**Excerpt of Text from Judge Roman�s Decision in the**

Alison Osborn case relative to Appropriate Standards of Practice

for California Licensed Midwives providing home-based care:

As has been demonstrated to this tribunal, the [Medical and Midwifery] models differ distinctively:'

**Medical Model                                                                  Midwifery Model**

Pregnancy is a "physical condition's                                      Pregnancy is normal

Pregnancy causes "symptoms"                                              Pregnancy includes physical changes

Pregnancy is external to the woman                                      Pregnancy is part of the woman

Pregnancy is "almost entirely a mechanical event"                  Pregnancy is a "working norm" for any woman

and is a stressor

**Regarding Physician Supervision**:

Respondent provided to (client) a Disclosure Statement which set forth, in pertinent part, "It is also a requirement of my license to have a 'specific OB informed of your pregnancy who is prepared to take your case if transport becomes necessary.'  Despite all reasonable efforts to have a relationship thus described, no obstetrician cares to have that kind of relationship with a homebirth midwife; however, many �. will receive cases if/when a transport becomes necessary or when a referral needs to happen."

The parties readily acknowledge that "supervision" as set forth in Business and Professions Code section 2507(c) does not "require the physical presence of the supervising physician" and does not purport to involve, as set forth in Business and Professions Code section 2501 (e), **the overseeing of activity or acceptance of responsibility for services rendered by licensed midwives** as required by such physicians for licensed physician assistants. **Clearly, a different standard was intended by the Legislature; however undefined.** *(emphasis added)*

**Regarding Standard of Practice**:

Midwives employ a midwifery model of practice distinct from the medical model of practice. The testimony of Complainant's witnesses as to the medical model's applicability to midwifery is **inapposite and summarily dismissed** *(emphasis added).*

� (S)ubject to a midwifery model, Respondent has engaged in neither unprofessional conduct nor violation of the Act. Within the ambit of that model and her professional licensure, Respondent acknowledges that she is subject to the following standards of practice:

A. Providing continuity of care for women and their families during the perinatal cycle.

B. Fostering the delivery of safe and satisfying care.

C. Recognizing that childbearing is a family experience.

D. Upholding the right of the woman/family to informed consent and self determination, within the boundaries of safe care.

E. Focusing on patient health and maturation during the reproductive years.

F. Working as an independent midwife towards an interdependent relationship within a healthcare system capable of providing consultation and referral.

G. Participating in continuing education that enhances professional growth and development and complete continuing education units required by licensure.

H. Performing duties within professional competence

**Midwifery duties and responsibilities include, but are not limited to**:

A. Following initial and ongoing client risk assessment, the assumption of responsibility for the management and care of the essentially healthy woman and newborn during the childbearing process.

B. Properly documenting and maintaining the confidentiality of client records, including physician visits and referrals.

C. Providing a disclosure statement to each client and family at the initial interview that includes

(1) Educational background,

(2) Level of experience,

(3) Types of services rendered,

(4) Licenses, certifications, and professional affiliations,

(5) Midwifery expectations of clients, and

(6) Financial charges.

D.  **Eliciting informed consent to declined services, home birth, and risks involved to both patient and infant.**

E. Requiring laboratory tests.

F. Employing team practice which includes, but is not limited to, the presence of a trained assistant or midwife.

G. Using and maintaining aseptically clean equipment.

H.  **Employing advance preparation which includes, prior to labor, arrangements for client and/or infant transport to hospital and client agreement to such transport.**

1. Employing newborn screening within three days of delivery.

J.  **Referring and/or consulting with healthcare professionals as required by each client presentation.**

**Within this obligation to refer or consult, the standard of practice compels obstetrical referral or consult for a client who exhibits:**

(1) Active syphilis, gonorrhea, or chlamydia.

(2) Unresolved signs of PIH.

(3) Chronic and unresolved vaginitis, UTI, and/or anemia.

(4) Persistent glucosuria.

(5) Diabetic symptoms.

(6) Third trimester vaginal bleeding.

(7) ROM prior to 37 weeks minus 2 days.

(8) Familial history of congenital abnormalities.

(9) Prior obstetrical difficulties (e.g., uterine abnormalities, placental acretia or abruptia, or incompetent cervix).

(10) Polyhydramnios or oligohydramnlos.

(11) A Class III or greater PAP.

(12) Size incompatible with date.

(13) Suspected malpresentation.

(14) Suspected twins or breech.

