SUNRISE REVIEW

OF

DIRECT ENTRY MIDWIVES

SUBMITTED BY

THE COLORADO DEPARTMENT OF REGULATORY AGENCIES

JUNE 1992

June 30, 1992

The Honorable Bob Schaffer
Joint Sunrise/Sunset Review Committee Chairman
Room 348, State Capitol Building
Denver, Colorado 80203

Dear Senator Schaffer:

We have completed our evaluation of the sunrise application for registration of direct entry (lay) midwives and are please to submit this written report which will be the basis for my office's oral testimony before the Sunrise and Sunset Review Committee. The report is submitted pursuant to section 24-34-104.1, Colorado Revised Statutes, the "Sunrise Act", which provides that the Department of Regulatory Agencies shall conduct an analysis and evaluation of proposed legislation to determine whether the public needs and would benefit from the regulation.

The report discusses the question of whether there is a need for the regulation in order to protect the public from potential harm, whether regulation would serve to mitigate the potential harm and, whether, the public can be adequately protected by other means in a more cost effective manner.

Sincerely,

Steven V. Berson
Executive Director

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EXECUTIVE SUMMARY

The Colorado Department of Regulatory Agencies has completed its 1992 Sunrise Review of the application for state regulation by Colorado direct entry midwives. Direct entry midwives assist women in childbirth in return for compensation but do not necessarily have any formal training in medicine in order to do so, as distinguished from nurse-midwives, nurses or physicians. Therefore, direct entry midwives are often referred to as lay midwives.

Assisting in childbirth in return for compensation is the practice of medicine under Colorado law. The applicants request an exemption from this law which would allow them to practice in Colorado.

The Colorado Department of Regulatory Agencies finds that Colorado's policy of requiring education and training of everyone who would assist in childbirth in return for compensation is a public policy which best protects the citizens of the state. Allowing an exemption from existing law for direct entry midwives not only represents poor public policy but also unfairly favors one class of providers over all other medical providers in the field and is therefore unconstitutional. Similarly, a complete exemption for anyone assisting in childbirth in return for compensation is poor public policy as it places Colorado citizens at greater risk.

The Department of Regulatory Agencies concludes that the only way to appropriately allow the practice of direct entry midwives is to require that they meet standards of education and training which would allow them to practice safely. However, since Colorado has already legalized the practice of midwifery by allowing certified nurse-midwives to practice in Colorado, the creation of new standards for direct entry midwives seems unnecessarily duplicative. Given that Colorado citizens already have multiple alternatives from which to select well-trained health care providers, allowing direct entry midwives to assist in childbirth in return for compensation without adequate education and training represents an unnecessary risk to Colorado citizens. Therefore the Department of Regulatory Agencies recommends that the State of Colorado not sanction the practice of direct entry midwifery in Colorado.

1992 SUNRISE REVIEW OF DIRECT ENTRY MIDWIVES

INTRODUCTION

The Department of Regulatory Agencies (DORA) has completed its evaluation of the application for regulation submitted by the Colorado Midwives Association (CMA), an organization representing lay midwives. The applicants seek state regulation of direct entry midwives who are also known as lay midwives. Pursuant to the Colorado Sunrise Act, C.R.S. 24-34-104.1, the applicants must prove the benefit to the public of their proposal for regulation according to the following criteria:

1. Whether the unregulated practice of the occupation or profession clearly harms or endangers the health, safety or welfare of the public, whether the potential harm is easily recognizable and not remote or dependent on tenuous argument;

2. Whether the public needs, and can be reasonably expected to benefit from, an assurance of initial and continuing professional or occupational competence;

3. Whether the public can be adequately protected by other means in a more cost-effective manner.

The current application by the Colorado Midwives Association (CMA) for regulation is a request for registration as opposed to the 1991 application request for licensure. In 1991 the applicants requested that the state of Colorado license direct entry midwives and adopt an existing certification program recognized by the Midwives Alliance of North America (MANA). The 1992 sunrise application proposes that the state of Colorado create a registry of direct entry midwives.

