MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Stella Jean Hansen, on February 6, 1989, at 3:00 p.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: None

HEARING ON HB 458

Presentation and Opening Statement by Sponsor:

Rep. Peck stated that the bill was an act establishing parents' rights regarding the birth of a baby; exempting direct entry midwives from the medical practice act.

Testifying Proponents and Who They Represent:

Mona Jamison, Montana Midwifery Association
Dolly Browder
Greg Rice, M.D.
Lesley Fellers
Cheryl McMillan
Mikelann Caywood Baerg
Brant Good
Clare Trouth
Sarah Cobb
Debbie Cochran
Pam Bowman
Chris Zimmerman
Jack Polesky
Anita Vashall
Douglas Rose
Jim Haynes
Constance Morris

Proponent Testimony:

Mona Jamison states that this bill is about choice, choice about how the citizens of Montana choose to have their babies. It's also simultaneously a recognition of a

tradition in this state and the United States since we have been a territory, since this country began and since all of time on people choosing to have their babies at home with midwifes. This bill is important because there is a focus to this bill and it has to do with the ability if midwives to practice outside the cloud of criminal sanction. Ms. Jamison also supplied an impact of the obstetrical liability crisis in Montana, Exhibit 1.

Dolly Browder stated that she was a direct entry midwife and practiced for eleven years in Missoula and attended 300 births. Ms. Browder was enjoined from the practice of midwifery. She stated also that this piece of legislation is an honorable way to clarify the choice of midwives for our state citizens. This represents an enhancement to infant and maternal care and Ms. Browder wants to continue caring for pregnant women and their families.

Greg Rice, M.D. attended over 800 births and has worked with several direct entry midwives. In Lincoln County there are many people who choose to have home births and supports the theory of midwifery.

Lesley Fellers, a midwife, stated that she had attended a midwifery school in Texas which was run by a licensed midwife. She has been a midwife in Montana for seven years and in that time has attended 200 births, no deaths either maternal or infant.

Cheryl McMillan, R.N. is a midwife and a instructor at Montana State University. She is here to support the bill to exempt the practice of midwifery from the Medical Practice Act and to support a family's right to choose where and with whom they will give birth. Exhibit 2.

Mikelann Caywood Baerg stated there were 21 states that do allow the practice of lay midwifery or direct entry midwifery.

Brant Good, R.N. and is organizing health care professionals from around the state who support this bill. Currently there are 50 plus people including physicians who specialize in family medicine, pediatric medicine and emergency medicine.

Claire Trauth supports this legislation.

Sarah Cobb supports this bill.

Debbie Cochran stated that she supports this bill.

Pam Lowman stated her support.

Chris Zimmerman supports this bill.

Jack Toholsky supports this bill.

Anita Vashall supports this bill.

Douglas Rose supports this bill.

James A. Haynes an attorney stated his support and supplied Exhibit 3.

Constance Morris states her support.

Written testimony was also supplied by Constance Morris, Anita C. Vatshell, Jack Tiholshe, Pamela Luoma, Debi Corcoran, Mikelann Caywood Baerg, Kris Zimmermann, Claire Trauth, Cindy Kaiser, John Whiston.

Testifying Opponents and Who They Represent:

Cindy Kaiser
R.D. Marks, M.D.
Barb Booher, Montana Nurses Association
John Jacobson, M.D.
Patricia England, Attorney at Law
James Nickel, M.D.
Jerry Loendorf, Montana Medical Association

Opponent Testimony:

Cindy Kaiser stated her opposition to this bill and said that when the end is not good it becomes the responsibilty of the state. This bill lacks in two critical areas, certification and licensure.

R.D. Marks, M.D. stated as a member of the medical profession he opposed any activity such as home birth, which increases morbidity and mortality. The proposed legislation is not well thought out and does not serve the public's interest. Exhibit 4.

Barb Booher stated that it is the belief of the Board of Nursing that all MOntana citizens should receive their health care from qualified, educated and licenses practitioners and that patients should be in a setting where modern technology and expertise is readily available to them. Exhibit 5.

John Jacobson, M.D. reiterated the Montana Codes, 37-3-101, Purpose under the medical practice act.

Patricia England an attorney stated that the midwives request an exception to the practice act without any provision for licensing or any other quality control.

James Nickel, M.D. a gynecologist sits on a committee

in Washington which is called the maternal field committee which is a group of physicians who look over statistics, publications, and try to help regulate the 26,000 board certified gynecologist. Dr. Nickel also supplied a chart. Exhibit 6.

Jerry Loendorf stated that if this bill becomes law, it grants the greatest license that could be given, an unlimited license. We grant an exemption to any licensing. If a lay midwife is not up to whatever the standard is, who can come forward and take that person before a board or anywhere and take that license. What is the standard, there is no standard in this bill.

Written testimony was also supplied by John R. Jacobson.

Questions From Committee Members: Rep. Simon asked Ms. Fellers about high risk factors and how she determines them. Ms. Fellers stated that she used a risk scoring system, does not work with women who had pre-existing medical disease, does not work with a woman that smokes cigarettes, does not work with a woman who is younger than 18 or over 40, or has high blood pressure. Rep. Simon then asked Ms. Fellers about malpractice insurance and Ms. Fellers stated that she did not carry malpractice insurance because it was not provided.

Rep. Whalen asked Ms. Booher how many certified midwives there were and she stated that there were 16 and 8 in practice. Rep. Whalen then asked who they were certified by and Ms. Booher stated that they were certified by the Board of Nursing and are also regulated by that board.

Rep. Good asked Ms. Browder if she had ever tried to acquire a license and Ms. Browder stated that she would if there were such a license in Montana. Rep. Good then asked Ms. Browder about accountability and why would she object to do the things that are required to be certified or licensed and Ms. Browder said that she did not object to them at all, this is the practice of midwifery and not the practice of medicine.

Rep. Brown asked Ms. Jamison about certification in other states regarding direct entry midwives and Ms. Jamison stated said that there were some that did have licensure and boards and many of them do not.

Rep. Boharski asked Ms. Jamison if it was illegal to practice direct entry midwifery in the state of Montana and Ms. Jamison stated that it was not.

Closing By Sponsor: Rep. Peck closes on the bill.

DISPOSITION OF HB 458

A subcommittee was formed consisting of Reps. Russell, Stickney and Nelson.

HEARING ON HB 381

Presentation and Opening Statement by Sponsor:

Rep. Menahan stated that this bill was an act requiring insurers and health service corporations transacting health insurance business in this state to offer coverage for the formula necessary in the treatment of phenylketonuria and providing an applicability date.

Testifying Proponents and Who They Represent:

Gene Huntington, Montana Dietetic Association
Mary Musil, Montana Dietetic Association
Nichole Pool
Sidney Pratt, M.D., Department of Health and Environmental Sciences and Maternal and Child Health Bureau
John Thorson, Montana Mental Health Association
Chris Valinkady, Developmentally Disabled of Montana
Chuck Butler, Blue Cross and Blue Shield

Proponent Testimony:

Gene Huntington spoke about the treatment that dietitians were involved in which the treatment of PKU and has a great interest in this bill.

Mary Musil supplied testimony about what PKU, how does it affect a child, how is the disease passed on, is there a test for PKU, can PKU be treated, what is the problem of maternal PKU, what is new in PKU research. Exhibit 7.

Nichole Cole testified as a mother with two children that had been born with PKU. She told of the cost of caring for these children and stress which her family had in acquiring insurance for the coverage of these children.

Sidney Pratt stated that he tested the newborns for PKU. The ailment is treated through diet alone. There is no cure for this disease. The prognosis without a diet is complete mental retardation.

John Thorson stated that the early diagnosis and treatment is the most beneficial treatment.

Chris Valinkady stated that she supported insurance payments for the formula needed for PKU babies. In the last fourteen years, Ms. Valinkady has worked with 2 victims

of PKU that were not fortunate enough to be early diagnosed.

Chuck Butler rose on the proponents side but would like to state that he is neither a proponent nor an opponent but suggested an amendment.

Testifying Opponents and Who They Represent:

Tom Hopgood, Health Insurance of America

Opponent Testimony:

Tom Hopgood stated the Health Insurance Association of America believes that product availability is a function of the market place and should not be legislatively directed and would note that in this bill it would make this coverage available and would not require it to be present in every single policy. The Association believes that product availability, that is the availability of an insurance product which is a function of the market place and should not be legislatively directed. In this bill it would require the insurance company to make this coverage available and would not require it to be present in every single policy, we do have to market a policy that has coverage for this particular condition.

Questions From Committee Members: Rep. Squires asked Mr. Hopgood if there would be a specific policy for the particular individual who would have this disease and Mr. Hopgood said that this bill would require an insurance company to offer a product which would provide coverage for this condition. It would not be a specific policy it would be a rider. Rep. Squires asked if they would be cost prohibitive and Mr. Hopgood said he did not know. Rep. Squires asked if this type of insurance was available and Mr. Hopgood said there was.

Rep. Boharski asked Mr. Hopgood if there were any laws on the books similar to this and Mr. Hopgood said he did not know and if there were. Rep. Boharski asked if there were Montana laws on this and Mr. Hopgood said there were.

Rep. Simon asked Mr. Hopgood about the ordinary health insurance and a baby that might be insured under that policy that does not have this coverage, that will not pay for the cost of the formula but in the future if that child then suffers the price of having the mental retardation, under most medical insurance policies would the medical insurance then be responsible for the treatment of that child for those other kinds of symptoms that would come as a result of lack of formula. Mr. Hopgood said there was mandatory coverage under Montana statutes for mental illness but if mental

illness would extend to that, he is not sure. Rep. Simon asked Mr. Hopgood if this kind of affliction would result from the lack of formula to be the kind of coverage that would be covered and therefore insurance company responsible. Mr. Hopgood stated that he would get further information for the committee on this.

Rep. Good asked Mr. Hopgood about a rider on her insurance policy for PKU and Mr. Hopgood said that if that were not in the negotiated policy the answer is yes. You may purchase that policy as a consumer if you desire. It has to be out there on the market place.

Rep. Whalen asked Rep. Menahan if there was going to be a rider required and Rep. Menahan said that no one has been able to purchase this type of insurance and neither Blue Cross could supply this insurance.

Rep. Gould asked Dr. Pratt if a physician could immediately determine at birth if a baby had PKU by a blood test and Dr. Pratt indicated that one could.

Rep. Boharski asked Mr. Hopgood how many insurance companies cover PKU and Mr. Hopgood stated that he could not answer the question.

Rep. Simon asked Mr. Bryant who did not offer testimony why it was never put into the statute and this type of food supplement is a medication and not a food supplement and Mr. Bryant said that they were classified as formulas but were essentially a medication. Without this, the child would be mentally retarded.

Closing by Sponsor: Rep. Menahan closed on the bill and supplied the committee with a list of amendments to this bill. Exhibit 8.

DISPOSITION OF HB 381

Motion: Rep. Good made a motion to DO PASS.

Discussion: Rep. Good discussed the need of this bill and suggested that amendments be adopted.

Rep. Boharski asked Rep. Whalen about whether or not these two formulas could not be included in the list of medications. Rep. Whalen stated that the formula does not contain an actual medication. Rep. Boharski then asked if this formula was available without a prescription and was told no.

Mary McCue stated that for the purposes of this part of the law, say that this was a medication but the broader issue is, do these policies require coverage from medication. Rep. Boharski asked if an insurance company will cover any medication that a doctor prescribes. Ms. McCue

stated that may be a possibility.

Rep. Simon stated that he would disagree with Rep. Whalen about the definition of a medication. The patent on aspirin, as an example, has run out although it has been available for 17 years. It is still considered a medication. Patentability or the existence of a patent or the exploration of a patent has to have anything to do with whether or not it is a medication. The formula may have been patented, but the fact that the patent has run out does not mean that it is not covered by health insurance plans.

Rep. Nelson stated that the bill as written would be a monster. If it is the will of the committee that PKU be covered, it would be better approached if we did what was suggested here that we just make this as something that is covered by all insurance whether it is an existing policy or a new policy. Rep. Nelson feels that this is exactly what this bill will do, skyrocketing of insurance policies, or encourage rapid increase in the cost especially if it is covered in group plans that are covering 10-15 employees. Rep. Nelson proposes that the bill be redone in such a fashion that it would be a covered item under current policies. On page 2, section 1, it is very hazy language.

Rep. Hansen then proposed that the bill be put into subcommittee with Reps. Good, Whalen and Boharski as members.

HEARING ON HJR 15

Presentation and Opening Statement by Sponsor:

Rep. Jan Brown stated that this bill was a joint resolution of the Senate and the House of Representatives of the State of Montana urging the Department of Family Services to review data needs and to develop and implement an automated management information system on children in out of home placements and services provided to meet the needs of these children and requiring a report to the 52nd legislature.

Testifying Proponents and Who They Represent:

Steve Waldron, Montana Residential Child Care Association
John Thorson, Mental Health Association of Montana
Robert Mullen, Department of Family Services

Proponent Testimony:

Steve Waldron stated that the accumulation of data and the utilization of that data and supplied Exhibit 9.

John Thorson stated that the Mental Health Association was trying to track the number of out of home and out

of state placements of youth. In Montana, as his association attempted to complete that study, they found that the records of the DFS were very inadequate to provide aggregate statistics on out of home placement of children.

Robert Mullen stated that the development of a automated management information system would be beneficial. Exhibit 10.

Testifying Opponents and Who They Represent:

None.

Opponent Testimony:

None.

Questions From Committee Members: Rep. Boharski asked Mr. Waldron why a resolution was prepared on this bill and not a bill and Mr. Waldron said that when management issues were present, a resolution was often sought.

Rep. Simon asked Mr. Waldron if this is really required and Mr. Waldron said that the director did support this resolution, however, even before the DFS became a department the issue of data on children was not addressed.

Closing by Sponsor: Rep. Brown closes on the bill.

DISPOSITION OF HJR 15

Motion: Rep. Brown made a Motion to DO PASS and also made a Motion to pass on the amendments.

Discussion: None

Amendments, Discussion, and Votes: All voted in favor of the amendments which were proposed.

Discussion: Rep. Boharski asked Rep. Brown why not put this bill into the appropriations by the Department and Rep. Brown stated that the Speaker chose to send it to our committee rather than to appropriations and since it is just a resolution, they could choose to ignore it.

Rep. Squires stated that the resolution would provide direction to the Department.

Rep. Whalen stated that there was frustration expressed in the House that we would appropriate money to different departments for different things and then the departments would go ahead and spend it on what they wanted to spend the money on and not what it had been originally appropriated for.

Recommendation and Vote: A vote was taken to DO PASS AS AMENDED with all voting in favor with the exception of Reps. Lee, Nelson, Good and Boharski.

DISPOSITION OF HB 282

The hearing on HB 282 was held January 27, 1989

Motion: Rep. Strizich made a Motion to move the bill. Rep. Strizich then made a Motion to move the amendments.

Discussion: Rep. Strizich discussed the amendments which included the statement of intent. The changes in the amendment deal with the design of the facilities and not the construction. Also the placement of the commission changes. It makes the commission the function of the Montana Board of Crime Control which is a division of the Department of Justice. The net effect of that is to reduce the administrative costs and an estimated cost sheet was then distributed to the committee. The fiscal not on this bill will be reduced by a like amount to this. The initial workup that was done by the Board of Crime Control went to the office and the return was almost identical. One additional member to this commission which was an amendment recommended by the Magistrate's Association is to include a lower court judge. The amendments therefore reduced the fiscal note, adjusted the bill to come in line with design standards rather than construction standards and add a lower court judge to the bill.

Rep. Gould asked how the fiscal note had changed and Rep. Strizich stated that it would be $52,187.00 for the first year and $63,688.00 for the second year.

Amendments, Discussion, and Votes: A vote was taken on the amendments and all voted in favor. Rep. Strizich then made a Motion to Move the bill as amended.

Discussion: Rep. Lee questioned the makeup of the board and stated that it would be the inclusion of the division of architectural and engineering from the state administration office or his designee.

Rep. Strizich then made a Substitute Motion that in the language be inserted in the bill in the statement of intent that "It is intended that the commission will retain the right to evaluate each construction or renovation plan on an individual basis. The design and specifics will be worked out between the commission, the local governing body, the respective project architect and the appropriate building code inspectors and the state architect".

Rep. McCormick that the information in question was already

stated in section 1.

Amendments, Discussion, and Votes: A vote was taken and all voted in favor with the exception of Rep. McCormick.

Rep. Simon then stated his concern in the area of liability. If standards are established, and the standards then appear to be inadequate, there is then a potential for liability for the state.

Rep. Boharski asked if it would now be appropriate to strike section 1 now that the statement of intent was rewritten.

Rep. Strizich stated no.

Rep. Whalen stated that the state was not creating any liability all that was being done was that we were setting up a commission to try and figure out the appropriate standard to follow in these cases. Where liability comes in is when someone is injured in one of these institutions then it becomes a question of fact to be decided by the fact finder. This does not create any liability it creates a state commission that will determine what is appropriate.

Rep. Simon asked what would happen if the standards were not met, the state would step in and take action and even in the future try to close down facilities, corrective action plans will be adopted, failure to take corrective action, the role of the commission in providing assistance; this bill goes far beyond developing standards. If all of the standards were enumerated by the commission, the commission was going to be the enforcer. Standards should be developed.

