedicated women who came to assist me in the most rewarding work of my life!

My husband and I work hard for a modest living. We can't afford health insurance because of the astronomical cost for self-employed individuals. Women whose ministry is to support during birth not only save those of us who use their services thousands of dollars, they give of their time and money freely as a gift to those they serve.

My husband and I have friends in surrounding states such as South Dakota whose states have passed similar legislation. These bills have done nothing to help the lay midwives or the home birthing families. In South Dakota, for example, there is only ONE midwife who is able to practice, a CNM, who will NOT travel more than 50 miles for a birth. For families who are outside of her 50 mile radius, they can travel to a hospital, to her, or go into the birth without any assistance. Most chose to birth at home without any assistance, or have family members in attendance that must lie about their involvement in the birth.

This bill does NOT consider the desires of home birth families. It does NOT consider the North Dakota home birth families and constituents who live in the unpopulated areas of North Dakota. It does NOT consider the financial implications for midwives and home birth families due to increasing costs of things like liability insurance coverage, licensure fees, accreditation, and continuing education. It does NOT protect against the unwanted regulation of the traditional medical establishment in the art of midwifery. In short, what this bill does do is limit the service of lay midwifery for families like mine. These hard working, intelligent families seek to raise their children in a state where unwanted government regulation and intervention have been reigned in and abolished. Home birth is NOT a thriving business. Maybe 50 North Dakota families birth at home per year. (Frankly, that is probably grossly over estimated!) This type of legislation is not needed for such a small group of people!

This bill is full of so many short comings that it can not be salvaged with amendments. You must recommend Do Not Pass on this bill to preserve the freedoms of rural North Dakota families! Thank you for your time.

Sincerely,

Summer Joy Peterson

2-1-11 afternoon #7

Mr. (Or Madam) Chairman, and members of the committee, my name is Andrea Toman from Bismarck, ND. I'm a member of North Dakota Birth Action and am here to provisionally speak on behalf of the proposed Senate bill 2315. While having a bill legalizing and regulating midwifery is acceptable, there are a few changes that we would like to see implemented. These changes have been submitted to Senator Matherns office for workup as amendments, so it's possible you have copies of these amendments already, but I'd like to go over the ones most important to our group.

First, I'd like to state our objection to a separate regulatory and advisory committee, specifically a regulatory committee formed of the Board of Nursing. We could find evidence of no other board that has two separate committees, and no other board that has members of another profession regulating them. The Nursing Board is made up entirely of individuals whose practice guidelines prevent them from providing similar services, which would place midwives under a regulating committee that have no, or practice limited, experience in their field. The appointment of a Certified Nurse Midwife to the board would provide a clear conflict of interest. Midwives would be regulated by a person with professional interests that are in clear competition with their own. Moreover, there are a very limited number of CNM's in the state of North Dakota (less than 10) and more than one has vocally and in a public format declared a profound disapproval of home birth and out of hospital practitioners in particular.

What we propose is the striking of the language that refers to a Board of Nursing regulatory committee and that the language referring to an advisory board be changed to support the formation of a midwifery regulatory board formed of members of the profession, a public member, and a physician. We understand that at this time such a board would not be able to compensate it's members for time and effort , but would suggest waiving such payments for an agreed upon time until the board is able to support itself from member fees, as do the other North Dakota boards.

Second, we ask for clarification of the wording of line 16 on pg 2. It seems to be stating that the state will undergo an approval process for apprenticeships which have led the applicant to receive their Certified Professional Midwife certification. We feel this would place an undue financial and time burden upon the state and therefore propose the wording be clarified as saying the state will accept apprenticeships that have been approved by the North American Registry of Midwives, the governing council that grants the Certified Professional Midwife certification.

We ask that line 3 page 7 have it's wording changed to strike the words "as permitted by the board" to the word "those". Such as, A Licensed Midwife may not prescribe, dispense, or administer prescription drugs except those specific to the maternity care, labor, delivery, and post partum for the care of the mother and newborn infant. The bill requires that midwives by certified in pharmacology and suturing- this word change will have the effect of allowing midwives to use the pharmacology training they are being required to have. We are not asking for prescription authority, but we are asking for the right to carry antihemorrhagic drugs, local anesthetic, vitamin k, and eye drops.

Lastly, we ask that an addition be made to line 19 on page 7. The line states that a midwife may not perform any operative or surgical procedures except for suture repair, etc. We would like to add the cutting of an umbilical cord and/or the cutting of an emergency episiotomy to those surgical procedures. We realize this falls under the typical scope of practice for a midwife, but since many states count these are surgical procedures we want to make sure that they are mentioned in regulation as permissible to prevent confusion.

Some families have expressed concern that if a family member or friend is present at the birth of their child and they assist in that birth with no healthcare present, for whatever reason, that those family members and or friends could be prosecuted for practicing midwifery without a license. In response, we would suggest adopting something similar to Minnesota's Freedom of Healthcare Act.

These are the main changes that we would like addressed, again please see the amendments that have been worked up for a full accounting.

Thank you for your time.,

Andrea Toman

#8

February 2, 2011

Senate Bill 2315

Dr. Jan Bury , Mid Dakota Clinic Center for Women

Our position with regard to home deliveries has to do with concerns for maternal and fetal safety. At the present time, there are untrained individuals holding themselves out to be "professionals' that are, in effect, practicing medicine without a license. Our goal is not to eliminate home births, but to ensure that when patients choose home birth, they realize the limitations of same, and that they will be in the hands of licensed individuals. This bill will ensure that there will be proper education, licensing, and oversight of those individuals who perform home deliveries. It also creates opportunity and financial support for those who are presently unlicensed to obtain the proper education and credentials so that we create safer environments for those who choose to deliver at home.

In the United States, only one-third of homebirths are attended by nurse midwives, which implies the other two-thirds are attended by unlicensed individuals. A large study of home births was recently reported in the Contemporary Ob/Gyn Journal (January 2011) . This included over 37,000 home births, of which 82 had stillborns, and 210 had NICU admissions, including 17 of which died.

Statistically speaking, infants who were born under the care of midwives to women at low risk are at more than 2 times the risk for delivery related perinatal death, and at the same risk for admission to the NICU as infants of high risk women born under the supervision of obstetricians.

Those patients who were referred to an Obstetrician by a midwife during labor were at a 4X higher risk for perinatal death than those who labored with an obstetrician.

