Fighting for Access to Midwifery Care and Home Birth:  
The Minnesota Story (A)

Introduction

Naomi’s first two births took place in the hospital, “over-managed, over-medicated, and strapped down,” as she describes them. Her third baby was born at home in July 1980, in Oregon, and she moved to Minnesota that fall. It was “a pivotal time” for her as a woman, she says. At this third birth, she felt “competent, capable, and empowered.” She “wept with joy” for what she had accomplished at this birth and had been robbed of with her two previous births. She wanted to help other women have births “with dignity” and so began her journey to midwifery. She trained to be a childbirth educator, and people began inviting her to their home births. There were no home birth midwives within her area of northwestern Minnesota and eastern North Dakota, so she located a retired lay midwife and took classes from her. This midwife came to one birth with her, but, other than that, she is basically self-taught with no formal apprenticeship. Since 1981, Naomi has never taken time off and has averaged at least one birth per month. She is a mother of six children, and at times regretted the time commitment and stress involved with birthing and raising her own

Mary M. Lay, Professor, Department of Rhetoric, University of Minnesota wrote this case for the Center on Women and Public Policy as part of its 2000 Case Writing Summer Institute. The Center on Women and Public Policy, the Minnesota Women’s Foundation, and the Minnesota Extension Service provided supporting funds. © Mary Lay 2001.

Author’s note: Except for Minnesota legislators whose names are a matter of public record, I have assigned pseudonyms to all people featured in this case study. Most personal information and quotations are based on interviews and personal correspondence completed June-August 2000. The information on Rita Otriz is based on testimony given in a public hearing on November 7, 1991 and on an interview conducted in November 1994. A more detailed account of the public testimony and Ortiz’s appears in my book The Rhetoric of Midwifery: Gender, Knowledge, and Power. New Brunswick, NJ: Rutgers University Press, 2000. The participants in this study kindly responded to two drafts of the case and were wonderfully generous in trusting me with their words and their stories. I cannot thank them enough.
children and maintaining her practice. But she knew that her clients had no other options—she was the only traditional midwife in her area. Perhaps the most important external driving force in her practice has been her involvement with the Midwives’ Alliance of North America or MANA (see the appendix for a list of professional organizations involved in this case); she served on their board from 1985-1988. Able to sustain her activism throughout the last two decades, Naomi joined the national task force of the organization that now certifies traditional midwives and helped develop the credential of Certified Professional Midwife. Naomi formed the Minnesota Association of Midwives, which eventually merged with the Genesis Guild, a group of midwives mostly practicing in Minneapolis-St. Paul, to form the Minnesota Midwives’ Guild. Naomi describes herself as follows: “I just seem to have an unquenchable thirst for midwifery and the political arena that seems to go along with it.” Naomi still has an active traditional midwifery practice in rural Minnesota and North Dakota.

Rita turned to midwifery after the hospital birth of her first child. Although Rita’s first pregnancy and birth “had a good outcome,” Rita says, “emotionally speaking, the birth to me was really disastrous and traumatic (Lay 2000, 1).” Rita herself had been born at home in Cuba, where home birth was common. When she became pregnant in the early 1970s, she found herself living in a subculture within the United States that said “there were really no problems with birth, except those caused by the medical establishment.” Initially Rita had no intention of becoming a midwife but, as she says, “I had certain expectations that birth was a non-medical event.” To ensure that other women would have more choices about their birth settings and attendants than she did, Rita became self-educated and self-taught in midwifery—she became “the person she had been waiting for” in her own births. She describes the first birth she attended in Minnesota at a time when women had little access to midwifery care for home births: “The first birth that I ever attended was in Rochester, Minnesota. It was cold . . . there was a blizzard outside. The equipment that was taken to this birth was a pair of sewing scissors with orange handles, which were sterilized over boiling water with two chopsticks, and a pair of white shoelaces which I obtained at Robert’s Shoes on Chicago and Lake on my way out of town (Lay 16-17).” The birth went well, but had Rita and her companion midwife not been there, the woman was determined to birth by herself. “So we came, so to speak, as ‘gravy,’” Rita comments; there was no one else attending home births in Minnesota at the time (Lay 2000, 16-17).
Rita’s companion went on to become an obstetrician on the staff of the Mayo Clinic, while Rita continued to educate herself and to attend home births for the next two decades. However, in the mid-1990s, Rita decided to take quite a different route to establishing the legitimacy of her practice. She completed nurse-midwifery school—to gain the professional standing and access granted to this different group of midwives.

Despite the differences in the stories of these two midwives, in the 1990s they had one thing in common. Naomi, Rita, and the other Minnesota midwives were confident that they could provide safe home birth care to their clients, but they faced a daunting political task. Studies often document that midwifery-attended home births can be as safe, if not safer, than physician-attended hospital births where medical intervention may be common.\(^1\) Many traditional midwives screen out high-risk clients whose physiological or psychological profiles make home birth unsafe. For decades they had practiced underground in a somewhat a-legal status. Although charged with licensing traditional

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\(^1\)For example, in July 1997 the Minnesota Midwives’ Guild reported to the Midwifery Regulation Task Force of the Board of Medical Practice that 15 members attended 381 births between 1990 and 1996. Of that number, 55 were transferred to the hospital during labor but only eight of which were considered emergencies: of those eight, three were emergency referrals after the initial assessment in labor; four occurred during labor; and one was postpartum. Three perinatal or infant deaths were reported: one at 32 weeks gestation after two days of labor in the hospital following the commencement of premature labor, and two at term with indications that the baby had died prior to initiation of labor. There was one death postpartum after surgery due to a heart defect. Medical intervention rates were very low, with one forceps delivery, three vacuum extractions, and nine cesarean sections after transport. The report, which was also analyzed by the Midwives’ Alliance of North America Statistics and Research Committee, concluded, “In this dataset there is no suggestion that home delivery is associated with increased risk.” Moreover, a 1991 study that looked at midwifery care throughout the United States concluded that the “nontraditional setting [of home birth] presents advantages for low-risk women as compared with traditional settings: lower costs of maternity care, and lower use of childbirth procedures, without significant differences in perinatal mortality.” Finally, a 1997 meta-study of other statistical studies of home and hospital births concluded:

[N]o empirical evidence exists to support the view that it is less safe for most low-risk women to plan a home birth, provided that the pregnant woman is motivated and, furthermore, selected and assisted by an experienced home birth practitioner, and provided that the home birth practitioner, in turn, is backed up by a modern hospital system should a transfer be needed. It is further concluded that home birth as managed in the included studies may well have other advantages compared with standard hospital care (Olsen 1997, 4-16, esp. p. 11).