Rep. Whalen stated that if the legislation would come up with the standards, the only use it would be would be a document that could be used against the state in any litigation,

Rep. Boharski stated that a two year study to set up minimum standards. If appropriations do not fund the project adequately, deletion of the initial regulation and bring that back in two years.

Recommendation and Vote: A roll call vote was taken. All voted in favor with the exception of Reps. Boharski, Gould, Lee, Nelson, Simon. DO PASS AS AMENDED is the vote.

ADJOURNMENT

Adjournment At: 7:00 p.m.

REP. STELLA JEAN HANSEN, Chairman

SJH/ajs

F0607.min.

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date February 6, 1989

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

ROLL CALL VOTE

HUMAN SERVICES AND AGING COMMITTEE

DATE 2-6-89 BILL NO. 282 NUMBER 1

NAME	AYE	NAY
Rep. Blotkamp	✓	
Rep. Boharski		✓
Rep. Brown	✓	
Rep. Good	✓	
Rep. Gould		✓
Rep. Knapp	✓	
Rep. Lee		✓
Rep. McCormick	✓	
Rep. Nelson		✓
Rep. Russell	✓	
Rep. Simon		✓
Rep. Squires	✓	
Rep. Stickney	✓	
Rep. Strizich	✓	
Rep. Whalen	✓	
Rep. Hansen	✓	

TALLY 11 5

Secretary Chairman

Motion: Do pass as amended

Form CS-31
Rev. 1985

STANDING COMMITTEE REPORT

February 7, 1989

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 282 (first reading copy -- white), with statement of intent attached, do pass as amended .

Signed: _____
Stella Jean Hansen, Chairman

And, that such amendments read:

1. Title, line 5.
Following: ";"
Insert: "PROVIDING THAT THE COMMISSION CONSIST OF NINE MEMBERS OF THE BOARD OF CRIME CONTROL;"

2. Title, line 8.
Following: ";"
Insert: "AMENDING SECTION 2-15-2006, MCA;"

3. Page 1, line 10.

Insert:" STATEMENT OF INTENT

The intent of this proposal is to establish a nine-member detention center standards commission. The majority of members must be representatives of local government. It is intended that the person representing the general public have an interest in and knowledge of inmates' rights. The commission will have a professional staff and will meet not less than quarterly to adopt standards, review applicable design or renovation plans, review inspections for compliance with standards, and assist governing bodies to comply with standards. It is intended that the commission and its staff serve to help detention centers and temporary detention centers comply with standards, rather than act solely as enforcers.

The commission shall adopt by rule minimum standards of design, maintenance, and operation for jails and lockups. Jails have been redefined as detention centers and lockups as temporary detention centers. The standards are intended to be an outline of

the mandatory minimum necessary for design, maintenance, and operation of constitutionally acceptable detention centers and temporary detention centers based on the "evolving standard of decency" provided in statute and case law.

It is intended that the commission hire staff to assist and to inspect for compliance with standards. When a detention center or temporary detention center is found to be noncompliant to certain standards, it is intended that any threat to life of inmates or staff be immediately remedied. In cases where noncompliance is not life-threatening, it is intended that governing bodies work with the commission to develop an action plan to remedy the problem within a reasonable time period. If, however, no action plan is developed and no corrective action is taken, it is intended that the commission may take appropriate court action, including closure of the facility.

It is intended that the commission will retain the right to evaluate each design or renovation plan on an individual basis. The design and specifics will be worked out between the commission, the local governing body, the respective project architect, appropriate building code inspectors, and the state architect.

Finally, it is intended that the standards be adopted by 1991 but that no facility be closed for noncompliance to design standards within 3 years of the adoption of the design standards. This is because design involves much time in planning, bonding, and bidding."

4. Page 1, line 15.
Strike: "construction"
Insert: "design"

5. Page 3, line 14.
Following: line 13
Strike: "appointed"
Insert: "of the board of crime control designated"
Following: "."
Strike: remainder of line 14 through page 4 line 14 in its entirety

6. Page 5, line 5.
Strike: "construction"
Insert: "design"

7. Page 5, line 16.
Strike: "construction"
Insert: "design"

8. Page 5, line 21.
Strike: "construction"
Insert: "design"

9. Page 8, line 9.
Strike: "Construction"
Insert: "Design"

10. Page 8, line 10.
Strike: "construction"
Insert: "design"

11. Page 8, line 12.
Following: "the"
Strike: "planning"
Following: "design"
Strike: ", and actual construction"

12. Page 8, lines 18 and 19.
Strike: "construction or renovation"

13. Page 8, line 22.
Following: "commission"
Strike: "shall hire"
Insert: "may to the extent possible utilize the"
Following: "staff"
Insert: "of the board of crime control"

14. Page 11, line 18.
Strike: "construction"
Insert: "design"

15. Page 11, line 21.
Strike: "construction"
Insert: "design"

16. Page 12, line 9.
Following: "Initial"
Strike: "appointments"
Insert: "designations"

17. Page 12, line 11.
Following: "shall"
Strike: "appoint"
Insert: "designate"

18. Page 12, line 12.
Following: "be"

Strike: "appointed to"
Insert: "designated for"

19. Page 12, line 13.
Following: "be"
Strike: "appointed to"
Insert: "designated for"

20. Page 12, line 14.
Following: line 13
Insert: "Section 16. Section 2-15-2006, MCA, is amended to read:
2-15-2006. Board of crime control -- composition -- allocation.
(1) There is a board of crime control.

(2) The board is allocated to the department for administrative purposes only as prescribed in 2-15-121. However, the board may hire its own personnel, and 2-15-121(2)(d) does not apply.

(3) The board is composed of 18 members appointed by the governor in accordance with subsections (4) and (5), 2-15-124, and any special requirements of Title I of the Omnibus Crime Control and Safe Streets Act, as amended. The board shall be representative of state and local law enforcement and criminal justice agencies, including agencies directly related to the prevention and control of juvenile delinquency, units of general local government, and public agencies maintaining programs to reduce and control crime and shall include representatives of citizens and professional and community organizations, including organizations directly related to delinquency prevention.

(4) Nine members of the board designated by the governor constitute the detention center standards commission provided for in [section 3]. The board members constituting the commission may be designated from recommendation lists containing at least three names from each of the following:

(a) the Montana judges association;
(b) the Montana sheriffs and peace officers association;
(c) the Montana association of counties; and
(d) the Montana county attorney association.

(5) The board members designated as the commission shall consist of:

(a) one district judge;
(b) one lower court judge;
(c) one county attorney;
(d) one county commissioner;
(e) one sheriff;
(f) one police chief;
(g) one detention center administrator;
(h) one representative of the corrections division of the department of institutions; and
(i) one person representing the general public.

(6) Members designated as the detention center standards commission serve staggered 4-year terms. A member may serve during his appointed term only if he remains a member of the entity from which he was selected. If a vacancy occurs, a member must be designated to fill the unexpired term in compliance with the representational requirements of subsections (4) and (5). Members may continue to serve past the expiration of their terms until reappointed or replaced by the governor."
Renumber: subsequent section

STANDING COMMITTEE REPORT

February 7, 1989

Mr. Speaker: We, the committee on Human Services and Aging report that House Joint Resolution 15 (first reading copy -- white) do pass as amended .

Signed: _____
Stella Jean Hansen, Chairman

And, that such amendments read:

1. Page 2, lines 20 and 21.
Following: "1991,"
Insert: "plan and"
Following; "develop"
Strike: "and implement"

2. Page 2, line 22.
Following: "placements."
Insert: "The department shall implement the automated management information system by July 1, 1993."

IMPACT OF THE OBSTETRICAL LIABILITY CRISIS IN MONTANA

Over the past three years, the Montana Academy of Family Physicians has distributed four separate surveys of physicians and hospitals in Montana to determine the extent of the obstetrical crisis in Montana. The Montana Area Health Education Center (Montana AHEC) requested the data from Dr. Paul Donaldson of the Montana Academy of Family Physicians in order that we might assist in developing an awareness on the part of health professionals and the public on the implications of the loss of obstetrical services to rural citizens of Montana. An analysis of the latest survey (October 1987) by the Montana Academy of Family Physicians is given below and illustrated on the reverse side map.

	Number	Percent
COUNTIES WITHOUT OB SERVICES	18	32%
ADDITIONAL COUNTIES SOON TO BE WITHOUT OB SERVICES	19	34%
PROJECTED TOTAL COUNTIES WITHOUT OB SERVICES	37	66%

The Montana Medical Association estimates that over 40% of all physicians in Montana have already stopped obstetrical services and that it will increase to 60% during June 1988. The Montana Academy of Family Physician survey shows that 123 physicians are still delivering babies. These data suggest that 67% of doctors have or will terminate obstetrical services in the near future. Forty-nine of the 123 physicians delivering babies are contemplating the termination of services as the insurance rates increase. The average insurance cost for Montana Obstetricians in 1987 was $42,900 and for Family Physicians delivering babies it was $11,300. Premium increases over the two year period from 1985 to 1987 have averaged 173% for obstetricians and 126% for family physicians. Additional increases are scheduled for 1988.

The information reported is constantly changing. Some counties without obstetrical services have now obtained the services of a physician. In others, physicians delivering babies have terminated their practices.

EXHIBIT 458 1
DATE 2-6-89
HB 458

TESTIMONY ON MIDWIFERY BILL

CHERYL MCMILLAN, R.N.,C., M.S.
FEBRUARY 6, 1989

MADAM CHAIRPERSON, AND COMMITTEE MEMBERS

MY NAME IS CHERYL MCMILLAN. I AM A NATIVE MONTANAN, HAVING GROWN UP IN LIVINIGSTON, AND AM A REGISTERED NURSE. I RECEIVED MY BASIC NURSING EDUCATION AT ST. VINCENT'S SCHOOL OF NURSING, IN BILLINGS AND LATER RECEIVED A BACHELOR'S DEGREE AT MONTANA STATE. I HAVE MASTER'S DEGREE IN MATERNAL CHILD NURSING FROM THE UNIVERSITY OF COLORADO. I WAS ALSO THE RECIPIENT OF A ROBERT WOOD JOHNSON FELLOWSHIP TO STUDY FOR A YEAR AT THE UNIVERSITY OF MARYLAND MEDICAL CENTER WAYS TO IMPROVE THE DELIVERY OF PRIMARY HEALTH CARE IN THIS COUNTRY. IT WAS DURING MY FELLOWSHIP YEAR THAT I ALSO RECIEVED MY CERTIFICATION AS A NURSE PRACTITIONER. I AM CERTIFIED AS A FAMILY NURSE PRACTITIONER BY THE AMERICAN NURSES ASSOCIATION.

I TEACH AT MONTANA STATE UNIVERSITY COLLEGE OF NURSING, MISSOULA EXTENDED CAMPUS. I AM AN ASSOCIATE PROFESSOR OF MATERNAL-CHILD NURSING, AND HAVE BEEN TEACHING IN THIS SPECIALTY AREA FOR SEVENTEEN YEARS. MY PRIMARY ASSIGNMENT AT MSU IS TO TEACH TWO COURSES IN MATERNITY NURSING. THE FIRST OF THESE COURSES FOCUSES ON NURSING CARE OF FAMILIES DURING THE CHILDBEARING CYCLE AND FOCUSES ON PREGNANCY AS A NATURAL PROCESS BY WHICH WOMEN AND THEIR FAMILIES ADAPT PHYSICALLY, PSYCHOLOGICALLY AND SOCIOLOGICALLY TO THE CHANGES BROUGHT ABOUT BY PREGNANCY. THE OTHER COURSE FOCUSES ON HIGH RISK CONDITIONS ASSOCIATED WITH CHILDBEARING.

I AM HERE TODAY TO TESTIFY IN SUPPORT OF THE THE BILL TO EXEMPT THE PRACTICE OF MIDWIFERY FROM THE MEDICAL PRACTICE ACT, AND TO SUPPORT FAMILY'S RIGHT TO CHOOSE WHERE AND WITH WHOM THEY WILL GIVE BIRTH.

I AM A FIRM SUPPORTER OF MIDWIVES AND OF THE ROLE THEY PLAY IN BRINGING ABOUT POSITIVE OUTCOMES TO PREGNANCY. MY STUDY OF THEIR SUCCESSES BOTH IN THIS COUNTRY AND ABROAD HAS LED ME TO THE CONCLUSION THAT THIS STATE IS IN DESPERATE NEED OF MUCH MORE EXTENSIVE MIDWIFERY SERVICES. THE CRISIS IN ACCESS TO MATERNITY CARE WHICH WE FACE TODAY IN MONTANA DEMANDS A SOLUTION AND IT IS TIME FOR ALL OF US, REGARDLESS OF PROFESSIONAL TURF OR INDIVIDUAL BIASIS TO WORK TOGETHER TO FIND SOLUTIONS TO THE CRITICAL PROBLEM FACED BY PREGNANT WOMEN--THAT IS, LACK OF MATERNITY CARE PROVIDERS AND ADEQUATE MATERNITY SERVICES. BUT IN ADDITION TO NEEDING MIDWIFERY SERVICES AS A SOLUTION TO THE ACCESS CRISIS, I BELIEVE WE NEED MORE EXTENSIVE MIDWIFERY SERVICES FOR ANOTHER AND PERHAPS MORE IMPORTANT REASON--THAT IS TO REMIND ALL OF US OF THE FACT THAT PREGNANCY IS NOT A DISEASE, NOR IS CHILDBIRTH AN OPERATION.

EXHIBIT
DATE 2-6-89
HB 458

WHEN ONE STUDIES THE STATISTICS RELATED TO THE PRACTICE OF MIDWIFERY, IT BECOMES CLEAR THAT WHEREVER MIDWIVES HAVE GONE, WHETHER TO THE HILLS OF KENTUCKY, THE MISSIPPI VALLEY OR INNER CITY CHICAGO OR SEATTLE, THERE ARE IMMEDIATE REDUCTIONS IN INFANT AND MATERNAL MORTALITY AND MORBIDITY. IT IS WELL DOCUMENTED IN MEDICAL LITERATURE THAT COUNTRIES SUCH AS SWEDEN AND THE NETHERLANDS WHICH EXTENSIVELY USE MIDWIFERY SERVICES HAVE FAR LOWER INFANT MORTALITY RATES THAN DOES OUR COUNTRY WHICH STANDS AT #19 IN THE WORLD FOR INFANT MORTALITY. IN FACT A MAJOR REASON FOR THIS HIGH RATE OF DEATH IS THE EXCESSIVE DELIVERY OF LOW BIRTH WEIGHT INFANTS E.I. BABIES WEIGHING UNDER FIVE AND A HALF POUNDS. IT IS THIS GROUP OF INFANTS THAT ARE MOST LIKELY TO DIE IN THEIR FIRST YEAR OF LIFE OR TO NEED THE SERVICES OF A NEONATAL INTENSIVE CARE UNIT. WHAT IS INTERESTING ABOUT THIS IS THAT A RECENT REPORT FROM THE MONTANA STATE BUREAU OF VITAL STATISTICS ON THE DELIVERY OF LOW BIRTH WEIGHT BABIES IN MONTANA, STATED THAT THE THE RATE OF LOW BIRTH WEIGHT DELIVERIES WAS ACTUALLY DROPPING IN ONE GROUP OF PROVIDERS IN THIS STATE---THE MIDWIFERY GROUP.

WHAT IS IT THAT ACCOUNTS FOR THEIR SUCCESSES? PRIMARILY I BELIEVE IT IS THEIR UNDERLYING PHILOSOPHY THAT BIRTH IS A NORMAL PROCESS NOT A DISEASE, AND THAT WOMEN ARE CAPABLE OF GIVING BIRTH NATURALLY. THESE BELIEFS GUIDE THEIR NON-INTERVENTIONIST APPROACH TO CHILDBIRTH. MIDWIVES UNDERSTAND INTUITIVELY WHAT A NOTED DUTCH OBSTETRICIAN, G.J. KLOOSTERMAN, PROFESSOR OF OBSTETREICS AND GYNACOLOGY AT THE UNIVERSITY OF AMSTERDAM WROTE:

SPONTANEOUS LABOUR IN A NORMAL WOMAN IS AN EVENT, MARKED BY A NUMBER OF PROCESSES, SO COMPLICATED AND SO PERFECTLY ATTUNED TO EACH OTHER, THAT ANY INTERFERENCE WITH THEM WILL ONLY DISTRACT FROM THE OPTIMUM CHARACTER. THE ONLY THING REQUIRED OF THE BYSTANDERS UNDER THESE CIRCUMSTANCES IS THAT THEY SHOW RESPECT FOR THIS AWE-INSPIRING PROCESS BY COMPLYING WITH THE FIRST RULE OF MEDICINE; DO NOT HARM.

WHAT ELSE DOES MIDWIFERY HAVE TO OFFER TO WOMEN AND THEIR FAMILIES? AN IMPORTANT ELEMENT OF THEIR CARE IS THE RELATIONSHIP THEY DEVELOP WITH THE FAMILIES WITH WHOM THEY WORK, AND THE WAY IN WHICH THEY ASSIST FAMILIES TO TAKE RESPONSIBILITY AND CONTROL OVER THEIR OWN PREGNANCIES. EDUCATION ABOUT PREGNANCY, CHILDBIRTH AND NUTRITIONAL NEEDS IS ALSO AN IMPORTANT ELEMENT OF THEIR CARE. THEREFORE MIDWIVES SPEND MUCH TIME WITH WOMEN ANSWERING QUESTIONS AND PROVIDING INFORMATION ABOUT PREGNANCY, LABOR, DELIVERY AND THE CARE OF THE NEWBORN. THIS EDUCATION HAS ITS PAYOFF--WITH HEALTHY WOMEN GIVING BIRTH TO HEALTHY INFANTS. NOT ONLY THAT, THE CARE GIVEN BY MIDWIVES COSTS LESS BECAUSE IT DOES NOT RELY TO A GREAT EXTENT ON HIGH COST TECHNOLOGY.