We support Senate Bill 2315, and feel strongly that women and babies deserve to not be placed at risk by untrained individuals who have no license or education to equip them for this most important journey. We support the education and licensure of these individals, and also support the use of grant monies to aid them in accomplishing this goal. As with physicians, we believe in the oversight of a board, and the use of penalties for failure to comply with set regulations.

I would be happy to answer any questions or have further dialogue. jbury@primecare.org or 530-6088. Thank you.

from 2-2-11 afternoon session

Bartz, Darleen R.

[redacted]n: Bartz, Darleen R.
[redacted]t: Tuesday, February 08, 2011 8:57 AM
To: Lee, Judy E.; 'Buzz Benson'
Subject: FW: Senate Bill - Testimony on Lay Midwife

Senator Lee:

The following are the examples that Dr. Bury used in her testimony.

Darleen

-----Original Message-----
From: Bury, Jan [mailto:JBury@primecare.org]
Sent: Monday, February 07, 2011 6:18 PM
To: Bartz, Darleen R.
Subject: RE: Senate Bill - Testimony on Lay Midwife

Hi Darleen,

Here are my examples. I have asked all my partners to email my any they have and I will forward them on to you tomorrow.

1. Patient brought to ER with midwife after pushing at home with prolapsed cord. Baby dead on [redacted]ival 8 pound normal male infant.

[redacted].Husband brought patient in after pushing at home for 6 hours - midwife told them all was well and the heartbeat was strong. There was no heartbeat on arrival - normal 7 pound girl born dead, and had clearly been dead for several hours.

3. Midwife brought patient to hospital after pushing for 2 hours at home. Thick meconium was noted, and patient was only 8 cm dilated on arrival. Pts. Labor was stimulated, and she ended up having a vaginal delivery and a live baby, but baby had meconium aspiration and a prolonged NICU stay.

4. Midwife had patient pushing more than 6 hrs at home and brought in. Baby was breech upon arrival and delivered vaginally - livebirth but very depressed at birth and required NICU care.

5. Teen age mom laboring at home with midwife - had eclamptic seizure at home and was brought in. BP 170/120 - decelerations of fetal heart rate. C Section done for delivery of live baby, required NICU care.

6. Delivered at home after pushing all day. Extensive laceration 8 inches up into the rectum, as well as significant hemorrhage. Required transfusion and to the OR for repair

7. Patient presented to clinic. Delivered 25 years ago by lay midwife at home. Had expensive laceration at the time that was never repaired. She now has a "cloaca" - essentially one [redacted]mmon opening for stool, urine and vagina. She is totally incontinent of stool and urine, [redacted]will likely never by repairable.

[redacted]. Home underwater birth. Midwife called 911 for extensive bleeding and patient taken to hospital for repair of extensive laceration.

9. Pushed 4-10 hours at home (times differ according to patient and midwife). Patient had had prior C section, so was attempting VBAC at home. Thick meconium was present. Patient delivered by C section after arrival, live baby, but prolonged NICU stay secondary to meconium.

10. Delivered at home after hours of pushing. Babe was alive but severely hypoxic, was brought by ambulance to the hospital in cardio-pulmonary arrest. Baby was resuscitated, but had flat EEG and was severely neurologically impaired. Baby died at several months of ago secondary to complications - was never normal.

11.Patient brought to hospital by midwife after failed home birth - pushing for hours, thick meconium. Patient only 8 cm, high pressure. Delivered by C-Section, live male, NICU stay for meconium aspiration.

12. Patient delivered at home by midwife one week prior. Patient brought in toxic with high fevers (105-106) required IV antibiotic therapy.

#9

From: Muhlhauser, Tara L.
Sent: Sunday, February 06, 2011 4:05 PM
To: Lee, Judy E.
Cc: Baker, Marlys A.
Subject: RE: Questions that came up in the midwife discussion

Senator Lee,

Here is some information prepared by Marlys that I think will be helpful to you in your committee work. Let me know if you would like us to stop down for discussion this week.

Tara

Information pertaining to SENATE BILL NO. 2315

- Under the provisions of the child abuse and neglect law (NDCC 50-25.1), in order for a county social service agency to begin an assessment for child abuse and neglect, the person must meet the definition of "A person responsible for the child's welfare".

- "A person responsible for the child's welfare" includes parents, adult family members, a member of the child's household, guardian of the child, foster parent, or any person providing care in a public or private school or child care setting.

- A midwife would not likely fit this definition unless there was a relationship to the child as listed above.

- A report of suspected child neglect concerning negative effects to a child's health from a home birth may be assessed by a county social service agency to determine whether a parent, as a "person responsible for the child's welfare", failed to provide proper care to the child immediately following the birth.

- Reports of suspected child abuse concerning a midwife would most likely come under NDCC 50-25.1-05.3; "Disposition of reports implicating a person not responsible for the child's health or welfare". This section directs such reports to be referred to an appropriate law enforcement agency for investigation and disposition.

#10

BLESSED EVENT
MIDWIFERY

Beth Bergeron, CPM, LM
218-256-0412, Fax 800-678-8401

February 7, 2011

Dear Senators,

I am writing in support of Senate Bill No. 2315, the amended version presented by ND Birth Action.

In my opinion, the most critical piece of the amended version is department oversight. We have provided documentation that no other state in the USA regulates midwifery through their Nursing Board. I think the Department of Health is a much better fit, or alternatively, an independent midwifery board.

I feel this amended bill best supports the Certified Professional Midwife and upholds the processes in place for licensure, peer review, and continuing education. I feel it would be an unnecessary expense to the state to require a board to duplicate the processes that already exist within the North American Registry of Midwives (NARM) and the CPM licensure process.

The tradition of midwifery is long, reaching to the very beginning of human existence. By supporting this bill you are recognizing the CPM license which blends the traditions of midwifery with current standards of safe, evidence based care.

Sincerely,

Beth Bergeron, CPM, LM
Certified Professional Midwife, Licensed Midwife

810 4th Ave S, Suite 266, Moorhead, MN 56560 beth@blessedeventmidwifery.com

Important Facts Addressing Concerns about Licensing Midwives

FETY:

- **The largest study of home births attended by Certified Professional Midwives has found that home birth is safe for low risk women and involves far fewer interventions, such as cesarean sections and inductions, than similar births in hospitals.** "Outcomes of planned home births with certified professional midwives: large prospective study in North America." Kenneth C Johnson and Betty-Anne Daviss. BMJ 2005;330:1416 (18 June).