As a part of this sunrise review, the literature was searched for data published within the past year. This review updates and explores the following issues regarding direct-entry midwifery: (1) 1992 Colorado legislative activities, (2) status of direct-entry midwifery in other Rocky Mountain states, and (3) efforts by the Department of Health and other agencies to mitigate maternal and perinatal care in rural Colorado. Additional information concerning the MANA registry examination is also included.

WHAT IS A MIDWIFE?

The Oxford English Dictionary defines midwife as "a woman who is with the mother at birth." The International Confederation of Midwives, the International Federation of Gynecologists and Obstetricians, and the World Health Organization (WHO) jointly defined a midwife. They wrote:

> **"A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labor and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counseling and education, not only for the patients but also within the family and the community. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service."**

The American College of Nurse-Midwifery provides further information on the background of midwifery.

> **For many centuries, the term "midwife" has been used to designate an individual who was "with woman" in childbirth. Predominantly women themselves, midwives learned their practice from others through oral history, observation and apprenticeship. As the physiological process of conception and birth were identified, the midwife added this scientific knowledge to her previously developed art and skill in attending women in childbirth.**
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> **At the beginning of the twentieth century in the United States, midwives, most without formal education, worked among women in rural south, the mountains of Appalachia, the sparsely populated lands of the west and with urban immigrant women. In 1925, public health nurses began to seek advanced education in midwifery, using a model developed in England, the nurse-midwife was added to the community of American Midwives.**

The distinction between direct entry midwives and certified nurse midwives is a critical one because of a number of factors, especially the difference in training. It is not always possible to accurately refer to "midwives" as a single group, one must often distinguish between direct entry midwives and certified nurse midwives.

Direct entry midwives attend home deliveries, function as independent practitioners, and very rarely use interventive therapies. They do not carry intravenous equipment and consequently, do not augment labor through the use of pitocin, a synthetic hormone used by physicians to expedite labor.

Philosophically, direct entry midwives have an essentially different orientation to childbearing than the medical community. According to direct entry midwives, they provide care that supports the woman and her family, is culturally sensitive, and reduces unnecessary interventions and dependence on technology.

PROPOSAL FOR REGULATION

Direct entry midwives propose that the State of Colorado create a registry of direct-entry midwives. Under the present law, the practice of nurse midwifery is legal but the practice of direct entry midwifery is prohibited. This has led to a situation in which direct entry midwives continue to practice illegally.

The proposed registration program would require direct entry midwives to provide disclosure statements as to their training and experience level. Direct entry midwives contend that the disclosure statement creates a climate in which consumers can discern who is the most qualified attendant. Presently, according to the applicants, there is no standard way for the public to distinguish between qualified and unqualified practitioners.

The applicants maintain that registration will:

* Provide a method for consumers to identify and investigate direct entry midwifery care givers.

* Allow direct entry midwives to address the shortage of maternity care providers.

* Allow the practicing direct-entry midwives of Colorado to practice their profession without risk of prosecution.

The Colorado Midwife Association currently administers a certification program that is recognized by both the Midwives Alliance of North America (MANA) and the International Confederation of Midwives (ICM), both private organizations representing direct entry miodwives. The applicants argue that in an atmosphere of legality, consumers can be encouraged to seek out qualified direct entry midwives as their care providers. A key element of this private certification program is a test developed by MANA.

For the purposes of the 1991 direct entry midwifery request for licensure, the Department of Regulatory Agencies, Division of Registration's testing expert reviewed the examination development, scoring, and security of the MANA North American Registry Examination. Also analyzed and examined were scoring criteria for the exam. The review included such specific questions as:

* Have tasks performed by persons in the occupation been identified and documented?

* Do the topics covered on the exam represent knowledge or ability areas that are most important to safe, effective public practice?

* What is the basis for the number of test questions devoted to each topic and to the test as a whole?

* Who, in terms of professional position, writes the test questions, who reviews and edits them, and who has final approval of the questions?

The conclusion of the review was that the test development methods used by MANA are insufficient to establish the validity of the Registry Exam as a regulatory standard. Please see Appendix A for the findings, conclusions, and recommendations of this report.

