Contemporary History of the relationship Between California midwives, the LMPA, the Medical Board and the Bowland Decision

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The first area of interest is the implementation and administration of the licensed midwifery program by the Medical Board of California (MBC) from March 1994 to December 2004. Second are the standard practices within the California community of the licensed midwives in response to policies established by the MBC; in particular the legal status of candidates for California midwifery licensing under the LMPA's challenge mechanism and since 2002, midwifery students formally matriculated in midwifery training programs.

I am one of the few individuals in either the midwifery community or employ of the Medical Board who has been involved full-time in these legal and legislative issues prior to and continually since the passage of the LMPA. I have done extensive academic research on the history of the medical practice act and midwifery licensing laws in California and maintain an archival library on the topic. The major sources of documentation quoted here are California medical practice legislation from 1876 to 1993, microfilm copies of state legislature bill sets, official letters of legislative intent, daily newspapers of the era, medical periodicals and the copious records provided by the Directories of Licentiates published yearly by the Board.

I've been present at virtually 100% of the public meetings and major events relative to the implementation and administration the midwifery licensing program. I am called upon by Legislative staff or MBC staff members when they require information about customary practices of direct-entry midwifery or the administrative issues relative to licensing.

Institutional memory is a particular issue in regard to the MBC agency staff person assigned to the midwifery licensing program, as there have been 7 different employees in the first eleven years of the program, starting with Tony Arjil in 1994. The position was subsequently filled by Gloria Maceus, Gizzelle Biby, Kim Marquart, Teri Kizer, Susan Lancara and currently is assigned to Mr. Herman Hill. During the first decade of the midwifery licensing program, the job went unfilled for long stretches. Employment of each of the six initial employees lasted only 6 to 18 months.

This high turnover and lack of continuity resulted in much confusion for both the MBC staff and for California midwives. In addition, there have been three different executive directors since 1994. As a result of my repeated requests, members of the Division of Licensing have pondered the possibility of a permanent 'midwifery advisory committee' for the last 5 years. However this issue was not acted on until the February 2006 quarterly board meeting, at which time it was decided that legislative authority would be necessary. At present no bill has been introduced which

would authorize a permanent midwifery advisory committee that could conceivably develop a dependable source for institutional memory and evidence-based policy decisions.

In light of these circumstances, I offer the following background facts as a source of "institutional memory". The majority of individuals who worked for the midwifery licensing program or participated in the Midwifery Licensing Implementation Committee are either still working for or are available to the MBC and should be able to corroborate the information provided by me. Audio tapes and written transcripts also exist for much of the material relative to the Midwifery Implementation Committee.

Historical Background:

The Licensed Midwifery Practice Act was signed into law in October of 1993. It repealed the 1917 direct-entry midwifery provision of the Medical Practice Act (AB1375-Gebhart Bil-/1917 Amendment to the 1913 Medical Practice Act) which had originally established educational qualifications and standards for the state-certified practice of direct-entry (i.e., non-nurse) midwives. The1917 physician-authors of the original midwifery statue were primarily concerned with setting criminal penalties for midwives who engaged in the unauthorized practice of medicine. The title of the 1917 enactment reads: "*to add a new section …relating to the practice of midwifery, providing the method of citing said act and providing penalties for the violation thereof.*"

In 73 years of non-medical midwifery practice (from 1917 to passage of the LMPA in 1993) there was a total of 217 California certified midwives. Only 3 disciplinary actions are recorded in the Directories of Licentiates from 1918 to 1950 and all three are for overstepping the identified non-surgical scope of midwifery practice established in the AB 1375 . Certified midwives Marie Caron (FX-83 -1918), Elena Rinetti (FX-97 -1918) and Caterina Reorda, a graduate of the Royal University of Turin (F-58 -1925) all had their licenses revoked or suspended for unprofessional conduct, citing "illegal operation" as the cause of action. It appears from the various documents of the era, including the Directories of Licentiates, that there were no prosecutions for the unauthorized or uncertified practice of midwifery before passage of the original 1917 provision and through out the 20th century until the Bowland case in 1974 -- a total of 97 years (1876-1973).