- **"Recognizing the evidence that births to healthy mothers, who are not considered at medical risk after comprehensive screening by trained professionals, can occur safely in various settings, including out-of-hospital birth centers and homes. ...Therefore, APHA supports efforts to increase access to out-of-hospital maternity care services..."** American Public Health Association, "Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives (Policy Statement)". *American Journal of Public Health*, Vol 92, No. 3, March 2002.

- **The low CPM rates of intervention are benchmarks for what the majority of childbearing women and babies who are in good health might achieve.** The Milbank Memorial Fund, a nonpartisan institute devoted to health policy analysis, issued a new report titled "Evidence-Based Maternity Care: What It Is and What It Can Achieve." October, 2008

ECONOMIC BENEFITS:

- **An economic analysis of the cost benefits of a licensed midwife program indicate that "The cost savings to the health care system (public and private) is estimated to be ten times the cost of the program."** Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits, (A report to the Washington Department of Health), Health Management Associates, October, 2007

EDUCATION:

- **The education of the CPM follows an extensive curriculum based on the NARM Job Analysis. Instructors are the preceptors and the education may occur in a classroom, private, or clinical setting. Instructors must verify that the student has mastered all knowledge and skills, and has demonstrated competency in the clinical setting, before proceeding through the testing process. Students then must pass a hands-on Skills Assessment and an 8-hour Written Examination. The process used to create this credential has been evaluated and accredited by the National Commission for Certifying Agencies. The excellent outcomes documented in the CPM 2000 study were a result of over 5,000 births attended by CPMs, most of which were attended by midwives who received the CPM credential through the NARM Portfolio Evaluation Process.**

The Clinical Component of the Educational Process for Certified Professional Midwives

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

- The student must provide prenatal, intrapartal, and postpartal care as well as newborn assessment, equivalent to a minimum of 1,350 clinical contact hours under the direct supervision of one or more instructors approved by the North American Registry of Midwives.

- The student must receive an assessment of skilled proficiency as an assistant midwife in order to assume responsibility as primary midwife. Supervised training includes, at a minimum, 40 births:

    - 75 prenatal exams as primary midwife
    - 20 births as an assistant midwife
    - 20 births as primary midwife from the onset of labor to the delivery of the placenta and the stabilization of mother and newborn
    - 20 newborn exams as primary midwife
    - 40 postpartum exams as primary midwife

- The student must provide all aspects of care as a primary midwife while under the physical, on-site supervision of the instructor.

- The instructor must verify that the student has demonstrated skilled proficiency in providing care to clients in out-of-hospital clinical settings.

- The student must be trained in adult CPR and Neonatal Resuscitation

- The student must pass written and practical skills national board exams for the practice of midwifery developed and implemented following the standards set by the National Commission for Certifying Agencies and administered by the North American Registry of Midwives.

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

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

Pharmacology:

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

Appropriate use and care of equipment, including:

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

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

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

Daily and weekly assessment of mother and newborn, including:

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

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

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

New Mexico

[redacted] E 16 OCCUPATIONAL PROFESSIONAL LICENSING

.IAPTER 11 MIDWIVES

PART 3 LICENSED MIDWIVES

1 ISSUING AGENCY: New Mexico Department of Health
Public Health Division
Maternal Health Program 110-31-961

New York **Midwifery Law**

The specific requirements for licensure are contained in Title 8, Article 140, Section 6955 of New York's Education Law and Subpart 79-5 of the Commissioner's Regulations. Office of the Professions, Division of Professional Licensing Services.

Oregon

Chapter 687 — Massage Therapists; Direct Entry Midwives

(2) Any person who desires to become licensed as a direct entry midwife shall submit an application to the Health Licensing Office stating the applicant's qualifications for licensure.

Rhode Island **Midwifery Law**

TITLE 23

HEALTH AND SAFETY

[redacted] PTER 23-13

TION 23-13-9 & sect; 23-13-9 Licensing and regulation of midwives --Penalty for violations. - The state director of health is hereby authorized and directed to .ake rules for the regulation of the practice of midwifery and for the licensing of midwives.

South Carolina Code:

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

CHAPTER 61

Statutory Authority. Sections 40-33-50, 44-1-140, 44-7-110,

44-89-10, et seq., of the Code of Laws of South Carolina, 1976, as amended.

REGULATION 61-24. LICENSED MIDWIVES

Tennessee Code: **TITLE 63 PROFESSIONS OF THE HEALING ARTS :**
CHAPTER 29 MIDWIFERY

(2) "Board" means the board of osteopathic examiners of the department of health to which the council of certified professional midwifery reports;

Texas

This chapter may be cited as the Texas Midwifery Act.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

[redacted] 1) "Board" means the Texas Board of Health.

2) (3) "Commissioner" means the commissioner of public health.
3) (4) "Department" means the Texas Department of Health.

Compilation of regulatory agencies of states that license midwives

Summary: This information was compiled by Beth Bergeron, CPM, LM on 2/5/11 and taken from www.mana.org or directly from individual state government websites.

Department of Health: 12 states: AZ, AR, DE, FL, LA, NH, NM, RI, SC, TN, TX & WA
Board of Medical Practice: CA, MN, NJ, VA
Other: Division of Registrations: Colorado; Bureau of Occupational Licenses: Idaho; Alternative Health Care Board: Montana; Office of the Professions: New York; Health Licensing Office: Oregon; Division of Occupational & Professional Licensing: Utah; Office of Professional Regulation: Vermont; Board of Midwifery: Wyoming; Department of Regulation & Licensing: Wisconsin; Board of Certified Direct-Entry Midwives: Alaska

In 14 states midwifery is not legally regulated but not prohibited or legal by Judicial interpretation or statutory inference
In 1 state it is legal but licensure or certification is unavailable.
In 10 states the practice of midwifery is prohibited by statute, judicial interpretation or stricture of practice.
(the above info re: all 50 states & DC)

Alaska
Title 08. BUSINESS AND PROFESSIONS
Chapter 08.65. DIRECT-ENTRY MIDWIVES

Sec. 08.65.010. Board established.

(a) There is established the Board of Certified Direct-Entry Midwives

Arizona

Article 7 - Licensing and Regulation of Midwifery

[redacted]partment" means the department of health services.

