California College of Midwives

April 18th, 1997

Member, Division of Licensing, MBC

1426 Howe Street,

Sacramento, CA 95825

**Re: February 7th Regulatory Hearing on Section 1379.21**

Dear Dr Bernard Alpert. MD

            It is my intention to attend the next DOL meeting on May 9th. However, there is a small possibility that I will be unable to do so and therefore am taking this opportunity to express my sentiments in writing.

            I am concerned that the procedural aspect of the Public Hearing on February 7th did not do the best job of bringing to light the necessary factual basis for decision making. The format currently used by the MBC does not organize the testimony into a cohesive unit which matches those supporting versus those opposing the regulation nor does this format allow for rebuttal. Each person who plans to testify signs in on a single sheet of paper and is called to speak in that random order. The time limitation is quite sever and no provisions are make to correct inaccurate information during the course of the hearing. I believe that this inadvertently created some major difficulties.

            In particular, the last speaker, a women anesthesiologist ( I believe representing CMA) made a series of inflammatory and erroneous statements which, due to imposed time restraints and the lack of procedural opportunity for rebuttal, went uncorrected. These statements characterized childbirth as �the most dangerous area of medical practice� and described midwives currently licensed by the MBC as ��untrained lay midwives�. I believe her extremely negative (and erroneous) portrayal of childbirth as a impending disaster and direct-entry midwives as inept and inadequately trained played a crucial role in the final vote by making it appear that Board members would be derelict in their duty should they come to any other conclusion.

            Having been at the seven Midwifery Implementation Committee meetings, I can assure you that this physician has not been personally involved in the implementation process or directly knowledgeable of the background of currently practicing and licensed midwives. She obviously does not understand that any midwife who qualifies for licensure under the challenge program approved by the DOL has documented that she posses professional experience, an identified skill level and a knowledge base equal to or greater than the standard curriculum for nurse-midwives. Since direct-entry midwives do not practice in hospital settings, this medically-oriented standard seemed to be a form of overkill to community midwives. None-the-less, this is the standard mandated by the current licensing scheme and one with which community-based midwives have fully complied. It seems most onerous to impose this overly-rigorous standard in the first place and then to ignore it when issues of professional competencies arise.

            In rebuttal to this unfortunate testimony, I am including a verbatim quote by CMA representative Joan Hall from the transcript of the 3rd Midwifery Implementation Committee meeting held at the MBC Sacramento office June 6th, 1994.

Joan Hall, CMA: �....  this legislation has been introduced in various forms over the last several years and I inherited this legislation. This was the first time the medical association was willing to sit down and discuss it and understand the need to legitimize this process because you *{indicating the midwives present}*definitely have something to *provide.* That�s why the bill developed and I�d be more than willing to talk about it because we believe that the standards that are in the bill are standards that make for safe, capable practitioners.

Yes, we believe in the standards in the bill. Maybe that needs to be more communicated because a lot physician I have talked to talk about licensing lay midwives, and I keep hearing that over and over again and people have an idea that a lay midwife is someone who learned how to �birth babies� on a farm somewhere or learned somewhere in the back woods how to deliver babies and not do it in a safe fashion. This bill doesn�t allow for that, there will be competent capable practitioners under the standards that are set up in this bill. So we very much believe in the standards in this bill.�

            The portrayal of childbirth as an impending disaster also reflects a popular misconception. Physicians never see the many families that have a trouble free birth -- only the rare complications and thus tend to characterize domiciliary midwifery care based only on their experience with complications. Historically, the realistic dangers of childbearing have fallen into three categories. The most frequent and most severe are the result of poverty (malnutrition, etc.), forced or frequent childbearing, mothers with pre-existing medical problems or obviously complicated pregnancies (bleeding, prematurity, multiple gestation, etc.), especially for those *without* access to appropriate health care.

            The second and smaller category are nosoconial and/or iatragenic -- complications arising from hospitalization (antibiotic-resistant, hospital-acquired infections, medication mistakes, other human error) and side effects of medical interventions which frequently require even more potent or invasive techniques to correct. Unfortunately, those additional treatments and drugs introduce additional risks such as surgery and the biohazards of blood transfusions. And the last and *least* are the truly �rare� category of unusual and statistically infrequent complications of pregnancy and birth which occur randomly, with little warning and which are frequently untreatable even in the best of institutions (such as an unexplainable stillbirth after a normal pregnancy and trouble-free labor).

            Statistically, every mother or baby who suffered or appeared to suffer because of the choice of out-of-hospital birth is matched by two or more who suffered or appeared to have suffered as a result of hospital interventions. Doctors are not to blame for this situation -- many mothers require medical intervention because of dangerous life-styles or substance abuse; other mothers experience complications due to the use of anesthesia or labor stimulants which were medically necessary. It is just a statistical fact that the more medically-complex the childbearing event becomes, the higher the likelihood of medical complications. This fundamental fact is why the practice of medicine requires such tight regulation -- it can best be likened to the use of power tools -- even a small slip can have disastrous consequences. In that regard, safety of domiciliary care benefits both from the *absence* of medical ministrations and the *presence* of healthy mothers with normal pregnancies.

            This last category of infrequent and unpredictable complications is the one referred to by physicians when expressing their fear of providing birth services in a domiciliary setting. It *is* true that an occasion mother or baby will experience a bad outcome that could have been lessened or eliminated had they been in the right hospital, cared for by an astute and unhurried nursing staff and lucky enough to have a physician physically present at the critical moment, along with just the right line up of anesthetic and lab services, surgical scrub techs, etc. But there are serious flaws with judging the overall efficacy of community-based midwifery care based on this rare category.

