



Illinois Department of Financial and Professional Regulation

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Home Birth Maternity Care Crisis Study Committee Meeting

Date: October 17, 2019
Meeting Convened: 1:05 P.M.
Meeting Adjourned: 4:41 P.M.
Location: Chicago: JRTC CBD Room 9-040; Springfield: Stratton CBD 376

Roll Call: Senator Iris Martinez, Chairperson
Representative Anna Moeller, Vice Chairperson
Senator Neil Anderson (Absent)
Barbara Belcore, CPM
Douglas Carlson, MD (Springfield)
Karen Harris, JD
Debra Lowrance, CNM (By WebEx)
Maura Quinlan, MD
Nadia N. Sawicki, JD
Mike Tryon (By WebEx)
Jeanine Valrie-Logan, CNM
Carrie Vickery
Rachel Wickersham, RN, CPM
Hunter Wiggins, JD
Cheryl Wolfe, MD

Staff Present: Lucienne Doler, IDFPR
Samantha Ortiz, IDFPR
Amanda Phelps, IDFPR (Springfield)
Richard Schultz, IDFPR
Ciara Wagoner, IDFPR (Springfield)

Speakers Only Present: Edward Pont, MD
Yvonne Oldaker, APN/CNM, MPA
Michelle Breen MHS
Deborah Fisch, JD
Robert Minkus, MD
Michelle Minikel, MD
Marilee Clausing, JD
Antonio Romanucci, JD

Guests Present: Destiny Lee, Senate Democrats (Springfield)
 Dan Howl, ISMS (Springfield)
 Gordana Krkic, Illinois Academy of Family Physicians
 Nora Kropp, ICAAP
 Deb Lyons, Illinois Hospital Association
 Lina Isabel Rauh
 Tim McLean, ITLA
 Katie Davis, ITLA
 Becky Coolidge, ICCPM

Topic	Discussion	Action
Call to Order	<ul style="list-style-type: none"> The meeting was called to order and an initial roll call was taken. As there were eight Committee Members present, in Chicago or Springfield, there was a quorum of the total fifteen Committee Members present. All speakers and attendees then introduced themselves. Ms. Lowrance was connected through her telephone at an off-site location and Mr. Tryon stated that he was going to be connected by a phone or laptop computer at an off-site location. Senator Martinez then stated that a quorum of Committee Members was physically present, and Ms. Lowrance and Mr. Tryon had requested to attend this meeting by phone or video conference. Ms. Lowrance was prevented from being physically present due to illness and Mr. Tryon was prevented from being physically present because of employment reasons. A motion was made and seconded to allow Ms. Lowrance and Mr. Tryon to attend the meeting by video conference. As there was no further discussion, the matter was called for a vote. Home Birth Maternity Care Crisis Study Committee votes: 8 yes votes (Ms. Martinez, Ms. Belcore, Ms. Harris, Ms. Sawicki, Ms. Vickery, Ms. Wickersham, Mr. Wiggins, and Ms. Wolfe), 0 no votes and 0 abstentions. 	Ms. Lowrance and Mr. Tryon permitted to participate by phone or video conference.
Old Business	<ul style="list-style-type: none"> The September 21, 2019 minutes were reviewed and approved with minor changes requested by Dr. Cheyney, regarding her title and her testimony, which was incorporated in the final draft of the minutes. 	Minutes Approved with minor changes.
Comments from the Chair	<ul style="list-style-type: none"> Senator Martinez: Stated that there are some ground rules that she would like all of the participants to keep in mind during the Committee meeting, because there are speakers that have opposing views. Regarding the speakers, she asked them to be as clear and concise as possible with their testimony and to leave time for questions from the Committee. She also asked the presenters to remember that the Committee Members have copies of the documents which they have provided, so there is no need to read from the documents, and summaries can be provided. In addition, she asked the speakers to focus on the most important facts in their presentations, so that all speakers will be able to make their presentations in the allotted time. Dr. Quinlan joined the meeting in Chicago. Regarding the Committee Members, she said that she knows that there is a great deal of information available. She explained that her intent was to 	

	<p>make sure that there is a conversation to determine if the Committee can put together some language for the next session that will pass the legislature. She asked the Committee Members to be respectful of all of the speakers and to hold all questions until the end of the individual’s testimony, unless there it is a question that just cannot wait. Also, if Committee Members have long detailed questions, she asked them to submit the questions to attorney Richard Schultz after the meeting, so we can discuss those issues that separate the Committee Members. Mr. Schultz will circulate the questions and the responses to the Committee prior to the next Committee Meeting. She wants to discuss things that separate the various groups and the point of the Committee was to get some kind of understanding about the issues involving the licensure of Certified Professional Midwives (“CPMs”). If you have any articles or studies questioning a speaker’s statements, please send those to Mr. Schultz and he will distribute the materials to the full Committee prior to the next meeting. Her concern has always been about how the various groups can come together because we are seeing births happening outside of hospitals want to always ensure the safety of babies and mothers. Her goal from the Committee meeting is to have some type of legislation to file in the next session that reflects the work that this Committee has done. Asked if the Committee had any questions. Seeing none she moved on to the speakers.</p>	
<p>New Business</p>	<p>A. <u>Witness Testimony</u></p> <p>1. <u>Dr. Edward Pont Testimony</u></p> <ul style="list-style-type: none"> • Dr. Pont: Thanked the Committee for the opportunity to address this important issue of home births in Illinois. He explained that he was a past president of the Illinois Chapter of the American Academy of Pediatrics (“ICAAP”), and that he was currently chair of its government affairs committee. He said that he has been a community pediatrician in Chicago’s western suburbs for over 20 years. He stated that his organization has concerns regarding current efforts toward the licensure of CPMs. ICAAP’s position has remained straightforward: the organization believes that all infants, irrespective of venue, deserve a safe and supported birth environment, with appropriate medical resources readily available should an emergency occur. This commonsense philosophy informs ICAAP’s opposition to the current effort to license CPMs in Illinois. CPMs make two principal arguments to promote their licensure. One is that they are adequately trained to anticipate and respond to issues involving the perinatal and immediate postnatal period. They often point to other countries’ experiences to bolster this claim. Yet the training and requirements for midwifery in other countries are often significantly more intensive than those to become a CPM in the United States. In Canada, for example, the program is four years long, and is a blend of university academics and an apprenticeship model of clinical education. The midwives earn a bachelor’s degree, taking 18 university level courses, including four separate placements. In contrast, almost 40% 	

of CPMs in this country have less than three years of training. It is ironic that Illinois CPMs would likely not be allowed to practice in the very countries they routinely cite as examples of successful midwifery. Another critical aspect of midwifery in other countries is collaboration with the larger medical community. ICAAP has consistently maintained that any discussion of licensure must include this requirement. In California, data from 2015 shows that relatively one half of the clients served by midwives received collaborative care. In that same year, a baby was urgently transferred about once a week from a home birth setting to a hospital. This emphasizes the importance of collaboration. Put simply, an infant crashing the ER with no prior collaboration is an inherently dangerous situation that any rational home birth system should take every measure to avoid. This is not just the opinion of the medical community. CPM advocates themselves also argue for integration of homebirth midwifery into the larger medical system. One of them writes, “The lack of integration across birth settings ... contributes to intrapartum mortality due to delays in timely transfer related to fear of reprisal.” ICAAP remains adamant that any homebirth licensing effort include ironclad regulations ensuring babies delivered at home have the same resources available as those delivered in a hospital. In addition to these training and collaboration concerns, ICAAP opposes the CPM licensure effort because of insufficient personnel at deliveries. Current American Academy of Pediatrics (“AAP”) policy states: “[T]here should be at least one person present at every delivery whose primary responsibility is the care of the newborn.” Situations in which both the mother and the newborn infant simultaneously require urgent attention are infrequent, but they do occur. Thus, each delivery should be attended by two individuals, at least one of whom has the appropriate training, skills, and equipment to perform a full resuscitation of the infant. As a clinician, he knows how quickly a routine birth can become one where both the mother and infant are in distress, and it is imperative that both be attended to without distraction. CPMs also assert that licensure will make home births safer by establishing clear standards to which all midwives must adhere. ICAAP would first note that this already exists under Illinois law. Certified nurse midwives (“CNMs”), who form a collaborative relationship with the medical community, ensure as safe a home birth experience as possible, and we would not oppose any efforts along those lines. As several states now license CPMs - some have for decades - it is reasonable to ask for evidence that CPM licensure improves the overall safety of home birth. Yet he and ICAAP are not aware of any studies that demonstrate this. In contrast, increasing evidence documents the risk of home birth. A recent report from Florida detailed eleven serious incidents, including seven deaths, in less than a year. He concluded his remarks with a personal story. His first daughter, Abigail, was born “occiput posterior,” meaning her head was pointing up instead of down, and this complicated what had been, up to that point, an otherwise routine delivery. After she was born, the obstetrician attended to his wife, who was exhausted after pushing for two

and one-half hours; while a neonatal team resuscitated Abi, who was tachycardic and not breathing on her own. To this day, his strongest memory of his daughter's birth is the sound of the ambu-bag forcing oxygen into her new lungs. Today, that child is a beautiful young woman who is currently applying to medical school, making her dad very proud. He is forever grateful that his family had every resource in place to help his daughter through those first difficult moments of her life. Our state's newborns deserve no less. He thanked the Committee for their attention and was willing to answer any questions.

- **Senator Martinez:** Thanked Dr. Pont for his testimony. She asked Dr. Pont what legislation he would suggest to protect women who desire a home birth in Illinois who live in very rural areas, without a hospital or doctor in the area, if they do not have access to a licensed CPM, especially when the women do not have the resources to travel to a hospital.
- **Dr. Pont:** Responded that ICAAP is not against home births *per se*, because Dr. Carlson had a child delivered in his home.
- **Senator Martinez:** Agreed that they want a collaborative agreement, but what should women who want home births currently do when CPMs are not licensed.
- **Dr. Pont:** Responded that ICAAP would not oppose any effort to increase CNMs, who form a collaborative relationship with a doctor. Also noted that there is evidence from several countries that this would promote the safest birth environment.
- **Senator Martinez:** Asked that he focus on the other 35 states which license CPMs rather than other countries, and whether the births are safe in those states.
- **Dr. Pont:** Explained that ICAAP cannot endorse something that they do not believe that is the safest environment as possible. However, they would not oppose CNMs who collaborate with doctors. Stated that ICAAP would support grants for more individuals to become CNMs.
- **Ms. Wickersham:** While CNMs can become licensed in Illinois and they can attend home births, there are only ten CNM practices in 102 counties of Illinois and there is no incentive for them to set up a home birth practice.
- **Senator Martinez:** Asked what Dr. Pont suggested in that case.
- **Dr. Pont:** Suggested that barriers should be removed so that the State could encourage CNMs in the State, so that we have the safest home birth as possible.
- **Ms. Sawicki:** Asked what the barriers were in his opinion.
- **Dr. Pont:** Said that she was asking something outside of his expertise, but if the Committee would want to offer some way to increase the number of CNMs that collaborate with physicians, he would look at the proposal and coordinate with his partners. He did not believe that ICAAP would have an issue with proposals that are designed to increase CNMs.
- **Ms. Belcore:** Asked whether Dr. Pont was aware that currently CNMs are not required to collaborate with doctors in Illinois.

	<ul style="list-style-type: none">• Dr. Pont: Responded that the ICAAP would insist on the collaboration requirement. He recalled that after four years of medical school and three years of residency he was terrified during his first year of practicing as a doctor. During this time, he believed that every child had meningitis until proven otherwise and had numerous questions about treating children. He also stated that the New Zealand data shows that the equivalent of a CPM, which he understood was not Illinois, where he believed they have collaboration and in the first year of a CPM's practice there is a significantly higher rate of new born mortality. This mortality rate is not reduced until five to nine years of practice. This does not occur with CNMs in New Zealand. The collaboration piece is very important. He believed that doctors who go into private practice from residency are very hearty souls to be working alone without the ability to collaborate with other colleagues. Collaboration is critical.• Dr. Carlson joined the meeting in Springfield, and Mr. Tryon joined the meeting by WebEx.• Ms. Wickersham: Noted that CPMs also collaborate with colleagues when questions arise. Asked whether Dr. Pont was calling other pediatricians or doctors with other practices, and whether Dr. Pont was aware that CPMs have a network which permits them to ask other more experienced senior midwives questions.• Dr. Pont: Stated that is wonderful but at the end of the day he believes that CPMs need the involvement of the physician community.• Ms. Belcore: Stated that the legislation currently does not require CNMs to collaborate and that the latest draft of the legislation required collaboration without the requirement of a written agreement, because written agreements were opposed by the medical community, due to an increase to their liability. Also, noted that midwives support the idea of collaboration. In addition, stated that was the reason that licensure was important because it allows midwives to collaborate with physicians that are specialists in emergencies that may arise openly and safely. Asked whether he would like to require a written collaboration or whether the physicians would be uncomfortable to have the legislation require the collaboration.• Representative Moeller joined the meeting in Chicago.• Dr. Pont: Stated that he was unable to respond because he did not have the authority to negotiate legislation. He said that ICAAP would review each bill and would decide on that bill. He believed that ICAAP is always open to consider some sort of written collaboration agreement. We all want the safest birth environment as possible, it is just how to get to that point that they differ. Stated that ICAAP believes robust collaboration would be a key ingredient, and that ICAAP would be reluctant to support anything that does not contain that ingredient.• Ms. Belcore: Confirmed Dr. Pont's statement that every delivery should be attended by two individuals. Then, noted that the CPM credential requires NRP certification, and NRP certification required two individuals	
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	<p>to attend to a birth. So, Wisconsin, where she is licensed and practices, requires two CPMs to attend the births, to assist in resuscitation of the neonatal infant, if necessary.</p> <ul style="list-style-type: none"> • Dr. Pont: Responded that he could not recall whether the requirement that two individuals attend the birth was included in the Wisconsin law, and that was not the impression that he recalled from discussions about a previous bill. • Ms. Belcore: Stated that it has always been a requirement for CPM and NRP certifications to have two individuals at a birth. She could not speak for everyone's practice, but it is generally accepted practice to have two individuals present at the delivery. • Ms. Wickersham: All CPMs need NRP certification and NRP guidelines themselves state that there must be two individuals attending the birth, and that one of the individuals has to be specifically dedicated to the baby. CPMs adhere to those guidelines in order to keep the NRP certification, and they renew it every two years. The NRP guidelines itself require them to be adequately staffed. Noted that as with physicians, midwives do not want to have to attend to a new born and a bleeding mother, so it is in their own best interest to have two or three CPMs attend at the delivery. Also noted that sometimes there are four people attending the birth, because CPMs recognize the potential risks involved in the home births, and they want to have as many people with these skills as possible attending the births for the safety of the mother and the child. • Dr. Pont: Asked whether CPMs would lose CPM licensure if they did not bring two CPMs to the birth. • Ms. Wickersham: Responded that licensure could potentially be lost if CPMs fail to have at least two people attend numerous births, depending on the circumstances involved in the birth. There is a procedure for complaints to be brought against a CPM and a process to have a person lose their credentials. It is similar to all other professional organizations for individuals who do not act appropriately by failing to follow the organizations guidelines or rules. • Dr. Pont: Agreed that this is the same for all professions including physicians. • Ms. Wickersham: We all have to trust professionals to act professionally and follow guidelines. • Ms. Vickery: Asked Dr. Pont whether he was aware of Dr. Cheyney's 2019 study which showed that in well integrated setting there is no difference in the infant mortality rates between home and hospital births. • Dr. Pont: Responded that he was not aware of the study. However, he was aware of a 2014 study by Dr. Cheyney. His one critique regarding that study is that it stated that about 80% of births included in the study were CPM led births, but the study failed to breakout the statistics which would provide additional information regarding those births • Ms. Vickery: Noted that Dr. Pont referenced a study about New Zealand, but there was no evidence that the training of midwives in New Zealand 	
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is comparable to training of CPMs in the United States. Also, if recalled correctly, the study did not differentiate between planned verses unplanned home births, and attended births verses unattended births.