These home birth advantages might be a calm and supportive setting, which enables the laboring mother to overcome fears and to deliver more easily; a midwife attendant who tries a number of options before suggesting intervention in the natural process of birth; and a philosophy that allows the family to determine the course of the birth, with the midwife helping the mother and “catching” the baby rather than controlling the birth.
midwives by Minnesota statute, the Board of Medical Practice had not granted such a license since 1938, stating that no appropriate school of midwifery or licensing examination existed for this group of practitioners. Without clear regulations of traditional midwifery, the midwives were continually subject to possible investigation for practicing medicine without a license, a felony that carried possible jail time and fines.

However, in the winter of 1993, one county attorney wrote to the Minnesota Speaker of the House to insist that the Board fulfill its obligation to oversee traditional midwives to ensure quality care. Many members of the Minnesota Midwives’ Guild also wanted the professional standing state licensure would bring, but they were unsure whether the Board or friendly legislators should take the lead in creating midwifery licensing rules and regulations. The Board, a state agency whose membership is dominated by licensed physicians, oversees a number of health care providers and is charged with not only creating licensing regulations but also hearing public complaints against such providers and disciplining those who violate licensing regulations. At this point, however, the Guild had informed the Board that a branch of the Midwives’ Alliance of North America (MANA), their professional organization, had developed an examination that might be appropriate for states to use as a licensing exam. The North American Registry of Midwives (NARM) exam was now being pilot-tested to experienced midwives nationally. MANA had a long-term vision to establish a national credential, with entry-level requirements, under which traditional midwives throughout the country would unify. Naomi was part of a pilot project of experienced midwives who were invited to take the NARM exam and had recently passed it. The existence of this exam became important when, on December 1, 1993, the Board of Medical Practice called together a group of traditional midwives, nurses, physicians, nurse-midwives, home birth parents, and attorneys to write collaboratively the rules and regulations to license traditional midwives—a rule writing group. Again, to license any practitioner, the state agency would have to identify an appropriate qualifying exam and to have available detailed licensing rules and regulations that spelled out the scope of practice for traditional midwifery (that is, what could be done in traditional midwifery care), the contraindications or forbidden aspects of the practice, and disciplinary and oversight procedures. Despite the incentives to make clear the legal status of traditional midwifery in Minnesota, the task of writing licensing rules and regulations that would please the diverse members of the rule writing group and the Board itself.
was quite a challenge.

This case highlights several events, decision points, and outcomes in the Minnesota traditional midwives’ efforts to become licensed:

- The rule writing group’s efforts to create acceptable licensing rules and regulations for traditional midwives (1993 to 1995).
- A separate Midwifery Regulation Task Force’s efforts to write a scope of practice section of licensing rules and regulations for traditional midwives (1997-1998).
- The Minnesota Families for Midwifery and Senator Sandy Pappas’s efforts to achieve licensing for traditional midwives through state legislation (January 1999).
- The Minnesota Families for Midwifery’s efforts to avoid veto of the legislation by Governor Ventura (1999).
- The Minnesota Families for Midwifery’s battle to save the midwifery legislation when the Board of Medical Practice attempted to overcome it by way of a hostile bill (January 2000).

**Background**

To understand the challenge that the Minnesota traditional midwives faced, it is necessary to know something about the history of midwifery and its current status within the United States. Moreover, it is essential to have a clear picture of midwifery clients—home birth parents.

**Historical and Current Status of Traditional Midwives**

Traditional midwives, also called direct-entry or lay midwives, enter the profession of midwifery “directly” rather than through the practice of nursing. Thus, they are distinct from nurse-midwives. They learn their skills through apprenticeships or within the few traditional midwifery schools within the United States. Many traditional midwives belong to MANA, pass the professional exam offered by the North American Registry of Midwives to become Certified Professional Midwives, and participate in their own state midwifery organizations, often called guilds. As of June 2000, they practice legally in 18 states. In other states, they practice illegally or a-legally depending on state culture and law; some are left alone, and some are openly prosecuted.\(^2\) There are from two to three thousand traditional midwives practicing within the United States.\(^2\) States that licensed traditional midwives as of July 2000 are Alaska, Arkansas, Arizona, California, Colorado, Delaware, Florida, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Oregon, Rhode Island...
Island, South Carolina, Texas, Washington, and Wyoming.

United States; they attend about 12,000 births a year at home or in freestanding birth centers.

For centuries the traditional midwife has encountered efforts by medical care givers to regulate, control, and even eliminate her efforts. Often ownership of scientific knowledge and technology becomes a focus point of these jurisdictional battles. For example, when the powerful Chamberlen family of London developed the forceps in the early 1700s, they were reluctant to allow female midwives to obtain and use forceps. The male midwife and the male surgeon were attempting to enter the birthing room, a setting previously dominated by women, and could use the forceps to intervene in difficult births. By grasping the infant’s head with the two flat blades of the forceps, the attendant could ease the infant out of the birth canal. The traditional midwife preferred to depend on her herbs and hands to ease the pain of labor and to handle any abnormalities. Many considered the invention of the forceps as marking the end of women’s control of their birth attendants and settings. For example, scholar Jane Donegan says: “It was the surgeons’ possession of the forceps that enabled them to challenge directly the women midwives’ traditional role as the attendants at all normal cases” (Donegan 1978, 47). Medical care givers thus distinguished their practices by their use of technology—forceps rather than hands—and eventually by their use of science—drugs rather than herbs. And, soon these medical care givers were attending more and more births as the range of “normality” shrunk and as women were attracted to the idea of a quick and less painful or dangerous birth through new technologies.