MANY WOMEN FIND IT EASIER TO RELATE MIDWIVES THAN THEY DO TO PHYSICIANS. THE NATIONAL INSTITUTE OF MEDICINE STUDY ON PREVENTING LOW BIRTH WEIGHT SAYS THIS IS PARTICULARLY TRUE OF LOW INCOME WOMEN AND TEENAGERS. HOWEVER, IT IS INTERESTING TO NOTE THE IT IS WOMEN OF HIGHER SOCIOECONOMIC STATUS AND EDUCATION WHO

ACTIVELY SEEK OUT MIDWIVES FOR CARE.

IN SHORT, MIDWIVES RESTORE TO WOMEN CONFIDENCE IN THEIR ABILITY TO GIVE BIRTH TO THEIR BABIES. WITH A CESARIAN SECTION RATE WHICH HAS RISEN FROM 5% IN 1970 TO ALMOST 27% IN 1989, THIS CONFIDENCE HAS BEEN SERIOUSLY ERODED.

INDEED, THE FACT THAT ONE OUT OF FOUR AMERICAN WOMEN ENDS UP HAVING A CESARIAN SECTION WHEN GIVING BIRTH IS A MAJOR REASON WHY INCREASING NUMBERS OF WOMEN ARE SEEKING SAFE ALTERNATIVES TO HOSPITAL BIRTHS AND WHY INCREASING NUMBERS WOMEN IN THIS STATE WILL CONTINUE TO HAVE BIRTHS AT HOME, WHETHER OR NOT THIS LEGISTLATION IS PASSED.

THERE ARE OTHER REASONS OF COURSE FOR SEEKING MIDWIFERY SERVICES. MATERNITY CARE IS EXPENSIVE. A STUDY DONE BY GOLD AND KENNEY IN 1985 ESTIMATED THE COST FOR A NORMAL DELIVERY TO BE MORE THAN $3,200 AND THE COST OF A CESAREAN DELIVERY TO BE $5,000. UNDOUBTEDLY THESE COSTS ARE HIGHER TODAY. WHILE MANY FAMILIES ARE ABLE TO DEFRAY THESE EXPENSES THROUGH HEALTH INSURANCE OR THROUGH PUBLIC HEALTH PROGRAMS, NOT ALL PREGNANT WOMEN HAVE ACCESS TO EITHER OF THESE RESOURCES. IN 1985, 9.5 MILLION WOMEN OF CHILDBEARING AGE HAD NO HEALTH INSURANCE. THE NUMBER IS HIGHER TODAY.

FOR THE PAST TWO AND A HALF YEARS I HAVE BEEN A CONSULTANT TO A PUBLIC HEALTH PROGRAM IN MISSOULA WHICH ASSISTS LOW-INCOME PREGNANT WOMEN IN GAINING EARLY ACCESS TO PRENATAL CARE. THIS SUMMER I COMPLETED AN EVALUATION STUDY OF THIS PROGRAM, AND AM CURRENTLY IN THE PROCESS OF DOING ANOTHER STUDY INTERVIEWING LOW-INCOME WOMEN ABOUT WHAT THEY SEE AS BARRIERS TO RECEIVING MATERNITY CARE. ONE OF THE SERRENDIPITOUS FINDINGS FROM STUDIES WAS THAT IN A SUBGROUP OF TWENTY WOMEN WHO DID NOT QUALIFY FOR THE LOW-INCOME PROGRAM, A QUARTER OF THEM, WHEN ASKED WHAT THEY WOULD DO ABOUT GETTING PRENATAL CARE, SAID THAT THEY WOULD SEEK THE SERVICES OF A LOCAL MIDWIFE AND HAVE A HOME BIRTH BECAUSE THEY COULDN'T AFFORD PHYSICIAN AND HOSPITAL CARE.

BUT WHAT ABOUT SAFETY? I WOULD IMAGINE THAT THIS IS THE CENTRAL ISSUE CONCERNING YOUR COMMITTEE, AND I WOULD IMAGINE THAT SOME OF THOSE WHO OPPOSE MIDWIFERY ARE GOING TO TELL YOU THAT PARENTS WHO CHOOSE THIS FORM OF BIRTH EXPERIENCE EITHER DO NOT UNDERSTAND THE RISKS THEY ARE TAKING OR WORSE ARE DELIBERATELY ENDANGERING THEIR UNBORN CHILD. WHEN I FIRST BEGAN EXPLORING THIS ISSUE, I DID SO FROM A POINT OF VIEW SIMILAR TO THIS. ALL THE CATASTROPHIC EVENTS THAT COULD OCCUR AT A BIRTH A HOME WERE CLEARLY PRESENT IN MY MIND AS I BEGAN READING THE LITERATURE AND TALKING WITH PEOPLE ABOUT THEIR EXPERIENCES.

LITTLE BY LITTLE MY POSITION CHANGED AS I FOUND THAT THE LITERATURE DID NOT SUPPORT THE NOTION THAT HOSPITAL BIRTHS WERE NECESSARILY SAFER THAN BIRTHS AT HOME. IN FACT MUCH OF THE LITERATURE SUPPORTED THE OPPOSITE CONCLUSION PARTICULARLY IF THE HOME BIRTHS WERE PLANNED, THE WOMEN WERE LOW RISK AND WERE

ATTENDED BY MIDWIVES.

I WAS PARTICULALY IMPRESSED WITH FINDINGS OF TWO STUDIES CONDUCTED BY LEWIS MEHL,A PHYSICIAN AND FORMER DIRECTOR OF THE CENTER FOR RESEARCH ON BIRTH AND HUMAN DEVELOPMENT AT BERKELEY, CALIFORNIA, REPORTED IN TWO MEDICAL JOURNALS. IN HIS WELL CONTROLLED COMPARATIVE STUDY OF 1146 PLANNED MIDWIFE ATTENDED HOME BIRTHS AND 1146 PLANNED PHYSICIAN ATTENDED HOSPITAL BIRTHS, MEHL ET AL FOUND THERE WERE NO SIGNIFICANT DIFFERENCES IN BIRTHWEIGHT, PERINATAL MORTALITY OR OTHER COMPLICATIONS. HOWEVER IN THE HOSPITAL, THE FETUS HAD A SIX TIMES GREATER INCIDENCE OF DISTRESS IN LABOR, BABIES WERE CAUGHT IN THE BIRTH CANAL 8 TIMES MORE FREQUENTLY, AND MOTHERS WERE 3 TIMES MORE LIKELY TO HEMORRGHAGE IN THE HOSPITAL THAN IN THE HOME. fURTHERMORE, 4 TIMES AS MANY BABIES IN THE HOSPITAL NEEDED RESUSCITATION, INFECTION RATES WERE 4 TIME HIGHER , AND CHANCES OF PERMANENT INJURY AT BIRTH WERE OVER 30 TIME GREATER IN THE HOSPITAL .

OTHER STUDIES HAVE YIELDED SIMILAR RESULTS. MEHL COMPLETED ANOTHER COMPREHENSIVE STUDY ADDRESSING THE QUESTION AS TO EXACTLY WHAT HOSPITAL PROCEDURES POSED THESE HAZARDS. THE ANSWER WAS THAT THERE WERE FOUR MAJOR HOSPITAL PROCEDURES ACCOUNTING FOR THE HIGHER INCIDENCE OF DAMAGED BABIES.; STIMULATING DRUGS TO SPEED UP LABOR (PITOCIN); PAIN RELIEVING DRUGS; FORCEPS, AND BREAKING THE BAG OF WATERS.

THIS OF COURSE IS NOT TO SAY THAT MIDWIVE ATTENDED HOME BIRTH IS SAFE FOR ALL WOMEN, OR THAT CATASTROPHIC EVENTS CANNOT OCCUR IN THE HOME. BABIES DO DIE, AND WOMEN CAN HAVE SUDDEN COMPLICATIONS. THERE ARE WOMEN WHO ARE AT HIGH RISK FOR POOR PREGNANCY OUTCOMES AND THESE WOMEN SHOULD BE DELIVERED IN THE HOSPITAL BY PHYSICIANS, AS SHOULD WOMEN WHO ARE NOT COMFORTABLE WITH THE IDEA OF A MIDWIFERY OR . HOME BIRTH. BUT WE NEED TO REMEMBER THAT CATASTROPHIC EVENTS HAPPEN IN THE HOSPITAL AS WELL AS AT HOME AND WE ARE NOT ABLE TO SAVE ALL BABIES AND ALL MOTHERS. IN LIFE AND IN DEATH THERE ARE NO GUARANTEES. THE FAMILIES THAT CHOOSE HOME BIRTH AND THE MIDWIVES THAT SERVE THEM KNOW THIS. THEY VIEW THE RISKS A HOME TO BE LESS HAZARDOUS THAN THE RISKS IN THE HOSPITAL.

YOUR JOB AS A COMMITTEE IS TO MAKE A RECOMMENDATION AS TO WHETHER MIDWIFERY SHOULD BE EXEMPTED FROM THE MEDICAL PRACTICE ACT. I VERY STRONGLY BELIEVE THAT IT SHOULD BE. NOT TO DO SO WILL AT BEST PUSH IT UNDERGROUND, AND A WORST RESULT IN WOMEN HAVING UNATTENDED HOME BIRTHS, A SITUATION WHICH IS CLEARLY NOT SAFE FOR PREGNANT WOMEN. IF AS IS THE CASE IN EVERY STATE IN THE UNION IT IS NOT ILLEGAL TO GIVE BIRTH AT HOME, PARENTS SHOULD HAVE THE RIGHT TO HAVE SKILLED BIRTH ATTENDENTS. IN A STATE SUCH AS MONTANA WITH ITS VAST DISTANCES, AND POOR ACCESS TO HEALTH CARE SERVICES, WOMEN WILL, BOTH BY CHOICE AND BY NECESSITY, CONTINUE TO GIVE BIRTH AT HOME. PLEASE TO NOT MAKE IT A CRIME FOR MIDWIVES TO ATTEND THOSE BIRTHS.

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TEW, MARJORIE. "WE HAVE THE TECHNOLOGY". NURSING TIMES. NOV. 20,1985. (MS. TEW CONCLUDES AFTER COMPREHENSIVE STUDIES OF STATISTICAL INFORMATION REGARDING HOME AND HOSPITAL BIRTHS THAT BIRTH IS THE SAFEST WHEN INTERVENTION IS THE LEAST.)

Office Memorandum

STATE DEPARTMENT OF HEALTH
AND ENVIRONMENTAL SCIENCES

May 27, 1988

TO : Dr. Espelin

FROM: Sam Sperry

SUBJ: Montana Resident Live Births And Infant Deaths By Attendant At Birth: 1980-1986

For the attached tables and graphs: Physician indicates delivery with a physician in attendance regardless of the place of delivery.
Midwife indicates delivery with a person in attendance who used the title CNM or NMW or "midwife" or "mid-husband", regardless of the place of delivery.
Other indicates delivery with a person in attendance who did not use a title. These births typically occur at a residence. We believe that these births are attended by "lay" midwives who have the father or some other family member sign the certificate as certifier and attendant.

A. During 1980-1986, 96 % of Montana's resident births were attended by physicians with the delivery occurring in hospital.

There is, however, a definite trend toward midwife-attended deliveries occurring out of hospitals. In 1980, 91 % of these births were in hospital and in 1986 the figure had dropped to 72 %.

B. Of 862 resident infant deaths in Montana during 1980-1985:

97 % were attended by physicians at birth.
1 % were attended by midmives at birth.
2 % were attended by others at birth.

These percents are the same for births not resulting in infant death.

C. Of 862 resident infant deaths in Montana during 1980-1985:

46 % were delivered LBW.

Of these 46 %:

97 % were attended by physicians at birth.
1 % were attended by midwives at birth (actually 0.3 %).
2 % were attended by others at birth.

D: Reference attached graphs:

Page 1. A definite downward trend in percent of LBW births for midwife-attended deliveries.

The apparent increase in this percent for other-attended deliveries since 1984 may be due to small numbers.

Page 2. The percents on page 1 are indexed at 1980 on this graph. It is evident that midwife-attended deliveries are experiencing much more rapid improvement with respect to LBW births than either of the other two categories of attendants.

Page 3. There is a slight, visual hint in this graph that mothers experiencing LBW births are seeking prenatal care a bit farther into pregnancy than those experiencing normal-weight births.

Pages 4-6. These are percent distributions for the month prenatal care began by attendant category. Midwife-attended deliveries appear to exhibit the same experience as physician-attended deliveries. The relatively high percents of "no care" and "unknown month" for other-attended deliveries may reflect poor reporting.

Pages 7-9. These are percent distributions of total number of prenatal visits by attendant. Midwife and physician experiences appear identical.

E: Conclusions:

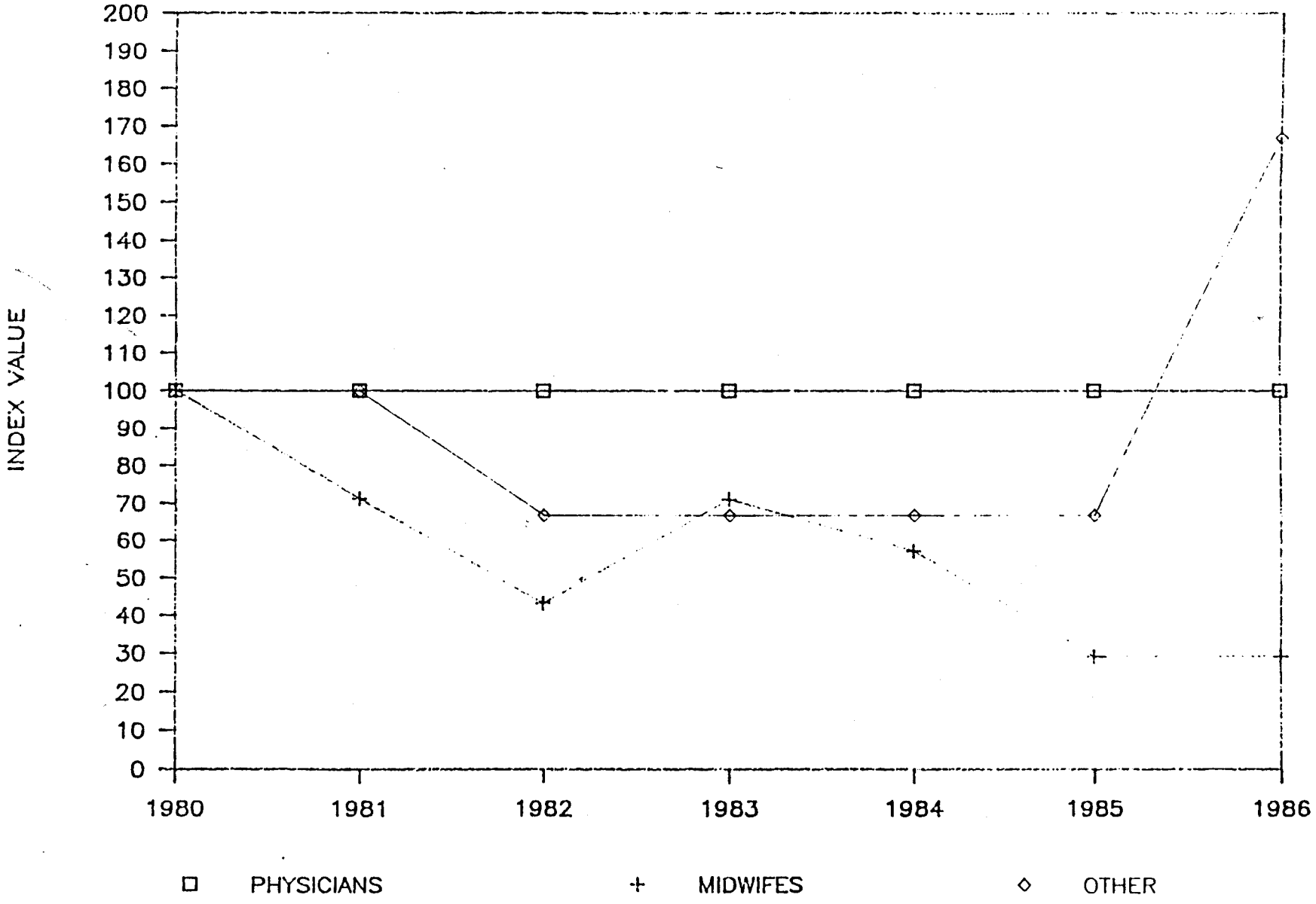
On the basis of this relatively superficial look at the data, we see no evidence that midwives are associated with infant death or LBW births to any degree different from physicians, with the possible exception noted for Page 1 and Page 2 under D, above.

F: Recommendation:

Part of the difficulty we are experiencing in detecting differences in attendant-related births as they affect LBW and infant death lies in our not knowing what to look for. I believe that it would be of great benefit to both our bureaus if we could schedule a few sessions over the next month or so in which you would provide me and my statistical staff with some medical instruction regarding the perinatal period and, perhaps, the months preceding this period. I would appreciate your serious consideration of this. We can certainly use your help.