- **Dr. Pont:** Responded that he would have to review study again but noted that the study differentiated between New Zealand midwives and New Zealand nurse midwives. Noted that the study stated the following: a New Zealand midwife has a three-year degree; immediately upon the completion and the receipt of the degree, the midwives can practice independently as lead maternal care givers or LMCs; prior nurse training is not required for a midwife; and there is no requirement of supervision of the midwife during the first year after graduation, although a mentorship practice does exist. He believed that it sounded roughly like a CPM, but he admitted that he was not an expert about the education and requirements of a CPM. He stated that if it is roughly the training of a CPM, the study relates to CPMs in the United States. Also noted that the study found that there was a significantly less neonatal mortality if the person assisting the birth is a CNM, but agreed that all the study looked at was mortality. He wished that the study would have dug deeper and looked at seizures, neonatal admissions to hospitals and numerous other disorders.
- **Ms. Vickery:** Asked whether it was fair to consider the result when it did not consider planned home births verses unplanned home births, and assisted verses unassisted home births.
- **Dr. Pont:** Did not agree with premise that the study did not consider these things. Noted that he could contact the author of the study who is in Chicago and ask her. He believed that the study is a fair comparison between CPMs and CNMs, but he would have to get back to the Committee regarding the question whether the home birth was planned verses unplanned. He said that when he spoke with her, Doctor Geller did not give him the impression that was the situation. He stated that he could report back to the Committee if desired.
- **Ms. Vickery:** Asked whether Dr. Pont had any opinion about a study from Israel that was cited by other speakers.
- **Dr. Pont:** Responded that he was not aware of this study but agreed that to make a valid comparison, the studies have to be comparable to the education and licensure in the United States. He said that he researched the internet for studies and that the New Zealand study appeared to be comparable to CPMs in the United States. He admitted that he did not look to whether the study considered planned verses unplanned home births and that the failure to consider this aspect is a fair criticism of the studies. He said that he could report back to the Committee on this if they would like.
- **Ms. Vickery:** Asked about Dr. Pont's comparison of midwife training in the United States with the training midwives receive in Canada and other countries, and whether it accurately reflected the training that CPMs receive in the United States.

	<ul style="list-style-type: none"> • Dr. Pont: Responded that was his point in mentioning the training received in Canada was that a review of classes necessary for licensure in Canada would be similar to a university level bachelor’s degree in the United States, with four years of placements. • Ms. Vickery: Asked whether Dr. Pont was aware that the Midwifery Education and Accreditation Council (“MEAC”) education that would be required in the proposed bill is an accredited education that does require university level classes and course work. • Dr. Pont: Responded that he was not familiar with the MEAC education requirements and the apprenticeship model but that he would look forward to reading the materials that were previously submitted to the Committee. • Representative Moeller: Noted that she will be asking a similar question to all individuals who speak against the licensure of CPMs. Stated that the Committee knows that home births are taking place and that some are being attended to by unlicensed individuals and asked for his recommendation on how to address these facts. • Dr. Pont: Responded that ICAAP would support CNMs working in collaboration with the physician community to address the issue of home births. He does not believe that ICAAP would oppose anything to support that particular pathway. • Representative Moeller: Stated that the State currently licenses CNMs and have the opportunity for collaboration, but we do not have physicians who are willing to provide that collaboration. Noted that technically the pathway already exists but functionally it is not working. • Dr. Pont: Responded that ICAAP would be happy to discuss ways to make a more functional pathway for assisted home births, but they cannot force doctors to collaborate with CNMs. Admitted that he represented a doctor’s organization and stated that he would be happy to look at any advice or language. • Representative Moeller: Asked Dr. Pont to look at the situation on the ground in Illinois and offer a solution that is actually functional and realistic. Noted that was what the Committee was investigating. Instead of being told what should not be done to resolve the issue of women having unregulated home births, the Committee wants to be offered solutions regarding what should be done about home births. • Dr. Pont: Agreed that the physician piece is important and stated that he did not come to the Committee prepared to offer a solution and was very sorry. He was interested in talking more about the issue. • Senator Martinez: Stated that it was important that Dr. Pont wanted collaboration with a doctor, and the CPMs want collaboration with a doctor or hospital, but the fact is that the CPMs are not getting collaboration. However, the home births are already happening with or without the medical community and the Committee needs solutions to have safe births at home, especially for mothers who cannot afford to go to a hospital for the birth. She wants to make sure that all of the impediments are removed and resources are available to have safe births. 	
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Stated that women have a right to have a birth at home, but the State will not license the individuals who will assist them in having the home birth, so that they are better off going to a hospital. Noted that home births are occurring right now, and she wants to be sure that the State addresses the needs of these women. Stated that she has been involved in this issue for three years and received a great deal of push back from the medical societies, rather than providing some creative solutions to ensure that mothers who choose to have their babies at home are safe. That is why she is asking for solutions. It was good that there must be some collaboration but need to have doctors collaborating.

- **Dr. Pont:** Agreed that there needs to be collaboration, but it is well taken that they need to find a way to begin collaborating.
- **Senator Martinez:** Added that the problem is getting ignored but it needs to be addressed in the coming session.
- **Dr. Carlson:** Noted that a doctor from southern Illinois testified about his practice and explained his collaboration efforts with midwives who assist in home births and asked whether that could be a model for the collaboration. Also, noted that for mothers who want to have a child at home an important point was to have a physician backup, which would be essential for the safety of women and the babies. Asked whether Dr. Pont had a hypothesis or opinion about why few doctors are willing to collaborate with or provide backup to CNMs.
- **Dr. Pont:** Responded that it was not something that he had received training for, and he would have to learn more about the role as a collaborator. However, he stated that it was not outside the realm of possibility for him to collaborate with a CNM regarding a home birth. He said that he would have to negotiate the collaboration agreement with the CNM, but he noted that his office employs an Advance Practice Nurse (“APN”) who is more popular than he is with the patients. Collaborating with nurse midwives about home births is not an alien notion because doctors currently collaborate with nurses. It is just a matter of introducing a new model into his practice.
- **Dr. Carlson:** Stated that there has been testimony that there are barriers to collaboration, and asked whether the barriers are economic, safety, or concerns about liability. Asked for Dr. Pont’s opinion why there is no collaboration because babies will be born that need urgent care, and there are safety concerns in these situations if there are no connections with the health care system for these emergencies. He noted that even if CPMs are able to resuscitate babies, the babies will likely need help after that, which only can be provided by a hospital. This escalation without collaboration seems to be very dangerous precedent.
- **Dr. Pont:** Agreed that the last thing that you want is an infant crashing the emergency room where no one knows anything about the mother or the birth. Believes that this is an inherently dangerous situation.
- **Ms. Wickersham:** Described a scenario in which a collaborator is in Chicago, the midwife is attending a birth in Joliet and a new born needs

emergency care. She suggested that passing good hospitals in Joliet to get to where the collaborator is located in Chicago, just because the collaborator knows about the birth and the family, is bad care. The mother and baby should go to the nearest ER. So, ERs are equipped to deal with surprises and emergencies. So, to have mandatory collaboration and require that everything is checked with the collaborator, avoids the most sensible thing to do which is to go to the closest ER when urgent care is needed.

- **Dr. Pont:** Agreed with the questioner but stated that you would want to limit that scenario as much as possible. Admitted that he has told his own patients to go to the nearest ER when emergencies occur, and they are not in the Chicago area, but when it happens it is a more inherently dangerous situation. He stated that collaboration cannot totally eliminate the danger of going to an ER, but it can limit the number of times that a mother and baby are brought to an ER and the hospital staff has no information about the birth. He also said that he did not realize the wide area covered by midwives and the distance that home births are from collaborating doctors.
- **Dr. Wolf:** Stated that as a doctor who has previously collaborated with midwives, she is aware that collaboration is a relationship or conversation with the midwife about the care which should be made available. It does not mean that the doctor has to be available onsite for the birth. However, the doctor can ask what arrangements have been made if an emergency happens. The doctor does not have to be onsite for the birth. In Illinois, doctors can collaborate with up to five CNMs, and cannot be with all of them for the births. But, the doctor provides that guidance and mentorship regarding the birth. When she collaborates with CNMs, it is not always on-site, but she was that person who could help them out in a challenging situation and provide the guidance to walk them through a “what if” scenario.
- **Dr. Quinlan:** Commented that years ago there was a requirement for collaboration and they learned that their group liability insurance would not cover them for their actions involving collaborative agreements for home delivery. The challenge involving mandating collaboration is that it is impossible for doctors because insurance will not cover those actions. Therefore, the American College of Obstetricians and Gynecologists (“ACOG”) removed its opposition to the bill the last time it was considered, because it did not mandate collaboration between midwives and doctors, but it was explicit about which women were appropriate for home births. She thinks that a collaboration requirement is not successful because doctors cannot do it with the licenses and insurance requirements. She noted that Dr. Wolf collaborates with CNMs in other hospitals, but not for home births. She said that she would be more concerned about collaborating with home births because she would not know how to get to the home or know what is happening with the birth at a patient’s home. The previous bill was more acceptable because it delineated strict criteria regarding which patients were appropriate for home births, and required

the establishment of relationships with local hospitals, so if there is a transfer, the local ER is prepared for that event.

- **Senator Martinez:** Thanked Dr. Pont for his participation and hoped that the dialogue could continue. She said that the Committee is attempting to reach a good solution to a situation that is currently happening and may increase. She said that she will definitely be in touch with him regarding proposed legislation. She introduced the new panel and asked them to avoid repetitive testimony and focus on providing new information to the Committee. She wants to ensure that there would be much more discussion regarding liability issues. She also requested that the presenters not just read presentations but focus on the issues that they feel most important.

2. Yvonne Oldaker, APN/CNM, MPA

- **Ms. Oldaker:** Stated that she is an Advanced Practice Nurse and Certified Nurse Midwife. She serves as the Board President of the Illinois Affiliate of the American College of Nurse Midwives (“ACNM”). ACNM supports CPM legislation that meets International Confederation of Midwives (ICM”) standards. This chapter has a long history of encouraging and supporting licensure for CPMs in Illinois. In addition, as a practicing advanced practice nurse, she provides reproductive health care to patients at Planned Parenthood of Illinois. Planned Parenthood has been neutral on the midwifery legislation that has been introduced in recent years. As an organization, Planned Parenthood wants to support the ability of individuals to access the birth option that is best for themselves. At the same time, Planned Parenthood wants to ensure that care is provided in a safe and effective manner. That is why Planned Parenthood is pleased that the Committee is meeting to hear from all sides of the issue. Years of experience in the field of reproductive health have taught us that underground healthcare is dangerous for the people seeking care. When existing healthcare systems are limited by geography, income, insurance status, race, gender, gender identity, sexual orientation, or other social factors, people will find and use whatever care is available. When certain aspects of care are criminalized, resources become even scarcer because access to needed medications and other life-saving tools are denied, putting people’s health and lives at risk. She came today to speak to the Committee about her personal experiences giving birth at home 11 years ago, and how her life was threatened by Illinois’ restrictions on midwives. Luckily, she survived, not only to tell you this story today, but also to believe that her life-threatening experience happened to her for a reason. She felt that she had to do something to make this different for the next woman in her shoes. Her first daughter was born at home, in a state where her care providers held licenses, and her health and safety were codified into law. In 1999, she lived in Washington State. She was 23 years old, pregnant, single, worked two part time jobs while going to college part-time, and had no insurance. Being pregnant qualified her for Medicaid. She waited for a few months after realizing that she was

pregnant to start prenatal care, because she was afraid to go to a doctor, and she was afraid of delivering in a hospital. Her fear of hospitals and doctors likely stemmed from her being hospitalized as an adolescent, where she felt out of control of her body and the things happening to it. She could not imagine feeling safe during such an intimate event as birth occurring in a hospital. She was fortunate enough to have a friend to notice her changing body, and she asked if she had a midwife. She learned from that conversation that she should see a care provider as soon as possible, and that if she was healthy and maintained a healthy pregnancy she could deliver at home with her midwife's guidance. In addition, she learned that Medicaid would pay for her care. She followed her friend's advice and found a group of three licensed midwives, the equivalent of today's CPMs. They ran a home birth practice in the county where she lived. The midwives had attended national certification programs that trained them specifically in out-of-hospital birth. They had licenses in Washington State to order labs, ultrasounds, medications, and had transfer agreements with an obstetrician at a local hospital. If her pregnancy or delivery became complicated, that obstetrician would handle her care. Once her care started, she attended every appointment, every childbirth class, for which the State also paid. Her daughter Rhoda was born at her home into the hands of her midwife in the middle of the night. She hemorrhaged after the delivery, but she was stabilized at her home with medication. The midwives returned the following day to check on her and her baby. They returned a few more times in the first two weeks after her birth. Her daughter was healthy, and she recovered quickly from a rather routine management of an obstetrical complication in her home. She moved back to her hometown in Chicago's south suburbs to live near extended family in Illinois in 2007 and became pregnant again in spring 2008. She wanted to have another homebirth. She called her insurance company, Tricare, as she was married to a career military service member. She also started an internet search. She found only two homebirth midwifery practices that were located on the north side of Chicago, over an hour of travel away from her home. She arranged interviews with these practices, took time off of work, and drove over two hours round trip to interview them. Both practices told her they would not take her as a patient, because they were not willing to travel "so far" for her delivery. She noticed there were many more midwives listed online, but they all delivered babies in hospitals, which was still a place she wanted to avoid. There were no licensed homebirth midwives who served her neighborhood in the south suburbs. Once again, she had the fortune of a friend's knowledge of the local midwife network. Her friend told her that there were some midwives who could deliver her baby at home, but it would be "under the table." In disbelief, she called Tricare and was told that yes, if she lived in a state where CPMs/LMs were licensed, her care would be covered. However, since Illinois did not license these midwives, she would have to choose one of the midwives who had already declined to take care of her. If she wanted a homebirth, she would have to pay cash