In 1949, at the request of the Board of Medical Examiners, a bill was passed (SB 966) that repealed the application process for midwifery certification (Article 9) and eliminated the midwife classification from the list of certificates issued by the BME. The reason cited was a lack of applicants. Those portions of the midwifery provision defining the extent and the non-medical character of midwifery (Section 2140) and those concerning penalties for unprofessional conduct were left intact (section 2400-08). The 46 midwives who held valid licenses at the time were unaffected. No criminal penalties for lay or uncertified practice were stipulated in this revision. The last state-certified midwife under Article 24 declined to renew her license in 1990.

In the 32 years following the original passage of the 1917 midwifery provision, a qualifying midwifery training program in the state of California was never approved by the Medical Board. This meant that California residents were unable to meet the criteria for licensing. The midwifery provision did not stipulate any courses in professional midwifery itself, but rather mandated that midwifery students complete the same classes in anatomy, physiology, hygiene and sanitation and

a 165-hour course in obstetrics taken from the medical school curriculum of physicians and drugless practitioners' educational standards. Ironically, while mandating the same medicalized education as physicians, the provision itself forbid licensed midwives to utilizing the medical skills taught to them in these classes.

Because there were never any Board approved midwifery training programs, the only source for new applicants were medical students that had completed the obstetrical portion of a medical school curriculum or immigrants – primarily Japanese – who were licensed by reciprocity from one of Japan's 27 midwifery schools. Due to WWII and the subsequent interment of the Japanese population, the source of new midwifery applicants virtually disappeared after 1942.

From 1949 to 1993, no licensing was available in California for non-nurse midwives. However, the practice of traditional midwifery was not statutorily prohibited in either the original 1917 statute or the 1949 repeal of the direct-entry midwife application, i.e., no provision in the original midwifery licensing law or its 1949 amendment created a public offense defined as 'practicing midwifery without a license'. Under our form of government what is not expressly outlawed is legal.

A convention of licensing has always been exclusive entitlement in both title and scope of practice in the domain of one's license. Unfortunately, midwives licensed under the 1917 provision did not enjoy this protection. Unlike the professions of medicine, nursing, dentistry, chiropractic and other allied healthcare disciplines, midwives have never been granted exclusive entitlement for the practice of the midwifery as a regulated profession.

The original midwifery statue was primarily concerned with setting criminal penalties for the use of drugs and "instruments" (i.e., primarily obstetrical forceps) by midwives. The midwifery provision prohibited the use of any "artificial, forcible or mechanical means", as well as forbidding the use of instruments to penetrate or severe human tissue beyond the cutting of the umbilical cord. These activities were newly defined as an unauthorized practice of medicine and thus illegal if performed by a midwife (except as a medical emergency under section 2063). As for the entitlement issue, these same physician-authors quietly side-stepped the complexities that licensure created by not including exclusive entitlement language for midwives in the 1917 provision.

One practical reason for this oversight is that physicians and midwives share a common patient base – that is, both provide normal maternity care to healthy women. Were midwives to have been granted exclusive entitlement to their own scope of practice, it would have created the 'unauthorized' or illegal practice of midwifery. Physicians who also wished to provide normal maternity care to healthy women could be charged with the unlicensed practice of midwifery. This would have required that physicians either become additionally trained and licensed in the discipline of midwifery *or* that an equivalent midwifery curriculum be incorporated in the medical school education, thus granting exemption to the midwifery licensing law.

During the four decades between 1949 and 1993 the public demand for midwifery care continued on as before, though statistically insignificant as compared to obstetrical care. The 1949 passage of SB966 repealing the certificate classification of 'midwife' withdrew the opportunity for future midwives to become state-certified "professionals", demoting them to the generic classification of

"lay" practitioners deprived of professional rights such as employment opportunities, teaching positions and receipt of third-party payments. In the course of my research I could find no records indicating that the Board of Medical Examiners ever viewed the lay practice of midwifery as an illegal activity through out the 19th and 20th century until the Bowland case in1973.