Arkansas

Act 481 1987

"AN ACT TO AUTHORIZE THE STATE BOARD OF HEALTH TO LICENSE LAY MIDWIVES STATEWIDE; AND FOR OTHER PURPOSES." BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

California

(a) "Board" means the Division of Licensing of the Medical Board of California.

COLORADO Midwives

Statute 12-37-103. Requirement for registration with the division of registrations - annual fee - grounds for revocation. (1) Every direct-entry midwife shall register with the division of registrations by providing an application to the director in the form the director shall require. Said application shall include the information specified in section 12-37-104.

Delaware

Click here for the regulations on the DE web.

STATE OF DELAWARE RULES AND REGULATIONS PERTAINING TO THE PRACTICE OF NON-NURSE MIDWIFERY

These regulations replace regulations previously adopted on April 17, 1978; amended September 19, 1978, December 22, 1982, and May 15, 1985, by the Delaware [redacted]Board of Health. Effective Date: April 10, 2002.

States that license Certified Professional Midwives

Program Began	State *Medicaid	Licensed Midwives	Agency	Annual Fees	Annual Cost of Program
2009	ID	Licensure not yet available 24 CPMs	Board of Midwifery under Board of Occupational Licenses		$27,000
2006	WI	38	Dept. of Regulation & Licensing	$54	$23,788
2005	VA	33	Board of Medicine	$156	
2005	UT	17	Dept. of Professional Licensure	$45	$6,200
2003	TN	31	Dept of Health	$500	$7,179 (revenue $6,165)
2002	NJ	6	Board of Medical Examiners	$135	
2001	*VT	25	Dept of Professional Regulation	$100	
2000	*NH	20	Dept. of Health	$100	
1999	TX	180	Dept of Health	$275	$45,820 (revenue $50,935)
1999	MN	14	Board of Medicine	$25	
1999	*AK	30	Dept of Commerce	$252	
1993	*OR	55	Health Licensing Agency	$950	
1993	CO	53	Dept of Regulatory Agencies	$900	
1993	*CA	172	Board of Medicine	$100	
1992	*FL	111	Dept of Health	$250	
1991	MT	21	Board of Alternative Healthcare	$250	
1985	LA	10	Board of Medicine	$100	
1983	AR	30	Dept of Health	No fee	Not itemized
1981	*WA	100	Dept of Health	$450	$138,731
1978	*NM	78	Dept of Health	$25	
1978	DE	1	Dept of Health & Social Services		
1977	*AZ	52	Dept of Health	$12.50	
1976	*SC	22`	Dept of Health	$75	Not itemized

States that accept a direct-entry route through ACNM: New York and Rhode Island
Missouri, Maine and Mississippi have statutes protecting the unregulated practice of CPMs
Florida is the only state that requires licensed midwives to carry malpractice insurance.

Chart developed by SDSCO 2009

Citizens for Midwifery

Supporting the Midwives Model of Care
www.cfmidwifery.org . 888-236-4880

Fact Sheet

Out-of-Hospital Midwifery Care: Much Lower Rates of Cesarean Sections for Low-Risk Women

Studies with Certified Nurse Midwives and Certified Professional Midwives have found that intended home and birth center births for low-risk women have significantly lower cesarean rates than do comparable low-risk women in hospitals with equally low infant mortality.

Citizens for Midwifery asks:

Since out-of-hospital midwives can help healthy low-risk women give birth safely to healthy babies with only 3 to 4% cesarean sections, why do hospital-based obstetricians find it necessary to perform cesarean sections on 19% or more of healthy low-risk women?

Studies of Low Risk Healthy Women in Home, Birth Center and Hospital Birth Settings *	**Cesarean Section Rate**
Certified Nurse Midwives[1] in Freestanding Birth Centers Nationwide 11,814 births (Rooks et al. 1989)	4.4%
Certified Nurse Midwives in Homebirth Practices[1] Nationwide 11,788 births (Anderson and Murphy 1995)	3.0%
Homebirths with Certified Professional Midwives[1] Nationwide 5,418 births (Johnson and Daviss 2005) **	3.7%
Low-Risk Hospital Births[2] California 806,402 births (Schlenzka 1999)	**22.9%**
Low-Risk Hospital Births Nationally in 2000[3] 3,360,868 births (Johnson and Daviss 2005 from National Vital Statistics)	**19.0%**

[1] In all the studies, outcomes of transfers during labor and/or after delivery to hospital care from intended home and birth center births are reported in the home and birth center categories, not the hospital category.

[2] Schlenzka (1999) developed a complex model of risk factors to derive a matched study population to more accurately compare safety in out-of-hospital and hospital birth settings for low-risk women from California birth certificate and discharge data from 1989 and 1990. www.cfmidwifery.org/resources/

[3] Low-risk is classified as a singleton, vertex, at 37 or greater weeks gestation birth. Derived from National Vital Statistics Birth Certificate Data, this subset of women would generally be low-risk but would include a small percentage of higher risk women who would require more medical intervention. Cited from Johnson and Daviss (2005).

*Some caution should be taken in direct comparison between studies because exact study methodologies differ. Table is presented for general comparison purposes.

** Summary of findings from Johnson and Daviss can be found at http://www.cfmidwifery.org/pdf/CPM2000.pdf

Intrapartum and neonatal mortality rates excluding lethal congenital anomalies were very low for all the cited studies, ranging from 0.6 (Rooks et al. 1989) to 1.9 (Schlenzka 1999) per 1000 births.

Anderson, Rondi E., CNM, MS and Patricia Atkins Murphy, CNM, DrPH. 1995. "Outcomes of 11,788 Planned Home Births Attended By Certified Nurse Midwives: A Retrospective Descriptive Study." *Journal of Nurse Midwifery* 40:483-492.

Johnson, Kenneth C. and Betty-Anne Daviss. 2005. "Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America." *BMJ* 330:1416-1421.

Rooks, JP, NL Weatherby, EKM Ernst, S Stapleton, D Rosen, and A Rosenfield. 1989. "Outcomes of Care in Birth Centers: The National Birth Center Study." *New England Journal of Medicine*:1804-1811.

Schlenzka, Peter F. 1999. "Safety of Alternative Approaches to Childbirth." Department of Sociology, Stanford University, Palo Alto, CA.

Citizens for Midwifery

Supporting the Midwives Model of Care
www.cfmidwifery.org . 888-236-4880

Fact Sheet

New landmark study shows that

Planned Home Births Are Safe

The largest study of home births attended by Certified Professional Midwives, as published in the *British Medical Journal*, has found that home birth is safe for low risk women and involves far fewer interventions than similar births in hospitals.