Persons who seek direct entry midwifery care represent diverse demographic groups. Many parents are well educated individuals choosing direct entry midwife assisted home birth for philosophic reasons. They want more control over their birth experience than they might have in a traditional hospital. They want to lower their chances of having interventions, such as drugs and surgery. Most direct entry midwives offer sliding fee scales and assist with births for free for the truly indigent. Another client group are the women who are geographically separated from hospitals that provide maternity care. Another group who seek direct entry midwifery care may be the low income families who have no insurance

Certified Nurse-Midwives on the other hand, are professionally trained nurses who receive advanced education in midwifery. They are regulated in this state by the Colorado Board of Nursing. In other words, a certified nurse-midwife is educated in two distinct disciplines: nursing and midwifery. Certified nurse-midwives practice in accord with defined standards and are held to a definite level of education that can be documented. The American College of Nurse-Midwives takes the position that anyone using the term "midwife" must be registered or licensed by the state.

The American College of Nurse-Midwives defines the practice as follows:

> **Nurse-Midwifery practice is the independent management of care of essentially normal newborns and women, - antepartally, intrapartally, postpartally, and/or gynecologically - occurring within a health care system**

which provides for medical consultation, collaborative managements, or referral and is in accord with the Standards for the Practice of Nurse-Midwifery as defined by the American College of Nurse-Midwives.

PREVIOUS REGULATION REQUESTED

Direct entry (lay) midwives sought licensure in 1985 under the State Board of Nursing. The applicants proposed that educational, training, and examination requirements be established by the nursing board.

In 1991, the Colorado Midwives Association again applied for licensure. Although the Department of Regulatory Agencies recommended against licensure of direct entry midwives, the Sunrise/Sunset Committee produced House Bill 1010, a bill that decriminalized lay midwifery. The bill established a direct entry midwifery registration program to be administered by the Division of Registrations in the Department of Regulatory Agencies. HB 1010 also required the disclosure of certain information regarding education, experience, and other qualifications. The bill established criminal penalties for practicing direct entry midwives if not registered and for violations of the disclosure requirements.

HB 1010 was widely criticized by the Colorado medical community. Many argued that the proposed regulation deceived the public because it did not establish minimum standards for direct entry midwives, including a reliable examination and minimum educational requirements.

HB 1010 was amended extensively during second reading in the House of Representatives. The bill was amended to require a direct entry midwife, in order to register as a direct entry midwife in Colorado, to provide proof of having successfully completed the national competency examination administered by the Midwives Alliance of North America. Alternatively, a direct entry midwife could prove that her qualifications, skills and training were substantially similar to those evidenced by successful completion of the examination. Other amendments gave the Director of the Division of Registrations disciplinary authority over registered direct entry midwives, specifically prohibiting a midwife from dispensing drugs and a requirement that a registered direct entry midwife file a birth certificate if the birth of a client's baby occurs outside of a medical facility. The amended bill passed in the House of Representatives but was defeated in the Senate.

REGULATION OF DIRECT ENTRY MIDWIFERY IN OTHER STATES

There is considerable diversity in the legal status of lay midwives in different states throughout the United States. The terms "lay midwives" and direct entry midwives are often used interchangeably in the literature. There are ten states that have prohibitory laws, five states with grandfathering clauses, five states and the District of Columbia with enabling statutes, and ten states that explicitly permit and/or regulate the practice of direct entry midwifery.

The Rocky Mountain Region. The status of direct-entry midwifery in neighboring states; Arizona, Idaho, Montana, New Mexico, Utah, and Wyoming is summarized below.

Arizona currently has forty-five licensed direct entry midwives with twenty-five in active practice. Cooperation among direct entry midwives varies, as does availability of consulting physicians. The practice of direct- entry midwifery is legal upon obtaining a license issued by the State Department of Health. The requirements for licensure are more rigorous in Arizona than other Rocky Mountain states.

The current regulations specify that each direct entry midwife applicant show evidence of completion of a course of instruction that includes emergency management techniques, aseptic techniques, observational skills, special requirements of home delivery, and clinical courses covering care of maternity patients and newborns. Once an application is accepted, there is a written, oral, and clinical examination of direct entry midwifery skills.