for “underground” care. She found out these “underground” midwives had attended the same schools as her Washington midwives, but the State of Illinois did not legally “recognize” them as a profession. Left with no “legal” options for a homebirth, she obtained a few phone numbers for CPMs in Indiana, as she lived less than 15 minutes from the state border. She found a midwife who had been a classmate of the midwife who delivered her daughter, Rhoda, in Washington and hired her. Again, she kept all of her prenatal care appointments, and her pregnancy was healthy. When labor started, she called her midwife and the rest of her support team to start preparing her house. Her labor became protracted and lasted over 24 hours without much progress. Her and her child’s vitals remained stable, and she chose to continue laboring at home. Finally, her daughter was born in a birthing tub in her living room shortly after sunset. A few minutes after delivery, she hemorrhaged once again, but this time she lost consciousness. When she came to, the midwife told her that she lost a lot of blood, and they talked about going to the hospital, or calling an ambulance. Her midwife stated that she may need a transfusion, but she had no way to measure her hemoglobin. Her bleeding had slowed down significantly, and she felt she needed rest more than she needed to go wait in an ER for assistance. She told me there were stronger more effective medications that would stop hemorrhaging that she could receive through an ER, but without a license in Illinois, she could not access them. Despite her midwife’s appropriate recommendations, she decided to stay home that night, in part because she was concerned about what she would say if she went to the ER. Her midwife would not be able to go with her, or transfer any of her prenatal or delivery information. The fact that her midwife had manually explored and compressed her uterus as well as given her methergine and oxygen, while managing the hemorrhage, could implicate her midwife providing unlicensed healthcare, which could lead to her midwife being punished. In her mind, her midwife did not deserve punishment; her midwife had performed life-saving procedures and administered life-saving medications immediately following delivering her baby. Certainly, this did not make her midwife criminal. Her midwife left extra doses of methergine with her, with instructions to take it if her bleeding increased, and instructions to her family to call an ambulance immediately if that happened. Her midwife made it clear that a second hemorrhage without going immediately to the hospital could threaten her life. Her bleeding did not start again, and she did not need more uterotonics. She stayed home on bedrest, and over the next few days breastfed the baby and increased her iron intake. A week after her daughter was born, Ms. Oldaker developed a fever. Her abdomen hurt with the slightest movement, and in fact it ached constantly. She called her midwife and told her how she felt. Her midwife told her to go to a doctor immediately; that she had the symptoms of uterine infection and if she did not start antibiotics immediately, she could become septic and possibly not survive. She called the family doctor that her insurance covered and got an appointment that day. Her mother drove her to the

doctor's office with the baby. The doctor's assistants took her vitals. She was feverish and tachycardic; and she told the doctor that she believed she needed antibiotics. The doctor told her to see her obstetrician. She explained that her daughter was born at home. The way the doctor heard this story: she had no prenatal care. Her doctor refused to examine or treat her and told her to go to the ER. She explained that she had the baby with her, had another child at home, and was getting a ride from a family member. The doctor refused to prescribe any antibiotics and refused to call the ER ahead for her. Ms. Oldaker went to the Ingalls ER. There, she was again told to see her obstetrician. Again, she explained that she did not have one and she could not get see her midwife. Being seen in an ER immediately following a delivery, staff at hospitals get very nervous about not having any history or labs or information about her prenatal care. They do not believe what the patients tell them. She endured a very painful exam. After the exam, the doctor advised starting IV antibiotics. Once antibiotics were started, the doctor insisted that the staff needed to repeat the exam in order to collect sexually transmitted disease ("STD") testing. Even though she assured them that she had been tested and the results were negative, she was pressured and humiliated into complying with a second painful pelvic exam. After receiving a bag of fluids and antibiotics, she left the hospital. Her hemoglobin was 7 (meaning that she was very anemic) but for some unknown reason, there had been no discussion whether she should receive treatment for anemia. She slowly recovered from the anemia that resulted from the hemorrhage. After the IV antibiotics, she recovered from the endometritis which was likely caused by being anemic and having interventions performed at home without sufficient supplies due to the legal limitations on her midwife from being able to order those supplies. The fact that she could have died at two separate points from very manageable complications that occurred during her home birth in Illinois stuck with her hard for a long time. But she never thought that she made a bad decision by hiring the CPM she chose. A hemorrhage is not a rare or unmanageable complication, nor is endometritis. She lived in a region that was underserved by the legally recognized system of home birth providers. The laws that limited access to medication and supplies to her CPM in Illinois set the stage where the same kind of hemorrhage she had experienced in a different state with the same type of provider had a more dangerous outcome that required ER intervention. This is one of the main reasons she decided to become a midwife. She weighed her options professionally: become a CPM and practice underground with the constant threat of arrest which would impact the daughters she was raising or become a licensed nurse midwife. It seemed counterintuitive that if she wanted to make Illinois a safer state for reproductive healthcare for the future, to risk her children's futures. So, she went back to school to become a Registered Nurse and then a CNM, completing her certification and licensure in 2015. Were she to set up a home birth practice now, she would possibly make a difference in the lives of a small group of women in a 1-hour radius around her. But, that

would do nothing to help the countless mothers who choose a home birth despite living in the many parts of Illinois that have no coverage by anyone other than community midwives. That is why she chose to share her story here – to help establish licensure for these community midwives – giving them a requirement to earn a CPM credential and then supporting them in their practice with legal access to life-saving medications, as well as collegial legal relationships with the nurse-midwives, obstetricians and hospitals in their area. Keeping CPMs unlicensed will expose more birthing mothers to the same dangers she faced when birthing in Illinois. Licensing CPMs can save lives.

- **Senator Martinez:** Thanked Ms. Oldaker for her statement and asked if there were any questions from the Committee. As there were no questions, Michelle Breen began her statement.

3. Michelle Breen, MHS

- **Ms. Breen:** Stated that she was going to proceed quickly. Stated that Eugene DeClercq, a CDC Statistician, encourages us that instead of asking is home birth good or bad, to ask “How can we make home birth better?” From a public health perspective, licensing home birth providers is essential for making home birth safer and better. She explained that licensing CPMs will make many public health improvements to Illinois. Improvements from licensing CPMs include increased accountability and recourse to consumers, reduced maternal health morbidity, creating cost savings through Medicaid, increased opportunities for initiatives to reduce health care disparities and improved local and state levels for disaster readiness. She described herself as a volunteer consumer advocate for home birth safety for 25 years. She has experience as a working Board Member on numerous local, state and national midwifery organizations. Her educational background is in public health and has a Master of Health Science degree from Johns Hopkins University, where she studied in the Department of Maternal and Child Health. She stated that she was interested in a home birth and based on her studies at John Hopkins she read about home birth and knew that she did not want a medical birth. She started looking and knew that she didn’t want to have a hospital birth with a low intervention physician. She was told that she could not have a home birth when she was asking questions about any programs at hospitals which supported them in 1994. She decided to have a home birth with an underground midwife. She is currently a statistician with the federal government. She stated that she is not representing her employer but was appearing as a volunteer. When she first started advocating for midwives, she used the language from the Midwives Model of Care, a wellness model of care with health promotion and disease prevention. She came to learn that health care licensure is not about wellness, but about public safety. Need to assure that: providers are safe and competent; and also providing recourse to consumers. So, she changed messaging away from the midwives’ model of care toward home birth maternity care crisis and black-market maternity care, because she believes that black market maternity care is not just a bad idea but is a bad reality in Illinois.

Licensing CPMs is a public health win-win, because it creates lower costs and better outcomes. First, there would be lower costs and the opportunity to use Medicaid. Currently, 14 states have Medicaid programs that reimburse CPMs, with three in the process so there would be a total of 17. Decades ago there was a community group that successfully sued Illinois for Medicaid reimbursement for CNMs. This provides a legal precedent for ways to receive medical reimbursement for the use of CPMs. Additionally, Federal legislation has been introduced that would require state Medicaid programs to cover services provided by CPMs. There was also similar language in the Affordable Care Act for birth centers, not for home births. So, CPMs can get Medicaid reimbursement in all 50 states based on the Affordable Care Act if it is a birth center birth. On average, the cost to Medicaid would save \$4,531 per birth based on 2017 dollars. She stated that this is nothing new, because Washington state has been doing this and receiving reimbursements for decades, where these numbers are derived. This means that in Illinois there is an estimated \$3.3 million in Medicaid offsets. While this amount is a drop in the bucket of Medicaid's overall budget, there are few places to get a \$3.3 million Medicaid savings without even trying. She mentioned that this is a conservative estimate based on 1% of women on Medicaid having home births being attended to by CPMs. In states where CPMs are licensed and are covered by Medicaid, approximately 1.5% of births are covered by Medicaid. As Dr. Cheney presented last month it depends on the integration of the whole system of how many people have home births and have Medicaid coverage. In Washington state the numbers are much higher. She explained that she was not going to talk a great deal about maternal health outcomes because Dr. Cheney has covered that topic. She just talked about reduced rates of cesarean section because that is a significant topic for maternal health. CPMs substantially reduce a woman's rate for having a cesarean section. Results of the CPM 2000 study demonstrated a 3.7% cesarean section rate for CPMs compared to 19.0% in a low-risk, hospital control group. She loved this study because it had a 100% of CPM credentialed midwives participation rate. They received that participation rate because the credentialing organization made participation a mandatory condition for renewal for the next year. The organization required this because it wanted to show the cost effectiveness of CPMs assisting in home births. Cesarean section involves major abdominal surgery and it is very common, as it is 31% in Illinois, but it is major surgery. While there is no good data about a link between home birth and maternal mortality because maternal mortality is fortunately very, very rare. While infant mortality is measured per thousand, maternal mortality is measured per 100,000. So, you are not going to see any study about home birth that considers the maternal mortality. However, the United States ranks 17th in the world in maternal mortality and 55 countries rank lower in the percentages in maternal mortality. (The reason that the United States does not rank 56 is because there were numerous ties in the ratings of maternal mortality. For

example, there are 6 countries that rank 16th in the world.) To study the issue of maternal mortality the US has established Maternal Mortality Review Committees. These Committee consider all of the maternal mortality in the country and associate them with common factors. Preliminary findings of these review committees have found an association of both cesarean section and fragmented care with maternal death. Maternal Mortality Review Committees have found that two-thirds of maternal mortalities in Illinois co-occur with cesarean sections. While there is no direct link between maternal death and home birth, home birth is directly associated with reduced risk of having a cesarean section delivery. Health care disparities are another measure of health care outcome. Racial and ethnic disparities in maternal and infant outcomes are well documented. The chart on page 15 of the slides illustrates these disparities are also present in out-of-hospital birth. The top line is the percent of out-of-hospital births among non-Hispanic, white mothers. The dotted line, with is the second lowest, is the percent of out-of-hospital births for Native American mothers, and the bottom 3 lines represent the percent of out-of-hospital births for non-Hispanic black mothers, Hispanic mothers, and Asian and Pacific Islander mothers. All groups show in increase over-time from 2004 to 2017. The non-Hispanic white group shows both the greatest percent of out-of-hospital birth and the greatest increase over time. The increase in home births among non-Hispanic white births accounts for 81% of the overall increase from 2004 to 2017. The table on page 17 of the slides shows that a woman is more likely to have a planned home birth if she is non-Hispanic white and if she has resources to self-pay. Licensing CPMs provides opportunities for cost effective and community-based health care innovations to address disparities. One example of this initiative is the National Perinatal Task Force (“NPTF”). The NPTF was founded by a Florida-based CPM, named Jennie Joseph, in association with Paula Rojas, CPM. The NPTF has endorsed two innovative model programs, which are entitled the JJ Way developed by Jennie Joseph, CPM, and The Maternal Justice Model, developed by Paula Rojas, CPM. The NPTF supports the creation and expansion of grassroots networks establishing Perinatal Safe Spots, targeting communities at-risk of poor maternal child health outcomes, such as low birth weight, preterm birth, infant mortality and maternal morbidity. These safe spots target areas of infant mortality or low birth weight that they can access and develop them in high-risk areas. So, if there is someone in the community that wanted to develop a para-natal safe spot, but they didn’t have high morbidity and mortality child health outcomes in their neighborhood, would be directed to another neighborhood where their help is necessary. All of the perinatal task forces are set up in communities that have poor maternal child health outcomes. Currently, there are 31 Perinatal Safe Spots located in 22 states. Fourteen states, or 81%, of the Perinatal Safe Spots are located in states that license CPMs. Page 22 of the slide presentation is a side-by-side map comparison of states with Perinatal Safe Spots and states with Medicaid

programs that reimburse CPM services. (A copy of the slide presentation is attached.) Page 23 of the slide presentation shows the outcomes of the Jenny Joseph method (the “JJ Way”), which resulted in the reduction of the percentage of preterm births. Jennie Joseph has been documenting her program’s birth outcomes for decades. Jennie Joseph is a CPM and practice the midwifery model of care. Her most recent statistics were from 2017 and were published in the 2018 NPTF Report. Preterm birth and low birth weight percentages are shown on page 23 for three groups of women, mothers receiving care from the JJ Way in birth centers, mothers in Orange County, Florida, and mothers in the entire state of Florida. The chart shows how birth centers and CPMs can be innovative in reducing health care disparities. All women involved in the study are socio-demographically at-risk for poor birth outcomes. The data is broken down by white mothers, black mothers and Hispanic mothers and shows improvement in all demographic and racial categories. The JJ Way reported the following a preterm birth rates: 5.0% for white mothers; 8.6% for black mothers and 4.0% for Hispanic mothers. As way of background, the Healthy People 2020 (“HP 2020”) target for preterm birth is 9.4%. The JJ Way program surpassed HP 2020 targets for all ethnic and racial groups. As shown on page 24, the JJ Way program achieved similar outcomes for low birth weight babies as the following percentages: 2.8% for white mothers; 8.6% for black mothers; and 1.0% for Hispanic mothers. The HP 2020 target is 7.8%. The JJ Way with CPMs surpassed the target for white and Hispanic mothers but missed the target for black mothers. One last public health advantage of licensing CPMs is integrating these out-of-hospital birth experts into our Disaster Preparedness Preparation and Planning groups. It is well understood that pregnant women and newborn babies have special needs during the event of a disaster, when hospitals may not be accessible. It would improve disaster preparedness if the planners have a home birth expert to help with the preparation and planning. She then emphasized how home birth is different from hospital birth. Physicians talk about how CPMs do not have as much education in terms of the amount of time that they spend in education compared to CNMs, but they have a different set of education. Home birth is a different field from physicians and the things that CPM can bring in a disaster is beneficial. Internationally, disaster preparedness groups include a home birth provider. The threat of pandemic flu is a good example because that could happen anywhere. The professionals that are making recommendations for pandemic flu preparedness recognize that one recommendation is home birth to reduce contacts or separation between infected individuals and pregnant women and newborns. Childbirth is the second most common reason for hospitalization. If there is pandemic flu in the hospital and babies need to be born at home, it would be nice to have licensed CPMs available. The last three slides are position statements from the American Public Health Association (“APHA”), regarding increasing access to licensed out-of-hospital birth services. Ms. Breen stated that fifteen years ago, she would have opened her