Safe & Healthy Outcomes

- Results are consistent with most studies of planned home births and low risk hospital births
- Zero maternal deaths
- Intrapartum and neonatal mortality: 2.0 per 1000 intended home births (only 1.7 per 1000 intended home births when planned breech and twin births are excluded)
- Immediate neonatal concerns resulted in just 2.4% of newborns being placed in neonatal intensive care
- At six weeks well over 90% of mothers were still breastfeeding their babies

Low Rates of Medical Intervention

- Much lower rates of interventions for intended home births compared to low risk hospital births:

	Planned home birth	Hospital birth
Induction of labor (only with oxytocin or prostaglandins)	2.1% *	21.0%
Stimulation of labor (only with oxytocin)	2.7% *	18.9%
Electronic fetal monitoring	9.6%	84.3%
Episiotomy	2.1%	33.0%
Vacuum Extraction	0.6%	5.5%
Cesarean Section	3.7%	19.0%

* *These numbers differ from the BMJ article where data for CPMs included forms of induction and stimulation only used by midwives and not comparable to hospital births.*

Satisfied Mothers

- Only 1.7% of the mothers said they would choose a different type of caregiver for a future pregnancy

Few Transfers to Hospital Care

- Only 12.1% transferred to hospital intrapartum or postpartum
- Five out of six transfers were before delivery, most for failure to progress, pain relief or exhaustion
- Midwife considered transfer urgent in only 3.4% of intended home births

High Credibility

- Included all home births involving Certified Professional Midwives in the year 2000
- 5,418 women in U.S. and Canada who intended to give birth at home as of the start of labor
- Prospective – every planned home birth was registered in the study prior to labor and delivery

"Outcomes of planned home births with certified professional midwives: large prospective study in North America." Kenneth C Johnson and Betty-Anne Daviss. BMJ 2005;330:1416 (18 June). This article and related letters to the editor are available online, free, at *http://www.bmj.com*. (Use the search feature and type Daviss for the author.)

Dear Senators,

We initially chose home birth for the following reasons.

#1 We knew I couldn't relax in a hospital while in labor. My blood pressure is normal but like many I have white coat syndrome, which can be very detrimental for baby and me during labor. Home seemed like the very best place for me to deliver, which our medical doctor agreed would be fine as long as I had no complications.

#2 We were fortunate enough to get a glowing referral for a local midwife. A friend who used a midwife for 4 of her children explained to my husband and I all about her experiences with her trusted and well trained midwife.

#3 After interviewing the midwife thoroughly and alternating care between her and my medical doctor for most of the first pregnancy, I preferred her care and the time she gave me. She would spend 45 minutes to an hour on average for each prenatal appt. The doctor 5 minutes. I grew to know her and trust her far more than I did the medical doctor.

#4 The rise in c-sections and interventions and drugs used in hospital during some births concerned us, and we wouldn't necessarily agree with the doctor's opinion if he felt the need for interventions during the birth (due to our research and knowledge of complications/side effects when interventions, drugs are used). This was an added stress for me to think about, stress which is also not good for me and my baby.

We had 3 healthy babies all born at home assisted by midwives, and we prefer it for any future pregnancies.

Sincerely,

Becky Olsen

Fifteen years ago, I was living in Minot, ND and pregnant with my first child. I had no insurance. I was ineligible for Medical Assistance based on a technicality, yet I was extremely low income. When I went to the hospital to seek medical attention during and for my pregnancy, I was refused care until I could put down $600.00 towards the birth and continue to make $200.00 payments a month until my baby was born. My income at that time was $300.00 a month. Because of this, I chose to see a homebirth midwife, who was willing to take me on as a charity case, paying only what I could afford. She went above and beyond the call of duty, making sure I had prenatal vitamins, food and even took me in to stay with her. This is care I never would have received from a medical facility.

Although I know insurance is becoming more broadly open to people these days, I must also emphasize the safety of homebirth. In a subsequent pregnancy, I was well insured and planning a hospital birth with Certified Nurse Midwives (CNMs). When the CNMs began to provide me with inaccurate information pertaining to Mitral Valve Prolapse (a common, benign heart difference, that I was told I had), I conferred with my Cardiologist. He explained to me that they were giving me wrong information. At this point, I lost my confidence in their abilities to safely attend me in birth. With the blessing of my cardiologist, I gave birth to a healthy baby at home attended by my Traditional Midwife.

The most important part of homebirth for me is the continuity of care. Even though I've had a few hospital births now, the one thing I miss from my days of homebirthing is the fact that my midwife made a commitment to be at my birth whereas in the hospital, the frequent practice is that whoever is on call delivers your baby. There isn't the same relationship between me and my doctor as there was between me and my traditional midwife. My midwife and I had a much deeper trust and bond between us. I was also able to get immediate feedback about my health from my Midwife than I've ever received from the doctors in the hospitals. This gave me more of an opportunity to promptly work on my diet, etc. She does more thorough prenatal screenings and has consistently had more thorough, evidence-based prenatal care suggestions than I have ever received from a medical doctor.

It is a very serious decision to choose the birth attendant that I feel can provide me and my baby with the safest possible birth. I appreciate having the right to make that very personal decision.

Sincerely,

Kristin Gaytan

I wonder if it would be possible to include my birth slideshow as my 'letter'? When I watch it, it displays my reasons for wanting a midwife assisted homebirth: water birth, calm own environment, surrounded by loved ones including my other children, the ability to nurse immediately and without separation until I was ready, etc. Here is the link (and it is public friendly, I promise). http://soulshinephoto.com/blog/?p=225

I love the new version of the midwifery bill. Thank you for all of your work on it! One question, will it be mandatory then to be licensed or optional like MN?

Erin McSparron
OT, Doula, Lactation Counselor, API Leader, Mom and Owner of Slings and More!