Later jurisdictional battles almost led to the complete elimination of traditional midwives in the United States. For example, Charles Ziegler published his “The Elimination of the Midwife” in a 1913 issue of the Journal of the American Medical Association. As the medical community raised its level of education and experience expected of the physician attending birth, Ziegler argued that the midwifery care should be eliminated. Ziegler asserted:

My own feeling is that the great danger lies in the possibility of attempting to educate the midwife and in licensing her to practice midwifery, giving her thereby a legal status which later cannot perhaps be altered. If she once becomes a fixed element in our social and economic system, as she now is in the British Isles and on the Continent, we may never be able to get rid of her” (Ziegler 1913, 32).
The midwife whom Ziegler imagined when he proposed that she be eliminated was an uneducated, perhaps immigrant woman, whose practice he and other physicians suspected also included abortions. To become knowledgeable about birth, physicians needed a woman to give birth in a hospital setting, where they could observe and learn from her condition. Physicians were also aware that if they could treat a woman during her pregnancy, they might also become the physician for the entire family.

Traditional midwives in Minnesota in the early to mid-1990s often belonged to the Minnesota Midwives’ Guild, which published a *Standards of Care and Certification Guide* and met regularly to conduct peer review of its members. Some midwives who did not belong to the Guild attended births within ethnic or religious communities or chose not to participate in the creation of formal organizational standards or peer review sessions offered by the Guild. Prior to the Board of Medical Practice meeting in 1993, the Guild, in particular, had attempted to become more professionally visible through meetings with the Department of Health and through legislative channels. One state legislator, Sandy Pappas, a home birth parent herself, had sponsored at least two bills to help the midwives gain professional standing. The midwives and home birth parents spent weeks lobbying legislators. Extensive hearings were held. Sandy Pappas read from her personal home birth journal to attest to the importance of the experience for her. But the medical establishment vigorously opposed any legislation, and Pappas was unable to garner the support in the late 1980s and early 1990s to push the bills through to a final vote.

Licensing, the traditional midwives knew, would bring a mixed bag. Although subject to legal scrutiny if a case had a bad outcome, the unlicensed midwives would be able to practice autonomously, without the supervision of a physician whose philosophy about birth might be quite different. Licensing would normalize their practices—for example, if carrying antihemorrhagic drugs became part of their scope of practice, all midwives then might be required to carry and administer these drugs, regardless of their skills and preferences or their “protocols.” However, licensing would bring clear professional boundaries. For example, some midwives believed that carrying such anti-hemorrhagic drugs would make home birth safer—and so they wanted the legal sanction to do so.
The Home Birth Parent

Many traditional midwives such as Rita and Naomi are also home birth parents. During the 1970s, when Rita was learning midwifery, a definite counter culture adopted midwifery care and home birth in opposition to what they considered medical care givers’ tendency to over medicate the laboring woman and to intervene in the natural process of birth. These attitudes remain the same today, although today’s profiles of home birth parents are quite diverse. As Judith Rooks describes home birth parents, they are

a mixture of traditional, conservative, home-oriented women; college-educated, middle-class professionals and intellectuals; “New Agers”; members of certain religious groups; women who live in rural areas; women who need inexpensive care because they are not covered by any third-party health payment plan; “survivalists” and other people who are trying to live apart from the mainstream of American society; and Mexican women who want to give birth in the United States (Rooks 1997, 152).

One Minnesota home birth parent who is not a traditional midwives herself became embroiled in the efforts of her midwifery care giver to become licensed, and her story gives a fuller picture of just who elects to birth at home with traditional midwives in the state. Nancy began thinking about home birth long before she was ever pregnant. Her sister had considered home birth, and Nancy liked the sound of the idea—“family members sitting on the couch in the living room while the mother labored in the bedroom.” Also, her mother had passed on to her the idea that pregnancy and birth were normal, natural processes. Her husband was open to the idea, and both were delighted when on a trip to England to see an old school friend of his who was studying to be a midwife, they saw a sign in her front window: “A home birth is a safe birth.” Nancy began reading everything about birth she could get her hands on. But finding a birth attendant for a home birth was not an easy process. And Nancy was still not sure whether she wanted a physician or a midwife. She and her husband sent letters all over the country to organizations listed in the back of the books they were reading and made local phone calls. They soon realized that, at least in Minneapolis-St. Paul, traditional midwives were the only home birth attendants. After a phone conversation and visit with a local practicing midwife, they left her home saying “she was the one”—“we were completely comfortable with her and pleased that her thoughts about birth were similar to ours.” Finally, for Nancy, both birth and death, the beginning
and end of life, should take place at home, a thought that was solidified in her research on home birth. In allowing these events to take place in hospitals, “places distanced from normal, everyday life, we distance ourselves from these events and lose touch with them.” Her grandfather died peacefully at home; her son was born peacefully at home.

The Traditional Midwifery Rule Writing Group

The rule writing group, set up by the Board of Medical Practice, began meeting in late 1993 to write rules and regulations for traditional midwifery practice. Meeting about every two months, the rule writing group would produce and revise drafts over the next two years.

Trouble Ahead: Breeches and Twins

The first indication of trouble in the process came during April of 1994. At that point, the rule writing group was working on what should be included in traditional midwifery care—the scope of practice section of the licensing rules and regulations—and what could not be included in traditional midwifery care—the contraindications for midwifery care and home birth. The rule writing group first tackled contraindications.