	<p>presentation with this statement. She said that she is not talking about anything new. Since 2001, the APHA has recommended that the states license CPMs through nationally certified credentials. So, the last three pages has information about the APHA position statement and they have nine position statements related to midwives.</p> <ul style="list-style-type: none"> • Senator Martinez: Thanked Ms. Breen for her presentation which contained a great deal of information. • Dr. Wolf: Confirmed the statement that two-thirds of maternal deaths co-occur with cesarean sections. Asked whether the deaths of the mother occurred because of the cesarean section. • Ms. Breen: Responded that when they review maternal mortality there is a co-association that two-thirds had a cesarean section. It does not necessarily mean that it is a causal relationship, it is just a relationship. • Dr. Wolf: Asked where the data for this causal relationship obtained. • Ms. Breen: Responded that Dr. Cheyney provided that information through a personal communication. It is preliminary and has not been published, but she said that she could get more information about that result. • Senator Martinez: Stated that if Ms. Breen could provide a copy to the Committee it would be very helpful. • Dr. Wolf: Asked about the Medicaid cost savings and her statement that the \$4,531 cost saving was from Washington State’s savings, or whether it is based on Illinois’ projected savings. • Ms. Breen: Responded that in 2007, Washington state did a very comprehensive study about how much it would cost Medicaid for home births. The 2007 results were projected to 2017 dollars, and that is based on national data. Then, the projection to Illinois regarding the \$3.3 million saved is using Illinois data. She still used the \$4,531 cost savings as an estimate. • Ms. Wickersham: Regarding the cesarean section, she confirmed that Ms. Breen could not say that CPMs reduce maternal mortality, but Ms. Breen could say maternal mortality has an association with cesarean sections, although not causal with cesarean sections. Also, confirmed that CPMs have an extremely low rate of cesarean sections, but cannot say that CPMs reduce maternal mortality there is a potential relationship between the two. • Ms. Breen: Agreed that there was an indirect relationship between the two and we do not know if there is a direct relationship because of the way that maternal mortality studies have been completed, cannot say that it is causal. There is just a co-association. There was also a co-association with fragmented care in that an increase in fragmented care was associated with an increase in maternal mortality. She also pointed out that the midwife model decreases fragmented care, because under the midwife model there is the same provider for the prenatal care, labor, delivery and post-natal care. • Senator Martinez: Asked if fragmented care involves a patient seeing several different care givers through the birthing process. 	
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- **Ms. Breen:** Explained that fragmented care is associated with maternal mortality.
 - **Dr. Wolf:** Pointed out that the higher-risk patients are having cesarean sections, then there were naturally be high morbidity and mortality for those patients. Therefore, it was reasonable to assume that higher-risk patients would have higher morbidity and mortality.
 - **Ms. Breen:** Agreed with that statement. She added that she could not state that there was a direct relationship between home birth and maternal mortality. She explained that the numbers are too small to measure, because there are small incidents of both home birth and maternal mortality. There would never be a study that considers that direct relationship in the United States. But we do know that when you review low risk women who give birth in a hospital and women who have home births, the woman who have home births have fewer cesarean sections. That is why she likes the slide with the CPM 2000, which compared rates of cesarean section for the low risk group and showed that there were only 3% cesarean sections for home births compared to 19% cesarean sections for hospital births. Also showed that the total cesarean section rate is about 30%. Agreed that the high-risk births should be excluded, but the difference is between 3% and 19% cesarean sections when these high-risk births are excluded.
 - **Ms. Wickersham:** Confirmed that the low-risk home births were matched with the low-risk hospital births, and that is how the 3% and 19% rates were obtained?
 - **Ms. Breen:** Answered yes. Added that there had to be a low-risk birth to be a home birth, and the hospital-based comparison that used in the CPM 2000 were all low-risk mothers. The slide with the percentage rates compared apples to apples, in regard to comparing cesarean sections rates for low-risk births.
 - **Ms. Vickery:** Asked how the \$4,531 savings for home births was calculated.
 - **Ms. Breen:** Responded that her understanding was that the largest cost saving was hospital facility fees, which are very high, because those are not included in home births. Also, included in the cost savings is the expenses for cesarean sections, which are more frequently performed in hospital births. In addition, there are expenses for hospital interventions which are not paid for with a home birth.
 - **Senator Martinez:** Seeing no additional questions, she thanked Ms. Breen for her testimony and moved to Ms. Fisch.
- 4. Deborah Fisch, JD**
- **Ms. Fisch:** Thanked the Committee for the opportunity to make a presentation. She is an attorney licensed in Michigan, where a law licensing CPMs was approved two years ago, and they just started issuing licenses in August 2019. Noted that she is not licensed in Illinois, and that most of the legal points that she will be making are based on common law or case law that generally applies to every state. She sits on the Michigan

Board of Midwifery, but is not representing them at this meeting. She was asked to talk about the history of midwifery governance in Illinois and noted that midwives had been licensed until the 1970s. Midwives served their communities until they were forced out, often by criminal prosecution. She noted that an Illinois Supreme Court decision in 2003 held that if a person is practicing midwifery in Illinois and is not a Registered Nurse or doctor, the person is guilty of the unauthorized practice of nursing or advanced practice nursing in the State. She said that criminal prosecution is not an efficient way to regulate a healthcare profession, because it is very costly, and it is a very blunt tool. There are better ways to regulate the profession. Regarding medical malpractice liability, obstetricians and surgeons experience highest rate of malpractice claims, but they also presume possible claims three times higher than actual number of claims. Increasingly, physicians are employees of institutions or large systems that are heavily risk-averse, which adds to the atmosphere of fear of litigation. The malpractice system is set up to work as a feedback loop, in that if a doctor provides inadequate or negligent care and damages are assessed, then the doctor and all other doctors know that they should be not providing such care. However, most cases are settled so the feedback loop is disrupted, in that the other doctors do not know whether providers were actually negligent or not, and the actual damages. Also, physicians particularly fear lawsuits because doctors are unlikely to be sanctioned by medical board or arrested for gross negligence following a bad outcome. On the other hand, midwives need to worry about being arrested for a bad outcome. Since it takes very negligent or egregious conduct to have a medical board sanction a physician, the physician's greatest concern is a civil lawsuit. Malpractice liability arises if there is a relationship between parties (so the provider owes a duty of care to the patient), the provider breaches the duty to provide adequate care, the provider's action caused an injury and the patient suffered an injury resulting in damages. A subset of liability is vicarious liability: one provider is held responsible for the harm or damages that are caused by another provider. This requires a relationship between those two providers, usually one of employment or supervision; if you do not have a relationship, you do not have vicarious liability. A corollary to that are compulsory collaborative relationships which can create potential liability. In addition, if the law required CPMs to enter into collaborative agreements with doctors, but doctors refuse to enter into such agreements, then the CPMs would be shut out of practice. This has happened in Delaware and California. In Delaware there was only a single CPM who could get a collaborative agreement with a doctor, because she worked with the Amish population, who are unlikely to bring lawsuits. In California, CPMs were ignoring the law because they could not reach an agreement with any doctor. Both of the states dropped this requirement for collaborative arrangements. She also stated that she recognized that hospitals and doctors are unable to enter into such agreements because their liability insurance carriers will not permit them to do so. Emphasized

that no one is opposed to having inter professional relationships between doctors and CPMs, but they should not be made compulsory because licensure allows inter professional relationships to flourish. Requiring collaboration will not make it happen, but licensure of CPMs will permit collaboration. To avoid vicarious liability, must make sure that there is no formal legal relationship between CPMs and other providers, making a statutory protection from vicarious liability is then unnecessary. There are also additional defenses that providers can raise to protect themselves from liability, such as assumption of risk, comparative negligence, or lack of agency relationships. Regarding the assumption of risk, if patient receives adequate informed consent and knows the risks and benefits and chooses a riskier procedure than the physician recommends, the patient assumes the risk. The provider cannot be liable for damages if the patient assumes the risk - but this has to be defended and not settled. If a doctor or hospital uses these defenses, then they are protected from liability. She explained that the problem with the liability language in the original SB 1754, it potentially makes *midwives* accountable for potential negligence of *other* providers.

- **Senator Martinez:** Explained that as the Committee moves forward and can create legislation, this component is very important. She did not know if the Committee could get into more of the details regarding what the language should read to make everyone comfortable. It was not that the Committee was attempting to dismiss it, because it is very important, however, the Committee knows that when it comes to language that everyone can agree on, this particular component will need input from other individuals on this language to make sure that the liability issues are addressed. When she issued the bill containing this language she received a great deal of pushback from all stakeholders. It created a great deal of misunderstandings of their attempts to issue a bill which she was attempting to improve. Sometimes she put out the worst bill possible, but in the end with advice from others they have a good bill. This language made the attorneys uncomfortable. She wants to make her aware that the Committee knows the wording of the previous draft and will make changes. She knows that there would be a separate conversation involving this proposed language.
- **Ms. Fisch:** Stated that she had compromise language regarding this issue which stated as follows: “An LCPM is not an agent, ostensible agent, or employee of a Health Care Practitioner (“HCP”) who is consulted with or who accepts a referral from the LCPM based solely on the consultation or referral.” If there is no agency relationship, there is no vicarious liability, and she noted that the proposed compromise language states that there is no agency relationship. In addition, she noted that midwives practice autonomously. If there is autonomous practice, then there is no agency relationship and that is supported by the US Midwifery Education Regulation & Association (“US MERA”), which is supported by ACOG and ACNMs. The only thing that needs to be added to this language in the bill is substantial informed consent provisions, because that complies

with case law which states that you cannot have vicarious liability if the patient doesn't have reason to believe that providers are holding themselves out as an agent of another, so its about the appearance of agency as well as the actual relationship. Stated that this was also supported by caselaw in the D.C. appellate court, in a case called *Gilbert v. Miodovnik*, 990 A.2d 983 (D.C. App. 2010). That matter involved a birth center and a transfer to a hospital. That case held that a consultation or referral could not create liability, and that the hospital was not liable for the patients' injuries, except for injuries which happened after the patients' transfers were complete. Regarding professional liability insurance, people believe that carrying liability insurance creates safety, but she does not understand that belief. She believes that safety is created by credentialing and licensing of professional skills and expertise, transparency about these requirements through strong informed consent, and accountability through administrative disciplinary measures. Sanctions can be levied against bad providers, including the removal of the person's license. However, the midwives' model of care is a reason that they have good outcomes because they care for fewer patients, which allows them to provide extensive and personalized care. However, that very model of care sets them up in an economic relationship where the cost of liability insurance can be prohibitive. Plus, that cost gets passed on to patients, which would increase the costs for home birth. It's instructive to compare the requirement to obtain professional liability insurance ("PLI") with other medical professions in Illinois and across the country. In Illinois physicians are not required by law to obtain PLI, but often by group practices and institutions. In addition, it is not required by law in 36 other states. Of the 35 states that currently license CPMs, only three require that they purchase PLI. Two of those states, Florida and Washington, were forced to enact joint underwriting agreements, where the States take care of the PLI, because private PLI was not feasible, and the third, Colorado decided not to enforce it because after 20 years the State believed that it was unnecessary and undoable. She said that she was also informed that Pennsylvania in some way subsidizes PLI. In addition, she stated that Indiana law is a bit confusing because it requires PLI and then requires midwives to say whether or not they are carrying PLI, so there is statutory conflict. She continued that PLI is unavailable to CPMs in states where they cannot be licensed, and once CPMs are licensed then insurance becomes available. Another option is that after licensing, CPMs may choose to join managed care groups or birth centers, which might require CPMs to acquire PLI, or CPMs may choose to obtain insurance themselves. She believed that the market will take care of this, and there is no reason to legislate this requirement. She also felt that if CPMs are required to acquire PLI by law, then there should be parity with other health care professions, in that they should be required to acquire the insurance as well. She is strongly in favor of requiring the disclosure of whether CPMs have PLI, because people who hire midwives have a right to know whether their CPM has acquired PLI or not. The patients can

then decide whether it is worth the additional cost of care. This position is supported by US MERA as well. In conclusion, if there is going to be statutory provisions regarding liability, these provisions should reinforce the common law protections that already exist. They should not create additional basis for liability through compulsory collaborative relationships. Statutes and rules should require only disclosure of insurance status, rather than requiring PLI, which she believes is the case for physicians in Illinois. She also recommended that policymakers should develop guidelines about the contact between midwives and the medical system, that is not an issue of liability, but about safe integration of systems. The goal should be to determine how this contact can be managed to protect the public. The interaction and transfer of patients between home births and hospital births should be designed to make it safer for the public, pursuant to safe transfer guidelines. Licensure actually improves the midwives' relationships with hospitals. Also, home birth providers should be added to the existing perinatal regionalization system, which will increase safety as well. Whether this is done by rules or other policy initiatives, these recommendations should be implemented to protect the public. She thanked the Committee.