LOW BIRTH WEIGHT INDEX BY ATTENDANT

MONTANA RESIDENT LIVE BIRTHS :1980–1986



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This certifies that the foregoing is a true and correct copy of the original certificate on file with the Mont. Department of Health and Environmental Sciences.

Sam H. Sperry

Sam H. Sperry, Chief
Bureau of Records and Statistics
Date 11-28-88 By

A. During 1980-1986, 96 % of Montana's resident births were attended by physicians with the delivery occurring in hospital.

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TELEPHONE: (406) 363-6431

JAMES A. HAYNES
Attorney at Law
P.O. BOX 544
HAMILTON, MT 59840

February 6, 1989

House Human Services and Safety Committee

RE: Montana Midwifery Association Bill, H.B. 458

In support of:

My family supports H.B. 458.

We have two children who were born at home with the assistance of a lay or non-licenced midwife. These home birth experiences were most important to my family. The choice to have this experience is ours alone, we feel, both from a personal and economic standpoint. We chose the midwife after careful consideration, she did not choose or solicit us.

Please avoid the tempting "what if something went wrong" syndrome and support H.B. 458. This bill will allow us to continue to legally make choices about the most important event in our family life; the birth of our children at home.

Very Truly Yours

J. A. Haynes

EXHIBIT 3
DATE 2-6-89
HB 458

TESTIMONY GIVEN BEFORE THE HUMAN SERVICES COMMITTEE

MONTANA STATE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1989

I am R.D. Marks, a family practitioner from Missoula, and I am testifying on behalf of myself, the Montana Medical Association, and the Montana Academy of Family Practice in oppostion to House Bill 458.

This bill represents idealism without realism or responsibility. It is very important that the realistic picture be seen and for the members of this committee and for the legislature, in general, to know what will be the effects of this legislation.

Certainly as Americans, particularly as Montanans, we all see ourselves as having the right to do as we please within the confines of the law. Usually the law limits our rights in areas where our activities may endanger or impinge upon the rights of others. However, it is important to note that Congress and the legislature in the past enacted laws that limit our rights to protect us from ourselves and our own misjudgement. We are all now required to wear orange while we are hunting and seat belts while we are driving. To assume, as this bill suggests, that our rights to birth where and with whom we please is exempt from this sort of legislative review is incorrect. Certainly. if the legislature sees the public good better served by limiting this right, they certainly have the authority to do so. It is my argument that the past legislatures in their wisdom have intentionally kept lay-midwifery as a non-legal entity and in violation of the medical practice act.

EXHIBIT 4
DATE 2-6-89
HB 458

"Direct-entry midwifery" in this legislation has no definition, and this bill certainly places no limitations on what a "direct-entry midwife" can do in terms of prenatal care, delivery, or postpartum care. This basically exempts "direct-entry midwives" from the medical practice act and in so doing gives them the authority to practice without regulation, without proof of education, ability, or training. Under this act, a "direct-entry midwife" would not even have to meet the "see one, do one, teach one" criteria.

Pregnancy and birthing is generally a very smooth progression of a very complicated physiologic, anatomic, and emotional events. As with any complex process, problems can arise. In pregnancy, these problems can be as minor as skin rashes or headaches or as major as toxemia, severe hypertension, or the often fatal uterine rupture and amniotic fluid embolism. Certainly, all of us who have spent years of our lives studying fertility, embryology, pregnancy, parturition and it aberrancies and idiosyncrasies view this process as a miracle. It is a miracle that it so often turns out right. While we appreciate the miracle that it is, we appreciate more the potential for sudden unpredictable, disastrous interruptions in this miraculous process. The practice of obstetrics is often seen as a practice in which there are long periods of routine calm interrupted by moments of sheer terror.

Because obstetrics is very complicated, technical, and risky, those involved with the profession have recognized the need for education and training. As such, nurse midwives are required to have 1-2 years of intensive training beyond their nursing degree. All M.D.s and osteopaths have obstetrics as part of the core curriculum of medical school which comes after four years of undergraduate training. Family practitioners do 6-12 months of further obstetric training in their residency, and obstetricians have 3-4 years of training beyond medical

school. Perinatologists, the real pregnancy experts, has 6-8 years of training beyond medical school. This represents for them four years of undergraduate training, four years of medical school, four years of obstetric training, and finally 2-4 more years of a perinatal fellowship. It is hard for me to believe that anyone can be really qualified to perform obstetrics after merely watching and participating in a few births.

This legislation is proposing that we give the supervision of pregnancy and birthing to "direct-entry midwives" who have little or no training. Lay midwives will have to show no credentials as part of their abilities. All they will need to do is to hold themselves out to the public as an authority as someone who has the necessary skills to deliver babies. It is uncomprehendable how the legislature and its regulator agencies require proof of training, certification, and licensure examinations for surveyors, boiler operators, beauticians, guides and outfitters, and truck drivers while under this legislation will require no such criteria for anyone who perceives him-or herself as skilled or qualified to deliver babies at home--which in itself is a risky proposition.

You may have or will hear much emotional testimony from members of the lay public regarding how good an experience they had with their lay midwife and how qualified she was and how good a job she did. Let me remind the members of this committee that good outcome does not necessarily indicate good quality or training. While I appreciate how these people feel towards their midwife and their home birthing experience, the lay people have no criteria or knowledge to judge the qualification of their midwife. For the most part, if their midwife. For the most part, if the midwife is personable, and the parents like her, and the outcome is good, they then see her as qualified. It becomes an emotional

judgement rather than a reason judgement. I believe the parents and babies of Montana deserve more than that.

Because "direct-entry midwives" are not able to get hospital privileges, this legislation, in effect, gives approval of home deliveries--a practice that everyone will agree has a very real increased risk.

The arguments that we hear in this regard is that if there is a problem we can go to the hospital, or the risk is acceptable to us as parents, or hospital care is too expensive.

Many complications of a delivery occurring at home are not emergent in nature and do allow time for transport to the hospital. However, many obstetric emergencies don't allow time for transport and need immediate intervention to save the life of the mother or baby or both. All of us in the profession have seen many such emergencies, and they occur with alarming frequency. Placental abruption, placenta previa, uterine rupture, severe fetal distress, and fetal asphaxia are just a few of the fairly common sudden emergencies. All of these are life threatening to mother and baby or both. All require immediate intervention available only at hospitals to prevent death or morbidity. In my personal experience of having attended about 500 deliveries, I can recall five instances in which a normal routine delivery had a sudden complication, and we had less than five minutes to act to prevent death. That to me is an alarming frequency.

Is that risk acceptable to the parents, or do parents really have the right to judge it as acceptable? Certainly as adults we are allowed to expose ourselves to certain risks (except the risk of driving without a seat belt or not wearing orange during hunting season), but society has spoken quite loudly that we

cannot expose our children to unnecessary risks. Our child protective services intervene for risks to children far less severe than this 1%-2% risk of morbidity and mortality that is associated with home birth. From a humanitarian and medical viewpoint, that risk is too high, and certainly, for the legislature to condone such a risk to the lives of children who have no say in the matter is unconsciable and unresponsible.

As for the argument that hospitals are too expensive, I ask you what a healthy living baby is worth? Most hospitals doing obstetrics have reduced charges for people who deliver and are discharged early. These charges are usually in the range of $700-$900. Is that too much? Certainly, those mothers who have lived and had babies who lived because they were in the hospital consider it dollars well spent.

In Missoula this past summer, we had an attempted home birth in which a prolapsed cord occurred, and the baby died before it was recognized and treated. This was an occurrence, which had it occurred in the hospital, would have been quickly diagnosed and probably resulted in a live healthy baby. What price will these parents pay forever in living with those memories?

Are the potential costs of home birthing acceptable to society? Consider for example the cost of severe cerebral palsy that may occur because resuscitation equipment is not available to treat an asphaxiated infant. The cost of the care of these children is astromonical and most often borne by the state welfare system. Can society accept these costs?

The members of this committee I am sure are painfully aware of the loss of obstetrical services in large areas of the state. Proponents of lay midwifery

and home births say that this legislation addresses this shortage of services. The present problem is here today because of the high cost of bad outcome of a high-risk profession. That is all part of a normal obstetric practice. It takes then a very skewed logic to propose a solution which guarantees higher risk and an increased level of morbidity and mortality.

The state of Oregon has a very non-restrictive law regarding who can deliver babies. Basically, the law is the same as what is proposed here--a mother can choose anyone she wants to deliver her baby--. The Oregon State Health Division conducted a study because there was a perceived increase in home birth related deaths. In the five year study, ending in 1981, they found that there was an unexpected large number of babies who died unnecessarily. As a result, a task force was formed to develop guidelines for the practice for out-of-hospital births, and may I emphasize that this was a task force made up of lay midwives, naturopaths, chiropractors, nurses, nurse midwives, osteopaths, M.D.s, and the lay public. The guidelines developed proposed requirements for licensure/certification, provider training, continuing education, and staffing necessary for home birthing. They went on further to develop a list of routines and standards for home births, part of which was a list of absolute and relative contraindications to home births. Finally, they established criteria for equipment which should be present in all deliveries and guidelines for quality assurance. I have distributed copies of this report to members of the committee.

It is important for this committee to recognize that lay midwifery is currently quite widely practiced in Montana. Probably 150-200 deliveries per year are at home. These midwives are for the most part very caring, concerned individuals.

They, however, seem not to recognize their limits as directed by their training or by the medical practice act. In a recent trial in Missoula regarding the practice of lay midwifery, Judge John Hanson, in his restraining injunction against the midwife involved, stated unequivocally that the administration of drugs, artificial rupture of membranes, the diagnosis and treating of conditions of pregnancy, the cutting of episiotomies, and suturing of tears was the practice of medicine without a license.

In conclusion, as a member of the medical profession, I oppose any activity, such as home birth, which increases morbidity and mortality. I realize that the ivory tower mentality of mine and the medical profession, in general, may not be consistent with the philosophy of the legislature and general public. I believe, however, that if the legislature really believes that lay midwifery and home birthing are choices which should be available to Montanans, then the members of this committee and the legislature, in general, need to take some responsibility to assure that some standards are set and to establish some means to monitor the compliance with those standards. The proposed legislation is not well thought out and does not serve the public's interest. The question of home births and lay midwifery is a complicated, controversial issue--the solution of which requires more than a simple one line statutory change. I encourage this committee to give House Bill 458 a recommendation of <u>DO NOT PASS</u>.

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February 6, 1989

The Honorable Budd Gould
House of Representatives
Helena, MT 59601

Dear Mr. Gould:

I am opposed to House Bill 458 in its present form. As described in this bill legalizing lay or direct-entry midwives leaves it entirely up to the discretion of the individual as to his/her qualifications. Unlike others exempted from the Medical Practice Act, they have no structured course of instruction, standards of care, certification or licensure requirements. There is no guarantee that these will be attained.

Ninety-eight percent of births in Montana occur in a hospital. Concurrent with the shift from home to hospital birth over the last fifty years has been the impressive drop in maternal mortality. In 1987 there was one maternal death compared to twenty in 1950. Neonatal mortality, (death of infants under 28 days of life) has declined to 4.6%. This is well below the national figures and would indicate that those professionals delivering babies in Montana are performing well.

Dr. F. G. Hofmeister, former president of the American College of Obstetricians and Gynecologists, and a leading advocate for maternal safety in childbirth has stated, .." the normality of obstetrics is its most dangerous feature... in a single short moment the anticipated great joy associated with an uncomplicated, spontaneous labor and birth can become a catastrophe..."

In our quest for improved maternal and infant outcome, we should realize that "high risk" may not be recognized even during provision of good prenatal care. The outcome of delivery varies with both the place and circumstance of delivery. In hospital versus out-of-hospital does <u>not</u> suffice to describe risks. Less prenatal care and not having a trained birth attendant at delivery predispose infants to high neonatal mortality. One cannot refute the affect of good prenatal and delivery care given so far by certified nurses and physician providers.

Women in rural areas are expressing concern about care during pregnancy and birth. Expanding the utilization of facilities and individuals already prescribed by law can help alleviate the situation: i.e. public health clinics, nurse practitioners and nurse midwives.

Childbirth is one of the greatest and most overwhelming events that a woman may experience in her lifetime. It influences our lives, bringing to a family the joy, sadness, pride, anger and frustration many of us are privileged to remember. Legalizing lay midwives under this bill will not assure the public safety. It has no requirements for standard of care, licensure, certification or education.

Dismissing all the special interest groups for the moment, the bottom line is a healthy baby and a healthy mother. That constitutes a good family experience in the end.

Thank you for your consideration and attention.

Sincerely,

Marietta Cross RN

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Maternal Child Health Care Services
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President
Healthy Mothers Healthy Babies
The Montana Coalition

MC:jbm

MATERNAL & CHILD HEALTH: 1988

A TASK FORCE REPORT ON GUIDELINES FOR OUT-OF-HOSPITAL BIRTHS

HEALTH DIVISION
OREGON DEPARTMENT OF HUMAN RESOURCES
1400 S.W. 5th Avenue
Portland, OR 97201

A TASK FORCE REPORT ON GUIDELINES FOR OUT-OF-HOSPITAL BIRTHS

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
OFFICE OF HEALTH SERVICES
MATERNAL & CHILD HEALTH PROGRAM

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1988

Acknowledgements

Guidelines for
Out-of-Hospital Births

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These guidelines are intended to define some parameters of safe out-of-hospital birth care. They can in no way be totally comprehensive or take the place of the judgement of the individual out-of-hospital birth practitioner. The out-of-hospital birth practitioner and the consumers choosing out-of-hospital care must ultimately take responsibility for the decisions that they make.

INTRODUCTION

Until about 1940, the majority of babies in the United States were born at home. From 1940 to 1970, there was a dramatic decline in the proportion of births delivered outside of the hospital--from 44.2% to 0.6%. There has been a small rise in out-of-hospital birth from 1970 onward, but the nationwide proportion has not risen above one percent (Pearse, 1982; U. S. Department of Health and Human Services, 1984).

Locally, the rate of out-of-hospital birth is reported higher. In Oregon, growth in the out-of-hospital birth rate began in the late 1960's and has "accelerated rapidly since" (Oregon Medical Association, 1984). During 1981 and 1982, Oregon demonstrated increases in the out-of-hospital birth rate that far surpassed the national trend (Anderson et al., 1984). At 4.3% in 1985, Oregon reported the highest percentage of out-of-hospital birth nationwide (Oregon State Health Division, Center for Health Statistics, September, 1987). In 1986, 3.8% of births were out-of-hospital (Oregon State Health Division, Center for Health Statistics, 1986).

Several factors probably account for Oregon's high out-of-hospital birth rate. Certainly the less restrictive nature of Oregon's statutes with regard to childbirth is an important contributor. In Oregon, any person may attend a woman during childbirth. The only restriction is that, unless the person is licensed to do so, medications may not be administered and episiotomies may not be performed. Births in Oregon are attended by medical doctors, certified nurse midwives, naturopaths, chiropractors, nurses, lay midwives, relatives and friends.

A review of out-of-hospital births in Oregon from 1975-1979 revealed a

potential excess in mortality. In order to attempt to identify factors amenable to public health intervention, the Oregon Public Health Association and Oregon State Health Division published a report entitled "Out-of-Hospital Births in Oregon" (Anderson, et al., 1984). A panel of experts reviewed birth and death records from 1979 to 1981. This panel was comprised of representatives from all of the major provider groups. The report summarized that:

> The study population contained an unexpectedly large number of mature, high birthweight (2500 grams or more) non-anomalous infants who should not have died...The Panel also found that certain individiuals had a poorer opportunity for a positive outcome when delivered outside an adequately equipped and staffed hospital due to their obstetric risk status. For example, cases of diagnosed breeches, large for gestational age infants, post-mature infants and infants with meconium stained amniotic fluid fell in this category (p. 8).

Furthermore, it was stated that 85% of out-of-hospital births are attributable to a defined group of providers, and that quality of care could be affected by addressing activities toward these individuals. The development of standards of practice for these out-of-hospital maternity care providers was one of this study group's concluding recommendations.

In May of 1985, The Oregon State Health Division invited representatives from the major out-of-hospital provider groups as well as several members-at-large (known for their expertise in issues involving maternity care) to comprise a Task Force. This Task Force was asked to respond to the aforementioned Oregon Public Health Association/Oregon State Health Division recommendation to develop guidelines for the practice of out-of-hospital birth. This Task Force met monthly through October, 1987, and has formulated the following suggestions to guide the practice of out-of-hospital birth in Oregon.

SECTION I

Scope of Service

When attending women during childbirth in an out-of-hospital setting, the out-of-hospital birth practitioner in Oregon (hereafter referred to as "the practitioner") should limit his/her scope of practice to care of the normal, healthy woman experiencing a normal pregnancy and labor. An uncomplicated birth and healthy neonate should be anticipated. Guidelines for such practice are outlined within this document.

SECTION II

Provider Requirements

Licensure/Certification

It is recommended that the professional organization of the practitioner implement written standards, peer review, continuing education, and the collection of statistics. Licensure or certification will be determined according to the requirements of each professional organization or applicable State law. Each practitioner should be accountable to a professional organization.