Contemporary Midwifery Licensing:

The LMPA set the stage not only for the licensing and practicing of LMs but also for the many facets of midwifery training and the educational relationship between practicing professionals and students of the art and discipline of direct-entry midwifery.

The MBC's Midwifery Licensing Implementation Committee ~ 1994-95

The LMPA identified the MBC as the licensing and regulatory agency for direct-entry (non-nurse) midwives and mandated that such licensing be in place by July 1, 1994. In March of 1994 the MBC convened the Midwifery Licensing Implementation Committee to assist in the process of implementation per the requirements of the statute. This committee met six times between March and September of 1994 and a seventh meeting was held in September of 1995. Each of the seven meetings was approximately six hours in length.

Medical Board member Dr. Thomas Joas, MD was appointed to be chair of the Committee. Other Medical Board officials included lay Board member Stewart Shaw (note: this is a phonetic spelling of an Chinese surname), MBC agency deputy director Doug Lauey, senior counsel Anita Scuri, legislative analyst Linda Whitney and several other former and current MBC staff. The California Medical Association (CMA) was represented by lobbyist Joan Hall and Tim O'Shay. The California Association of Professional Liability Insurers (CAPLI) was represented by retired Judge Cologne. Approximately 12-15 midwives in leadership roles attended these meeting, including myself. The midwives also audio taped the last four meeting (June 1993 to September 1994). These tapes were transcribed and transcripts made publicly available on the Internet at www.collegeofmidwives.org.

During the approximately 40 hours of lively and frequently contentious discussions on a wide range of thorny issues, the topic of midwifery students, the legal implication of student status and/or any Medical Board policies relative to the legal relationship between midwifery students and other licensed professionals (midwives or physicians) was never discussed or identified as a problem to be addressed on a future occasion. There were no Board-approved midwifery training programs in the state at that time and the only route to licensing available to California residents was through the LMPA's "challenge mechanism". This permitted 'qualified' applicants to challenge the educational requirements of the LMPA and, after satisfying other regulatory criteria, to become licensed midwives under the authority of the MBC.

The Educational 'Challenge' Mechanism

The first hundred direct-entry midwives licensed in California since 1949 did so through this challenge process. The law stipulated that the challenge mechanism be administered by a Board-approved midwifery school which would, in essence, require the candidate to test out of a three-

year training program. The Seattle Midwifery School (SMS) in Washington State applied for and was approved to administer the challenge program in California.

Applicant midwives were required to establish their eligibility to challenge the educational requirements of the LMPA by documenting the necessary clinical experience as stipulated in regulations promulgated by the MBC. Prerequisite clinical experiences had to be within the previous 10 years and required the applicant to document 235 comprehensive patient-care experiences -- 95 initial and follow-up prenatal visits, 40 labors, 20 births as primary attendant and follow-up care for 40 postpartum exams, 40 neonatal exams and 20 well-woman gyn visits. The documentation process required that an MD *and* a certified nurse midwife both review and sign off on the midwife's records, which included the names and addresses of all patients.

This paperwork was then carefully reviewed by SMS (including independent verification via letter or phone calls to identified childbearing family). If approved, the candidate was permitted to sit for a series of days-long didactic and clinical exams administered by SMS. These exams conformed to the educational curriculum as stipulated in the LMPA and were equivalent to those passed by SMS graduates. Successful competition of the first three steps qualified the candidate to sit for the state's midwifery licensing exam. Only after passing the fourth and final hurdle of state boards could the candidate become licensed as a direct-entry midwife.

How or where the prerequisite clinical experiences were acquired by applicant midwives was not stipulated in either the LMPA or pertinent regulations. It was the agency itself that determined the technical configuration of the challenge process via regulations that it promulgated. However, the agency staff informally stated to me (and to agents of Seattle Midwifery School administering the challenge process) that all documents identifying the experiential background that established each applicant's eligibility must be *kept confidential by the midwifery school.*

The explanation given was this: If the Board were to be in receipt of any of the documents identifying the applicant's lay practice of midwifery in California prior to the candidate's completion of the challenge process and receipt of her license, the agency would be forced to either prosecute the applicant for the unlicensed practice of medicine *or* the Board would be technically guilty of aiding and abetting the unlicensed practice of medicine. Obviously, this was a 'catch-22' premise, as the applicant could not qualify for licensure without the stipulated clinical experience and yet the MBC insisted that such perquisite experience without a licensed was itself a crime. As a result, the challenge process took on an air of "don't ask, don't tell" as the MBC attempted to logically administer a program based on this incongruent premise.