My reasons for choosing homebirth midwifery care go back to my first child, born 19 years ago when I had never heard of homebirth as a modern option. My OB was very typical. Appointments were usually 5 minutes long, with 10 minutes being the longest. I didn't know very much about pregnancy and childbirth back then and the doctor did nothing to increase my knowledge, assuring me that if I just trusted her, all would be well. All was not well. She missed signs that I was developing a life threatening condition called pre-eclampsia. Looking back, she wasn't screening me carefully and had done nothing to be sure I was educated about signs of problems in pregnancy even though I was experiencing pre-term labor thus already proving to be more than the typical pregnancy case. Shortly after my water broke, I arrived in the hospital where my blood pressure grew alarmingly high while we waited for the OB to arrive. She didn't answer her pages and left the maternity staff hanging for hours, unsure what to do with me. Finally, she gave orders of what to do with my care, but I already had progressed to the point of having a life threatening seizure. A c-section was required to save both my life and my baby's life. What happened was preventable and should have been diagnosed earlier. I later found out I had experienced several of the signs of pre-eclampsia but they had all been missed.

Three years later, I was pregnant again and this time seeing a doctor who was supportive of my having a vaginal birth after cesarean (VBAC). She felt my best chance to have a VBAC was to go into labor spontaneously and to labor at home by myself for as long as possible. I did not personally feel it was safe for me to labor at home alone given my history of eclamptic seizure. I felt it was important for me to be monitored throughout the labor to be sure I was showing no signs of increasing blood pressure. I found a homebirth midwife who was happy to come monitor me during my labor. Initially, I planned to go to the hospital for the actual birth, but two things changed. One was that I immediately saw the difference in doctor based vs homebirth midwifery care. My first prenatal appointment with the midwife was 4 HOURS long compared to the still typical 5-10 minute doctor visits. She took a comprehensive maternity health history and spoke to me at length about the specific complications I'd had the first time around with medical studies that contained information about how to reduce my risks, what signs to look for that would indicate oncoming problems, all in addition to providing a much more thorough prenatal that included in depth urinalysis, closer monitoring of my hemoglobin and blood pressure, and a lot of education about nutrition during pregnancy. She also grew to know me as a person, to understand how my first birth had impacted me on all levels: emotionally, physically, recovery, etc. At the same time, the doctor was doing a simple protein/sugar urine test (whereas the midwife had a urine test that analyzed 12 items) and only intermittently monitored my hemoglobin etc. and gave me the advice that if I "just drank a lot of water and took my prenatals, that was good enough for nutrition". The doctor also began pressuring me to accept certain medical interventions only because they were standard of care, not because they would provide me with a safer birth. The doctor herself admitted this to me and said she was having pressure from her superiors at the hospital to push these things. I began to feel safer with the homebirth midwife because her care was vastly different than what I was receiving from the doctor. The midwife said that she would closely monitor me and that as long as I showed no signs of problems, she felt I could safely birth at home. During the birth, I saw once again the difference ~ my midwife was with me 24 hours a day until the baby was born, providing frequent monitoring and answering any questions I had. My baby was born safely at home.

I have since had a total of 5 babies at home. In all but one case, I had concurrent care from a doctor throughout the pregnancy. In every case, the doctor has been able to give me the standard medical advice, but the homebirth midwife has gone the extra mile, providing me with medical studies, books with in depth information about pregnancy and birth, information about prevention and nutrition, a list of options to try when any concerns cropped up (such as a sideways baby or low hemoglobin), referrals to the doctor for any medical tests needed, etc. Doctors have provided me with those needed medical tests and any medical technology I've required, up to and including two more c-sections for mal-positioned babies. My last 4 pregnancies, I have developed a problem

where my babies like to be sideways. The doctor, midwife and I all work hard to help my babies go head down and stay head down. We have been successful in two of those pregnancies resulting in two of those babies being born at home. The other two times, the babies were still sideways when labor started so I went to the hospital in both cases and had a c-section each time. I believe I have experienced the best of both words, and I see the way that the homebirth model of care and the obstetrical model of care complement each other.

That is something I want to emphasize about homebirth midwifery care. It is NOT opting out of hospital based care. Transport is an important part of the safety of homebirth care. There may be some who would think that the two c-sections I had for my baby's positioning would be a sign of homebirth being unsafe or a failure of homebirth. I would counter that those two births are the proof of the safety of homebirth and the success of homebirth. The on call OB for my most recent c-section walked away feeling like she had "saved this baby from homebirth" when the reality is that I had been planning for *both* homebirth or hospital birth the entire time, planning to do whatever was safest for my baby when labor came. In both cases, the need for transport happened at the very beginning of the labor and in each case, I went into the hospital at the same time I would have gone in had I been planning a hospital birth. The doctor I saw throughout my pregnancy knew that my transports were not a failure of homebirth but instead was the success of a well educated mom, in this case educated and supported by both her midwife and doctor (as both worked with me to educate me on how to tell my own baby's position so I could check immediately in early labor). It's unfortunate that the on call OB didn't take the time to ask me any questions or become educated about my case. I think that is often true when an OB goes around telling people about bad homebirth outcomes. I wonder how often they take the time to question the mother what exactly happened leading up to the decision to go to the hospital.

For myself, the most important components of homebirth care have been: The focus on prevention and early detection of problems, involving the mother as an important partner in her own healthcare, the consistency in care which means that the birth attendant is very familiar with the mother's health history and current status (not getting whomever is "on call"), and the ability to benefit from both the homebirth model of care (emphasizing prevention and early detection) and the doctor based model of care (with access to medical technology and surgical intervention as needed). I urge the ND legislature to make sure homebirth midwifery is legal in ND. I believe that homebirth midwifery care has been a very important component in my being able to have the safest births possible for myself and my babies.

Thank you for your time and your care for ND mothers and babies.

Sincerely,

Karla Wiegrefe
736 9th St N
Fargo, ND

#11

11.8245.02005
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
February 8, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2315

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-12.1 of the North Dakota Century Code, relating to creation of a lay and traditional midwife registry; to amend and reenact sections 43-12.1-02, 43-12.1-09, and 43-12.1-09.1 of the North Dakota Century Code, relating to the registry of lay and traditional midwives; to provide for a legislative management study; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-12.1-02 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-02. Definitions.

In this chapter, unless the context otherwise requires:

1. "Advanced practice registered nurse" means an individual who holds a current license to practice in this state as an advanced practice registered nurse.

2. "Board" means the North Dakota board of nursing.

3. "Lay or traditional midwife" means an individual who is currently registered as a lay or traditional midwife under this chapter.

4. "Licensed practical nurse" means an individual who holds a current license to practice in this state as a licensed practical nurse.

~~4.~~5. "Nurse" means an individual who is currently licensed as an advanced practice registered nurse, registered nurse, or licensed practical nurse.