The rule writing group had decided that all members would have an equal voice in the writing process. Members representing such distinct groups as the Minnesota Ob/Gyn Society, the Minnesota Nurses’ Association, the Minnesota Midwives’ Guild, and the Twin Cities chapter of the American College of Nurse Midwives often met with their constituents and brought to the rule writing group carefully worded drafts of specific rules under discussion. But individual members were also encouraged to participate equally in the writing process. For example, when the rule writing group members discussed contraindications for midwifery care and home birth, they were confronted with three proposed drafts—one from the Minnesota Ob/Gyn Society, one from a physician writing independently, and one from the Guild. Faced with differences in the length and content of the three lists of contraindications, the Board member coordinating the writing process recommended that the lists be merged. Any item on all three lists would be considered non-controversial and would remain as something that could not be part of traditional midwifery practice—the item would be a clear indication of a contraindication as agreed upon by all members. Then rule writing group members could lobby to include or exclude other items.

At this point, it became clear that some midwives were willing to compromise their individual
protocols to create licensing acceptable to the medical care givers who were carefully following the rule writing group’s work, but other midwives wanted to depict their practices as they “really were.”

Even though the Guild’s list of contraindications for home birth contained forty-nine items, far more than the other two lists submitted, it became controversial. The Guild’s list contained both multiple gestation and breech births (for definitions of birth terms such as these, see the appendix to the case), despite the fact that these were conditions some Minnesota midwives felt they were skilled in handling at home. Multiple gestations or twins tend to be smaller or underweight, and often one twin might be in the breech position. Breech babies are turned on their side or approach the birth canal feet or rump first, rather than head first, and might suffer oxygen deprivation if the head is delivered last. Some traditional midwives were skilled in turning breech babies manually to the vertex or the head-down position before birth. However, in preparing their list of contraindications, the Guild members had decided that they were willing to “give up breeches and twins” to demonstrate their willingness to narrow their practices in order to become licensed. For example, Rita was clear in why she decided on this compromise: “I have done the most breech births [at home] in the state of Minnesota, and I was the person most against breech births [in the hearings] because I knew politically that it could not be defended” (Lay 2000, 138). Naomi defined this compromise as not “wanting to win the battle but lose the war.”

On the other hand, midwives not willing to make this compromise said,

Almost the only people in this country who know how to deliver breeches [vaginally] are traditional midwives. They do a lot of them. And they do know how to deliver them. A lot of twins are born at home, very safely” (Lay 2000, 141).

Statistically there are just not that many breeches and twin births, but the parameters of normality are quite complicated in such conditions. The breech position might be detected prior to birth or it might come as a surprise, and breech births are best addressed if the baby is of average or smallish size. Again, the majority of twin births do not reach term, and many midwives would screen out these pregnancies from home birth for that reason alone. However, in the discussions of breeches and twins before the whole rule writing group, the discussion focused on whether or
not to include twins and breeches within traditional midwifery care.

In the April 1994 rule writing group meeting, when some midwives objected to excluding breeches and twins from their practices, medical care givers who considered such conditions too high risk for midwifery care and home birth became alarmed. These medical care givers believed that many twins and breeches needed to be delivered by cesarean section rather than vaginally. Why were breeches and twins not on the proposed drafts coming from the Minnesota Ob/Gyn Society? Perhaps these physicians did not realize that breeches and twins were being delivered at home. Perhaps they knew little of individual midwives’ skill in handling these cases. At any rate, objections to including breeches and twins on the contraindications list, objections raised by Guild midwives themselves, meant that they would not remain on the list of what would be excluded from midwifery care—they were considered controversial. Breeches and twins therefore might be possible for home birth, and the discussions about them exposed what seemed divisions within the vulnerable midwifery community. Such divisions were unsettling, as, once licensed, all midwives would be required to follow the same protocols. And, the exclusion of breeches and twins from any prohibited conditions for home birth alarmed medical care givers, whose definitions of normal and safe birth seemed narrower than those of some midwives.

The next meeting of the rule writing group, in July of 1994, brought even greater controversy—when the group discussed the scope of practice section or what could be done in traditional midwifery care.

**More Trouble: Pitocin, Episiotomies, and Suturing**

Guild midwives were willing to give up breeches and twins in their practices to gain what they considered essential to ensuring safe and comfortable home births. They wanted to carry oxygen, essential for neonatal resuscitation, as well as pitocin, a drug effective in stopping postpartum hemorrhage, and they wanted these tools listed in the midwifery scope of practice section of their licensing rules and regulations. They felt that they were just more likely to need these tools than they were to attend a breech baby or a set of twins. They also wanted to perform emergency episiotomies, a cut in the perineal tissue to allow a distressed baby’s head to be more easily delivered, and to suture first- and second-degree perineal tearing. Although many midwives had never had to do an episiotomy, they wanted to be able to perform one should they encounter
a situation when such a procedure would help a distressed baby. Also, although midwives do everything they can to prevent a tear in the perineum, but sometimes tears happen despite the midwives’ precautions, and they wanted to avoid having to send the mother to the hospital for suturing. But these were procedures that some medical care givers defined as diagnostic, surgical, and pharmaceutical—procedures that required formal education, testing, and supervision to perform adequately. Medical care givers participating in the rule writing efforts asked: How would traditional midwives, without formal medical training, be able to distinguish a second-degree tear from a third-degree or fourth-degree tear, one that tore into the anal sphincter muscle? Should they be permitted to perform a surgical procedure, an emergency episiotomy, or should the mother be instead transported to the hospital? Who would train the midwives in administering pitocin? These questions surfaced quickly when, at the next meeting of the rule writing group, two Guild midwives requested that these procedures be part of their scope of practice. However, their request came just after the group had decided to exclude breeches and twins from the contraindications list, and once more it appeared that the midwifery community was divided.