- **Senator Martinez:** Thanked Ms. Fisch for the informative presentation and the slides. Said that this will be an important part of the legislation and will help with the language that will be prepared for a proposed bill.
- **Ms. Sawicki:** Approved the discussion of Tort Law and asked whether the compulsory collaborative arrangements which Ms. Fisch was discussing involved a formal written agreement, rather any casual conversations between a doctor and a midwife.
- **Ms. Fisch:** Responded that she is talking about a written collaboration agreement which details the responsibilities of the doctor and the midwife and is signed by both individuals. Such an agreement would join them in liability. Collaboration is something that all of the parties want.
- **Ms. Sawicki:** Noted that she said some insurance carriers do not allow a collaborative agreement with home birth providers. Asked whether insurance carriers do not allow these collaborative agreements because the home birth providers are not licensed, since physicians routinely have collaborative agreement with other doctors and nurse practitioners, or because they generally prohibit agreements with CPMs.
- **Ms. Fisch:** Responded that the answer was both. She could not determine the percentages for insurance carriers' refusal to offer PLI, but the unlicensed status certainly gets in the way of midwives being covered with PLI. Insurers do not like unlicensed providers with good reason. However, around the country there are insurance carriers who insist that the midwives they insure only provide hospital care. Whether it is because they will not provide a policy, or they will raise the cost of the policy to a prohibitive amount, both come into the consideration. There are probably researchers who could find the exact numbers for the Committee.

- **Dr. Wolf:** Asked about Ms. Fisch’s statements regarding the midwife model of care, which implied that physicians do not provide excellent care because they have a lot of patients.
- **Ms. Fisch:** Responded that she would not say that in general. Physicians, like anyone who goes into health care, do not go into it because they want to be bad providers, or because they are only in it for the money. Everyone goes into it trying to be the best provider they can. However, she noted that everyone is a product of their institutions and the structures that surround them, and those institutions and structures encourage certain behaviors. As a home birth patient herself one of the reasons that she chose a midwife was because she did not like being hustled out of her doctor’s office in 12 minutes. That was not her doctor’s fault, because she was wonderful, she adored her, but the economic forces that set up a hospital practice did not let her spend the time that she wanted to with her. Ms. Fisch’s doctor was equally disappointed about this restriction. Ms. Fisch when to her midwives who regularly gave her hour to hour and one-half prenatal appointments. She cannot speak to who is a better practitioner, but she can speak about systems of care that force people to behave in certain ways. We need all health care providers desperately and we need them all to cooperate with each other. That is how it is made safer for the public, which is the purpose of the meeting.
- **Dr. Wolf:** Stated that she thought that it is dangerous when she sees statements like those about models of care. As a physician she believes that saying midwives are better because they spend more time with the patients, but that doesn’t equal providing excellent care. She believes that excellent care equals excellent care, no matter how much time is spent with the patient. She also stated that, while she is not an attorney, she is definitely concerned about vicarious liability as an OB/GYN physician. She believes that as we move through this process and talking about whether physicians feel comfortable about collaborating with CPMs who would become licensed, she wants to make certain that as a health care provider that if she talks to someone on the telephone, or serving as a referral, that she is not held liable for something that she has no input in at all. So, the language of vicarious liability when she reads it in the Senate bill, she believes that is very important language and that needs to stay, if there is going to be a bill.
- **Dr. Quinlan:** Echoed Dr. Wolf’s statement and noted that it was a huge step which ACOG took by removing its opposition to this bill the last time it was introduced. If the vicarious liability language is not in a proposed bill, ACOG would have to oppose such a bill’s passage. The physician groups cannot support a bill without that language.
- **Ms. Fisch:** Stated that she could not speak to what physician groups would or would not do, but she stated that it is time for all of those groups to have discussions with malpractice carriers and risk management departments in hospitals regarding what is necessary to protect expectant mothers and babies, and whether licensing home birth midwives is really the problem. She noted that she has yet to see a list of case law that shows

hospital providers assuming that liability. Also, case law is made on the appellate level, just having a trial court decision or a settlement does not provide a precedent for other matters. In addition, there is case law which states that there is no liability, but it has to be defended. Of the very small percentage of cases that are transferred to hospitals with a bad outcome, the concern seems disproportionate to the reality. When with a little effort we could be coordinating care in other ways and making it safer, but that was just her opinion.

- **Ms. Harris:** Mentioned that they are going to be speakers on the next panel who will talk about these kinds of cases. There are a couple of things that she disagreed with in Ms. Fisch's presentation. One was Ms. Fisch's statement that physicians are just unnecessarily afraid of cases that involve home births.
- **Ms. Fisch:** Responded that she did not say "just," and recognizes that physicians have good reasons to be concerned about some cases. The data shows that doctors' estimates of liability are much higher than their actual potential liability.
- **Ms. Harris:** Noted that there will be further discussion about the matter on the next panel but noted that she has data that shows that Cook County is the worst county in terms of all sorts of litigation in the United States in terms of the number and the amount of cases that are decided in with astronomical figures. Also, Illinois is the worst state in the entire 50 states. So, hospitals have to actually deal with the environment where we live, not in the environments that we wish that we lived. Illinois is a very litigious state, and she does think that providers and hospitals have a right to be concerned about liability exposure as exists today, let alone any added exposure to liability. Her concern is that Ms. Fisch is basically seems to be saying that if they do not require collaborative agreements then there is no vicarious liability exposure. However, there are Illinois cases where a hospital has been held liable for actions of a nurse midwife at a federal qualified health care center ("FQHC"). So, the hospital was found liable in a law suit even though they had nothing to do with the nurse midwife or the FQHC staff. That decision was luckily overturned. However, just because you do not have a written collaboration agreement doesn't mean that when something bad happens and people are looking for resources to care for a child who may have lifelong issues, that providers who may have been ancillary to that care, but not responsible for the outcome are brought into the lawsuit. So, just not having a collaborative written agreement does not take care of the vicarious liability issue. Those were some of the circumstances that she would not portray as Ms. Fisch has involving these issues.
- **Ms. Fisch:** Responded that people will always bring lawsuits, which is a fact of life. This is especially true in the absence of other structures that are set up to care for children who suffer lifelong health problems. That is a much larger problem than any of us can solve. Obviously, children who are injured through no one's fault do not get anything. We cannot take that into account. There is no question that it is traumatic to go through

litigation, but in the end, as Ms. Harris said the case involving the nurse midwife was overturned on appeal. So, that is the precedent.

- **Ms. Harris:** Noted that a great deal of time and money was spent attempting to have the decision overturned on appeal. Also, the other thing that Ms. Fisch is advocating is that there should not be a requirement for PLI being carried by midwives, which other states do not seem to follow that precedent. She stated that if that is the route that is chosen, then there are no resources, because there is no insurance. So, if something goes wrong, whom is going to be responsible for the bad acts committed by midwives. Asked whether the patient would be left on their own.
- **Ms. Fisch:** Responded that she believes that this is the choice that patients have to make on their own. Part of the low cost for midwives is that they are not paying the premiums. Patients can decide about home birth based on: their own risks; what they think will happen; and their available resources. The bottom line is, if a physician is not at fault, those cases will be dismissed, or if not overturned on appeal. You cannot have liability if you are not at fault. She then described a test case where a midwife drops a baby, who gets a bruise, and the baby is transferred appropriately to a hospital. Then at the hospital, the doctor again drops that baby and the baby suffers a skull fracture. She concluded that both the midwife and the doctor are probably at fault, but you have to tease out who is responsible for what injury. You would not say that the midwife is responsible for the skull fracture, but she will be responsible for some percentage of the fault. In Illinois, juries can apportion a percentage of the fault among the parties. If the doctor had not dropped the baby, the doctor would not be at fault. She stated that if doctors or hospitals were not at fault, they should not settle the matters but oppose the litigation.
- **Ms. Harris:** In response to Ms. Fisch's statement that hospitals should defend cases, which should not have been brought into in the first place, Ms. Harris stated that the hospitals would then be spending resources on litigation to prove that they are not responsible. She stated that those resources would be better spent on patient care at the front. She believes that it does need to be very clear in proposed legislation that a hospital or physician is not responsible for care that is provided by a midwife. It is the hospital's responsibility, someone in the hospital does something after there is a transfer to the hospital. But, it is also important to make it very clear in legislation that anything prior to the transfer it is the midwife's responsibility. Believes that there has to be some guidelines in the legislation.
- **Ms. Fisch:** Believes that they are both on the same page, because they all want people to be liable for their own negligence and not someone else's negligence. She suggested one way to draft legislation, but there may be other ways to get to the same result, but she believes that they all want the same thing.
- **Ms. Sawicki:** Commented that there is wide spread agreement that there are problems with the tort system, both for defendant physicians and for

plaintiffs. She emphasized that what the Committee should be focusing on now is not the systemic problems that arise in the health care system generally, but how the licensure of midwives is going to impact that system. The Committee cannot solve the systematic problems, but at the same time, she does not believe that it is appropriate to blame midwifery for the continuation of problems that are already in the tort litigation system.

- **Senator Martinez:** Thanked Ms. Fisch for her testimony.

5. Robert Minkus, MD Testimony

- **Mr. Minkus:** Stated that he was present because of all of the Board-Certified pediatricians in the Chicago area, he is positive that he has seen more home births than anyone else. So, he believes that he has some personal expertise in this area. He said that he strongly supports the licensure of CPMs. He graduated from Northwestern University Medical School. He is a Board-Certified pediatrician with the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics and an Associate Professor of Clinical Pediatrics at what is now called the Fienberg School of Medicine (but used to be called Northwestern University Medical School). He has taught high level courses at the school for over 45 years. He said that his main credential was that he has been practicing pediatrician in private practice for 45 years. He is currently the senior physician for his group in the NorthShore University HealthSystem. He initially became aware of, and interested in, home births in medical school. As a Northwestern University Medical School student, he had the amazing opportunity to work with midwives with the famed and alas extinct, Chicago Maternity Center, which delivered babies all around Chicago. He saw the dramatic differences between hospital and home deliveries and believed that it was an epiphanal experience. During his third-year hospital obstetrician rotation, he observed that almost all mothers has anesthetic drugs. He was told that this was the way that it had to be. He observed that many babies were born being lethargic and often as least partially blue and was told that this was normal. He also went with the midwives to all of the homes and saw that none of this was actually true. Most of the home births were actually beautifully controlled experiences without drugs. Even as a “pathetically ignorant” medical student, he could not fail to see the difference in the new born babies, who were always pink and vigorous. He said that he did not understand why the Medical School allowed him to have this radicalizing experience. He was also fortunate to have a faculty member during his fourth year who was supportive of home births and who instilled in him respect and admiration for home birth providers. Over his 45 years, he has had thousands of patients who have been born at home, and he feels that he has a deep insight into home birth and its implications. He has been continually impressed with the competence and professionalism of the midwives with whom he has shared patients. Continuity and communication between him and midwives have never been an issue. One

advantage of home births, which has not been mentioned, before is initiation of breast feeding is much easier in the relaxed atmosphere of a home rather than in the rigid institutionalized strict structure of a hospital. Consequentially, he has never seen breast feeding failure in babies born at home, which is a very significant health advantage for the long-term health of the children, as he hopes everyone knows. He has found that parents who chose the home birth option are not crazed, irresponsible flower children. On the contrary, he saw that they are almost always very well educated, thoughtful and well informed. They have chosen this unpopular option after very careful consideration. He has always been impressed that properly done home birth is as least as safe as hospital deliveries. He stated that “properly done” means that: midwives have to be properly trained and equipped; pregnancy needs to be properly and carefully monitored, so that any problems are appropriately treated, and so that high-risk pregnancies can be selected out and diverted to a planned hospital deliveries; and lastly, labor needs to be properly screened so that developing problems can be treated, and if necessary, the mother expeditiously and efficiently transferred to a hospital for delivery. He noted that multiple studies around the world, including one published in 2005, in the British Medical Journal, have shown that competently attended midwife assisted home births are safe. Summarily, a large 2007 study analyzing midwife assisted home births in Washington State found them to be not only as safe as hospital births, but also showed that they generated huge cost savings to the State’s Medicaid system. He explained that this was why the United Kingdom has actively encouraged home births as part of their health system. He stated that it is why home births account for a significant number of births in the Netherlands. It is also why the American Public Health Association has supported home births as an option and advocated in favor of licensure of CPMs. He stated that this is why 35 states in the United States have already made effective laws regulating and permitting midwife assisted home births. Illinois is an outlier and far behind the times. He believes that Illinois is behind other states, which is a disgrace. He also noted that none of the states or nations have repealed laws that license CPMs, because they have been successful everywhere. He said that the doctors and public health officials in the United Kingdom (“U.K.”), the Netherlands, Switzerland, and 35 states are not cavalier and irresponsible. They would not endorse practices that they thought were dangerous. The American Public Health Association is not run by a bunch of wild-eyed radicals. He stated that his peers would have you believe that home births are risky and hospital births are safe. He believed that this is untrue. Nothing in our world has zero risks, but there are significant risks inherent in hospital births that are completely lacking from home births, including hospital acquired infections, liked MRSA, which are not unusual in hospitals. These infections do not occur in home births. He also stated that hospitals have an unacceptable high rate of cesarean sections, which are often in the 30% to 40% range. He believed that this was enormously high, and well beyond the percentages in other