Idaho does not have any laws governing direct entry midwifery. The lack of regulation in Idaho has encouraged midwives to define themselves on their own terms. The Idaho Midwifery Council (IMC) instituted a voluntary certification program in 1986 which they obtained from the Colorado Midwives Association (CMA). The IMC has also defined standards of practice including appropriate equipment, skills, records, medical consultation, screening, peer review, and protocols. Twenty to thirty direct entry midwives, including apprentices, practice in Idaho. Over the years, Idaho direct entry midwives have more clearly defined their roles. The environment existing in Idaho is attributed to the fact that many citizens are only one generation removed from home birth in which a lay midwife may have assisted.

Montana's regulation since 1991 provides for the licensing of direct-entry lay midwives and is administered by the Department of Commerce. Prior to 1989, midwifery was interpreted as practicing medicine and was cited as a misdemeanor. The law changed in April of 1989. The practice of midwifery was legalized and was exempted from licensing requirements.

A 1991 Montana law included a grandfathering clause that set forth conditions for acceptance into the profession. A liability clause provides nurses, hospitals, and doctors relief from liability for emergency situations of patients of direct-entry midwives except in cases of gross negligence. A joint board with the naturopaths was established. The board has accepted the Midwife Alliance of North American (MANA) registry examination and is in the process of initiating a training program. Fifteen direct-entry lay midwives practice in Montana.

The New Mexico Public Health Department administers the regulations regarding lay midwives. State regulations require an advisory board and govern standards of practice, recordkeeping, the nature of the physician/midwife consultation, and emergency measures. Educational requirements include apprenticeships, self-study and formal education.

The present Utah law states that the practice of midwifery is not the practice of medicine. In addition, the law maintains that parents have the right to choose their birthplace and attendants, regardless of the attendant's certification. Approximately sixty direct-entry lay midwives practice in the state. Physician consultation relationships are easier to obtain in Utah than in other Rocky Mountain states. Utah lay midwives do not seek certification or licensure, however, the Utah Midwives Association is working on a voluntary certification program and has a peer review process and practice protocols.

Wyoming had no laws defining or regulating direct-entry lay midwifery practice until 1987. In 1987 a bill that redefined and clarified the practice of medicine exempted the practice of midwifery from the Medical Practice Act. A bill introduced in 1989 prohibited midwives from giving prenatal or postnatal care but still allowed them to attend births. Wyoming midwives supported legislation introduced in 1992 that would have allowed midwives to give prenatal or postnatal care. The legislation was defeated by a narrow margin and the midwives plan to reintroduce a bill during the 1993 session.

Regulation Of Direct Entry Midwifery In States Outside The Rocky Mountain Region.

Alaska's lay midwifery regulatory procedure is in the process of being revised. Currently, thirty lay midwives practice in Alaska. The Division of Public Health remains concerned about the public safety of home births in Alaska. The geography of the state, the limited road system, and the varying weather conditions make medical transfers to the nearest hospital facilities hazardous and time consuming. However, to some extent, the families choosing a home birth in an outlying area would not seek health care in traditional settings, which makes the lay midwife the only point of contact for care.

Arkansas has regulated lay midwifery since 1983. There are currently twenty-three licensed lay midwives and eight apprentices. The Department of Health, the regulatory authority, reports that regulation is time consuming and expensive, and the state law does not contain an appropriation to cover the expenses involved.

New Hampshire has a voluntary certification program with only six midwives currently certified. The certification process administered by the Division of Public Health is manageable as long as there are relatively small numbers of providers to be certified. However, the Division has no ability to follow up on consumer or professional complaints or concerns. The Division believes that the best option would be the development of a valid, acceptable national certification process to handle the credentialling aspect of the regulatory process. Individual states would then be responsible for overseeing the candidates who had successfully fulfilled the requirements.

New Jersey's State Board of Medical Examiners has regulated lay midwifery since well before 1900. However, presently there are no practicing lay midwives in the state and no one has been licensed for twenty years. The Board believes there is no useful purpose for the licensure or regulation of lay midwives as certified nurse midwives are prevalent through New Jersey and have the training, experience, and education to provide appropriate prenatal care and delivery to pregnant women.

South Carolina's present regulation provides for the licensing of lay midwives and is administered by the Department of Health and Environment Control, Division of Health Licensing. The Department reports that persons practicing lay midwifery provide a much needed service to the people of South Carolina, especially those in rural and underserved areas.