Some midwives did not want to carry pitocin and were unskilled in suturing tears and cutting an episiotomy—these midwives made their feelings known at the rule writing group meetings. Moreover, including these procedures in the scope of practice section would extend the traditional midwives’ practices beyond those of many nurses and nurse-midwives. And, how could the midwives defend such extensive practices when their training seemed informal in contrast to medical care givers. As one nurse said, “The wider the scope, the more educational preparation you need; the more educational preparation you need, the more you’ve got to prove” (Lay 2000, 154). So if the midwives wanted to carry pitocin, suture tears, and cut and suture emergency episiotomies, their licensing rules and regulations would have to specify how they learned such practices and how their skills and knowledge of these practices would be tested before licenses were granted.

The Licensing Process Fails: The Board Suspends the Meetings

Late in the summer of 1994, the Board of Medical Practice became convinced that the midwifery licensing rules and regulations would not pass the scrutiny of the wider medical
community. Groups such as the Minnesota Medical Association were lobbying against the emerging draft. The Guild quickly set up an educational program that was more formal than their usual apprenticeship and self-education efforts and recruited midwives and family practice physicians to teach such sessions as “Pharmacology for Midwives” and “Suturing for Midwives.” But despite these efforts to demonstrate formal training of their ability to administer pitocin, suture tears, and cut episiotomies, the Board began to raise objections to the NARM exam. Were the standards for passing too low? NARM was in the process of testing and revising the exam, but up to this point only the most experienced midwives had taken the exam—and none of them had failed. Did the NARM exam have a sufficient clinical component? Again, at this point, NARM was in the process of adding a clinical test to the written test. The minutes of the August 1994 meeting rule writing group then contained the following:

Several members of the [rule writing] group expressed concern about the current draft of the rules. The reliability of the NARM exam is still in question and there is no approved program of study. Some members still believe that...breech and twin births are contraindications for home birth. Nurses will not support the rules in their current state...the rules are written are problematic and additional work needs to be done (Lay 2000, 168).

The rule writing group met twice more, but it was clear that the Board itself and those actively lobbying the Board would not support any rules that granted traditional midwives such a wide scope of practice. The rule writing process had failed.

Then, in 1995, the NARM exam became more widely available to anyone and MANA actively recruited new midwives to take the exam. Prior to this point, the exam was only available to midwives who had practiced for at least five years and who had attended a specific number of births. Also, the exam had been proven to have valid standards and contained a clinical component. The Minnesota Board of Medical Practice itself had now invested several thousand dollars in having the exam validated. So the midwives approached Senator Sandy Pappas for advice on how to proceed. She made a series of phone calls, and, in 1996, the traditional midwives attended a full meeting of the Board of Medical Practice to present birth statistics to the

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3The exam was “psychometrically validated” which, in essence, means that the “bar” for passing the exam was considered high enough.
Board compiled with the efforts of MANA’s statistics committee and to defend the latest version of the NARM exam. To support the Minnesota midwives, a national representative from the NARM board attended the Board meeting.

The Board then formed the Midwifery Regulation Task force, a smaller group, which met between June 1997 and January 1998 to write a scope of practice for traditional midwifery. Only those who represented a recognized group could participate—the Guild, the Department of Health, the American College of Obstetricians and Gynecologists, the American College of Nurse Midwives, the Minnesota Academy of Family Physicians, the Minnesota Medical Association, the Minnesota Board of Nursing, and the Minnesota Nursing Association. Although most midwives were also home birth parents, home birth parents were not represented as an organization or group. The Board had decided only groups with a constitution or mission statement could send a representative. There were strong calls for physician oversight of traditional midwifery practice. The midwives objected that few of them could convince liability conscious physicians to provide them with backup care. The process again failed—the task force was suspended without producing a final product. The Board warned that if the midwives were not licensed but continued to practice, even though MANA might certify them as having passed the NARM exam and achieved the status of Certified Professional Midwife, they would be practicing medicine without a license. In the spring and then the fall of 1998, two traditional midwives came under investigation by the Attorney General’s Office and suspended their practices. Exhausted and discouraged, the midwives were uncertain about the next step.

Choosing a New Approach

Should the traditional midwives continue to appeal to the Board of Medical Practice to coordinate the writing of licensing rules and regulations for traditional midwifery? If they did, what process would ensure success in a new effort?

Or, should the midwives pursue legislative means again? Sandy Pappas had now moved from the House to the Senate, was still willing to work with the midwives, and had more professional clout in the state legislature. If they pursued this route, the Board of Medical Practice might still lobby against any portion of a bill. Other alternative health care bills were being discussed by legislators, but did the midwives have the stamina, given the divisions that
seemed to emerge during the rule writing process, to unify and lobby? The Guild itself had dissolved prior to the two investigations of the midwives. Those who wanted to become Certified Professional Midwives through the NARM exam and MANA formed a new group—the Minnesota Council of Certified Professional Midwives. A new organization, Midwifery Now!, was started in the late fall of 1998 in response to the political necessity for an “umbrella” for midwives, a group voice, separate from the Minnesota Council of Certified Professional Midwives (CPMs) that would embrace both CPMs and non-certified midwives. One of Midwifery Now!’s first considerations was possible legal action against the Board of Medical Practice for restraint of trade. Naomi was committed to any new effort to obtain licensing, but Rita had entered nurse-midwifery school and was now determined to pursue a different way to achieve professional status.

Or, should the midwives continue to practice their a-legal status? According to Minnesota statutes, the Board of Medical Practice was charged with licensing traditional midwives, but the midwives had been told that because the Board had not fulfilled its obligation, traditional midwives’ practices were not technically illegal. However, two of their members were now under investigation—and any midwife who decided she must transport a distressed infant or mother to the hospital might be reported by the receiving medical care giver. Were these two investigations a sign of more to come—suspension of practices, fines, and attorney fees?

Or, should the midwives go further underground to avoid public scrutiny? If they pursued this route, it would be difficult for prospective home birth parents such as Nancy to find them—and impossible for the midwives to advertise, work for insurance reimbursement, or carry the drugs and conduct the procedures that they were sure made home birth and midwifery care safe. However, they would be harder for the Board of Medical Practice and the Attorney General’s Office to find. Few home birth parents ever held their midwife legally responsible for a poor outcome, so only transports to the hospital might invite the attention of state agencies.
Fighting for Access to Midwifery Care and Home Birth:
The Minnesota Story (B)
This Might Happen to Me!