Provider Training

The training for an out-of-hospital birth practitioner should include theoretical preparation and the practice of clinical skills necessary for the management and care of normal women and newborns as well as for the prompt recognition of abnormalities that would indicate the need for consultation and/or referral. The following are suggested for inclusion within basic training. The depth of content in some instances will be determined by legal scope of practice.

Didactic Content[1]

A minimum of two-hundred hours of didactic content including the following is recommended:

Basic aseptic technique;
Basic adult and newborn physical assessment, including vital signs;
Basic adult and neonatal cardiopulmonary resuscitation;
Oregon State statutes pertinent to childbirth;
Special considerations for out-of-hospital delivery;

Antepartum
Female anatomy and physiology Anatomy and physiology of conception and pregnancy;
Preconceptional factors likely to influence pregnancy outcome;
Clinical application of genetics, embryology and fetal development;
Effects of pregnancy on the woman;
Etiology and management of common discomforts of pregnancy;
Parameters and methods for assessing the progress of pregnancy;
Parameters and methods for assessing fetal well-being;
Nutritional assessment of the maternal-fetal unit;
Environmental influences on the maternal-fetal unit;
Psychosocial, emotional and sexual changes during pregnancy;
Common screening/diagnostic tests used during pregnancy;
Indicators of risk in pregnancy and appropriate intervention;
Assessment of relevant historical data regarding the client and her family;
Assessment of physical status;
Assessment of the soft and bony structures of the pelvis;
Assessment of the emotional status of the client and the dynamics of her support system;
Diagnosis of pregnancy;
Nutritional counseling;
Counseling in the physical and emotional changes of pregnancy and preparation for birth, parenthood and changes in the family;
Planning for individual/family birth experiences;
Planning and implementation of individual and or group education;

Intrapartum
Normal labor process, including the mechanisms of labor and delivery;
Anatomy of the fetal skull and its critical landmarks;
Parameters and methods for assessing progress of labor and delivery;
Parameters and methods for assessing maternal and fetal status;
Common screening/diagnostic tests used during labor;
Emotional changes during labor and delivery;
Comfort and support measures used during labor and birth;

Didactic Content

Intrapartum (continued)

Anatomy, physiology and indicators of normal adaptation of newborn to extrauterine life;
Methods to facilitate newborn's adaptation to extrauterine life;
Indicators of deviations from normal and appropriate interventions;
Assessment of relevant historical data about clients;
Assessment of general physical and emotional status of clients;
Diagnosis and assessment of labor and its progress through the four stages;
Techniques for spontaneous vaginal delivery;
Techniques for spontaneous delivery of the placenta;
Techniques for the management of common obstetric emergencies;

Postpartum

Anatomy and physiology of the puerperium including the involutional process;
Anatomy and physiology of lactation and methods for its facilitation or suppression;
Parameters and methods for assessing the puerperium;
Etiology and methods for managing discomforts of the puerperium;
Emotional, psychosocial and sexual changes of the puerperium;
Establishment of maternal-infant-family bonds;
Common screening/diagnostic tests used during the puerperium;
Assessment of client's general physical and emotional status;
Nutritional needs during the puerperium;
Indicators of deviations from normal and appropriate interventions;
Appropriate anticipatory guidance regarding self-care, infant care, family planning, and family relationships;

Neonatal Care

Anatomy and physiology of continuing adaptation to extrauterine life and stabilization of the neonate;
Parameters and methods for assessing neonatal status;
Parameters and methods for assessing gestational age of the neonate;
Nutritional needs of the neonate;
Screening/diagnostic tests performed on the neonate;
Assessment of relevant historical data about maternal and neonatal course;
Indicators of deviations from normal and appropriate intervention;
Resuscitation and emergency care of the newborn.

[1] The didactic content are adapted from Core Competencies in Nurse-Midwifery by The American College of Nurse-Midwives, May, 1985, Washington D.C. Adapted by permission.

Written examinations designed to test knowledge of didactic content should be administered and scored by the practitioner's professional organization.

Clinical Experience

Clinical experience should include documentation of the following types and numbers of experiences. These experiences should be obtained while under supervision with mastery of these skills approved by the practitioner's professional oraganization.

The primary management of fifty (50) spontaneous vaginal births. (Some of these births must have taken place in an out-of-hospital birth setting);
Prenatal visits of at least fifteen (15) different women for a total of one-hundred (100) visits;
Thirty (30) newborn physical examinations;
Thirty (30) postpartum visits to mother and baby within thirty-six hours of delivery;
Observation of one complete series of prepared childbirth classes and one complete series of breast feeding preparation series.

Continuing Education

Continuing education is strongly recommended. Continuing education may be obtained through organized courses, conferences, or other mechanisms. During any year, the State Health Division may suggest specific topics for continuing education based upon any problem areas identified.

Staffing

Since any birth involves two clients potentially in need of simultaneous care, a second practitioner who has received the recommended training should be in attendance for all out-hospital births.

SECTION III

Routines and Standards

Antepartum Care

Orientation

With the initiation of prenatal care, practitioners should present to each client information about their practice. This orientation might include: their experience and training, protocols and standards, professional affiliation, emergency back-up arrangements, how to obtain twenty-four hour access to their services, explanation of financial arrangements, services they provide and the responsibilities of the pregnant woman and her family.

Initial Visits

In the first prenatal visits, the following history should be obtained: health, reproductive, family, social and current pregnancy. The practitioner will evaluate nutritional status, height, weight and blood pressure, uterine size relative to gestational age, and the size and shape of the bony pelvis. A comprehensive physical examination should be performed early during the course of prenatal care by the practitioner or another health care provider.

Laboratory Tests

Each woman should receive the following tests: hematocrit and/or hemoglobin, blood group and Rh type, antibody screen, syphilis screen, rubella titer, pap smear, urinalysis, and appropriate blood glucose screening. Additional tests may be indicated by history and physical exam or the initial laboratory data.

Prenatal Visits

Prenatal visits in an uncomplicated pregnancy should be every four weeks for the first 28 weeks, every two to three weeks until 36 weeks, and weekly thereafter. Each visit should include the interval history and physical examination, including blood pressure, weight, fundal height, fetal presentation, fetal heart rate, urinalysis for protein and glucose, and the mother's assessment of fetal activity. The practitioner should continuously evaluate the pregnancy for risks taking into consideration information derived from: physical examination, laboratory tests, maternal complaints, and the overall physical and emotional well-being of the mother. The family should be kept informed of these risks.

Education/Counseling/Anticipatory Guidance

The practitioner should offer information or referral to community resources on childbirth preparation, breastfeeding, exercise and nutrition, parenting, and care of the newborn. Birth attendants should inform pregnant women and their families about available obstetric and pediatric tests and procedures, such as: alpha fetoprotein (AFP) screening, chorionic villi sampling, amniocentesis, prenatal Rhogam, ultrasound, human immunodeficiency virus (HIV) testing, newborn metabolic screening, eye prophylaxis, neonatal vitamin K and circumcision.

Emergency Access

Each practitioner should provide a mechanism that ensures twenty-four hour coverage for his/her practice.

Intrapartum Care

Assessment During Labor

As part of the initial assessment of a woman in labor, the following should be checked: maternal temperature, blood pressure, pulse, urine (for glucose, protein, and ketones), frequency, duration and intensity of uterine contractions, the physical and emotional environment, fetal position and presentation, and fetal heart tones before, during, and after uterine contractions. All of the above factors are re-assessed throughout labor, with maternal temperature and blood pressure monitored at least every four hours, and fetal heart tones evaluated every 15 to 30 minutes during active labor and immediately after ruptured membranes. During the second stage of labor, fetal heart tones should be auscultated after each contraction or every five minutes.

Premature Rupture of Membranes at Term

When a client reports suspected rupture of membranes before the onset of labor at 37 weeks gestation or greater, timely evaluation should include obtaining a careful history, documentation of ruptured membranes, and ruling out infection and/or fetal distress. Clients should be instructed in measures to prevent and identify infection. It is recommended that practitioners specify additional protocols for the management of premature rupture of membranes at term.

Physiologic Care During Labor

The practitioner should make certain that the mother is receiving nourishing, easily digestible foods in early labor and adequate fluid intake later in labor. The woman should be encouraged to urinate every one

to two hours.

Postpartum Care

Postpartum Assessment and Care

The blood pressure, pulse, uterine fundus, and lochia should be checked every 15 minutes for the first hour after birth and thereafter until the woman's condition is stable. The perineum and vagina should be inspected for lacerations requiring repair. If the required repair does not fall within the scope of practice or expertise of the practitioner, arrangements should immediately be made for transfer or proper attendance.

Before the practitioner leaves or the family is discharged, the mother's general condition, blood pressure, pulse, temperature, fundus, lochia, and ability to ambulate and urinate should be assessed and found to be within normal limits. The practitioner or other qualified person should stay with the mother and infant until both are stable and secure and at least two hours have passed since the birth. The family should be instructed to make certain that someone is with the mother at all times during the first twenty four hours and that she receives support and care for at least the first few days.

Postpartum Instructions

The family should be provided with instructions that include: self and baby care and hygiene, signs of infection and methods for prevention (mother and infant), signs of illness in the newborn, normal infant feeding patterns, uterine massage and normal parameters of lochia, and safety in the home and car. Emotional needs, the changes in family dynamics, and the importance of rest, fluids, and good nutrition should be reviewed.

Further follow-up should be arranged and instructions for the reporting of problems or deviation from normal will be given. Parents will be encouraged to contact the practitioner for any questions or concerns.

Laboratory Studies/Medications

Rubella vaccine should be given to non-immune women postpartum. An Rh Immune Globulin workup should be done for Rh negative women, including cord blood. Unsensitized Rh negative women who have given birth to an Rh positive infant should be given Rh immune globulin (300 micrograms) intramuscularly within 72 hours post-birth.

Follow-up

Postpartum follow-up care should minimally include visits done 24-48 hours, the third day, 1-2 weeks, and 4-6 weeks post-birth. The practitioner should continue to monitor appropriate vital signs, and physical and social parameters including adequacy of support systems and signs of infection. Information should be provided regarding lactation, postpartum exercise, family planning, and community resources available.

Newborn Care

Newborn Assessment and Care

Newborn assessment should include the monitoring of temperature, pulse, and respirations each hour for the first two hours post-birth and thereafter until stable. A thorough physical exam should be done shortly after birth including assessment of length, weight, head circumference, fontanels, palate, heart, lungs, abdomen, genitalia, muscles and skeletal

system, back, buttocks, rectum, assessment of neurological status (including assessment for jitteriness or lethargy as well as the presence of normal newborn reflexes), and general appearance. A gestational age assessment should be done. The family should be informed of any deviation from normal.

The practitioner or other qualified person should stay with the family until a minimum of two hours post-birth have passed, all parameters of physical assessment are found to be within normal limits, and the infant has demonstrated normal suck and swallow reflexes.

Laboratory Studies/Medications/Birth Registration

Out-of-hospital births must adhere to state guidelines for the administration of Vitamin K and opthalmic prophylaxis. Cord blood for Type and Coomb's might be sent for infants whose mothers have Type O blood. Cord bilirubin levels should be determined on Direct Coomb's positive specimens. Infant metabolic screening should be according to OSHD recommendations. Additional laboratory studies may be warranted as determined by the infant's condition or pediatric consultation. All births must be registered with the Oregon State Health Division.

Prolonged Rupture of Membranes

If the birth has taken place more than twenty-four hours after rupture of membranes, additional observation and laboratory information is recommended. The baby should be observed closely for twenty-four hours by personnel trained in the monitoring of temperature, respirations, and assessment of peripheral circulation. It is recommended that specimens for culture be obtained from the baby's ear canal and gastric aspirate and that

a complete blood count (CBC) be obtained.

Follow-up

Within the first week, arrangements should be made with the parents for the provision of ongoing pediatric care. It is recommended that this follow-up care include visits done at 24-48 hours, 3 days, 1-2 weeks, and 4-6 weeks of age. This provider should continue to monitor appropriate vital signs, weight, length, head circumference, color, infant feeding, and sleep/wake and stool/void patterns. A complete physical examination should be repeated at each visit. Information should be provided about age-appropriate safety and developmental issues, vitamins/fluoride drops, immunization, circumcision, and community resources available.

SECTION IV

Risk Assessment

Risk assessment is separated into two categories, absolute and non-absolute. These different categories will be defined. "Absolute" risk means that clients presenting with these conditions or clinical situations are felt to be at extreme obstetrical or neonatal risk. These clients are not considered appropriate for out-of-hospital birth. Such clients should plan an in-hospital birth if risk factors are identified in the antepartum and transferred to in-hospital care if risk factors are identified in the intrapartum or postpartum. Certainly, if a risk factor first develops when birth is imminent, the individual practitioner must use his/her best judgement to determine what is safest for mother and baby.

"Non-absolute" risk includes situations that sometimes place a client at high obstetric or neonatal risk. Some of the factors to consider

regarding these non-absolute risk criteria would include the specific practitioner's experience and expertise, the particular birth setting, and the ease and time involved in accessing emergency transport/back-up systems. Furthermore, community standards of care for some of the items included within these categories may change frequently. In order to allow for the individualization of these situations, the non-absolute risk criteria do not automatically exclude a client from out-of-hospital birth. Instead, they require careful consideration. In some instances consultation is recommended. Whenever possible, consultation should be sought with State licensed physicians who have Obstetric and/or Pediatric hospital admission privileges. This consultation may be by telephone depending on the the clinical and geographic situation.

The following absolute and nonabsolute risk criteria do not negate additional standards set by various professional organizations.

Antepartum

Absolute Risk Criteria

Cardiac disease;
Renal disease - active or chronic;
Liver disease - active or chronic;
Active hyperthyroidism;
Active neoplasia;
Chronic obstructive pulmonary disease;
Asthma requiring medical supervision;
Psychotic disorders;
Essential chronic hypertension;
Pre-eclampsia/eclampsia;
Acute or chronic thrombophlebitis;
Hemoglobinopathies (excluding thalassemia);
Anemia (Hematocrit less than 30) at term;
Blood Coagulation Defect;
Infectious disease requiring medical supervision or isolation;
Current substance abuse;
Uterine anomaly;
Multiple gestation;
Malpresentation at start of labor;

Antepartum - Absolute Risk Criteria (continued)

Labor or Spontaneous Rupture of Membranes prior to 37 weeks gestation;
Abruptio placenta;
Placenta previa;
Previous Rh sensitization;
Rh negative blood with a positive antibody titer;
Positive antibody titer for factors known to cause hemolytic disease;
Polyhydramnios;
Fever (101 degrees Fahrenheit or above) at the onset of labor;
Fetuses with life-threatening congenital defects;
History of thromboembolism;
Previous uterine wall surgery;
Estimated fetal weight less than 2500 grams (5 pounds 8 ounces);
Seizure disorder;
Documented Intrauterine Growth Retardation;
History of previous uterine inversion;
Suspected ectopic pregnancy;
Suspected incomplete spontaneous abortion;
Pregnancy lasting longer than 42 weeks gestation;
Significant Glucose Intolerance (including glucose intolerance of pregnancy);
Estimated fetal weight greater than 4500 grams (9 pounds 15 ounces);
History of retained placenta (greater than 1 hour);
Rupture of membranes 24 hours before the onset of labor;

Non-Absolute Risk Criteria

Grandmultiparity;
Uncertain dates with no confirmation of gestation within the first trimester;
Family history of life-threatening congenital disorders;
Deep conization of cervix;
Suspected intrauterine growth retardation;
Significant 2nd or 3rd trimester bleeding;
Abnormal fetal cardiac rate or rhythm;
Disease requiring pharmacologic intervention;
Weight greater than 20% above ideal for height and body type;
Greater than 50 pound weight gain during current pregnancy;
Estimated fetal weight between 4000 grams and 4500 grams (greater than 8 pounds 13 ounces but less than 9 pounds 15 ounces);
Positive genital Herpes culture or symptomatic disease less than 14 days prior to the onset of labor;
History of postpartum hemorrhage (greater than 500cc);

Intrapartum

Absolute Risk Criteria

No prenatal care or unavailable prenatal records;
Prolapsed cord or cord presentation;
Abnormal bleeding;
Fever of 101 degrees Fahrenheit or above taken orally on two occasions two hours apart or any other evidence of active infectious process;
Development of pre-eclampsia (an increase in blood pressure greater than 30/15 from baseline or greater than 140/90 when taken on two occasions 30 minutes apart;
Meconium-stained amniotic fluid;
Evidence of fetal distress, abnormal fetal heart rate pattern or inability to auscultate fetal heart tones;
Failure to progress in the active phase of labor with the presence of strong contractions;
Failure to deliver within the expected time during the second stage of labor (Generally, 2 hours for primip; 1 hour for multip);
Fetal malpresentation;
Excessive vomiting, dehydration, acidosis or exhaustion;
Multiple gestation;
Oligohydramnios;
Active genital herpes lesion;

Non-absolute Risk Criteria

Suspected active genital herpes lesion;

Postpartum

Absolute Risk Criteria

Retained placenta (greater than 1 hour);
Incomplete placenta;
Major laceration requiring hospital repair;
Uncontrolled postpartum bleeding;
Painful hematoma;
Development of pre-eclampsia (an increase in blood pressure greater than 30/15 from baseline or greater than 140/90 when taken on two occasions 30 minutes apart;
Signs of shock;

Non-absolute Risk Criteria

Evidence of active infectious process;
Any condition requiring more than 12 hours of postpartum observation;

Infant

Absolute Risk Criteria

Apgar less than 7 at 10 minutes of age;
Signs of prematurity;
Respiratory rate greater than 60 accompanied by any of the following: nasal flaring, grunting, or retraction lasting greater than 1 hour;
Cardiac irregularities, heart rate less than 80 or greater than 160 (at rest), heart murmur(s), or any other abnormal or questionable cardiac findings;
Seizures;
Temperature less than 97 degrees Fahrenheit or greater than 100 degree Fahrenheit when taken rectally or any other evidence of infectious process;
Major congenital anomaly;
Apnea or central cyanosis;
Large or distended abdomen;
Decreased peripheral perfusion (greater than 3 second capillary refill);
Any infant that has required intubation;
Any infant where meconium has been visualized at the level of the cords;
Any condition requiring more than 12 hours of observation post-birth (This does not include the previously mentioned 24-hour observation recommended for infants born after 24 hours of ruptured membranes);

Non-absolute Risk Criteria

Apgar less than 7 at 5 minutes;
Weight less than 2500 grams (5 lbs. 8 oz.) or greater than 4500 grams (9 pounds 15 ounces);
Gestational age assessment less than 37 weeks;
Poor suck, hypotonia a weak or high-pitched cry;
Jitteriness;
Failure to void or stool withing 24 hours from birth;
Maternal substance abuse identified intrapartum or postpartum;
Projectile vomiting or emesis of fresh blood;
Excessive pallor, ruddiness, or jaundice;
Any generalized rash at birth;
Birth injury such as facial or brachial palsy, suspected fracture or severe bruising);
Blood glucose less than 40;
Weight decrease in excess of 10% of birth weight;
Maternal-Infant interaction problem(s);
Direct Coomb's positive cord blood with bilirubin level greater than 3.5 milligrams;
Birth occurring greater than 24 hours after rupture of membranes

SECTION V

Specific Guidelines

Referral, Transfer and Transport Capability

The practitioner must maintain and document a plan for referral, transfer, and emergency transport.