The present Texas law regarding law midwifery is a totally non-regulatory act that only requires the yearly identification of practicing lay midwives. Complaints are processed and sent to the local district attorney who rarely takes any action because it only involves a $200 fine. A recent Senate bill introduced to the legislature carries mandatory education as of 1993, and provides injunctive relief to stop a lay midwife who continues dangerous practices. It should be noted that a state supreme court decision in Texas found that midwifery is not the practice of medicine.

Washington licensure requires three years of midwifery training, education requirements, and the successful completion of an examination. A study sponsored by the Department of Health reviewed the feasibility of a midwife-in-training (MIT) program for Washington. The study found that birth outcome data demonstrates that lay midwives do not constitute a threat to public health and safety. However, the limited number of potential candidates for the MIT program makes the cost/benefit ration insupportable. In addition, this report states that there appears to be little support for the premise that providing an alternative means of licensure for lay midwives will increase access to maternity care. Lay midwives attend very few of the total births in Washington.

RURAL HEALTH CARE CRISIS

One argument forwarded in support of legalization of direct entry midwifery asserts that legalization would help to provide needed health care in rural Colorado. Presently, 39 Colorado counties are federally designated Health Professional Shortage Areas. The impact on these areas of legalized lay midwifery is debatable. However, some measures to ease the shortage are being taken at this time.

The Colorado Department of Health identified six projects aimed at increasing the numbers of health professionals in rural areas.

1. **State Loan Repayment Program**
   Health care providers, including Certified Nurse Midwives, practice in an undeserved area for a minimum of two years and a portion of their educational loans are repaid.

2. **Recruitment and Retention**
   Department of Health provides various services including advertisements and resume files to connect providers with undeserved areas.

3. **Community Development Assistance**
   There are a variety of federal programs such as Community and Migrant Health Centers, Rural Outreach Program, and the Essential Access Community Hospital/Rural Primary Care Hospital Program designed to increase the numbers of providers.

4. **Colorado Department of Health**
   Provides federal funds to county nursing services and health departments to provide prenatal care for low income women and to arrange for delivery by a local physician.

5. **University of Colorado Health Sciences Center**
   Emphasizes exposing students and residents to the rural and undeserved areas of Colorado. Federal funds are available to support these efforts. Research shows that health care providers who have experience in these rural and underserved areas are more likely to practice there at the completion of training.

6. **Colorado Community Health Network**
   Works to increase access to care at Community and Migrant Health Centers throughout Colorado and the neighborhood health centers in Denver.

There are a variety of other programs through the Health Sciences Center. The six highlighted programs provide an overview of the kinds of efforts being made presently.
If one goal of legalizing direct entry midwifery is to increase access to health care in rural Colorado, or among undeserved populations, then the proponent of that goal must speak to other strategies that might help achieve that goal. Similar issues were explored by the Virginia Department of Health Professions and the Virginia Health Planning Board.

1. How can the state expand the practice of certified nurse-midwifery, which is already legal, to impact these areas?

2. What are the barriers to the practice of certified nurse midwifery?

3. What ways can policy makers encourage physicians to continue, resume, or return to the practice of delivering babies?

4. How can the Department of Health increase its efforts to bring health care to undeserved areas of Colorado?

5. What ways are available to increase the number of persons pursuing nurse-midwifery as a career?

Legalization of direct entry midwifery as one answer to shortages of health care providers in rural areas does not guarantee that the problem will be solved. There are many factors contributing to the current shortage of providers and there is no particular reason to suspect that the majority of direct-entry midwives will practice in rural or underserved areas.

REVIEW AND UPDATE OF THE LITERATURE ON DIRECT-ENTRY MIDWIVES

A review of the literature since the 1991 Sunrise Report demonstrates that there continues to be no overwhelming scientific or factual data that supports the premise that births attended by direct-entry midwives increase health risks to the mother and baby.

Current articles reviewed and summarized below illustrate the wide differences still existing regarding the practice of direct-entry midwifery:

> Opponents of direct entry midwifery argue that mortality statistics show babies are at a greater risk if they are born outside a hospital, a setting frequently used by midwives. But the "out-of-hospital" category included not only intentional home births, but also late miscarriages, premature and precipitous births, and unplanned home births. Such undifferentiated data say nothing about the safety of planned, properly attended home births.