countries. He stated that cesarean section is major surgery with many risks, which are too many to mention. The cesarean section rate for planned home births, including those that are transferred to a hospital is about one-tenth of the hospital rate. Hospital births commonly include multiple drugs which have side effects that sometime severely effect the mother or the baby. Drugs are almost never used in home births, and the few drugs listed in some bills which license midwives that can be administered by the midwives are all to be given to the mothers after birth, so they will have no effect on the baby. He stated that these drugs are extremely simple and easy to administer to the mother. He says that his peers would have the Committee believe that administering these standard drugs requires years and years of medical training. He believes that is “nonsense.” He read Dr. Pont’s testimony and he was very moved by the story of his daughter’s great outcome after a very difficult hospital birth. He stated that it reminded him of another story about one of his patients who is now 18-years old. She was born in a nearby hospital, which is often recognized as being the best in the country. The patient’s mother received an epidural, which was routine in that hospital, unfortunately, the mother had a severe hypotensive reaction, went into shock and had to have an emergency cesarean section. Fortunately, her baby was born alive. However, unlike her fellow 18-year old, that child is not in the process of sending out college applications. She cannot fill out those applications, or walk or talk and tragically, she is profoundly brain damaged from the birth. It was nobody’s fault, except it was something that could happen in the hospital delivery. He stated that it would not have happened if she was born at home because her mother would not have received the epidural. He explained that this was an avoidable complication of a hospital delivery. He said that he mentioned this story to illustrate his position that hospital deliveries are not without their own unique risks. He understands that there are “minor issues” involving liability that have to be resolved, but as a physician, he understands both sides of the controversy very well. He acknowledged that it was a very complicated issue, but he cautioned everyone about “going down that rabbit hole,” and let the issue prevent the licensure of midwives because it would be a shortsighted tragedy. He believes that Illinois’ citizens deserve to have access to the safe health option. The prior bill should have been passed so that properly done home births could have been the norm. The bill mandated strict education and certification requirements to become a CPM. He is sure that was why professional nursing groups have not opposed that bill. The opposition by organized medicine has been predictable and in line with a long and consistent history of obstructionism to any development that is viewed to threatening to its turf or economic hegemony. He mentioned physicians’ and organized medicines’ opposition to Medicare in before it was introduced in 1966. Regulated midwife assisted home births offer a financially attractive and safe birth option to countless thousands of Illinois residents, many of whom lack the insurance to afford the extremely expensive hospital deliveries or live in areas where providers

are totally lacking. He said that there can be a discussion about Cook County and the liability issue, of which he is well aware, but there are a lot of other counties in Illinois and a lot of them do not have health providers and this bill would help address that shortage. He fears that if another bill licensing midwives fails, Illinois citizens will still avail themselves of midwives, but we will have passed up great opportunities to regulate them and ensure that these births are safe. There are virtually no physicians and few nurse midwives in Illinois who assist home births. Well trained and regulated CPMs are the only alternative. Home births are the reality and they are here to stay. He stated that CPMs can be driven underground or render them risky. Or a bill can be passed to license CPMs and make home births as safe as they can possibly be. To do otherwise is to jeopardize Illinois' most precious assets, our children. As a physician he has taken the Hippocratic Oath, which he believes is about one thing, which is to do the best for their patients. The Committee needs to do the right and ethical thing, by protecting patient safety, which trumps all other consider all other considerations. He also added that this debate is reminiscent of the debate legalizing abortion. Before that occurred, women did not avoid abortions, but sought them out in dangerous conditions and many women died because abortion was forced underground to unlicensed, unregulated and incompetent providers. That is exactly what he is trying to prevent. He asked the Committee to protect mothers and babies. He added that to do otherwise is unconscionable. He asked the Committee Members to remember that home births with CPMs are safe, which is said as a fact not an opinion. He thanked Senator Martinez, who he believes is a hero, for her attention to this pressing issue, and he prays that the Committee Members will have the political courage to stand up and do the right thing for Illinois mothers and children. He concluded that this was literally a life and death issue.

- **Senator Martinez:** Thanked Dr. Minkus for his testimony and stated that she appreciated it because this has been something important to her for a very long time.

6. Michelle Minikel, MD, MS Testimony

- **Dr. Minikel:** Stated that she was asked just this week to testify to the Committee. She works in Wisconsin, where CPMs can be licensed and did not realize until last week that there were still states that did not license CPMs. She received her degree from University of California in San Francisco. It was a combined MD and Master's degree, with her Master's degree in Statistics in Epidemiology. She is also an Adjunct medical faculty for the Medical College of Wisconsin in Green Bay. In addition, she is a Family Doctor and Board-Certified in family medicine. Her journey started when she became pregnant. She did not have any exposure to home birth during her medical training other than to be told that it was not safe. Shortly before she became pregnant, she was finishing up a hospital shift at a small hospital in northern California and was called to a

“code blue” on the maternity ward. So, she went to the maternity ward, and observed that her coworkers were busy resuscitating a baby, who had likely died prior to delivery. The staff was not successful in that resuscitation. That was a traumatic event for her. Shortly thereafter she became pregnant, and as she was thinking about her own delivery, she was envisioning that it would be in a hospital setting. However, all that she could think about was the dead baby, so she started wonder how she could have a delivery that would not be traumatic. That is when she started exploring the option of home birth. Several of her colleagues had home births as well and they were resources for her. Also, having a Masters in Statistics, she needed to look at the literature regarding home births and researched the issue. Based on her research, she was convinced that it was equally safe for her to have a birth at home as compared to a hospital. So, she made that choice for a home birth. She had her second child at home as well. She believed that both of her home births were phenomenal experiences. She noted that even though she made those decisions based on the negative experience in the hospital, ultimately, she would choose home birth again because they were such positive experiences. She said that she was over the trauma from the hospital experience and noted that there are a number of great resources available at a hospital, but home birth comes with having a known birth attendant at your delivery, being in your own environment, and the trust that you are given to make your own decision about where to deliver that empowered her and led her to have a home birth. She explained that she moved to Wisconsin four years ago, where she still practices obstetrics in a family medicine practice located in Green Bay. About three years ago she was approached by a CPM to be her collaborating physician. She agreed to do that for the CPM. She explained that so far it has been a great relationship. In Wisconsin, the CPM needs a collaborating physician to sign-off on her standing orders that she can get medications that she uses with her protocols, and she is allowed to order and access all of those medicines because of their collaboration. She added that their collaboration goes much deeper than just providing medicine, in that the CPM will call her to discuss questions about prenatal issues from time to time. She felt that was helpful to assist the CPM. In addition, there are more urgent situations that come up, in which she felt that she was helpful in expediting the care of the expectant mothers and babies to achieve a successful outcome. She mentioned that the CPM had one hospital transfer to her hospital that involved an obstructed labor, which ultimately had a great outcome. The CPM also had a neonatal transfer with respiratory distress, and she was able to expedite that, and everything went very smoothly. The child is doing great and continues to be one of her patients. Also, recently there was a preterm vaginal bleeding case and because of some of the factors in that case, she recommended that she transfer to an OB/GYN, and the transfer was made to the other doctor instead of her. So, she felt that in all of those cases, the CPM had the confidence that she could collaborate with who she needed to on a timely basis and that improved the outcome for all of those patients

involved. She explained that she did not know what it was like to work in a state without licensure of midwives, but at least for her, she feels that it has been a really healthy and beneficial relationship. She also said that she consults the CPM on some occasions, because she is an expert when it comes to complimentary and alternative medicine. She explained that some of her patients are not interested in pharmaceutical options when they have various conditions, and she will often consult with the CPM with questions about herbal remedies for various ailments. She explained that the CPM has a wealth of information in that regard. She said that her collaboration with the CPM goes both ways for them.

- **Representative Moeller:** Asked how Wisconsin dealt with liability insurance for CPMs.
- **Dr. Minikel:** Responded that Wisconsin is one of the states that has a limitation of liability with the collaboration. She explained that she researched the question before she agreed to have the collaboration and was reassured that she would not be liable for anything that happens prior to any transfer to her.
- **Representative Moeller:** Asked whether she had a written collaborative agreement with the CPM.
- **Dr. Minikel:** Responded that she only signs-off on the CPM's standing medication orders and does not have any other written collaboration agreement.
- **Ms. Wickersham:** Asked if there was some other way of managing midwife's needing medication other than her signing-off on the CPM's medication orders.
- **Dr. Minikel:** Responded that from her conversations with the CPM, she has learned that it has become increasingly difficult. Most of the larger pharmaceutical companies are requiring that physician collaboration to supply the medications now. She stated that it varies by state and the CPM has told her that it was not always that way, but it has become more and more difficult to get the medications.
- **Ms. Wickersham:** Asked if that was true even if there was a formulary.
- **Dr. Minikel:** Responded that they do not have a formulary and she did not have experience with that question. However, she stated that having a formulary would help standardize things if that was accessible.
- **Senator Martinez:** Thanked the panel for providing great information. She said that she would be back in touch as they move ahead with legislation which she sees coming out of the Committee.

7. Marilee Clausung, JD Testimony

- **Ms. Clausung:** Stated that she is very grateful to be given the chance to speak before the Committee, and appreciative of Ms. Harris and the Illinois Health and Hospital Association to be requested to speak to the Committee. She explained that it was her hope to provide the Committee with a backdrop of the current obstetrical liability environment as the Committee considers its recommendations. She has been a defense medical malpractice attorney for 34 years. Prior to that she worked as an

obstetrical labor delivery nurse caring for patients in the hospital setting. She went to DePaul Law School, and her undergraduate education was at Marquette. She is currently the Managing Partner of Hall Prangle & Schoonveld, LLC, which is a defense firm that is dedicated primarily to the defense of health care providers in different kinds of cases. Her personal background has made her focus primarily on obstetrical cases. She believed that obstetrical cases form the majority of the lawsuits which she handles, and the individuals that she represents. She stated that she represented hospitals, obstetricians, midwives and doulas. Most of her cases involve obstetrical situations that arise at the hospital, although there have been cases involving failed home births that present later to the hospital. She stated that the number of filings in the obstetrical arena, as well as the medical malpractice arena generally, is basically flat. She said that what is striking, and undeniable, is that in these cases the severity of the verdicts, and the settlements that go along with the verdicts, have increased in amount. She explained that there are significant key trends involving health care liability claims. She said that the average claim severity continues an upward trend, with some jurisdictions are seeing a significant increase in severity. In addition, Illinois, as a jurisdiction, has an overall claim severity that is higher than the national average, and that the Chicago area, including its collar counties, consistently has two to three times the national average loss cost, which means that the indemnity dollars paid whether in settlement or in a judgment if the case goes to verdict combined with the costs associated with those cases are significantly high. Another trend that she discussed was that claim costs are rising as the severity of the cases rise, which she said makes sense because the defense bar needs to defend them with greater intensity by retaining additional numbers of expert witnesses. She also noted that some of the cases are very broad in their scope and depth and as a result, the kinds of costs and expenses that go into these cases are substantial. As a result, in Illinois the total payments, whether paid in settlement or judgment, for 2018 were over \$204 million. She also noted a recent study completed by the U.S. Chamber of Commerce Institute for Legal Reform, entitled the "Lawsuit Climate Survey," from 2019, which found that out of all 50 states, Illinois ranks number 50, in terms of it having the most unreasonable and problematic litigation environment for these cases. She also noted that in the midst of this survey, the participants were asked to identify the specific counties which they understand to be considered the most problematic. The respondents identified two Illinois counties ranked in about the top half dozen counties that are problematic, and those were Cook County and Madison County. She said that they were considered to have the least fair and reasonable litigation environments in the entire country. She stated that she always knew that Cook County was a difficult jurisdiction, as it is where she has predominately practiced, along with the collar counties and Federal Court, here in Chicago, but this survey confirms that it is not only bad, but it is the worst of all of the states. She explained that they arrive with the ranking of the states by taking a survey

of all participants regarding ten elements to establish rankings which were the following: enforcing meaningful venue requirements; overall treatment of tort and contract litigation; treatment of class action suits and mass consolidation suits, she noted that this element does not apply to the kind of cases that she is discussing; damages; proportional discovery; scientific and technical evidence; trial judges' impartiality; trial judges' competence; juries' fairness; and the quality of the appellate review.

- **Ms. Sawicki:** Noted that some of the elements were vague when considering fairness of the juries. Asked whether the survey asked these fairness and reasonableness questions to both plaintiffs and defendants attorneys.
- **Ms. Clausing:** Responded that she is certain that they were, in that they were looking at the system overall, with respect to the ten qualities. As to each of the ten qualities, they ranked all 50 states. She explained that Illinois was not necessarily last in regard to each of the element, but it was near the bottom in all of them and last in some of them. That led to its overall ranking of number 50 out of 50 states.
- **Ms. Sawicki:** Requested a copy of the 2019 Lawsuit Climate Survey.
- **Ms. Clausing:** Stated that she would provide a copy of the Survey. She then discussed three particular verdicts. The largest verdict was approximately \$53 million for a brain damaged infant who did have cerebral palsy. The second largest was a \$50,300,000 verdict for cerebral palsy and the last verdict was for \$23,138,380, again for cerebral palsy. She said that this is an example of the kinds of verdicts that she is seeing in obstetrical negligence cases. She also noted that these occurred between 2016 and 2018. Is has also been her personal observation that these kinds of remarkable verdicts are what she is seeing in the last several years, as the size of the verdicts trends upwards in terms of case severity and the kinds of damages that are sought.
- **Senator Martinez:** Asked whether this is overall damages for hospital birth centers and home births.
- **Ms. Clausing:** Responded that these involved the highest verdicts that have been yielded for all obstetrical cases that have gone to trial.
- **Senator Martinez:** Asked for a breakdown of the cases that involved hospitals, birth centers and home births, and more information about the verdicts which were listed on the chart.
- **Ms. Clausing:** Responded that all three matters which ended with the large verdicts noted above involved hospitals. There were no reported verdicts that involved a failed home birth, but she will discuss a settlement of a failed home birth which ended up at the hospital. She explained that the point of the slide about verdicts against hospitals is to show the significant dollar value associated with obstetrical litigation where the choice is made to take the case into the court room. Regard Ms. Fisch's testimony about the system being in part fear based, Ms. Clausing noted that these kinds of verdicts are where that fear derives. The concern that if an obstetrical provider or a hospital takes a case into the court room that

these are potentially the kinds of verdicts that can result. She said what follows from the trending verdicts are the settlements, which we see in Illinois. The largest settlement that she could locate in her research is a \$35 million settlement in an obstetrical case. She listed various other settlements that have occurred over the last five years and noted a trend that the amount of the verdicts customarily be in the eight-figures. She stated that it was her observation, which the Verdict Report would show, that getting an obstetrical settlement in seven-figures is unusual. For most of the cases, the plaintiff's attorneys are holding out for an eight-figure settlement. She noted that there were a number of settlements in the \$15 million range, which is being sought even in a case where the defendants have a causation defense, which means any brain injury was not caused by the obstetrical provider's care based on the opinion of the defense and defense experts. She said that what this reflects is if a hospital or provider wants to settle their portion of an obstetrical negligence case, it is increasingly costing these kinds of numbers. Even if there is brief involvement in the patient's care and there is a viable causation defense. She stated that was because of the concern about bringing the case into the court room and potentially getting hit for a verdict that is substantially in excess of those kinds of settlement numbers. She explained that was the concern to health care providers and hospitals in the arena. Regarding the types of injury that she sees most in these matters are the injury to the infant involving: brain damage often with cerebral palsy, but not always; fetal or neonatal stroke; death of an infant; Erb's palsy; brachial plexus; or infection. She also sees maternal injuries that include: maternal hemorrhage; maternal uterine rupture; loss of reproductive capacity, if a hysterectomy had to be done; stroke cases; brain damage; and death. These are the types of injuries that lead to the types of settlements and verdicts that are of concern. Relating this to home births, she said that the things that would lead to liability for health care providers not only at home birth but involving the hospital.