The MBC's Dilemma

The Medical Board found it nearly impossible to harmonize the three fundamental elements of the LMPA, i.e., the professionalization of midwifery through 1) education 2) testing and 3) licensing. Either the LMPA was inconsistent and contradictory OR the MBC interpretation of the statutory scheme created internal conflicts not intended by the framers of the legislation. On one hand, the LMPA described an elaborate and complex system for the comprehensive training, testing, licensing and regulation of the professional discipline of direct-entry midwifery. This was presumed by the MBC to mean that the legal practice of midwifery required that *all* the various aspects of professionalism be met *before* any one individual midwife was lawfully "authorized" to

practice. However, a plain reading of the text of the LMPA does not actually say this in black letter law.

On the other hand, the challenge mechanism of the LMPA clearly acknowledged in black letter law that traditional (ie, direct-entry, non-nurse) midwifery was, at the time the LMPA was being written, an on-going practice that had existed in a legal limbo ever since the repeal of the midwifery application process in 1949. None of the three statutes dealing specifically with direct-entry midwifery licensing (1917, 1949 or 1993) ever criminalized the practice of midwifery by persons not holding a midwifery license *or* extended exclusive entitlement to licensed midwives relative to their identified scope of practice – maternity care to healthy women with normal pregnancies. Exclusive entitlement language for midwives was also not included in the LMPA. By convention, it is that exclusivity of licensing that generates the various crimes of practice without such a license.

The LMPA not only acknowledged these simple facts but emphasized professionalizing the formally 'lay' practice of direct-entry midwifery via a legislative scheme which permitted "qualified" midwives (who obviously had been practicing midwifery prior to passage of the law) to challenge the three-year educational process. If one ponders that for a moment, it is plain that the Legislature presumed that the hundred or more empirically trained and experienced California midwives could adequately demonstrate the technical skills and a knowledge base equal to a graduate of a formal three year training program. Such an assumption speaks of a basic confidence in this formally disenfranchised and frequently denigrated group. It also *appears to recognize* that a significant number of healthy childbearing families wanted and had a constitutional right to choose normal birth under the medically non-interventive principles of midwifery.

Implementation of the Licensing Process 1996 to December 2004

In the fall of 1996 a small test group of midwives were walked thru the licensing process by the MBC. This included documents from the Seattle Midwifery School attesting to the successful completion of the challenge process and administering the newly minted state boards in midwifery. By January of 1997 licensing was opened up to all qualified midwives. This was almost 3 years behind July 1, 1994 date set by the LMPA. The midwives felt that the Board was working hard to meet the deadline but frequent changes in the personnel assigned to the midwifery program negatively impacted the Board's ability to meet these goals.

With the exception of two midwives licensed by reciprocity from Washington State, all California LMs qualified under the challenge process until sometime in 2002 (research date). In 2002 the MBC approved several out-of-state three-year training programs. However, there are still no approved midwifery programs in California. It was not until Board-approved training programs became available that 'students' of midwifery became part of the responsibility of practicing LMs. The majority of the Board-approved midwifery programs do not provide internships or resident training, thus all the "hands on" or clinical experience of the student is acquired under a preceptorship arrangement with a practicing LM. Agreeable LMs formally contracted with an individual training program to be designated as a specific student's 'preceptor', and thus to take on the clinical training of that student.

Prior to this, licensed midwives were informally involved as a source of clinical experience for women who were in the process of acquiring the necessary clinical experience for the challenge process. The majority of midwives practicing prior to the passage of the LMPA had many times more clinical experience than necessary and had no reason to acquire additional clinical experience under the tutelage of an already licensed midwife. However, the challenge process continued to be the only pathway into the profession and that eventually generated a small but steady stream of 'challenge' applicants who could informally be considered students. The LM-challenge applicant relationship did not have any well-defined 'rules' beyond those generated by the common sense of the parties.