The recent resurgence of lay midwifery in the United States has been connected with the establishment of grassroots organizations that address women's health issues. While there remain few formal training programs specifically for direct-entry midwives, the majority of lay midwives acquire cognitive knowledge informally through reading and a process of mutual exchange with other midwives.

A recent study on direct entry midwife-attended births investigated the race, age, nationality, educational attainment and birth order of the mothers and found that women opting for midwife attended birth tended to be Caucasian, over 30 years of age, above average in educational attainment, American born, and experiencing at least the third birth.

There are numerous obstacles to establishing an environment conducive to the practice of lay midwifery while creating regulatory oversight that establishes safety standards that provide the necessary protection to the public. In the final analysis, the sunrise criteria require that regulation of an occupation benefit the public. Creation of legalized lay midwifery in Colorado would require a significant change in the way this state views the regulation of occupations in general as well as a change in the specific philosophy of regulating health care if regulation of this occupation is to benefit the public.

WHAT PROBLEMS WOULD COLORADO HAVE TO SOLVE TO REGULATE DIRECT ENTRY MIDWIVES?

1. Cost of regulation. Licensed occupations in Colorado are funded by the revenues paid by the licensees and applicants for a license. Based on figures from other states, Colorado could reasonably anticipate less than fifty applicants for a license to practice lay midwifery. Not all of these applicants may meet the state's requirements so the actual number practicing could be even fewer. While it is true that more midwives may relocate to Colorado if the practice were legal, there is no evidence that they would relocate here in large numbers. Other states with licensing programs continue to have less than fifty licensees though one would expect that the regulated environment in these states would attract the best practitioners of the occupation.

   The Department has recently created new regulatory programs and a conservative estimate for start-up of a program is $30,000. Assuming that Colorado did produce 50 midwives qualified for a license, the cost to these practitioners would therefore be $600.00 per license per year. This is an unreasonable burden with respect to this profession.

   Although the 1992 application does not include an examination component, the examination presently used for the private credential must be considered. It is not unreasonable to conclude that a potential bill to regulate direct entry midwifery may include such a component.

This report has discussed the findings of the Division of Registration's review of the private examination's development. If that test does not meet the requirements of validity and reliability of examination used in other regulatory programs in Colorado, then a new exam must be developed. Colorado typically requires that examination costs be borne by the occupational group. The Department received an estimate of approximately $70,000.00 from an independent examination consultant to develop a reliable and valid lay midwife licensing examination.

2. Direct entry midwife training is not accepted by some. The applicant provided copious information regarding the proposed training standards. However, the proposed standard continues to be controversial. Many physicians contacted by the Department question the apprenticeship format of the training. It should be noted that even those physicians who felt that a birth attended by a direct entry midwife could be safe with normal delivery, were uncomfortable with the proposed training. These physicians made it clear that they would not entrust the care of their patients to a direct entry midwife trained through such an apprenticeship program.

   The Department also found that direct entry midwifery training in some countries is much different than that proposed by the applicant. In fact, some training standards incorporate a medical model that includes 98 weeks of clinical training during a three year course of study and training in pediatrics, pharmacology, embryology, physics, chemistry, and nursing. Moreover, this training is augmented by specific experience in neonatal wards, surgical wards and delivery wards. It is not unreasonable to conclude that this training is more similar to the training of certified nurse-midwives in the United States than it is to the training program suggested by the applicants.

   This draws into focus one of the difficult decisions Colorado would need to make in order to regulate direct entry midwives. Colorado has chosen one accepted path to the practice of midwifery. Certified nurse-midwives must acquire additional training beyond the nurse's degree and they must be then certified as a nurse-midwife. To allow a lay midwife to deliver children based on the training received through an apprentice program, even though demonstrated through examination, would be a significant departure from the existing system and is seen by some as unfair to nurse-midwives and dangerous to the public.