Equipment/Care of Equipment

The practitioner should provide equipment necessary to monitor the health status and provide emergency care to the mother, fetus, and newborn within the limits of the practitioner's scope of practice. Equipment must be periodically inspected and found to be in working order. Methods to assure the sterility or cleanliness of equipment should be implemented.

Facility Standards

Home Delivery

Each family should have all necessary supplies at least three weeks before the due date. The following information should be posted at the phone: address and phone number of the nearest hospital, phone number of ambulance, route to the hospital, the family's address, and clear directions to their house.

At least one prenatal visit should be done at the intended place of birth. Each house should be checked for adequate light, heat, water and cleanliness. If there is no phone, arrangements must be made for immediate telephone access or emergency communication. The family should be instructed to correct problems or deficiencies. If the family is unwilling or unable to provide an adequate sanitary environment for home birth, the practitioner should support a hospital or birthing center delivery.

Birth Center Delivery

A free-standing birth center should meet the facility requirements of the State of Oregon.

SECTION VI

Quality Assurance

Medical Records[2]

Client records should be maintained in a format designed to provide continuity and documentation of legible, uniform, complete, and accurate maternal and newborn information readily accessible and containing information both necessary and helpful in the event of transer to in-hospital care. Confidentiality must be maintained. It is recommended that the medical record on each client include documentation of:

Demographic information and client identification;
Documentation of client orientation and informed consent;
Complete social, family, medical, reproductive, and nutritional histories;
Initial physical examination, laboratory tests and evaluation of risk status;
Development of a plan for care (including appropriate referral of ineligible clients) and payment for services;
Periodic prenatal examination and evaluation of risk factors;
Instruction and education including nutritional counseling, changes in pregnancy, self-care in pregnancy, understanding of findings on examinations and laboratory tests, preparation for labor, sibling preparation (if applicable), and newborn assessment and care;
History, physical examination and risk assessment at the onset of labor;
Monitoring of the progress in labor with on-going assessment of maternal and fetal reaction;
Consultation, referral and transfer for maternal or neonatal problems that elevate risk status;
Physical assessment of newborn including Apgar scores, maternal-newborn interaction, prophylactic procedures, postpartum monitoring of vital signs and accomodation to extrauterine life;
Labor summary;

Medical Records (continued)

Discharge summary for mother and newborn;
Plan for home care, follow-up, referral to community resources;
Plan for newborn health supervision and required screening tests;
Late postpartum evaluation of mother, counseling for family planning and other services.

[2] These guidelines for Medical Records have been adapted from Standards for Freestanding Birth Centers (Pages 19-20) by The National Association of Childbearing Centers, (1987), New York, New York. Copyright 1987 by The National Association of Childbearing Centers. Adapted by permission.

Mechanism for Review[3]

Each professional organization should have an established program for the evaluation of the out-of-hospital care that its practitioners provide. An organizational plan must be in effect to identify and resolve problems. It is recommended that quality assurance include the following mechanisms for review:

Regular meeting of practitioners to review the management of care of individual clients and to make recommendations for improving the plan for care;
Regular review of all hospital transfers of mothers and neonates to determine the appropriateness and quality of the transfer;
Regular review and evaluation of all problems or complications of pregnancy, labor, and postpartum, and the appropriateness of the clinical judgment of the practitioner in obtaining consultation and attending to the problem;
Regular review of all health records for legibility and completeness;

[3] These guidelines for Medical Records have been adapted from Standards for Freestanding Birth Centers (Pages 21-23) by The National Association of Childbearing Centers, (1987), New York, New York. Copyright 1987 by The National Association of Childbearing Centers. Adapted by permission.

Statistics

Quality of care is assessed by the analysis of data collected. Statistics collected should include both utilization of services as well as outcomes of care provided. It is recommended that statistics be collected and include the following whenever possible: number of women registered for care, spontaneous abortions, antepartum transfer and reason for transfer, intrapartum transfer and reason for transfer, length of labor stages, unattended births, postpartum transfer and reason for transfer, newborn transfer and reason for transfer, type of delivery, where delivered, complications of delivery, episiotomies, lacerations, infant birthweight, Apgar scores, neonatal morbidity/mortality, maternal morbidity/mortality, maternal and newborn hospital admissions for the first six-weeks postpartum along with reason for admission.

Informed Consent

Informed consent for out-of-hospital birth care should be obtained from each client. Clients should indicate that they fully understand the following: benefits, risks and eligibility requirements for an out-of-hospital labor and birth, services that can be provided by the practitioner as well as those provided by contract, consultation and referral, the qualifications of the practitioner, the scope of practice of the practitioner as determined by State law, consultants and related services and institutions, the practitioners plan for the provision of emergency care in the event of complications to the mother and fetus/newborn, written statement of fees for services provided and responsibilities for payment, and the responsibilites of the client.

VI SUMMARY

These suggested guidelines for the practice of out-of-hospital birth in Oregon are the result of over two years of discussion between representatives of the various groups providing out-of-hospital care in Oregon and other concerned individuals. They can in no way represent consensus opinion of all of the members of the groups represented including the Oregon State Health Division.

The members of the Oregon State Health Division Task Force on Out-of-Hospital Birth support the spirit of cooperation and compromise that was an inherent part of formulating these guidelines. It must be emphasized that, for the most part, standard of care for the groups involved has previously been established. Where Task Force guidelines differ from existing group standards, it must be acknowledged that the various professional organizations and groups have determined what they feel to be the best care for their clients.

REFERENCES

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Montana Nurses' Association
715 Getchell
Helena, Montana 59604

Testimony Presented to
House Human Services and Aging Committee

February 6, 1989

by

Barbara Bocher, Executive Director

I am Barbara Bocher, Executive Director of the Montana Nurses' Association and I am here to testify against Section 2 of HB 458. The Montana Nurses' Association is opposed to this Section for the following reasons:

Based upon the current OB access crisis in Montana, where availability of professional medical obstetrical care may be restricted, the Montana Nurses' Association advocates the use of certified nurse midwives as an alternative or cooperative source of obstetrical care. As a client advocate, MNA supports the parent's right to have their desires for childbearing considered, but also feel obligated to ensure that quality standards and safety in perinatal care be available and practiced.

The educational background and certifying process involved in becoming a certified nurse mid-wife qualifies this nurse to provide the level of expertise needed to bring about a healthy outcome. MNA will continue to encourage the medical community to increase collaboration efforts with certified nurse midwives in the utilization of CNMs in providing alternative birthing methods. MNA supports this as a viable, cost-effective alternative for access to obstetrical care. Lay-midwifery does not meet the structural and functional standards of a profession, i.e. accountability, education, preparation or assurance of competency. MNA cannot support the use of lay midwives in the provision of maternity care.

It is our belief that all Montana citizens should receive their health care from qualified, educated and licensed practitioners and that patients should be in a setting where modern technology and expertise is readily available to them, if necessary.

EXHIBIT 5
DATE 2-6-89
HB 458

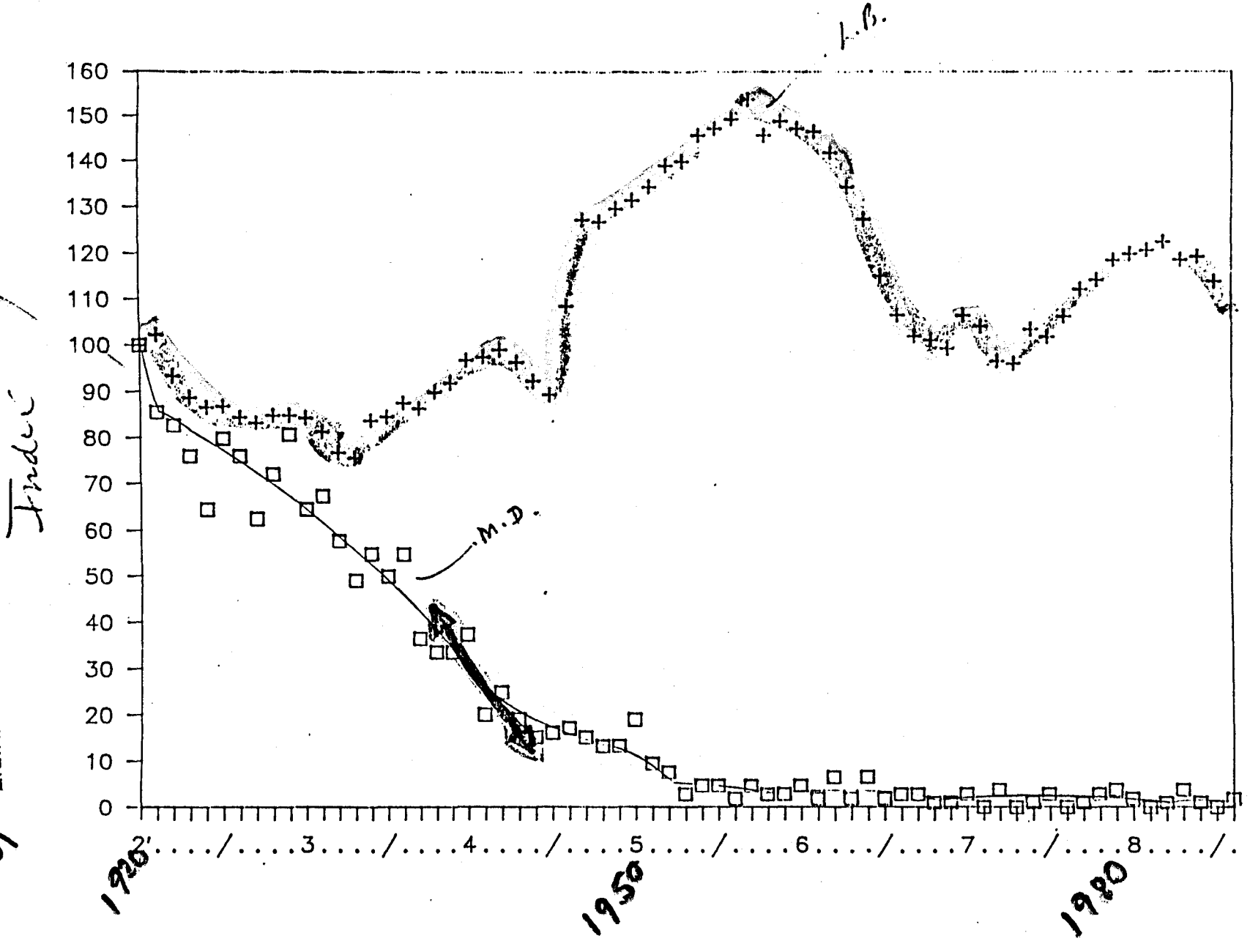


EXHIBIT 6
DATE 2-6-89
HB 458

March of Dimes
BIRTH DEFECTS FOUNDATION
1275 Mamaroneck Avenue
White Plains, New York 10605

Genetic Series

Public Health Education Information Sheet

PKU

PKU (phenylketonuria) is an inherited disease that, if untreated, causes mental retardation. About one baby in 8,000 is born with PKU in the United States each year. Most are of North European descent, but the condition is found in all ethnic groups. It is uncommon among Jewish, Asian, or Black families.

Although the disease is rare, its costs are great—not only in terms of money (several million dollars spent in state hospitals alone each year), but in family sorrow as well.

WHAT IS PKU?

PKU is a disease that affects the way the body is able to process the food it takes in. The process is called metabolism. Children born with PKU can't metabolize a part of protein called phenylalanine, which then collects in the blood stream. This abnormal build-up of phenylalanine can prevent the brain from developing as it should.

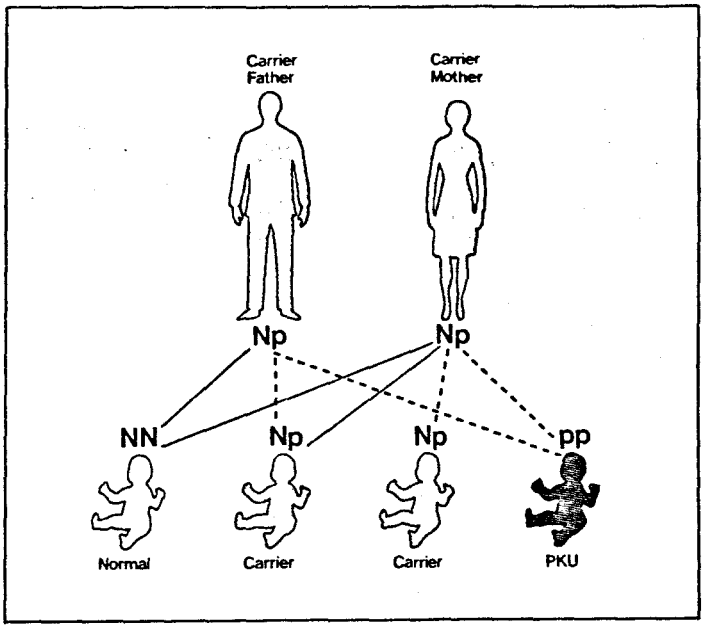
HOW DOES IT AFFECT A CHILD?

Children born with PKU appear normal for the first few months. Untreated, at three to five months they begin to lose interest in their surroundings, and by the time they are a year old they are mentally retarded. PKU children often are irritable, restless, and destructive. They may have a musty odor about them, and often have dry skin or rashes. Some have convulsions. Usually, they become physically well-developed children, and have blonder hair than their relatives.

HOW IS THE DISEASE PASSED ON?

PKU is inherited when both parents have the PKU gene and pass it on to their baby. (Genes are the particles of heredity in cells of the body. They pass on such traits as eye color and facial features, and sometimes diseases.) A parent who has the PKU gene, but not the disease, is a "carrier." A carrier has a normal gene as well as a PKU gene in each cell. A carrier's health is not affected in any known way.

When both parents are "carriers," there is a one-in-four chance that each will pass the defective gene on to a child, causing it to be born with the disease (see diagram). There also is a one-in-four chance that they will each pass on a normal gene, and the child will be free of the disease. There is a two-in-four chance that a baby will inherit the



PKU gene from one parent and the normal gene from the other, making it a carrier like its parents.

The chances are the same *in each pregnancy* that PKU genes will or will not be passed on. All the children in one family may be free of the disease, even though their parents are carriers. All or some may have PKU or may be carriers.

IS THERE A TEST FOR PKU?

Yes. Babies can be tested for PKU when only two days old and still in the hospital. The baby's heel is pricked and a few drops of blood are taken. The blood is sent to a special medical laboratory to find out if it has more than a normal amount of phenylalanine. If so, more tests are done to learn whether the baby has PKU or some other cause of high phenylalanine.

There also is a urine test, but the blood test is more reliable.

Most states in this country now have laws saying that babies must be tested at birth for PKU.

EXHIBIT 7
DATE 2-6-85
HB 381

CAN PKU BE TREATED?

Yes. The baby is put on a low phenylalanine diet. That means no cow's milk, regular formula, or meat, because these protein foods have too much phenylalanine in them.

At first, the baby is fed a protein formula milk that has had the phenylalanine taken out of it. Later, certain vegetables and other foods that are low in phenylalanine are added.

As the child grows, his blood is tested regularly because the diet has to be changed if the amount of phenylalanine becomes either too high or too low. Some researchers believe PKU children can stop the diet when they reach school age (about five or six years). They feel that a child's nervous system is then developed and can no longer be damaged by a high phenylalanine level. Other researchers disagree, because some children who have stopped the diet at school age appear to have later showed drops in intelligence test scores.