~~5.~~6. "Nursing" means the performance of acts utilizing specialized knowledge, skills, and abilities for people in a variety of settings. The term includes the following acts, which may not be deemed to include acts of medical diagnosis or treatment or the practice of medicine as defined in chapter 43-17:

   a. The maintenance of health and prevention of illness.

   b. Diagnosing human responses to actual or potential health problems.

   c. Providing supportive and restorative care and nursing treatment, medication administration, health counseling and teaching, case finding and referral of individuals who are ill, injured, or experiencing changes in the normal health processes.

   d. Administration, teaching, supervision, delegation, and evaluation of health and nursing practices.

e. Collaboration with other health care professionals in the implementation of the total health care regimen and execution of the health care regimen prescribed by a health care practitioner licensed under the laws of this state.

~~6.~~7. "Prescriptive practices" means assessing the need for drugs, immunizing agents, or devices and writing a prescription to be filled by a licensed pharmacist.

~~7.~~8. "Registered nurse" means an individual who holds a current license to practice in this state as a registered nurse.

~~8.~~9. "Specialty practice registered nurse" means an individual who holds a current license to practice in this state as a specialty practice registered nurse.

~~9.~~10. "Unlicensed assistive person" means an assistant to the nurse who regardless of title is authorized by the board to perform nursing interventions delegated and supervised by a nurse.

SECTION 2. AMENDMENT. Section 43-12.1-09 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09. Initial licensure and registration.

1. The board shall license and register nursing, lay or traditional midwife, and unlicensed assistive person applicants. The board shall adopt rules establishing qualifications for initial nursing licensure and unlicensed assistive person registration and for issuing limited licenses and registrations pursuant to subsection 3.

2. Each applicant who successfully meets the requirements of this section is entitled to initial licensure or registration as follows:

   a. An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall:

      (1) Submit a completed application and appropriate fee as established by the board.

      (2) Submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought. The board shall adopt rules establishing standards for the approval of out-of-state nursing education programs. These standards for out-of-state programs must include consideration of whether the program is accredited by the national league for nursing accrediting commission, incorporated, or the commission on collegiate nursing education and whether the program meets the requirements of the state in which the program is provided.

      (3) Pass an examination approved by the board.

   b. An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought.

(3) Submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure.

(4) Submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

(5) Notwithstanding the foregoing requirements of this subdivision, if an applicant for licensure as a licensed practical nurse has been licensed in another state as a licensed practical nurse based upon completion of a registered nurse education program and has had at least twenty-four months of unencumbered practice as a licensed practical nurse in another state within the five-year period preceding the application, then the applicant is not required to meet any additional educational requirements for licensure as a licensed practical nurse.

c. An applicant for licensure as an advanced practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in an advanced nursing role by a national nursing organization meeting criteria as established by the board. An advanced practice registered nurse applicant must have a graduate degree with a nursing focus or must have completed the educational requirements in effect when the applicant was initially licensed.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

d. An applicant for licensure as an advanced practice registered nurse who completed an advanced nursing education program and was licensed or certified in advanced practice by another state before January 1, 2001, or who completed an advanced nursing education program and was licensed or certified as a women's health care nurse practitioner by another state before January 1, 2007, may apply for and receive an advanced practice license if that applicant meets the requirements that were in place in this state at the time the applicant qualified for initial advanced practice licensure in that state.

e. An applicant for unlicensed assistive person registration shall:

(1) Submit a completed application and the appropriate fee as established by the board.

(2) Provide verification of appropriate training or evidence of certification or evaluation in the performance of basic nursing interventions.

f. An applicant for licensure as a specialty practice registered nurse shall:

(1) Submit a completed application and appropriate fee as established by the board.

(2) Submit evidence of appropriate education and current certification in a specialty nursing role by a national nursing organization meeting criteria as established by the board. A specialty practice registered nurse applicant must have the educational preparation and national certification within a defined area of nursing practice.

(3) Possess or show evidence of application for a current unencumbered registered nurse license.

g. An applicant for registration as a lay or traditional midwife shall:

(1) Submit a completed application and the appropriate fee as established by the board. A qualified applicant may not be licensed as a physician or nurse.

(2) Submit evidence of education related to the practice as a lay midwife; experience, including preceptorship, in the practice of a lay midwife; and effective January 1, 2013, certification by a national organization.

3. For good cause shown, the board may issue a limited license or registration to an applicant.

SECTION 3. A new section to chapter 43-12.1 of the North Dakota Century Code is created and enacted as follows:

Lay or traditional midwife registry.

The board shall administer a voluntary registry for an individual who provides services to women and their newborn children outside of a hospital or clinical setting which is consistent with the individual's training, education, and certification. In order to register as a lay or traditional midwife, an applicant shall submit to a statewide and nationwide criminal history record check under section 43-12.1-09.1.

SECTION 4. AMENDMENT. Section 43-12.1-09.1 of the North Dakota Century Code is amended and reenacted as follows:

43-12.1-09.1. ~~Nursing licensure~~Licensure or registration - Criminal history record checks.

The board may require each applicant for initial or renewed ~~nursing~~ licensure or registration and any licensee or registrant who is the subject of a disciplinary investigation or proceeding to submit to a statewide and nationwide criminal history record check. The nationwide criminal history record check must be conducted in the manner provided by section 12-60-24. All costs associated with obtaining a background check are the responsibility of the applicant, licensee, or registrant. The board may

grant a nonrenewable temporary permit to an applicant for initial or renewed license or registration who submits to a criminal history record check as required by this chapter if the applicant has met all other licensure or registration requirements in accordance with subsection 2 of section 43-12.1-09.

SECTION 5. LEGISLATIVE MANAGEMENT STUDY - REGULATION OF LAY OR TRADITIONAL MIDWIVES. During the 2011-12 interim, the legislative management shall study the feasibility and desirability of developing a mechanism for mandatory regulation of lay or traditional midwives. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 6. EXPIRATION DATE. This Act is effective through July 30, 2013, and after that date is ineffective."