            Labor room nurses (unlike midwives) do not provide ongoing, one-to-one bedside care. Obstetricians are not routinely present in the hospital during labor, usually arriving only a few minutes before the birth. Due to economic considerations, most institutions do not have enough personnel to give personalized care and do not have round the clock surgical and anesthetic coverage. Real hospitals are not like the ones on TV. The average community hospital takes a *minimum* of 30 minutes to get the doctors and operating room staff physically present to do a cesarean. This chain of events can be just as satisfactorily trigger from the client�s home so that while the mother is being transferred to the hospital, the appropriate personnel are being notified and will be present and ready when we arrive.

            To say that complications arising from *over*-treatment are somehow less �problematic� or more �noble� that those from *under*-treatment is illogical, especially in light of the fundamental right of parents to make the choice of a midwifery care and a low-tech birth setting. This is not a situation being forced on them by denial of access to hospital services. The majority of healthy childbearing women having a normal pregnancy and a spontaneous onset of labor at term do not need or benefit from routine hospitalization for normal, unmediated childbirth and it is this classification of mothers that are traditionally cared for by licensed, direct-entry midwives. And for those few women who are willing to labor without narcotic analgesia and give birth without anesthesia (under 5%), it is the statically superior choice.

            The midwifery model of care, in which healthy mothers are cared for primarily by midwives and which includes the option of home-based birth services (in conjunction with access to hospital obstetrics), is the very safest form of maternity care. This has been statistically validated for nearly 100 years. Since the late 1800s, the five industrialized countries with the best maternal-infant outcomes and lowest per-capita cost for childbirth services have employed the midwifery model for normal maternity care and obstetrics for complications.  During that same time, the US, which purposefully eliminated midwifery caregivers in the early 20th century, has consistently been in the bottom five and currently is 23rd out of 25 first-world countries in perinatal outcome.  (see enclosed statistical comparison for 1929 and 1989)

            Historically, the safest form of home-based midwifery care has been linked with easy access to hospital-based obstetrics in the event that the mother either needs or wants medical intervention. Consumer safety is *compromised* when physician care is *unobtainable* and it is likewise enhanced by collaboration which fosters a complementary relationship between the midwife, the mother and the medical profession. Midwives are seeking to be closely articulated with contemporary medicine and asking for help from the Medical Board in bring about this kind working relationship.

            A community hospital on the San Francisco peninsula most frequently used by midwives was recently bought out by a large hospital chain and has just informed the nurse-midwives in our area that all physicians with admitting privileges at their institutions have been forbidden to provide any care to pregnant women after 28 weeks (term is 40 weeks) if they are planning to give birth at home under the care of a certified nurse midwife. As you may well image, this is very disturbing to all domiciliary midwives and furthermore the refusal to provide all but ER physician care is detrimental to the practical wellbeing of childbearing mothers and their unborn or newborn babies.

            In pursuit of that quality of collaboration with medical care providers and assured access to hospital-based obstetrical services, I am reiterating my request that the MBC include a questionnaire in the quarterly magazine (Action Report) to solicit information from qualified physicians on their willingness to provide the statutorily-mandated physician supervision and their ability to do so in regard to any limitations imposed by their malpractice carriers. We believe that this information will be crucial to the basic workability of the current licensing scheme.

            Again, I want to stress how important the resolution of this problem is to midwives and the families that they serve and how much we appreciate your participation in bring about a safe and mutually satisfactory solution.

Warm Regards,

faith gibson, community midwife

Certified Professional Midwife #96050001

Executive Director, ACDM

CC:            Members, DOL-MBC

            Senator John Vasconcellos, 13th District

            Assemblywoman Susan Davis, 76th District

Encl:    Statistical Comparison -- 1929 & 1989

            Fact Sheets from *Citizens for Midwifery*

            Britain�s *House of Commons Report on Midwifery & Homebirth*

            April 18th newspaper article -- Dr. Rosenblatt, University of Washington study confirming the improved outcome of midwife-managed birth services -- Cesarean section rate for midwife-attended births was 8.8 percent, for obstetricians it was13.6 percent and 15.1 percent for family practice physicians

Statistical Citations

Statistical studies and abstracts of published research cited in this letter are available on our web site @ [www.collegeofmidwives.org/safetyissues](http://www.collegeofmidwives.org/safetyissues). You may also use the �Site Search�  to locate additional sources.

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The Texas Department of Health's own statistics show that midwives in Texas have a lower infant mortality rate than physicians. (Texas Lay midwifery Program, Six Year Report, 1983- 1989, Berstein & Bryant, Appendix Vlllf, Texas Department of Health, I 100 West 49th St., Austin, TX 78756-3199.)

In the state of Oregon from 1975-1979, there were approximately 3-4 neonatal deaths per 1000 births in homebirths attended by midwives, as opposed to approximately 9-10 deaths per 1000 births for all residents. The same figure indicates approximately 5 infant deaths per 1000 births in homebirths attended by midwives, as opposed to approximately 12 deaths per 1000 births for all residents. (Research Issues in the Assessment of Birth Settings, Institute of Medicine, National Academy Press, Washington, 1982, p. 175)

Records kept from 1969-73 in England and Wales indicate still birth rates of 4.5 per 1000 births for home deliveries as opposed to 14.8 per 1000 births for hospital deliveries. (The place of Birth, Sheila Kitzinger & John Davis, eds., 1978 Oxford University Press, pp. 62-63)