(15) Indications that fetus has died in utero or marked decrease in fetal movement.

(16) Rh negative mother with positive titers.

(17) Signs of preterm. labor (before 37 weeks minus 2 days).

(18) Gestation past 43 weeks.

(19) Fever of 100.4 for longer than 24 hours.

(20) Herpes: initial primary outbreak anytime during pregnancy.

(21) Abnormal FHTs

**Within the scope of midwifery practice, planned home birth may be contraindicated and is specifically precluded in the following instances**

A. Diabetes, essential hypertension, active TB, epilepsy, heart lung, liver or kidney disease, cancer, bleeding disorders, or any other major medical problem or congenital abnormality that affects childbearing.

B. History of thrombophlebitis and/or pulmonary embolism

C. Use of psychotropic medication or evidence of significant mental illness.

D. Addiction to or use of narcotics or other drugs (except marijuana

E. Excessive use of alcohol.

F.Smoking more than one-half pack of cigarettes with no likelihood of cessation.

G. Unresolved anemia.

H. 1UGR.

I. Preeclampsia.

J. Placental previa or abruption.

K. Active herpes when commencing labor.

L. Fetus with congenital anomalies that may require immediate medical attention.

**The midwifery model includes, during labor and delivery, that a licensed midwife:**

A. Monitor the mother and baby.

B. Coach the mother.

C. Assist in the delivery.

D. Examine and assess the newborn.

E. Manage any third stage bleeding.

F. Inspect the placenta, membranes, and cord vessels.

G. Inspect the perineum vagina, and, if necessary, the cervix.

H. Repair lacerations, as necessary.

I. Provide no less than two hours postpartum care for the mother and infant and, in any event,

    until stable.

J. Transport or referral upon any of the following:

(1) Signs of preeclampsia.

(2) Fever over 100.4 degrees.

(3)  PROM accompanied by diminished maternal or fetal well-being.

(4) Evidence of fetal distress as indicated by fetal heart rate unless birth is imminent.

(5) Abnormal bleeding or blood loss.

(6) Significant meconium with birth not imminent.

(7) Prolonged labor accompanied by potential or actual diminished maternal or fetal well-being.

(8) Signs of maternal shock.

(9) Retained placenta or placental parts.

(10) Unexplained pain.

(11) Two hours of second stage with no progress.

(12) maternal desire.

**Breech:**

�A midwife's assistance in a breech presentation that fails to meet such specific criteria violates the midwifery model's standard of care and/or practice and would be unprofessional conduct.  � to the facts and law herein; particularly where, as here, the Legislature failed to specifically preclude breech presentation and relied, instead and consistent with its deference to developing healthcare models, on professional standards of care.� *(emphasis added)*

Respondent, while acknowledging an obligation to refer or consult for a breech presentation and possessing a current neonatal cardiopulmonary resuscitation certificate, submits that vaginal breech home births are within the standard of practice for midwives, possessed of appropriate experience, knowledge and training, provided further particular criteria are satisfied; namely:

**Within the context of the midwifery model, possesses the appropriate knowledge, training, and experience to conduct planned and emergent vaginal home deliveries, including vaginal breech deliveries.**

A. Frank breech presentation: sacrurn in the anterior aspect at onset of labor.

B. Flexed head.

C. Adequate pelvis for estimated fetal weight (by palpation and pelvimetry).

D. Sonogram to rule out anomalies.

E. Proximity to hospital.

F. Gestation is greater that 37 weeks and less than 41 1/2 weeks

G. Psychosocial aspects of client, client's partner, and midwife.

Relative to Informed Consent / Declination in the presence of an Identified Risk Factor (such as Breech, Twins, VBAC, Post-dates, PROM)

'The medical 'standard of care' for breech babies is to do a cesarean section in most cases. First time mothers are considered to have an 'unproven pelvis', which means that it is not certain that a baby can fit through it. Even women who have had a baby are encouraged or required to have a cesarean due to the increased risks to the baby during delivery.

Guidelines for standard midwifery practice in the US include the right of the client to choose to continue care with the professional midwife after a complete discussion of the risks involved, which includes the experience level (of the midwife) and the signing of an informed consent form.

**"Risks may include increased fetal morbidity and mortality (injury and death)."**

The waiver further states that:

"After careful evaluation of the above information I am exercising my right to choose to birth my [breech, vbac, post-dates, PROM] pregnancy/ baby at home and waive referral to another provider. This decision is made of my own free will and I absolve and hold harmless my attending midwife,