   Beyond the issue of training but related to the comparison of nurse-midwives and direct entry midwives, it should also be noted that nurse-midwives practice in Colorado under a medical model that includes physician oversight of the nurse-midwife. This, in turn, means that the delivery will occur in a hospital in virtually all cases. Therefore, even if training standards are agreed upon, the actual scope of practice for nurse-midwives as defined by present statute is different than the scope of practice proposed by the direct entry midwives.

3. Physician backup and emergency care. One view of the practice of direct entry midwifery holds that midwives should be able to practice independently with no required involvement of the physician. It is then up to the direct entry midwife and the client to acquire medical examinations, provisions for medical backup in case of a problem birth, and emergency transportation in case of a problem.

   Most persons contacted by the Department see physician involvement as a crucial component of the successful practice of direct entry midwifery. Their involvement may include such procedures as conducting an examination, determining that the mother is low risk, and being on standby should an emergency occur during delivery.

   Many physicians, as stated earlier in this report, are opposed to home births, even by doctors. Therefore, it appears that a minority of physicians would be interested in supervising, directing, or being responsible in any manner for home births by any midwife and most direct entry midwives appear to be interested in delivering babies at home, not in a hospital.

   Should Colorado grant direct entry midwives the authority to practice under complete independence, it would mark a significant shift in the state's regulatory philosophy. More importantly, some argue that such a decision would have adverse effects upon the health and safety of the state's citizens.

   Even if a system that includes medical backup is created and physicians participate in it, another serious problem looms. One argument for lay midwifery contends that the practice can ease the critical medical shortage in Colorado's rural areas. Paradoxically, these are the geographic areas that would create the most risk for mother and child in the case of a problem birth requiring medical transport.

4. Availability of medications. Direct entry midwives employ a different philosophical approach to birth than does the model of the medical community. Direct entry midwives tend to disagree with the use of medications, using more natural approaches to managing pain or stopping a hemorrhage of the mother.

   The traditional medical approach would argue that it is actually unsafe to birth a child without certain medications available. Nurse-midwives can administer medications. Special provisions would need to be established to permit direct entry midwives to administer certain medications and to establish training programs for administration of them since this is not a routine part of the direct entry midwife curriculum. Again, to permit the practice of direct entry midwifery without such provisions is seen by many as a danger to the public and a radical shift in Colorado's approach to health care regulation.

5. Malpractice coverage. Certified nurse-midwives work under the direction of physicians and are covered under the physician's malpractice insurance according to a major malpractice provider in Colorado. One factor that contributes directly to Colorado's medical crisis in rural areas is the number of obstetricians leaving practice because of the financial burden of malpractice coverage.

   If one concludes that direct entry midwives can contribute to solving the crisis in health care delivery because of their services are less expensive than those of the doctor, it does not follow that they could afford to purchase malpractice insurance and still charge reasonable rates. If they are allowed to practice and are not required to have malpractice coverage, then it could easily be argued that the public is not being protected by the regulatory scheme. This would also seem to be a case in which government offers increased financial incentives to one group over another. After all, medial practitioners could argue that their prices would be lower if they were not required to carry malpractice insurance and therefore, they too could help solve the health care problem in rural Colorado.

SOLUTIONS TO THESE PROBLEMS ARE NOT APPARENT

One administrator in another state, a nurse midwife herself, stated, "direct entry midwifery is coming: the only question is whether states take the lead or are content to follow." Yet, there are serious problems facing the implementation of regulation, as this report has shown. Answers to some of these challenges require a change in Colorado's philosophy if direct entry midwifery is to be permitted and the public protected through regulation. Implementation of these regulations would require the participation of physicians and the state cannot mandate that doctors provide backup for a health care model to which they are philosophically opposed.

There are also questions regarding the proposed level of training for direct entry midwives. Physicians interviewed by the Department express reluctance to supervise direct entry midwives in connection with the type of training proposed.

The Department finds that it cannot recommend regulation of direct entry midwives. A proposal to permit direct entry midwifery should demonstrate conclusively that it benefits the public, that it protects the public, and that the regulation is enforceable. This proposal does not meet that burden.

RECOMMENDATION 1: THE GENERAL ASSEMBLY SHOULD NOT AMEND COLORADO LAW TO ALLOW THE PRACTICE OF DIRECT ENTRY MIDWIFERY.

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