Letter to the Editor ~ criminal prosecution
North Carolina midwife
Amy Medwin, CPM
March 19th 1998

Dwight Sparks, Editor,
Davie County Enterprise Record
P.O. Box 99
Mocksville, NC 27028
704/634-9760 (Fax)

RE: **Reversing the unscientific principles which currently are the foundation for maternal-infant health policies in the US**

Dear Mr. Sparks,

I am the executive director of a professional organization for physicians and midwives who provide "domicilairy" or out-of-hospital (either home or birth center) maternity care. Our organization seeks to "normalize" midwifery (and thus maternity care) in the US by freeing midwifery from popular prejudices, legislative encumbrances, legal bias, and most recently, the criminalization of midwives so that midwifery can be restored to its traditional place as an honorable and independent profession with a central role in a national maternity care system. The core of the problem for mothers, midwives and tax payers is the uncritical acceptance of unscientific principles as the foundation for maternal-infant health policies in North America**.** A quote from the 1963 edition of *Davis Obstetrics* says it quite well: **"There can be no alibi for not knowing what is known"**. Evidence-based practice parameters are the future of maternity care in North America and they identify the midwifery-model of care for normal pregnancy as the ideal based on proven safety and cost-effectiveness. That ideal includes voluntary access to domicilairy birth services for healthy mothers who choose to be cared for in homes or birth centers by skilled midwives or physicians and easy access to hospital-based obstetrical services for complicated pregnancies or mothers who desire medication or require anesthesia during the labor or birth. *The safest form of midwifery is that which is well-articulated with obstetrical services and the safest form of obstetrical service is that which is integrated with the midwifery model of care.*

World-wide maternity statistics testify to the superior outcomes for both mothers and babies of midwifery care, liberal breastfeeding, female literacy, valuing the parent-child bond and access to obstetrical medicine for complicated pregnancies. For the better part of 2 centuries during which data is available these common-sense methods have been strongly associated with both good outcomes and low rates of mortality and morbidity. They are the lynch-pin of cost-effective healthcare for childbearing families as financed by governments and other third-party payers. Many of us believe that it is simply unacceptable as citizens of a democracy to continue supporting a maternity care system that systematically ignores more than a 100 years of factual data identifying independent midwifery management for normal birth as the only safe and cost maternal-infant national health policy for the 21st century.

In light of this overwhelmingly positive data, it seems only fitting that the valuable contribution of skilled midwives currently practicing in North Carolina be recognized and preserved through the creation of a state licensing mechanism. I would like to recommend to your legislature that same type of direct-entry midwifery licensing adopted in the "Licensed Midwifery Practice Act of 1993" by the state of California. Educational and training standards for direct-entry midwives were set to be "equivalent but not identical to those required for certified nurse-midwives". This provision creates a single body of knowledge which helps to defuse the resistance from the medical and nursing community who oppose what they

consider to be a substandard classification of midwifery licensure.

This Midwifery Practice Act includes a "challenge" mechanism which permits experienced midwives to demonstrate their competency and become licensed. To qualify one must be able to document 235 discrete caregiver activities (95 antepartal exams, 40 labors, 20 deliveries, 20 newborn exams, 80 postpartum and neonatal exams and family planning visits). Only after successfully meeting this criteria can a practicing midwife preceed with the challenge mechanism which is administered by the Seattle Midwifery School (an accredited 3 years midwifery training program in Washington state). Then each midwife must successfully passing an extensive six hour written exam as well as an eight hour clinical demonstration of midwifery skills and finally, the passage of an eight hour state board. She must also become certified in neonatal resuscitation and advanced CPR and participate in 36 hours of continuing education per 2 year licensing cycle.

As you can see the Licensed Midwife challenge mechanism is very rigorous (in fact it was written by the California Medical Association). Community midwives licensed under such as plan must meet national standards which reflect those set by the North American Registry of Midwives(NARM). A midwife who qualifies for this professional credentialing process by NARM is known as a "Certified Professional Midwife" (CPM). California uses the NARM credentialing exam as its state licensing board. North Carolina midwife Amy Medwin is a Certified Professional Midwife who meets these same national standards of experience and has passed the NARM midwifery board and thus would qualify for this licensing process were she a resident of the state of California.