In October and November 1998, advisers within the Midwives’ Alliance of North America urged the Minnesota midwives to pursue licensure through legislation. When charges were being criminally investigated involving the two midwives, others thought: “This might happen to me!” The investigations had also galvanized consumers into action. A town meeting was held to discuss, among other issues, how “burnt out” midwives. The meeting drew over 100 people, many of whom were from home birth families. The timing seemed right for a grass roots effort to write and lobby for legislation for traditional midwifery.

Home Birth Parents Take the Lead

An organization of consumers, called Minnesota Families for Midwifery (MfM), had formed in 1996 from parenting groups. MfM was still in the process of establishing by-laws in 1997 when the Board of Medical Practice called the small groups together to work again on the scope of practice of traditional midwifery. Therefore, MfM was not able to participate in this process. However, now members of MfM such as Nancy offered to write a licensing bill and to help coordinate lobbying efforts through MfM. Mainly consisting of home birth mothers, the MfM first met in a Friends meeting house and began to explore how to support their midwives and ensure that they would continue to have access to home birth and midwifery care. Nancy was an active member until the birth of her first child—she warned the group that she would have to curtail the time devoted to MfM after this birth. Nancy first thought about how she would support her midwife during their educational efforts—when the midwives were taking their classes, MfM members offered to cook them dinner. But Nancy and other were very concerned by the criminal investigations of the two midwives. If their midwives suspended their practices during these investigations, how would Nancy, who wanted a home birth, be able to find midwives to help her?

Together with Senator Pappas, MfM and Midwifery Now! with help from the Minnesota Council of Certified Professional Midwives began to draft a bill, pulled together from the various pieces of writing the midwives had done within the groups formed by the Board of Medical
Practice and from other states’ statutes. Portions were also created anew to address the political concerns the midwives, consumers, and legislators might express. In the state Senate, liberals were in the majority, but in the state House, conservatives were. So Senator Pappas, a well-known liberal democrat in the Senate, asked House representative, Jim Abeler, a conservative, chiropractor, and home birth father, to sponsor a companion midwifery bill. The bills would allow those midwives to become licensed if they passed the NARM exam, attended and supervised a certain number of births, went through an apprenticeship or graduated from a midwifery school, had a written medical consultative plan, provided an informed consent form to each client, and attended infant and adult CPR courses to become licensed. The informed consent form stressed the shared responsibility of the parents:

We realize that there are risks associated with birth, including the risk of death or disability of either mother or child. We understand that a situation may arise, which requires emergency medical care and that it may not be possible to transport the mother and/or baby to the hospital in time to benefit from such care. We fully accept the outcome and consequences of our decision to have a licensed traditional midwife attend us during pregnancy and at our birth. We realize that our licensed traditional midwife is not licensed to practice medicine. We are not seeking a licensed physician or certified nurse midwife as the primary care giver for this pregnancy, and we understand that our licensed traditional midwife shall inform us of any observed signs or symptoms of disease, which may require evaluation, care, or treatment by a medical practitioner. We agree that we are totally responsible for obtaining qualified medical assistance for the care of any disease or pathological condition.4

Home birth parents such as Nancy would be responsible for their decisions—for any risks involved in not electing a hospital birth with a medical care giver. However, the licensed midwives would be able to suture first- and second-degree perineal lacerations and to administer antihemorrhagic drugs such as pitocin and to carry oxygen. Moreover, the conditions requiring medical consultation were to be those conditions established in the most current edition of the Minnesota Midwives’ Guild’s Standards of Care and Certification Guide. Twins and breeches were not mentioned within the law, but the reference to the Standards of Care left the door open to traditional midwives’ attending these conditions.

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4Minnesota Statutes 1999, Chapter 147 D. Traditional Midwives Section 147D.07 Informed Consent.
There would be three steps to licensure: (1) a Midwifery Advisory Council would review applications and recommend granting or denying specific licenses to the licensing committee of the Board of Medical Practice; (2) the licensing committee would then make its recommendation to the full Board; and (3) the full Board of Medical Practice would either grant or deny the license. Nominations for the positions available for traditional midwives on the Midwifery Advisory Council were submitted by Midwifery Now!, and the Board of Medical Practice would choose names from that list of nominees.

MfM early on considered getting a professional lobbyist to help them. One lobbyist in particular, experienced in doing watch dog work, offered to take on this role. His goals seemed in line with those of MfM, but Nancy and others asked: “Could he represent us as a whole?” It was also very expensive to enlist his help. They soon decided that they needed to lobby on their own—to present their image and needs for themselves, despite the time and energy demanded, despite the short term commitments that expectant mothers such as Nancy could make. Senator Pappas came forward to conduct a lobbying workshop for the group. As the bills were being drafted, MfM and its midwives created packets to be distributed to legislators. The packets would contain answers to frequently asked questions, articles and statistics on the safety of home birth, and an outline of the bills. The group decided on some key “talking points.” In lobbying efforts, MfM members would portray themselves in a specific way: “I am just a regular person—not too unusual—and I want these options as to where I want to birth. I am not too far left or far right—not hippie or religious. I am in the mainstream.” To garner support for the bills, MfM and the midwives would stress that licensing would better guarantee safety and training. Midwifery clients would be able to not only work with a traditional midwife but also have all the medical tests and procedures that might ensure a safe birth in each case. Informed consent would ensure that the parents would take on the responsibility for their choices. Finally, the public would be protected by uniform standards for midwifery practice.