- **Ms. Sawicki:** Noted that it is undisputed that verdicts have increased, and empirical evidence to show that over the past couple of years there has been a decrease in the number of actions filed and a decrease in insurance premiums. She stated that she could provide that information. She wanted to focus on the current system, where we have home births that are not supervised by licensed providers. The question that she is struggling with is if CPMs are licensed, how is that going to be more disadvantageous to the liability of doctors and hospitals than the current situation. She explained that if she is a woman having a home birth today and has to go to a hospital because of complications involving the birth but does not want to tattle on her midwife, the doctor and hospital have all of the liability. The current person who is participating in the process is not identified, but if there was licensure of CPMs they would be a participant in the system, the presumably the licensed midwife could be brought into the litigation and bear potentially a share of the fault. Asked why

restricting the licensure of home birth midwives going to exacerbate the systemic problem, rather than one tied to home births.

- **Ms. Clausing:** Responded that the piece that she is discussing is the litigation environment in the current time that the current legislation is being considered. She is not discussing whether she is in favor of or opposed to licensure and regulation. She is saying that even with licensed and regulated midwives, the reality of the obstetrical liability facing providers collectively is profound and it is something that has to be considered. She understood that there is consideration regarding language regarding the limitations of liability of providers. She will defer to Ms. Harris to discuss the IHA's perspective regarding that issue. She stated that she believes that a review of case studies will illustrate the connection between what happens in the home birth arena and what ends up being brought to the hospital and how that potential liability is going to interface between them, which may be guided by the insurance questions. She then provided the potential obstetrical theories of liability geared to planned home births as those cases are transitioned to hospital deliveries. Most common is expediency which birth is delivered once that woman is brought to the hospital, which is the failure to do a timely delivery or perform a timely cesarean section. Another theory is the improper use of Pitocin or the manner in which that is superimposed upon whatever the clinical scenario by the time that the woman presents to the hospital. A woman hemorrhage at home and brought into hospital could lead to the failure to properly manage maternal hemorrhage. A prolapsed cord in the home where the patient is brought into the hospital and a placental abruption could lead to a failure to intervene to prevent maternal complications, after the mother is brought to the hospital. She explained that her point is that when the home birth fails, and some do fail, the patient has to be brought to the hospital, the normal patient has switched in some fashion to a hospital patient, and there may be a problem for the hospital to treat that patient. The need for the hospital to act quickly in response to an unknown patient just increased the potential liability exposure once the patient gets to the hospital. She then discussed a failed home delivery where she represented the obstetrician who cared for her once the patient presented to the hospital. The facts are that the patient was 37 years old, on her third pregnancy and had two prior miscarriages. Both her prenatal care and planned home birth were with midwife, who was a CNM. She has about three days of latent labor at home which was supervised by the midwife. Spontaneous rupture of membranes occurred at home during latent labor, and it happened more than 24 hours prior to her presentation to the hospital. The patient at a point stopped progressing. She came into the hospital because of her failure to progress, her inability to void or pass urine and her prolonged rupture of membranes. The home midwife stayed at patient's bedside once she presented to the hospital. She was an Illinois patient, and the home midwife was a part of the ongoing care in the hospital. almost like a doula at that point. The hospital had a midwifery service and the patient was on that service. At the hospital there was a

second CNM, delivering nurse and the obstetrician, who she represented. Pitocin augmentation of labor was undertaken at hospital to move the labor along. Importantly, the home midwife was precious to the patient. The midwife continued to exert influence in decisions that were made at the hospital. In this situation, problematic decelerations of the fetal heart rate developed, and the decelerations remained persistent. Pitocin augmentation of labor was continued in the face of the decelerations meriting a watch. The patient notably wanted as few interventions as possible consistent with her birth plan. The patient refused internal monitoring of fetus and any operative assistance with delivering this baby. Her goal remained having a natural delivery. The patient pushed for over three hours in the hospital. The fetal heart rate did continue to deteriorate, and meconium developed. The infant was delivered naturally. The obstetrician's only involvement was when she saw the fetal heart decelerations, she walked into the room staged two head on the perineum and inquired is delivery close. The hospital-based midwife and the home-based midwife both assured her delivery was close. The obstetrician retreated from the room and felt that she was not welcomed in the room. The patient delivered in about five to ten minutes thereafter.

- **Ms. Sawicki:** Asked to clarify that the doctor left the room because she did not feel welcome.
- **Ms. Clausung:** Responded that the obstetrician felt that the birth was under control with the delivery being imminent, having watched one or two pushes to see that the head was indeed down on the perineum. The delivery occurred, and the infant was born depressed and limp with no respiratory effort. Apgars were 1, 2 and 8, with 1, 5, and 10 minutes respectively. The infant has a stormy neonatal course, hypoxic ischemic brain damage was diagnosed. The child ended up with developmental delay, seizures and cerebral palsy (spastic quadriplegia). A medical negligence lawsuit filed over two years after delivery. The complaint named the hospital-based obstetrician, midwife and nurse as defendants, but the home midwife was not named as a defendant. The plaintiff alleged a failure to properly monitor the fetus, injudicious use of Pitocin and failure to timely delivery via cesarean section. four years of protracted discovery ensued, and the hospital had to engage three separate attorneys to represent all three separate providers who were involved in the hospital end of the delivery. There was a \$35,000,000 settlement on behalf of defendants in this case. The obstetrician with the limited involvement of checking on the delivery was reported as part of the settlement and the Department was notified in requesting the doctor's input on this issue. Her observations regarding the case were that: the patient was significantly committed to her natural birth plan; the home midwife was a strong advocate for that plan even after arrival at the hospital; the patient had prolonged rupture of membranes greater than 24 hours upon arrival; the patient had shown signs of infection at home; the maternal fetal medicine expert retained by the defense was of the opinion that intrauterine infection was likely to blame for what had happened to the child; and yet

the hospital-based healthcare providers shouldered all the responsibility for the child's damages based solely on their relatively brief, just a few hours, management of the patient. She said that she showed the matter to explain how the facts can unfold with the individual circumstances of a case.

- **Ms. Wickersham:** Asked that if the obstetrician was out of the room knowing that the patient was pushing and the deceleration of the heartbeat, was the neonatal pediatric team notified as is standard practice.
- **Ms. Clausing:** Responded that that was an additional issue in the case, as to whether they had been timely called. There was apparently, according to the testimony, a bit of a controversy in the room as to whether it was acceptable to the home midwife and patient that the neonatal team be called for potential interventions with the baby, versus the hospital's usual and customary policy to call them into the room automatically. Also, no written consent was obtained from the mother to decline to have the neonatal team present. The neonatology providers were called, but it was a few minutes after delivery with initial resuscitation then being provided by the delivery room nurses until the neonatal team arrived. The team was there promptly, and the resuscitation was well done. It ended up not being an issue in the case, because the nurses in labor and delivery were certified themselves to provide that kind of resuscitation. She then described a second case which was a breech deliver at home. The patient desired midwifery management of pregnancy, and the Prenatal course was uneventful. The plan was for a home birth with midwife and doula. The patient labored at home, and a breech presentation was identified, and an OB was called to assist at home. He was willing to do so. He was able to deliver the breech, but the head became entrapped at home. 911 was called and the paramedics brought the patient to the hospital. The baby was delivered with the assistance of the doula helping the OB. The entire delivery was videotaped by the midwife, so it was available for the litigation. The doula was instrumental in helping to disengage the fetal head during the delivery. The patient was transferred with the stillborn baby. The lawsuit only involved the home providers, and not the hospital. The baby was deceased upon arrival at the hospital. Neither the midwife nor the doula had PMI. The obstetrician had PMI but had an exclusion on his policy that did not allow for home deliveries. Case was settled for \$515,000, with the midwife and doula paying out of their own pocket. The midwife paid \$12,500, the doula paid \$2,500 and the obstetrician's insurance carrier paid \$500,000 toward settlement despite the exclusion of home deliveries. Her observations were that this particular patient was likely a poor candidate for home delivery given the size and presentation of the fetus. Also, the transfer of the infant to the hospital came much too late to change the outcome. She believed that had the patient been transferred to the hospital sooner, she thought that the hospital and hospital providers potentially would have also faced liability, particularly since they were insured for the expediency with which they delivered and resuscitated the baby. She concluded by stating obstetrician cases present

significant potential liability to health care providers. Being on the receiving end of failed home birth can exacerbate already increased liability concerns to hospitals and health care providers and uninsured or underinsured home midwife providers will shift the focus to the hospital or hospital-based obstetrician providers. This shift will result in settlements or verdicts that likely will be paid by the hospital or its obstetrician providers in a disproportionately heavy way if not provided for in the legislation.

- **Senator Martinez:** Thanked Ms. Clausing and asked for questions.
- **Ms. Sawicki:** Stated that she understood that the summary provided an overview, but she wanted to bring this back to the issue of licensing. Stated that currently there are home births that may cause additional problems in the hospitals, and the Committee is trying to deal with the crisis right now. Currently, home births are being transferred to hospitals when there is limited collaboration and transfer of documentation. Asked her if she could imagine that having a system of home midwife licensure may actually reduce the liability and exposure of hospitals and doctor for the following reasons: another person is brought into the delivery; home midwives may be insured, because now they are prohibited from getting malpractice insurance; and collaboration and integration in the transfer documentation has been found to be advantageous in reducing malpractice litigation, noting that there was a study from 2005 where based on a review of 162 cases involving midwives which found that the best way to reduce the litigation was to increase documentation in transfer and collaboration.
- **Ms. Clausing:** Responded that the short answer was “no.” The reason is that the trend is so significantly upward in these cases that she does not see any indication that that will reverse. Over the 34 years that she has been practicing, she has never seen it go down. Once the verdicts and settlements are high, the expectations are that even higher settlements and verdicts are achievable in these cases. She envisions that there will be more home births with the licensure that is being discussed. She stated that Ms. Sawicki’s observation is a good one that there may be more individuals to target as defendants in cases, but the issue is that home births do exist and that home births may increase in their frequency. She added that the real issue that she focuses on and advise the Committee to focus on is the fact that the liability exposure is substantial and there has to be what ever safeguards that can be appropriately put in the legislation so that the risks is assumed by those to whom it belongs, not by whom it does not.
- **Ms. Wickersham:** Asked if the breech delivery involved a CPM or an CNM.
- **Ms. Clausing:** Responded that the breech delivery litigation involved a CNM, and a doula who was assisting her at home with a licensed OB, who was called into assist with the breech was also a proponent of home births. That matter involved facts from 15 years ago.
- **Ms. Wickersham:** Asked if there were any Illinois cases involving CPMs which caused physicians or facilities to pay more in settlement.

- **Ms. Clausing:** Responded “no.” When questioned about whether there were any such cases in the United States, she said that she did not look nationally because she was speaking about the Illinois liability environment.

8. Karen K. Harris, JD Testimony

- **Ms. Harris:** Stated that she would focus her comments on liability issues due to time constraints. She stated that license CPMs, only three require malpractice insurance, which are Alabama, Florida and Colorado. She said that she was quite surprised when she researched the issue to learn that the limits were \$100,000 for each incident and \$300,000 in the aggregate. The point that she wanted to make was when considering verdicts as described by Ms. Clausing, insurance with these limits is not even a drop in the bucket compared to the potential liability for other providers. She stated that whether the Committee decides to require midwives to obtain PLI or not, the amount of coverage from that insurance would be very low or even insignificant based on the verdicts and settlements involved in these types of cases with CNMs. Even if PLI is not mandated and CPMs purchase the insurance without the requirement, the coverage would still be a low amount. She noted that she mentioned this to put the benefits of requiring CPMs to purchase insurance in perspective. She then noted that 16 states require whether midwives disclose whether they have PLI as part of the laws requiring informed consent. She stated that Ms. Fisch also mentioned the inclusion of this as part of informed consent. She believed that if the Committee decides not to mandate midwives to purchase PLI, then the Committee should require such disclosure as part of informed consent, so that patients know the kind of insurance is potentially available is important. She also believed that that type of notification in the informed consent, which was another thing that Ms. Fisch mentioned that this is specifically saying that the CPM is responsible for the care given and not another provider whether that is a hospital or obstetrician, unless they are providing the care. She said that it is important to make a clear distinction when liability attached and when it does not. She also found that 21 states, which license midwives, have some form of liability immunity provision. The states vary how it is written, but they all say that health care providers, whether they are obstetricians, hospitals or emergency technicians, are not responsible for any actions, except for their own. She believes that this is all that the Hospital Association and the physicians are asking for in this matter. She summarized that if the injury is the hospital’s or the physician’s responsibility, then it should be their liability; if the injury did not come from care that they provided then the hospital or physician should not be liable for the injury. She believes that this is the crux of the matter on this issue and is the hospital’s main concern. She wanted to make sure that there are adequate remedies for when something does happen. Otherwise, you have a family, a mother and child who do not have any resources after a negative outcome. She said that her Association does not believe that the financial burden of a negative outcome should fall solely on the

hospital. Based on Ms. Clausing's testimony, the financial burden will fall on hospitals because they are the deep pockets, unless it is very clearly spelled out in the legislation who is liable and when liability attaches. While there are other topics she could cover, that is the essence of what the Illinois Health and Hospital Association wanted to communicate to the Committee.

- **Senator Martinez:** Thanked Ms. Harris for her testimony, and as there were no questions, continued on to the testimony of Antonio Romanucci.