I would strongly urge your paper to investigate the factual basis of the information in this letter. You may access a great deal of historical and contemporary material without having to do an equally large quantify of "leg-work" by visiting our web site at <http://www.goodnewsnet.org>. In particular, I suggest reading the file that appears at the top of the frontpage entitled **"The Official Plan to Eliminate the Midwife".** It will give you the historical background of the Hundred Years War against midwives by organized medicine. Of course, there are many other interesting files with statistical and scientific data which support the principles of a midwifery model of care and the safety of domiciliary birth services when rendered by skilled practitioners.

After having completed this phase of verification, I hope that your paper would be an outspoken advocate of a direct-entry licensing mechanism for North Carolina. State licensing would make cost-effective domicilairy midwifery care available to the childbearing population of North Carolina, maximize consumer protection by providing competency-based licensure and would remove the onus of criminalization. In addition, state-licensed community midwives of all educational backgrounds (both CNMs and CPMs) now have access to affordable liability and malpractice insurance with 1 million/3 million dollars coverage (the industry standard) through a nationally-based master policy. This not only increases the safety net to consumers but makes the economical services of domicilairy midwives available through HMO and PPO insurance plans, helping to control the costs and increase the profitability to the insurer. Clearly this is a win-win opportunity which is particularly valuable from the standpoint of reducing the expense of maternity services while improving maternal-infant outcomes.

At present, the maternal-infant statistics for North Carolina reflect some of the highest mortality and morbidity in the country. Affordable and efficacious midwifery care would contribute to significantly improved outcomes (especially reduction in prematurity which is a costly condition to treat!) while reducing the burden to tax payers, employers and private citizens. In an expanding global economy, in which we are competing against the 66% to 80% of the world already taking advantage of this economical form of maternity care, it is not a trivial matter that we are 23rd (that is third from the very bottom) in perinatal mortality while spending the very most per capita and having one of the very highest cesarean section rates in the world (second to Brazil). Obviously we are not getting our money"s worth or meeting

the practical needs of mothers and babies.

The double whammy of higher insurance premiums to corporations and individuals and expenses of the medically indigent born by governments must then passed on in the price of the product -- thus making us less competitive globally and/or resulting in the exporting of jobs abroad. While rehabilitation of our national maternity care policies are not the final answer to all the pressures of the globalization, it would at least help us to reverse the trend toward ever-high healthcare costs and would do so while improving performance. Currently, hospitalization for normal childbirth is the number one diagnosis county-wide and the number one diagnosis for the federal Medicaid program. When one considers that healthy mothers are not sick and normal childbirth is not a disease, to have childbirth be the number one cause of hospitalization is a startling statistics. Money used for expensive and unnecessary hospitalization of well women displaces that available for ill, injured or elderly people. This is an additional reason that our national maternity policy is of concern even to those who are not personally involved in utilizing birth services. No one expects that domiciliary care would ever replace hospitalization as the dominate form -- for instance it is only about 33% in Holland, the industrialized country with the highest per capita rate of domiciliary confinements (and top five in perinatal statistics!). However, with trained and licensed community midwives and a good system of obstetrical backup, we could easily reduce unwanted hospitalization by perhaps as much as a third. Truly this is worth the investment of our time and attention to bring about.

In closing I wanted to mention that I moved from Gibson, NC (15 miles west of Laurenburg in Scotland country) to California in 1979. I plan eventually to return to North Carolina, which is certainly God's country. Wouldn't it be lovely if reciprocity of licensure was available as I would be honored to serve the childbearing women of North Carolina as I have those in my adopted state of California.

I look forward to your reply.

Faith Gibson, LM, CPM
Licensed Community Midwife
Executive Director, ACDM

cc: Ina May Gaskin, President of the Midwives Alliance of North America
Sherry Boehme, President of the North Carolina Midwifery Alliance
Susan Hodges, President, Citizens for Midwifery
Sue O'Connor, President, California Association of Midwives