As the companion bills emerged, MfM and the midwives began to prepare for the committee meetings that would review and hear testimony for and against the bills. The midwives and MfM began to stress in their lobbying efforts the issue of “access.” MfM members avoided using the word “choice,” as it was too close to pro-life and pro-choice debates over abortion.
“How come Minnesota citizens cannot have access to midwifery care? How can they have access to any necessary medical tests and backup if they wish a home birth?” they wanted their legislators to ask. MfM sent postcards to consumers, providing the names and phone numbers of legislators and urging the consumers to ask their representatives to support the bill. MfM members traveled to Duluth, Fargo, Mankato, and other towns to meet with consumers and legislators.

The Hearings: Snow Storms and Crying Babies

Early in January 1999, before the committee hearing in the Senate to review and hear testimony about the proposed midwifery bill, the lobbying groups knew that three of the seven committee members would support the bill—four were against or undecided. MfM put out the word that people needed to show up for the hearing. Although the group had found physicians willing to speak in support of home birth, the focus must be on families—the Minnesota citizens whose needs and rights the legislature was charged to address. The group agreed that no one would speak of the hot issues that had dissolved the Board of Medical Practice rule writing meetings such as breeches and twins. Other techniques such as pitocin could be defended as safety measures.

But one of those typical Minnesota blizzards began to rage the day of the committee hearing. The drive into St. Paul would take hours, rather than minutes, for MfM members and their midwives.

From seventy to eighty parents made long commutes in the snow and wind to pack the hearing room. Parents constantly took fussy children out in the hallway and then came back in again—there was no mistaking their physical presence. It was an “emotional hearing,” said Senator Pappas. Home birth parents began to share their stories in testimony. One spoke about receiving a termination letter from her physician because she was planning a home birth. Others spoke of being denied blood work and ultrasounds because they were working with traditional midwives rather than physicians. How could birth be safe if consumers could not have access to these screening techniques? Supportive physicians also testified but not with the passion of the home birth families. And, those home birth babies, safe and healthy, testified by their physical presence.
Because of the snowstorm, the hearing was postponed before amendments were considered and a final vote taken. A member of the Senate Health and Family Security Committee from Rochester wanted certain amendments added that were not acceptable to all the midwives. Senator Pappas argued that they needed compromise to get the bill out of committee, but could “fix it in conference committee.” Mandatory licensing was one of the controversial possible provisions.

Although the weather was more cooperative, the same strategies were used in the House committee hearing. The bills were overwhelmingly supported. Nancy says, “It was the power of us speaking out and saying what was important to us.” Representative Abeler had managed to keep voluntary licensing in the House version of the bill.

Where was the Board of Medical Practice? Where were those medical care givers who would lobby against the midwifery bills? At the same time that the companion bills were being debated in the committee hearings, the Board of Medical Practice, the Minnesota Medical Association, and the Minnesota Nurses’ Association were involved in a fight over advanced practice nursing. Focused on this larger group of practitioners, the Board had no time to lobby against the bills as it had against earlier versions in the 1980s.

The next battle came within the conference committee meeting—the bills must be merged into one. But the Pappas bill, the one coming through the Senate, was more regulatory, with mandatory licensing. Although considered a companion bill, a practice quite common in the legislature, the Abeler bill described instead voluntary licensing. Abeler’s experiences as a chiropractor, negotiating with physicians and insurance companies within this somewhat “alternative” practice, had convinced him that mandatory licensing was too restrictive. If the mandatory licensing version of the bill were selected by the conference committee, then eventually any midwife who was not licensed but continued to practice would be subject to arrest for practicing medicine without a license. If the voluntary licensing version of the bill was selected, then each midwife could decide for herself whether she wanted to become licensed. Senator Pappas and Abeler agreed to accept voluntary licensure and that version of the bill emerged from the conference committee. This same language passed in the House and Senate bills, although not without controversy on the Senate floor.
The next task was to get Governor Ventura to sign the bill—or at least not to veto it. Ventura’s philosophy seemed to support less government, more individual choice. But Ventura’s chief of staff had lobbied for obstetricians before joining the governor’s office.

In the end, Ventura would not sign the bill—but would not veto it either. Two letters explaining this decision were prepared for him by the Department of Health (DOH) and by his staff. The one written by the DOH stated that the bill was too regulatory and was not needed because midwifery was not a public health issue. The letter written by his staff stated that the bill was not regulatory enough and the proper safeguards were not in place. He signed the first version of the letter—the bill would become law, but the governor expressed the opinion that the bill really was not needed. The law went into effect in July 1999. However, the applications were not available until December 1999, and then Minnesota midwives could apply for a license. Several did.

**Preparing for Regulation**

With a midwifery law in place, it seemed that the Minnesota traditional midwives and their clients could relax. Or could they? Would the Board of Medical Practice, distracted by other issues when the bill was written and passed, go forward with licensing without raising any opposition? If the Board raised opposition at this point, how would it do so? And how should the midwives prepare for this opposition?

**A Hostile Bill Is Written**

In January 2000, a piece of legislation was written by the Board of Medical Practice and supported by a key staff member in the governor’s office. It was introduced by Senator John Hottinger, a member of the DFL party\(^5\) and chair of the Health and Family Security Committee. It came to the attention of MfM, the midwives, and Senator Pappas. As Nancy said, “We were too complacent. We should have expected a hostile bill.” MfM was concerned that their tired forces would not hold up to another effort such as the one they made in 1999.

But why was the bill written to begin with? Did someone on Ventura staff have a connection with the Board of Medical Practice? Was it written as a political favor to Ventura and...

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\(^5\)In Minnesota, the two major parties are Independent Republican and Democratic-Farmer-Labor.
his staff members? Did Hottinger know the ramifications of the bill? Rumors circulated. Despite the difficulty in tracing the origins of the bill, the midwives and their home birth clients needed to respond quickly. They again needed Senator Pappas’s help.

This new bill would require physician oversight of midwifery practice. It would limit traditional midwifery care to the home, whereas the 1999 law read “outside a hospital,” which left birth centers as a welcome future option for midwives and their clients. This bill would make licensing mandatory. It would require more paperwork and change the scope of practice. The 1999 law stated that the practice of traditional midwifery included but was not limited to five essential aspects of practice.\(^6\) The proposed bill would limit the practice of midwifery to these five points. Finally, the Midwifery Advisory Council would be restructured to have nine members rather than five, the additional members representing physicians, nurse-midwives, and the public.