9. Antonio Romanucci, JD Testimony

- **Mr. Romanucci:** Stated that he was honored to be permitted to testify and thanked the Committee for the opportunity to testify. Stated that he is a practicing attorney in Chicago. His law firm, Romanucci and Blandin, LLC, handle cases of medical malpractice, such as the ones that Ms. Clausing discussed. He has been a practicing attorney for 34 years, after graduating from University of Wisconsin at Madison and John Marshall Law School. He started his career as a Cook County Public Defender. He is also President of the Illinois Trial Lawyers Association ("ITLA") and is speaking on behalf of the more than 2,000 members of the ITLA and more importantly the victims that they represent. He initially responded to a couple of issues that were raised by other speakers. He noted that a Committee Member raised a question about the fairness and reasonableness of a study by the Institute of Legal Reform ("ILR"), which had been mentioned by another speaker. He noted that the ILR is run by the United States Chamber of Commerce, and if the judicial system was truly unfair and unreasonable to both sides, then it would be a fair study because it would be unfair to both sides and that is how you reach a settlement, when both sides are not happy with the result. That is a definition of a settlement. He did not believe that the conclusions by a U.S. Chamber of Commerce study by the should be a part if the discussion. He believed that was a greater policy wide discussion and did not want to impugn the results of the study but believed that you cannot marry those results with the study. The reason that you see such high numbers in verdicts for obstetrics cases is very simple, they are typically catastrophic cases. He said that when discussing catastrophic cases, we mean that there are harms or losses to the baby which were caused by the doctors or hospitals that are in the millions of dollars. As Ms. Clausing indicated, some are in the tens of millions of dollars. Typically, there is a "life care plan," associated with a catastrophic injury, which would provide care for the life of a child, even if the child has a normal life expectancy. A \$20 or \$30 million life care plan can happen very easily. He said that it was not that the numbers were artificially inflated, but they are there because there is empirical data behind the numbers. Also, life care plans are approved by a life care planner and a doctor, they are reviewed and there is data to support the amounts. He stated that he just did not want the Committee to marry verdicts with big numbers with the concept that Illinois is a bad place for doctors or for lawyers because it is not. There is

data behind the dollar amounts. Any state that allows a consideration of economic damages for negligence, torts or medical malpractice, will have similar verdicts with large dollar amounts. This is not an issue unique for Illinois. He understands that the licensure and regulation of midwifery has raised a number of challenges for lawmakers for a number of years. He stated that he will not provide commentary regarding those challenges, as they are public policy considerations. He will provide commentary relative to the preservation of victims' rights. Should the legislature approve the licensure and regulation of midwifery, it is incumbent on the Committee to ensure that any law passed provides protections for victims of negligence. In this context, he is focused on ensuring justice for mothers and babies that may have become victims during maternal care or delivery. The unfortunate reality is that adverse outcomes for mothers and babies occur and will continue to occur in the future. His job is to ensure that victims of adverse outcomes resulting from the negligence of health care providers have access to justice in Illinois courts. Under the Seventh Amendment of the Constitution, attorneys have the right to try cases for negligence as alleged. Previously, health care professionals have referenced their concerns relative to liability, if the General Assembly creates a pathway for licensure for midwives. In sharing their concerns, those health care professionals alluded to proposed language which contemplates vicarious liability. He said that he has read the language of those proposals, and it creates a clear departure from the status of current law relative to victims' rights. This language proposes to create an immunity from liability for providers of care and creates a fire wall between providers and patients with whom they consult. The language contained in the proposed bill is unduly restrictive, and it unnecessarily exculpates the wrongs of care managed by more than one. It is now rare that care in any circumstance is managed by just one health care professional, but rather it is by teams. It would naturally follow that harms are not always caused merely by one, but also by teams. He explained that fault could lie with more than one individual, and this bill would create an escape route for some and deny justice to mothers and babies. He stated that this proposal could shield providers from negligence claims made by mothers and babies who were injured through no fault of their own. He added that no such language exists for other providers' negligence under Illinois law. He asked why lawmakers would want to create a lower and outlier standard or provide less protection for mothers and babies.

- **Ms. Sawicki:** Asked for his interpretation of the previous bill's language, because fault could lie with more than one party. She stated she reads the language under discussion as attempting to ensure that midwives are responsible for their own negligence, and doctors are responsible for their own negligence. Asked how that language does not provide access to justice for victims of negligence.
- **Mr. Romanucci:** Responded that Illinois currently has comparative fault, under which fault can be attributed by percentages. The ITLA wants to

make sure that this process is not taken away. He explained that if you look at the draft bill, it clear states either “shall not” or “will not” be liable.

- **Ms. Sawicki:** Stated that Ms. Fisch talked about that language and did not want to exclude liability in any case of consultation, but just exclude liability on the sole basis of that consultation.
- **Mr. Romanucci:** Noted that his comments were based on the language in Section 90 of SB 1754. He suggests that this language be rejected from that bill, or any language that erodes, reduces or creates barriers to legal remedies for victims of negligence, especially mothers and babies. He said that if tragedy strikes a family, the family should have assurances that they have access to justice. He also stated that notably absent from the bills is language which contemplates financial responsibility for those proposing to legally practice midwifery. He noted that Ms. Harris provided a slide, which was startling to him. He explained that attorneys that practice in auto negligence speak of the type of insurance policy that the drivers maintain, and the 100/300 is still considered low in the auto arena because of the seriousness of occurrences. When talking about midwives and the potential for catastrophic consequences of injury, compared of low coupon value of insurance, he believed that it does not make sense in terms of the low levels of insurance compared to the potential cost of negligence in regard to a birth.
- **Ms. Sawicki:** Noted that most states do not require that physicians purchase insurance, but that insurance is imposed upon them by hospitals. The reason for this is that the markets work out the need for PLI. Asked that if physicians are not required to maintain insurance, whether he is suggesting that professional midwives be required by law to maintain insurance coverage that physicians are not required to maintain.
- **Mr. Romanucci:** Responded that in real life, physicians have more to lose from a negligence law suit. They have practices, they earn money they save money, and as a result of that they typically do get insurance. He said that there are very few times when he has practiced or seen a doctor not covered by insurance, either voluntarily or if he is required to maintain insurance. The typical amount of the insurance by a doctor is \$1 million, but sometimes a doctor would have \$2 million in insurance, while in rare cases it is \$5 million in insurance. These amounts do not satisfy the numbers involved in verdicts and settlements discussed earlier, but in some circumstances that insurance is enough. Regarding midwives, if something goes wrong with the birth of a baby, so the chances of catastrophic injury increases proportionately based on what could go wrong. His answer to the question is what happens in an instance where there is no hospital or doctor involved, no collaboration, no consultation, no transfer, and that baby is catastrophically injured with the midwife having no insurance.
- **Ms. Sawicki:** Asked what Mr. Romanucci’s perspective on informed consent requirements, by allowing patients to enter into an agreement with a midwife for a delivery after being informed that the midwife does not have insurance. Asked if that would eliminate his concern.

	<ul style="list-style-type: none"> • Mr. Romanucci: Responded that “it could.” He explained that he does not like the issue that the mother assumes the risk. He stated that when he thinks of the “assumption of risk,” he thinks of an example of a person jumping on a scooter without a helmet. However, when a mother is giving birth to a child, which is a right that she has, you expect in that trust relationship, whether with a midwife, a doctor, a hospital or nurse practitioner, that the mother will be safe. There is no expectation of safety when you jump on a scooter without a helmet. • Ms. Sawicki: Noted that she was not asking about assuming the risk of negligence, but assuming the risk of engaging in a relationship with a health care provider who is not insured. • Mr. Romanucci: Responded that he is in favor of informed consent, and secondly, he believes that what the Committee has to weigh is whether the tax payers want to accept the cost of this life care plan for the child should something go wrong. • Ms. Wickersham: Asked whether the tax payers assume the risk when an unlicensed midwife drops a family at a hospital’s emergency room door. • Mr. Romanucci: Responded “sometimes yes.” • Representative Moeller: Noted that if the cost of \$2 million to \$5 million PLI make it financially impossible for the practice of midwifery in Illinois, they would be leaving an unregulated system in place which is potentially more dangerous for mothers and babies. • Mr. Romanucci: Responded that he anticipated that question, but he is not sure that he has the answer, in that he is able to quantify the tradeoffs. He said that he does not have the background to be able to answer whether those limits would cause an unregulated profession. He said that he did not know and could not answer that question. • Representative Moeller: Asked if he knew how much that type of insurance policy would cost. • Mr. Romanucci: Responded only anecdotally, and it could be in the hundreds of thousand of dollars a year. He did not know if he was the right person to answer the question. • Representative Moeller: Questioned the point of licensing midwives if the State would require that amount of PLI because it would not be a financially viable profession. • Dr. Wolf: Stated that she did not believe that it would cost in the hundreds of thousands of dollars for the PLI. • Ms. Wickersham: Stated that for Cook and Madison County, a PLI policy for \$100,000 per incident and \$300,000 aggregate, would cost about \$14,000 a year for a CPM. The premium would be less in the other counties of Illinois, but midwives in other counties earn quite a bit less. She stated that she is creating a handout that will be distributed which will contain premium posts from last week. • Ms. Belcore: Stated that with the understanding that CPMs make significantly less than the average physician is going to be making and 	
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how cost effective that is going to be for PLI policies that range from \$8,000 to \$20,000, insurance payments would be a significant amount of money for a CPM who may gross \$35,000 a year. So, saying that people should work and be on poverty level earnings to provide medical services. As midwives, it is something that they consider deeply. Noted that the states that required midwives to carry PLI insurance have failed by not enforcing the requirement or the insurance is underwritten by the state and asked if he believed that it was reasonable for the state to require insurance and then to underwrite the insurance coverage so that the midwives can make a living wage.

- **Mr. Romanucci:** Responded that because Illinois would be treating the midwives as a special class that the practice may be unconstitutional. He recommended caution in establishing such a program, because that would open the door to Illinois underwriting insurance for other licensed professions.
- **Ms. Belcore:** Noted that if there is a requirement that CPMs maintain PLI, they would be the only medical profession in the State that would be required to maintain such insurance. Asked if that would be unfair and unconstitutional.
- **Ms. Harris:** Stated that IHHA is not requesting that CPMs be required to purchase PLI, but only pointing out that if they elect not to require that it be maintained, then the Committee must deal with the issue of apportioning liability appropriately and making sure that we do not leave families who have tragic incidents completely on their own. She said that we have to balance the interests of who should be responsible when something happens. She said that is the crux of where IHHA is on the issue.
- **Ms. Vickery:** Stated that consumers want to have recourse when recourse is necessary. But, the consumers need to have access to midwives and if midwives cannot afford PLI or refer to others if appropriate collaboration is necessary, it sends the situation right back to where we are today with an underground system. There has to be a balance where not everyone will be happy, but hopefully they could find a space in the middle.
- **Senator Martinez:** Raised the questions about the states that require PLI.
- **Ms. Harris:** Responded that only three states require CPMs to purchase insurance and based on Ms. Fisch's statements, it sounds like two of the states are subsidizing the insurance pool, and the other has abandoned the requirement to purchase insurance because it is not feasible. Believes that everyone is coming to if you are not going to require the insurance, then other provisions become essential. For example, the informed consent language to let patients know that the CPMs do or do not have insurance, so that they can make the decision. Also, what happens is that when a bad outcome happens, and you need a life plan that is going to cost a minimum of \$40 million, the fact that the mother signed the consent stating that there is no coverage, is still going to sue because the mother needs the money to take care of the child. She stated that that is why it becomes even more essential that language is placed in the legislation to specify very clearly

when liability attaches for each parties' action. For midwives, it should be their responsibility before coming to a hospital or before being seen by a doctor. When it is the physician's or the hospital's responsibility, they should take that responsibility.

- **Senator Martinez:** Asked Mr. Romanucci for his final thoughts because the resolution of the issue regarding vicarious liability will be very important to the passage of any bill licensing midwives.
- **Mr. Romanucci:** Stated that there has to be a just, fair, legal consensus on language for the bill, but certainly the language in SB 1754, which put up a firewall to separate the doctors or hospitals from the midwives, is not appropriate. Under common law negligence there is no requirement that a person enter into a written agreement in order to collaborate. He stated that he believes that there is work required to be done to reach a consensus on the language in a bill. He also believes that midwives do, and should, play a role in Illinois. The parties just have to figure out language that would be acceptable to everyone.
- **Senator Martinez:** Agreed that the parties have to figure out some language, because people are currently having home births and there are going to be more home births because of the high cost of health care. This is especially true in rural or downstate areas where there are few hospitals and they are not always close to where pregnant mothers live. The Committee has to address what happens to these mothers who choose to have a baby at home. She stated that she understands the liability issues, and that everyone wants to make sure that Illinois has providers that are available to provide services and can address these liability issues. Regarding the midwives, she is still attempting to address the licensure issue, and looking to find a way to make sure that they can be licensed and that the birth mothers and babies are still protected. She believes that everyone wants this to happen, but a way has to be found to look at the other states' laws and rules to make sure that the Committee is following in the same way, knowing that Illinois is more complex in its licensure laws. The issue of licensure of midwives has to be addressed because home births are happening, and they are not going to decline. The Committee has to find ways and measures to make sure that there is protection of the parents and babies, but more importantly of the midwives who perform these kinds of services. Asked if there were any additional questions of the attorneys, and seeing none, she thanked the panel for their time and testimony.
- **Mr. Schultz:** Noted that the Department Staff is preparing a chart of the laws and rules from other states that have licensed midwives and mentioned various subjects that are being included in that review. Stated that these topics would be circulated to the Committee and requested that the Committee Members inform the Staff of any additional subjects for laws and rules which they believe would be helpful in their review of laws and rules related to midwives.

	<ul style="list-style-type: none"> • Senator Martinez: Stated that the Committee will need to start talking about issues at the November meeting. She stated that the Committee needs to start focusing on how to move forward to conclude with a report. • Mr. Schultz: Stated that the Department was able to have a person from Indiana provide a statement regarding the regulation of midwives in that state. The Department is drafting various topics for discussion regarding recommendations for the report and suggested that the remainder of the time during the November meeting be spent discussing the various issues and attempt to reach a consensus and vote regarding those issues. Stated that decisions have to be made during the November meeting so that the report can be close to being final by the December meeting, to meet the January 1, 2020 deadline. He expected that the December meeting would focus on the draft report regarding the recommendation that would be made in the November meeting. • Senator Martinez: Thanked Mr. Schultz and said that information will be sent to Committee Members about the topic of discussion. She asked that the Committee Members keep an eye on their emails so that they could have some feedback and get this ready for a final report. She also mentioned that if they had any other concerns or questions the Committee Members should forward the requests to Mr. Schultz. Noting that there was no further discussion, she called for a motion of adjournment. • Meeting was adjourned by unanimous consent. 	
Adjournment	<ul style="list-style-type: none"> • Adjourned 4:41 p.m. 	