All testing and treatment should be done by health care professionals who have special training in PKU.

WHAT IS THE PROBLEM OF MATERNAL PKU?

When a woman who has PKU becomes pregnant, her baby is likely to be born retarded. This has become a great problem because many girls who were treated for PKU and grew up normally now are having babies. These infants rarely inherit PKU, but they are likely to be brain-damaged in the womb by their mothers' abnormal body chemistry. Such babies can't, of course, be helped by a special diet, because the damage was done before they were born.

Mental retardation may be prevented if the mother goes back on her PKU diet before and during pregnancy. The problems are many:

- women often become pregnant without planning to, and damage may have begun before the diet takes effect;
- the diet is costly, inconvenient, and unpleasant for people who have become used to eating what they wish;
- many women have forgotten that they ever were on an early childhood diet, or were never told why.

WHAT IS NEW IN PKU RESEARCH?

The March of Dimes supports clinical and basic research aimed at improved methods of treatment and prevention of such diseases as PKU.

Investigators are studying the liver enzyme involved in PKU as a basis for improved diagnosis and treatment. Gene transplantation is being studied as a means of correcting PKU. Researchers are making duplicate genes for the enzyme whose failure causes PKU, to use in making a prenatal test for the disease and in transplantation efforts.

Reports of success in animal studies give hope that certain drugs may help phenylalanine metabolism, especially in cases of PKU that don't improve with diet.

Meanwhile, medical centers are constantly improving their methods of PKU detection and treatment, especially in relation to maternal PKU; while health education professionals try to make people realize the need for screening.

For additional copies contact your local March of Dimes chapter.

March of Dimes
BIRTH DEFECTS FOUNDATION

This information sheet is made possible through contributions to the March of Dimes.

9-0274 11/83

Amendments to House Bill No. 381
First Reading Copy

Requested by Representative Menahan
For the Committee on House Human Services

January 30, 1989

1. Title, line 6.
Strike: "FOR"
Strike: "FORMULA"

2. Title, line 7.
Strike: "NECESSARY IN THE"

3. Page 1, line 11.
Strike: "children"
Insert: "persons"

4. Page 1, line 14 and line 15.
Strike: "children" on line 14 through "formula" on line 15
Insert: "maintaining a normalized blood level of phenylalanine is the only treatment of the disease"

5. Page 1, line 16.
Strike: "formula children"
Insert: "treatment persons"

6. Page 1, line 18 and 19.
Strike: "this" on line 18 through "is not" on line 19
Insert: "not all costs of treating phenylketonuria are"

7. Page 1, line 24.
Strike: "formula."
Insert: "treatment -- definition. (1)"

8. Page 2..
Following: line 3
Insert: "(2) As used in subsection (1), "treatment" means licensed professional medical services and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine, and adequate nutritional status."

EXHIBIT 8
DATE 2-6-89
HB 381

9. Page 2, line 3.
Strike: "formula necessary in the"

Amendments to House Joint Resolution No. 15
First Reading Copy

For the Committee on Human Services and Aging

Prepared by Mary McCue
February 2, 1989

1. Page 2, line 14.
Strike: "urge"
Insert: "direct"

2. Page 2, line 15.
Following: "review"
Insert: ", by July 1, 1991,"

3. Page 2, line 20.
Following: "July 1,"
Strike: "1991"
Insert: "1993"

EXHIBIT 9
DATE 2-6-89
HB HJR 15

DEPARTMENT OF FAMILY SERVICES

STAN STEPHENS, GOVERNOR

(406) 444-5900

STATE OF MONTANA

P.O. BOX 8005
HELENA, MONTANA 59604

TESTIMONY IN SUPPORT OF HJR 15
Presented by Robert Mullen, Director
Department of Family Services

The Department of Family Services recognizes the need to develop improved data on children served by the Department in out-of-home placements. A better data management system will assist the Department in planning for and providing services to those children who must be removed from their families and placed in foster care. For these reasons, the Department supports HJR 15.

The Department proposes to amend HJR 15 to postpone the new system's implementation date until July 1, 1993. The Department is prepared to begin planning and developing an automated management information system as soon as possible. However, the complexity of the data needed and the system development would make full implementation by the 1991 deadline proposed in HJR 15 difficult.

The development of an automated management information system will be costly. We have estimated that the Department will need at least an additional .5 FTE to devote to this project. With the additional personnel, the Department would give priority to the identification of our data needs, development of the automated system and development of the necessary departmental policies and procedures to implement the system. The Department joins with Representative Brown and the Montana Residential Child Care Association in supporting the passage of HJR 15 and funding the .5 FTE necessary to accomplish these data management goals.

EXHIBIT 10
DATE 2-6-89
HB HJR 15

AMENDMENTS TO HJR 15
PROPOSED BY THE DEPARTMENT OF FAMILY SERVICES

1. Page 2, lines 20-21.
Following: "1991,"
Insert: "plan and"
Following: "develop"
Strike: "and implement"

2. Page 2, line 22.
Following: "placements."
Insert: "The department shall implement the automated management information system by July 1, 1993."

HB 282 ESTIMATED COST PER AMENDMENTS

	FIRST YEAR	SECOND YEAR
PERSONNEL		
1 FTE INSPECTOR (G15)	$23,228	$23,720
.5 FTE SECRETARY (G9)	$7,271	$7,430
BENEFITS @ 20%	$6,100	$6,230
TOTAL PERSONNEL	$36,599	$37,380
EQUIPMENT		
OFFICE WORK STA	$2,500	$0
OTHER	$400	$0
EQUIPMENT TOTAL	$2,900	$0
SUPPLIES/MATERIALS		
OFFICE SUPPLIES	$500	$500
TOTAL SUPPLIES	$500	$500
OPERATING		
PHONE	$1,200	$1,200
POSTAGE	$1,200	$1,200
ARM PUBLICATION	$0	$3,600
DUES/SUBSCRIPT/REGIS	$500	$500
TOTAL OPERATING	$2,900	$6,500
CONTRACTED		
PHOTOCOPING	$2,000	$2,000
PRINTING	$1,200	$1,200
TOTAL CONTRACTED	$3,200	$3,200
TRAVEL/PER DIEM		
MILAGE (staff)	$1,500	$1,500
PER DIEM (staff)	$600	$600
LODGING (staff)	$1,000	$1,000
COMMISSION MEMBER PER DIEM[1]	$2,988	$2,988
TOTAL TRAVEL	$6,088	$6,088
TOTAL FOR YEAR	$52,187	$63,688

1. Assumes Commission members meet an extra day to handle Standards Commission on day before or after Crime Control Board meetings. Covers per diem and lodging combined.

EXHIBIT 10
DATE 2-6-89
HB 282

WITNESS STATEMENT

NAME John R Jacobson BUDGET _____

ADDRESS 401 S. Alabama Butte MT.

WHOM DO YOU REPRESENT? Bd. Med. Examiners

SUPPORT _____ OPPOSE X AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

NAME: Constance Morris DATE: 2/6/89

ADDRESS: 128 S. 5th E. MSLA

PHONE: 549-4039

REPRESENTING WHOM? myself & family

APPEARING ON WHICH PROPOSAL: HB 458

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: I have had four sons born at at home with the care and attendance of a mid-wife present. My first 2 born with a certified mid-wife in Mississippi. Others born in Montana. The care provided by all the different midwives was completely satisfying. Our choice to have birth @ home freedom as parents we wanted to make. Birth is life giving act & sickness and abnormal state of body function of a woman.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Anita C. Vatshell DATE: 2/6/89

ADDRESS: 407 E Pine st #3 Missoula MT

PHONE: 549-3303

REPRESENTING WHOM? Myself + my partner

APPEARING ON WHICH PROPOSAL: H.B. 458

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS: I am confident and comfortable to have my first child at home with a direct entry midwife. I made this choice not out of financial need but because I believe in the care and respect a midwife gives. I do not care to be forced into a forceps delivery or an unnecessary Caesarean delivery. The chance that I will not even need an episiotomy is greatly reduced due to the nature of a homebirth. Please consider H.B. 458 and if a licensing legislation needs to be enacted than that also would be helpful.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Jack L. Townsend DATE: 2-6-89

ADDRESS: 1479 Harrison Miles City

PHONE: 232-7326

REPRESENTING WHOM? self + family

APPEARING ON WHICH PROPOSAL: H.B 458

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: Please give all Montanans the right to choose. Its our births, not the medical establishment's. Let us make decisions about our families

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

WITNESS STATEMENT

NAME Pamela Luoma BUDGET

ADDRESS 1360 Bridger Mela MT 59803

WHOM DO YOU REPRESENT? Myself and Family

SUPPORT ✓ OPPOSE AMEND

COMMENTS:

My 4th baby is due in the beginning of June. We are planning our 3rd homebirth. We believe that it ought to be our right to have a homebirth with a midwife in attendence.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

NAME: Debi Corcoran DATE: 2/6/89

ADDRESS: 7012 Austin Rd. Helena, Mt.

PHONE: 443-2146

REPRESENTING WHOM? myself & children & husband.

APPEARING ON WHICH PROPOSAL: HB 458

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS: I have had 3 children at home with a lay midwife. I will have my fourth w/ no attendent as there are none attending in the Helena area. My midwife practiced no medicine. I went to an OB or nurse midwife for blood & urine test. My midwife attended my births. I birthed my children under her watchful eye. The money exchange was normal to give myself the security of someone who could look for any abnormalities in the natural process of labor & birth. I have attended home & hospital births both that proceeded normally. Yet the hospital births were full of interference & lack of respect for a beautiful transformation. For me, hospital birth is no option. I believe in birth at home I would like an attendent. This bill would make it possible by not scaring lay midwives away because of possible court actions. Thank you.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

WITNESS STATEMENT

NAME Mikelann Caywood-Berg BUDGET ?

ADDRESS RT 85 Box 4309 Livingston, MT 59047

WHOM DO YOU REPRESENT? Self

SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

Most hosp in MT. do not have immediate capability to perform C-Sections in 3 min. The team has to be called in - time minimum 30 min !!

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

NAME: Kris Zimmermann DATE: 2/6/89

ADDRESS: 3639 Trail Creek Rd Bozeman, MT

PHONE: 587-3353

REPRESENTING WHOM? Self * my husband

APPEARING ON WHICH PROPOSAL: HB 458

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS: I ask for your support of this bill (HB 458) because it's important for me as a parent to have the right to choose a midwife.

If I'm denied the opportunity or the right to choose a midwife to attend the births of my children at home, my husband and I would have to have our future children at home without an attendant.

Please support this bill so we, as parents can exercise our rights.

Thank you!

Kris Zimmermann

* attached are the names of nine other people that were unable to attend today.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Claire Trauth DATE: Feb 6, 1989

ADDRESS: 400 Kootenai Ct, Stevensville, MT

PHONE: 777-3791

REPRESENTING WHOM? myself - Homebirth mothers

APPEARING ON WHICH PROPOSAL: HB 458

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: I had a midwife attended homebirth! I believe parents should have the right to chose the birth option they feel is best for themselves and their baby. Our homebirth was a wonderful experience and I feel my choice was an informed and responsible one.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

WITNESS STATEMENT

NAME Cindy Kaiser, certified nurse-midwife BILL NO. 458

ADDRESS 232 Lyndale Lane - Butte, Montana 59701 DATE 2/6/89

WHOM DO YOU REPRESENT? myself

SUPPORT _____ OPPOSE X AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: No provision in HB 458 for certification or licensure of direct-entry midwives as opposed to the nurse-midwives who are currently licensed & certified to practice in Montana;

NAME: Cindy Kaiser, certified nurse-midwife DATE: 2-6-89

ADDRESS: 232 Lyndale Lane - Butte, Montana 59701

PHONE: (406) 494-2301

REPRESENTING WHOM? myself

APPEARING ON WHICH PROPOSAL: HB 458

DO YOU: SUPPORT? _____ AMEND? _____ OPPOSE? X

COMMENTS: NO provision in HB 458 for certification or licensure of direct entry midwives as opposed to the nurse-midwives who are currently certified to practice in Montana.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

HB 458

WITNESS STATEMENT

NAME John Whiston BUDGET

ADDRESS Rossbach & Whiston, P C, PO Box 8988, Missoula 59807

WHOM DO YOU REPRESENT? self

SUPPORT ✓ OPPOSE AMEND

COMMENTS: Unless this bill is passed, the practice of midwifery will be illegal in the State of Montana. Failure to act will subject this profession to severe criminal penalties - jail and extremely heavy fines.

It simply makes no sense now, when so many families cannot find someone to help with the birth of their children, to criminalize those who are willing to help.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

TO: The House Human Services Committee February 6, 1989
RE: HB 458, exempting direct entry midwives from the Medical Practice Act
FROM: Beth Brennan, 1533 Jackson, Missoula, MT 59802

Ladies and gentlemen, I'm sorry I could not be present for your hearing on HB 458 today. I am writing to urge your support of this important bill.

Direct-entry midwives have assisted women in childbirth since the beginning of time. According to statistics from Montana and elsewhere around the country, there is no apparent risk associated with midwife-attended births. But according to the many stories you can read and, I'm sure, will hear, there are many increased benefits.

Montana faces a severe shortage of doctors who can attend births. The doctors have said so themselves in their 1988 proposal, "Who will deliver your babies?" Midwives can help meet that need, and have helped to meet that need, especially in rural Montana.

Some pregnant women prefer a natural birth at home with the help of an experienced midwife even though a doctor is available. Not many, certainly. Their reasons for doing so are many, varied, and personal. Some birth at home because of religious beliefs that prohibit blood transfusions; some stay at home because the 'germs' there are far more familiar and less potent than those at a hospital; some believe they can birth more easily in a relaxed, familiar environment. Whatever their reasons, they are the minority, and your job is to protect the rights of the minority unless it can be shown that their actions endanger public health. The evidence does not show that midwife-assisted births endanger public health.

Please look at who is supporting this bill and who is opposing it. Women want midwives. Montana needs midwives. Please vote for the choice that will be most helpful to Montana families. Please vote for HB458.

Febuary 6, 1989

I am a R.N. who had my last child at home. Before our last child was born, I worked in O.B. and pediatrics at a local hospital. I am fully aware of the services that a hospital provides and am aware that they are necessary in some cases. However, a normal delivery can be accomplished safely at home with the benefits of the home environment, less tension which many experience in the hospital setting and a rich family experience--not to mention the freedom from a heavy financial burden. Our home birth experience was a beautiful experience. We worked with the medical community as much as we could, but were unable to find a certified midwife. We did find a lay midwife to help and she was a great support.

My husband and I believe that there is a desparate need for midwifery in the state of Montana. Midwifery will continue to be a black market commodity until the legislative sees the need to legitimize and regulate it.

Sincerely,

Sharon Grosse

Sharon Grosse, R.N.

February 5, 1989
JMJ

REGARDING H.B. #458:

TO ANY FOOL WHO THINKS THAT MIDWIVES SHOULD BE OUTLAWED:

We have heard some rumbling about midwives being harassed for "practicing medicine without a license".

In August of last year, I used the services of a lay midwife (after having previously had 5 hospital births), and my experience with the "homebirth" situation was excellent. There was a better perspective on what childbirth is all about.

With many unnecessary medical procedures, high costs, C-sections, multiple complications and diseases that are picked up in hospitals, and the high-priced farce of malpractice insurance, I felt much more comfortable with a midwife and much more secure in the surroundings of my own choice.

The art of Midwifery has been around longer than the art of Medicine (wasn't Eve the first midwife?). And having a baby is a natural condition and a fact of life, not a disease or illness that unconditionally requires hospitalization or medication.

Midwives do not practice medicine (i.e. doling out medicines, drugs, etc.) any more than legislators who make laws are practicing law without a license (if they lack a law degree).

If you want to shut down someone, shut down abortion mills. Midwives bring lives into the world, abortionists take them out.

Leave midwives alone... please!

Respectfully,

Mr. & Mrs. B.

Concerned Citizens of Montana

TESTIMONY FOR HB 458-certification of midwives.

From: Debbie Kersten
P.O. Box 95
Ulm, Mt 59485

Please give copies of this testimony to Rep. John Cobb and Rep. Jerry Noble.

Dear Montana Representatives:

I am writing to support the right of individuals to have lay midwives, or for that matter, whoever they choose, assist them in the birthing process.

I believe birth is a natural, non-medical procedure, that has only in our century been taken outside of the home. In most all cases, homebirth needs no medical intervention and can brag of a higher success rate than hospitals. After all, midwives certainly don't show a 33% ceserean rate!

I myself, have chosen homebirth after much in-depth study and common sense thinking, even though our insurance would have fully paid for a hospital birth. The benefits of having had my **five children** at home (successfully) have far outweighed a hospital setting. A relaxed atmosphere, familiar people of my choice in attendance... such as my husband, children, etc., my own germs and cleanliness...which my unborn child is already immune too, and the bonding with my newborn in comfort and privacy are just a few of the good points of homebirth.

I certainly hope you will choose to vote for HB 458 and continue to support the building up of families, instead of giving more power to those who wish to do my thinking for me by creating a monopoly for the medical profession.

My thanks to you for all your hard work in preserving freedom!