Renumber accordingly

11.8245.02004
Title.

Prepared by the Legislative Council staff for
Senator Mathern
February 8, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2315

Page 1, line 2, replace "licensing and regulating direct entry or lay" with "a"

Page 1, line 2, remove "services and to preserve"

Page 1, line 3, replace "the right of women and families to home delivery of infants" with "registry"

Page 1, line 3, remove "to amend and reenact section"

Page 1, remove line 4

Page 1, line 5, replace "nursing" with "to provide for a report to the legislative management"

Page 1, remove lines 7 through 17

Page 1, line 22, remove "established to assist the"

Page 1, remove line 23

Page 1, line 24, remove "such other matters relating to the practice of midwifery as the board may require"

Page 2, line 1, replace ""Board" means the state board of nursing" with ""Department" means the state department of health"

Page 2, line 2, remove ""Licensed midwife" means an individual who is not licensed as a physician or nurse"

Page 2, remove lines 3 and 4

Page 2, line 5, remove "4."

Page 2, after line 9, insert:

"4. "Registered midwife" means an individual who is registered on the department's midwifery registry."

Page 2, overstrike lines 10 through 30

Page 3, remove lines 1 through 31

Page 4, replace lines 1 through 26 with:

"**Midwifery registry requirements.**

The department shall administer a midwifery registry and shall issue midwife registry certificates to qualified applicants. The department shall set an annual registration, not to exceed one hundred dollars per year. Registration on the midwifery registry is voluntary.

Rulemaking.

The state health council shall adopt rules as necessary for registry of midwives, including:

1. To establish minimum age levels.

2. To establish education and training levels for midwives.

3. To issue, deny, suspend, or revoke certificates of registration.

4. To develop application and registry forms."

Page 4, line 28, replace "board" with "department"

Page 4, line 28, after "for" insert "registered"

Page 4, line 30, replace "licensed" with "registered"

Page 4, line 31, replace "licensure" with "registration"

Page 5, line 4, remove "board-approved"

Page 5, line 6, remove "within the two-year initial licensure period"

Page 5, line 6, replace "board" with "department"

Page 5, line 10, replace "licensed" with "certified"

Page 5, line 10, remove "consistent with the chapter"

Page 5, line 26, remove "The certified nurse midwife member of the advisory board is a member of the board"

Page 5, replace lines 27 and 28 with "The advisory board shall assist the department in establishing a midwifery registry, provide education and act as a resource for registered midwives, and provide education relating to midwifery to members of the public."

Page 5, remove lines 29 through 31

Page 6, remove lines 1 through 28

Page 7, remove lines 1 through 30

Page 8, remove lines 1 through 16

Page 8, line 18, remove "1."

Page 8, line 18, replace "licensed" with "registered"

Page 8, line 19, remove ", "L.M.","

Page 8, line 20, replace "authorized to practice midwifery" with "registered with the department's midwifery registry"

Page 8, line 21, remove "licensed under this chapter or is exempt from the requirement to be licensed"

Page 8, line 22, replace "until July 31, 2012" with "so registered"

Page 8, remove lines 23 through 26

Page 8, line 27, remove "4."

Page 8, after line 27, insert:

"**SECTION 2. ADVISORY BOARD ON MIDWIFERY - REPORT TO THE LEGISLATIVE MANAGEMENT.** During the 2011-12 interim, the advisory board on midwifery shall study the feasibility and desirability of regulating the practice of midwifery in the state. The state department of health shall provide administrative services to assist the advisory board in conducting this study. Before September 1, 2012, the advisory board shall report its findings and recommendations, together with any legislative proposals, to the legislative management."

Renumber accordingly

#13

PROPOSED AMENDMENT TO SENATE BILL NO. 2315

SECTION 5. LEGISLATIVE MANAGEMENT STUDY – REGULATION OF LAY OR TRADITIONAL MIDWIVES. During the 2011-2012 interim, the legislative management shall study the feasibility and desirability of developing a mechanism for mandatory regulation of law or traditional midwives. The [(Board of Nursing), (North Dakota Department of Health), or (~~North Dakota Health Department~~)] Board Nursing Nurses Association shall convene a task force of interested parties to study the feasibility and desirability of developing a method and source of funding for the regulation of lay or traditional midwives, including the gathering of current and relevant data, and shall report to the 2011-2012 legislative management any recommendations. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

#14

From: Nelson (Buzz) Benson [mailto:BBENSON@mohs.org]
Sent: Tuesday, February 08, 2011 10:23 AM
To: Lee, Judy E.
Subject: lay midwife testimony from nurses that work with Dr. Ocejo

Senator Lee,
I have received a couple of e-mails from nurses that work with Dr. Ocejo. He is out of the country at present and unavailable.
Two of his nurses have recounted situations in dealing with lay midwives that I wanted to share with you.
Buzz Benson

From: Noel Miller [nkmiller@mohs.org]
Sent: Tuesday, February 08, 2011 5:50 AM
To: Nelson (Buzz) Benson
Subject: Judy Lee

Buzz,

I am not sure how personal or lengthy Judy wanted this so I keep it short feel free to add more to it if you want. I tried to be very general. If you need more I'm at the trauma skills labs all day so page me on #1100

Thanks,

Noel

As a pediatric nurse I love children. I have a joy of taking care of the child and their families. Most of the outcomes in pediatrics are the child is discharge to home with their parents, but this is not always the case. The death of a young child may have been prevented. This infant was delivered at home by a lay midwife with complications immediately after birth. The infant was unable to breath, deprived of oxygen resulting in brain damage. The brain damage in this infant resulted in further complication later in life which in turn led to the death of the child. As a nurse who loves taking care of children and their families and as a mother this day was heart breaking.

Noel Milller, RN BNSc
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Clinical Coordinator
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nkmiller@mohs.org

In April of 2004, a patient presented after having pushed for several hours at home with a lay midwife. On arrival, the staff noted the patient to be dilated to 8 cm (not complete). The patient had a primary cesarean section for cephalo-pelvic disproportion. Thick meconium stained amniotic fluid was noted at delivery of the baby. The baby presented with Apgars of 4 at one minute and 9 at 5 minutes. The baby did experience meconium aspiration, cardio-vascular instability, sepsis and asphyxia and required a 4 day NICU stay.

In November of 2006 a set of undiagnosed triplets were born in rural ND. The third triplet – a boy – required hospitalization for 18 days. He was admitted to the NICU via ambulance with hyaline membrane disease, hypotension and required ventilatory support. The ambulance crew who transported the baby relayed to the NICU staff that they were called to go to the home, then called back and cancelled. The crew, feeling they should at least assess the situation, went to the home anyway. They reported that they found that the girl triplets were "OK" but the boy triplet was in distress. The crew stated that the lay midwife had run out of oxygen and the baby was cyanotic upon their arrival.