**MfM and the Traditional Midwives Rally Again**

MfM and the midwives went into action. They took advantage of Governor Ventura’s popular bus tours of the state and greeted the governor with signs saying “Support Midwifery.” Ventura’s office received so many calls in support of the midwifery bill that it made his “top ten topics” list for the week.

One of the midwives called for a meeting with Senator Hottinger in early February. About 20 people met at the Capitol in St. Paul. They argued that the bill should not be heard. As head of the health committee and author of the bill, Hottinger had the power to choose whether the bill would come up for discussion. “Give us a chance,” the midwives asked, “to see if it’s going to work.” Hottinger, a friend and office mate of Senator Pappas, decided that the House committee would not hear the bill. The 1999 law would therefore not be open to change—for the moment.

Based on this latest effort to change the law, Nancy predicts, “We are going to be doing this every year for who knows how long—and it’s probably going to get more difficult every year.” In February 2000, the Midwifery Advisory Council had recommended for licensing the first group of applicants. The Board of Medical Practice met in early July and licensed the applicants. Now all eyes would be on this first group of licensed traditional midwives to evaluate their

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\(^6\) Minnesota Statutes 1999, Chapter 147 D. Traditional Midwives Section 147D.03 Midwifery.
success in practicing under the licensing rules and regulations set into law.

What lessons should the midwives and their clients and supporters remember or learn from all these efforts and events? What should they prepare for next—and how should they prepare for it?
Glossary of Birth Terms and Professional Organizations

Birth Terms

**Breech birth:** The biggest risk with breech birth occurs when the baby’s body is born first and its head is too large to deliver. In frank breech births, the baby emerges bottom first with the legs extended upwards over the chest. In complete breech births, the legs are up and crossed. A mother may be successful in helping her baby turn to vertex (head down) with postural tilting or lying with her hips elevated. An experienced physician or midwife may try to turn the baby who persists in the breech position by manually manipulating the baby through the mother’s abdominal wall.

**Episiotomy:** Incision of the perineum during labor to avoid tearing of the perineum or to aid in the immediate delivery of a baby in distress.

**Multiple gestation:** More than one baby in the womb, such as twins. The risks involve compression of the umbilical cord, particularly if one of the babies is in the breech position, and postpartum hemorrhage.

**Perineal tears:** The mass of tissue, muscle, and skin between the vagina and rectum which might become torn during the birth of the baby. Tearing can be measured in degrees—with first degree the least severe and fourth degree the most severe as not only the skin but also the muscles tear all the way to the anal sphincter. Slight tearing (first degree) may heal without suturing, but more severe tearing (second through fourth) requires repair. Midwives often try to help the mother avoid tearing by lubricating the perineum and gradually stretching the tissue through massage.

**Pitocin:** A synthetic form of oxytocin, which is the hormone in women that causes uterine contractions in the onset of labor. Pitocin and similar drugs are also used in hospital or home births (where permitted) to control extreme postpartum hemorrhage, particularly due to lack of tone and contraction in the uterus needed to recover from labor.

**Suturing:** Perineal tears and episiotomies may be sutured rather than allowed to heal on their own. Suturing involves stitching the wound closely with or without the administration of local anesthetic.

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Professional Organizations

**American College of Nurse-Midwives:** Professional organization of certified nurse-midwives who receive a bachelor’s degree in nursing before going on for additional training as a nurse-midwife.

**Genesis Guild:** Later merged with the Minnesota Association of Midwives to form the Minnesota Midwives’ Guild.

**Midwifery Advisory Council:** Under the 1999 state statute that addresses the licensing of traditional midwives, considers applicants for licensing and recommends acceptable candidates to the licensing committee of the Board of Medical Practice.

**Midwifery Now!:** An umbrella organization formed by traditional midwives to respond to the need for a uniform political voice. Charged with providing the Board of Medical Practice with a list of acceptable candidates to serve on the Midwifery Advisory Council.

**Midwives’ Alliance of North America (MANA):** International organization of traditional midwives. Clients and supporters of midwifery, childbirth educators, and interested nurse-midwives might also join the organization. Holds an annual conference, publishes a newsletter, and supports the efforts of traditional midwives to become licensed in each state.

**Minnesota Association of Midwives:** Later merged with the Genesis Guild to form the Minnesota Midwives’ Guild.

**Minnesota Board of Medical Practice:** The agency that oversees the licensing of health care practitioners. Charged with licensing traditional midwives by Minnesota statute. Physicians frequently serve on the Board.

**Minnesota Council of Professional Midwives:** Formed after the demise of the Minnesota Midwives’ Guild. Consists of state traditional midwives who have passed the NARM exam and received certification.

**Minnesota Families for Midwifery (MfM):** Formed in 1996 from primarily home birth parents to provide support for traditional midwives in legal and educational efforts.

**Minnesota Medical Association:** State organization of physicians. Observes and may lobby for and against various decisions by such agencies as the Board of Medical Practice.

**Minnesota Midwives’ Guild:** Organization of traditional midwives who were very active in the Minnesota licensing efforts. Their *Standards of Care and Certification Guide* is referenced in the Minnesota statute that addresses the licensing of traditional midwives.

**Minnesota Nurses’ Association:** Professional organization of nurses within the state. During the licensing hearings, worked closely with the Minnesota chapter of the American College of Nurse-Midwives.

**Minnesota Ob/Gyn Society:** Organization of medical care givers specializing in obstetrics and gynecology. Sent a representative to the rule writing group constituted by the Board of Medical Practice.

**North American Registry of Midwives (NARM):** Established by MANA but has become a separate but affiliated organization. Certifies midwives as Certified Professional Midwives as of 1994. The NARM exam has a written and skills component and is used in several states as a licensing and/or certification exam.
Bibliography