Dear House Committee Members -

I am writing with regards to HB458. I was at the hearing on Monday and when I got home, it struck me just how differently the opponents and proponents of the bill viewed birth. The opponents view "birth is a miracle that it ever turns out", "it can turn into a horror at any moment", a medical event that requires the watchful eye of a trained technician. The proponents (myself included) see birth as a natural process of life, when approached with proper nutrition, exercise, mental disposition & loving support it proceeds normally in 96-97% of the ~~time~~ cases. Of myself & all the women I've known who've had home births, I've heard of one who ended up going to the hospital because her labor was three days long. She gave birth uneventfully as soon as she entered the hospital doors (which makes me feel that it was a mental security she felt was lacking at home). However, of all the women I know who went to the hospital to give birth, there was always a need for intervention — pitocin, forceps, episiotomy (in the milder cases) demerol & heavier drugs, c-sections, resuscitation & baby being put in an incubator (in more pressing cases). Alot of the women were angry at the interference. Others felt their bodies had betrayed them.

More & more studies are being presented which show that the technical, interfering nature of hospital births & the readily available medical tools are what is creating all these problems. Women required to ~~be~~ lie on their backs throughout labor, which is mentally unstimulating & ~~but~~ physically ineffective for the process, but can also put undo pressure on the umbilical artery which triggers a drop in fetal heartrate as the baby strains for oxygen. Demerol & other pain killers reduce oxygen & make the mother lethargic. Pitocin increases the effectiveness of contractions to the point it can stress the baby who can release meconium into the amniotic fluids & ~~aspirate~~ aspirate them causing respiratory problems. Forceps can damage face & sometimes brain tissue. C-sections are at a 27% national rate up from 6% 20 years ago. And the greatest sin, the separation of mother & baby after birth, disrupts the bonding process. Any herdsmen or naturalist knows the a mother animal separated at birth, washed & returned at some later date is rejected by the mother. Are these hospital (routine) practices causes for drug addictions, emotional distress, child abuse & developmentally & physically damaged ~~studies~~ children? There are plenty of studies to support that thought.

More & more studies are being presented which show that the technical, interfering nature of hospital births & the readily available medical tools are what is creating all these problems. Women required to ~~be strapped~~ lie on their backs throughout labor, which is mentally unstimulating & ~~but~~ physically ineffective for the process, but can also put undo pressure on the umbilical artery which triggers a drop in fetal heartrate as the baby strains for oxygen. Demerol & other pain killers reduce oxygen & make the mother lethargic. Pitocin increases the effectiveness of contractions to the point it can stress the baby who can release meconium into the amniotic fluids & ~~aspirate~~ aspirate them causing respiratory problems. Forceps can damage face & sometimes brain tissue. C-sections are at a 27% national rate up from 6% 20 years ago. And the greatest sin, the separation of mother & baby after birth, disrupts the bonding process. Any herdsman or naturalist knows the a mother animal separated at birth, washed & returned at some later date is rejected by the mother. Are these hospital (routine) practices causes for drug addictions, emotional distress, child abuse & developmentally & physically damaged ~~studies~~ children? There are plenty of studies to support that thought.

Now, take a typical home birth. I've had three to date. I woke in my own bed to feel the first signs of labor. I called my lay midwife to let her know birth would occur sometime that day. I ~~tidied~~ tidy up my house, ~~made~~ make breakfast for my family, take a walk, take a bath, prepare sterile bags of towels, wash rags, diapers, sheets & a sleeper for my babe. Friends arrive. I read my children stories, prepare some tea, ice cubes to munch. My husband massages my back. My midwife, family & friends share a dinner. We clean up. All the while, I feel the strength of my contractions growing, my baby within keeps kicking when the stronger ones subside. Twice my midwife checks my dilation, several times she checks the babies heartrate after contractions. My older children nap. Transition begins, contractions become very strong. I squat & rock, my husband holds me, breathes with me, lends me his loving eyes of support. Water is boiled, a friend takes pictures. The light is very golden. I feel & see every range of emotion. There my waters break. My children are awakened. I get to the birthing stool & began to push, two, three contractions & my baby starts to crown. I panted to hold the contractions back to ease the baby's head thru. My mid-

Now, take a typical home birth. I've had three to date. I woke in my own bed to feel the first signs of labor. I called my lay midwife to let her know birth would occur sometime that day. I tidy up my house, make breakfast for my family, take a walk, take a bath, prepare sterile bags of towels, wash rags, diapers, sheets & sleeper for my babe. Friends arrive, I read my children stories, prepare some tea, ice cubes to munch. My husband massages my back. My midwife, family & friends share a dinner. We clean up. All the while, I feel the strength of my contractions growing, my baby within keeps kicking when the stronger ones subside. Twice my midwife checks my dilation, several times she checks the babies heartrate after contractions. My older children nap. Transition begins, contractions become very strong. I squat & rock, my husband holds me, breathes with me, lends me his loving eyes of support. Water is boiled, a friend takes pictures. The light is very golden. I feel & see every range of emotion. There my waters break. My children are awakened. I get to the birthing stool & began to push, two, three contractions & my baby starts to crown. I pant to hold the contractions back to ease the baby's head thru. My mid-

applies hot wash rags to soften my perineal muscles & avoid tearing. She supports my baby's head, my husband holds my hands, my children & friends gaze on in wonder. The room is lit dimmly, but it is very golden. Then my baby's face eases out & with the next contraction, her whole perfect body. My midwife checks to make sure she is breathing & no mucous blocks her breathing passage, wraps her in a towel & hands her to me. My children gather to see their new sister. There are tears of joy. Five minutes elapse, the baby's umbilical cord is cut & tied. New contractions. My husband holds baby while I deliver the placenta into a bowl. My midwife again checks baby for muscle tone, heartrate breathing & me for any signs of hemorrhage, takes the placenta & all non-family members into the kitchen to check for it's wholeness & to leave the family to bond with it's newest member. Later we celebrate with ice cream and my midwife stays while I my new baby & I & children sleep. My husband is too excited, too. She will stay another 5-6 hours to make sure everything is copesthetic.

There is just no comparison to a home

& hospital birth & no amount of medical equipment can give me security that my home & family give me. I've been to home & hospital births & I believe hospitals create so many of the problems they're equipped & trained to deal with. At home, life proceeds as normal. Birth is a natural process, not a medical calamity. I feel so strongly about this, that I will have my fourth child without a midwife, as none are practicing in the Helena area now. I am not stupid. I eat right exercise have prepared mentally, am getting prenatal ~~medical~~ care from a nurse midwife (blood analysis, blood pressure, urine analysis, fundal & measurements, heart rates, etc.). Birth is the metamorphisis of a couple to a family. Hospitals are for sick people. I am not sick. Lay midwives do not practice medicine. They wait patiently with a laboring mother for nature to take it's course. Look at the statistics of countries who have midwives, then look at the U.S.'s. Please pass HB 458.

Thank you.

Debi Corcoran

P.S. as far as the notion that home-birthed babies are low birth-weight mine were 7½, 8¾ & 8 lbs. to date

PLEASE SUPPORT H.B. 458 ON MIDWIVES.

PARENTS SHOULD HAVE THE RIGHT TO CHOOSE A MIDWIFE.

Tracie Collins
419 Strand Ave
Missoula MT
59801

PLEASE SUPPORT H.B. 458 ON MIDWIVES.

PARENTS SHOULD HAVE THE RIGHT TO CHOOSE A MIDWIFE.

Couples should have the right to choose where and with whom they have there children

Linda McLean
P.O. Box 242
Superior MT
59872

PLEASE SUPPORT H.B. 458 ON MIDWIVES.

PARENTS SHOULD HAVE THE RIGHT TO CHOOSE A MIDWIFE.

I believe the choice is important and mothers should have the choice.

Kenneth E Peters
Box 446
Superior Mont.
59872

PLEASE SUPPORT H.B. 458 ON MIDWIVES.

PARENTS SHOULD HAVE THE RIGHT TO CHOOSE A MIDWIFE.

Couples need to have the right protected of a free choice of where & with whom they choose to give birth. Montana is a state with a lot of rural history. Where would we be without the mid-wives in this state for the past 100 yrs? We have now [illegible] delivered our babies at home. It was safe, competent & beautiful.

- Kathie Harkinson
Kathie Harkinson
Box [illegible]
Superior Mt. 59872

PLEASE SUPPORT H.B. 458 ON MIDWIVES.

PARENTS SHOULD HAVE THE RIGHT TO CHOOSE A MIDWIFE.

Will Hodgens
442 Kensington
Missoula, Montana
59801

PLEASE SUPPORT H.B. 458 ON MIDWIVES.

PARENTS SHOULD HAVE THE RIGHT TO CHOOSE A MIDWIFE.

Loreen Falcon
442 Kensington
Missoula, MT 59801

PLEASE PRINT!

VISITORS' REGISTER

Human Services COMMITTEE

BILL NO. 458 DATE 2-6-89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Mandi Flynn	Troy, MT		
Rep Bob Marks	Clancy, MT		✓
REP. ROBERT CLARK			
SUZANNE HANLON	Missla MT	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

_____ COMMITTEE

BILL NO. _____ DATE PRINT

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
LILLY TUHOLSKE	1149 HARRISON Missoula	X	
Mona Jamison	Montana Midwife Alliance	✓	
Lisa Elfstrom Hempele	Avon, Mt.	✓	
Cindy Kaiser	Butte, MT		✓
Mike Frankovich	Butte, MT		✓
Barb Howe	Helena	✓	
Betty Lehr	Havre	✓	
WILLY VON BRACHT	WHITEFISH, MT.	✓	
Susan Rice	Libby Mt	X	
Mary Bartley	Hamilton Mt.	✓	
Sara Horst	Formly St. Ignatius currently Missoula	X	
Jacqueline Locke	Hamilton, MT	X	
Mary Werner Brown	Missoula MT	X	
Beatrice Hochstetler	221 N.E. OLD CORVALLIS RD HAMILTON	✓	
Eldon Hochstetler	221 N.E. OLD CORVALLIS RD HAMILTON, MT 59840	✓	
Judy Jorgeson	711 S 4TH E Missoula MT 59802	✓	
Sue Slaybaugh	Missoula	✓	
Shannon Pocha	Missoula	✓	
Debi Claussen	FLORENCE, MT	✓	

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VISITORS' REGISTER

______________________ COMMITTEE

BILL NO. HB 458 DATE ______________

SPONSOR ______________

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Andrea Dupea	Helena MT	✓	
JAMES HAYNES	HAMILTON, MT	✓	
NANCY RODDY	" "	✓	
PHYLLIS RHODES	WHITEFISH, MT.	✓	
Kim Brown Bates	Helena, MT.	✓	
BARBARA A. HELEN	315 State St Helena	✓	
[illegible]	2274 Oro Fino	✓	
[illegible]	104 Glendale	✓	
Marilyn Kettuler	2705 1/2 Dodge	✓	
[illegible]	1021 10th Ave	✓	
Florence E Kettuler	2705 1/2 Dodge	✓	
Mary Fake	370 Lost Horse Rd Hamilton	✓	
Bea & Eldon Hochstetler	221 N.E. OLD CORVALLIS Rd Hamilton, MT	✓	
Marty LORD	610 Logan HLN	✓	
Cathy Mudd	1018 N WARREN	✓	
Larry Landers MD	Helena		✓
Don Johnson M.D	Helena		✓
James Nickel M.D	Helena		✓
Carrie Wallace	Bozeman	✓	~~✓~~

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BILL NO. 458 DATE ______________

SPONSOR ______________

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Karla R. Court	2012 7th Ave N. Gt Falls 59401	✓	
Cheryl McMillen	1428 [illegible] MSLA, MT 59807	✓	
JUDI TAFTER	PO BOX [illegible] MSLA	✓	
Claire Trauth	400 Kootenai Ct Stevensville	X	
[illegible]	[illegible] Livingston	✓	
Marilyn Bacon	805 Van Sant Kalispell	X	
[illegible] Van Wicklin	5004 Whitefish Stg Rd. Col. Falls 59912	✓	
Cheryl Nickel	2742 Foothill Rd Kalispell [illegible]	✓	
Joanna Slavich	1845 W. Reserve Dr Kalispell 59901	✓	
Jill Yelvick	5625 [illegible]	✓	
Tammie [illegible]	528 1/2 S. [illegible]	✓	
[illegible] Baldwin	816 [illegible]	✓	
[illegible] & [illegible] Luoma	136 Badger Ct, Missoula	✓	
Patricia L. England	1035 1/2 12th Ave Helena		X
Barb Booher	MNA Helena		X
R.D. Marks	Missoula MT		X
Laughing Water	2409 Colo. Gulch Helena	✓	
M. Stranahan	Dixon, MT	✓	
Debi Corcoran	7012 Austin Rd Helena	✓	

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CS-33

VISITORS' REGISTER

_____ COMMITTEE

BILL NO. _____ DATE _____

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Eliza Goode	MSLA	✓	
Karen Bacon	Kalispell	✓	
Joanna SLAVISH	Kalispell	✓	
Greg Rice	Libby	✓	
Michael Kelinek	Columbia Falls	✓	
Nanette Hawley	Stevensville	✓	
Ginger Sprunk	MSLA	✓	
Caron Garry	MSLA	✓	
F M Alvarez MD	Helena		✓
Jerome T Loendorf	Helena		✓
JoAnne Foley	Missoula	✓	
Hazel Baldwin	Missoula	—	
Kathy Sayler	Missoula	✓	
Margaret Vance	Missoula	✓	
Juliette Bowman	Augusta	✓	
Ken Light	Arlee	✓	
Cristine Kerr	Victor	✓	
Ken Kerr	Victor	✓	
Donna Swan	Helena	✓	

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VISITORS' REGISTER

_____ COMMITTEE

BILL NO. HB 458 DATE 2-6-89

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Naomi Lev	Missoula, MT	✓	
MaryJane Brown	Gt Falls	✓	
Brant Goode	Missoula MT	✓	
Catherine Schenck	Missoula Mt.	✓	
Anita Vatshell	Missoula, MT	✓	
Constance Howell-Morris	MSLA MT	✓	
James Harkinson	Superior, Mt	✓	
Kathie Harkinson	Superior Mt	✓	
Leslie Fellers	Whitefish, Mt.	✓	
Mikelann Caywood-Baerg	Livingston, MT	✓	
Kris Zimmermann	Bozeman, MT	✓	
Pete Zimmermann	Bozeman MT.	✓	
Katie Hanson	Victor Mt.	✓	
Meg Hanson	Victor MT	✓	
Kathleen Hanson	Victor MT	✓	
JERRY SCHNEIDER	MSLA. MT	✓	
Tom Leonard	Missoula MT	✓	
ERICA BROWN	MSLA MT	✓	
Alexandra Goode	MSLA	✓	

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PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

_____ COMMITTEE

BILL NO. HB 458 DATE _____

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
PATRICK Shea	Seeley Lake, MT	✓	
KAY M. BALLARD	HELENA, MT	✓	
Brian Weber	Florence Missoula MT	✓	
Debi Claussen	Florence, Mt	✓	
Shannon Poche	Missoula MT.	✓	
Nicole Claussen	Florence MT	✓	
Katherine Smith	Helena MT	✓	
Jed Smith	Helena MT	✓	
Susan Pratt	Missoula, MT	✓	
Dorothy Whiston	Msla	✓	
Pam Luoma	Mila	✓	
Pamela B. Shaw	Lake County	✓	
Jeannine Flaten	Missoula	✓	
Jerry Walker	Missoula	✓	
Frances Conklin	Missoula	✓	
Carla Green	Msla	✓	
Richard F. Trauth	Stevensville	✓	
Polly Browder	Missoula	✓	
John Whinton	Msla	✓	

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VISITORS' REGISTER

_____ COMMITTEE

BILL NO. SB 58 DATE 2-4-89

SPONSOR Pech

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
DIANE SANDS	SELF	X	
Donna Small	MT Nurses Assoc.		X

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VISITORS' REGISTER

_____ COMMITTEE

BILL NO. HB 381 DATE _____

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
S. C. PRATT MD	DHES	X	
Mary A. Musil	556 Sparta, Helena	X	
RAY BRYANT	MISSOULA	X	
Gene Huntington	Helena Mt. Dietetic Assc	X	
Nicole Pool	1010 26th Ave Msla Mt	X	
Pat Schilling	116 New Meadows Msla	X	
JOHN THORSON	MFWPA INFANTH ASSN	—	
Chris Valenciety	DD Lobbyist	X	

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VISITORS' REGISTER

_____ COMMITTEE

BILL NO. HJR 15 DATE _____

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
John Thorson	Orem Health Assn	✓	
Robert Mullen	dfs	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

February 4, 1989

We the undersigned, support House Bill 458 on Midwives:

	Name	Address
1.	KEITH TALLEY Keith Talley	3592 BRIDGER CANYON RD
2	AMY MACDONALD Amy MacDonald	323 So. BOZEMAN
3.	Gary Clutter, Gary Clutter	1290 story mill rd. Bozeman
4.	Martin Faulkner Martin Faulkner	6451 Gooch Hill Rd Bzn.
5.	SHERIDAN JONES Sheridan Jones	Bozeman
6.	ROSANNA ROHRS Rosanna A. Rohrs	3592 BRIDGER CYN. Rd. Bzman
7.	Diana Cooksey Diana Cooksey	1290 Story Mill Rd. Bozeman
8.	Robert Elsey ROBERT ELSEY	11655 BRIDGER Canyon Rd
9.	Lee Faulkner Lee Faulkner	6451 Gooch Hill Rd. Bozeman,
10		