In general, these relationships were defined more by the conventions of the LM's contract with her own clients, which is to say that the student/applicant under the challenge process functioned as an assistant to the LM and did not independently take over the care of the LM's client. However, within the context of the role of 'assisting' the LM, the challenge applicant did perform the full range of clinical skills (vital signs, fetal heart tones, vaginal exams, etc) including being the initial person to go to the mother's home to determine her status or assess her progress and then report by phone to the senior LM. It also included, at the discretion of the LM and with the permission of the mother, managing the labor and birth and technical procedures such as suturing a minor perineal laceration. It must be noted that this was a necessary prerequisite under the regulations which required the applicant to demonstrate her experience as the primary attendant for a specified number of births.

I cannot emphasis enough that these arrangements had absolutely no antecedent policies or other forms of guidance from any other source – nothing in the LMPA, the regulatory process or any formal or informal policies of the MBA. In particular, the MBC continued to insist that they not want to know what we midwives were doing – "We don't ask and *you better not tell us*".

On many occasions, applicants and candidates for the challenge process and practicing LMs contacted the staff member in charge of the midwifery program with what they considered to be legitimate questions. Many reported that they left 5 or more phone messages without a response and that it often took 2 months before they were called back and even then they had to argue mightily to get the help they were seeking. When the midwifery staff person was particularly unavailable or unhelpful, these women would call me and ask if I could somehow get the midwifery program to be responsive to their issue. Most LMs interpreted the agency's unwillingness to "help" midwives as an expression of disrespect or even a bias against midwives. All of us felt like that midwifery was the ugly step-sister at the Medical Board.

I tried to mitigate this impression by explaining that some of the expectations of licensed midwives were unrealistic, as the Medical Board didn't "help" doctors or other licentiates either. Their official role was to simply administer the licensing process – applicants send in the appropriate paperwork and the staff processes it. Until about 18 months ago, this stiff-arm approach consistently communicated the idea that we midwives were "on our own". Whatever the problem, it seemed that the MBC wanted us to figure it out for ourselves and not bother them.

As a result, California LMs adopted a pragmatic approach in which we sought out advice from one another in an informal network that took the place of official guidance from the Medical Board. I was frequently one of those consulted for an opinion or advice.

The Idea that it was "illegal" for LMs to preceptor midwifery students

Late in the spring of 2004 I began to hear a 'rumor' that the midwifery program staff person, which at the time was Teri Kizer, was telling people that it was "illegal" for a licensed midwife to have a midwifery student. I dismissed it as nothing more than an unfounded rumor. Then I started to receive an occasional call from a student or LM in which they insisted they personally had been told by Teri Kizer that it was illegal for a midwife to have a student. I assured them this was a misunderstanding on the part of either the midwife or the Medical Board staff.

I based this opinion on two things. First was my familiarity with the Medical Board itself and my attendance at all the Division of Licensing meetings. This idea was certainly not something that had ever been discussed by the DOL members. Second was my familiarity with the LMPA, which does not contain any provision that could possibly be interpreted to make students "illegal". In fact, more pages of the law address midwifery education than any other topic.

Equally important was the consumer safety function of the LMPA. Appropriate clinical training of students was vital to the educational process. Without opportunities to learn technical skills and most especially opportunities for students to develop clinical judgment; midwifery licensing would be a cruel joke. It would be foolish and oxymoronic for the Medical Board staff (of all people!) to make this interpretation. A principle in physics known as 'Achem's razor' – the idea that the simplest or most straight forward explanation is also the most likely to be correct – brought me back to the conclusion that this was simply an error of some sort.

Then I received a call on a Friday afternoon in May 2004 from LM Constance Rock. She was clearly upset and recounted to me that she had just been visited by a special investigator for the Medical Board in regard to a complaint and was told that it was illegal for her to be working with a midwifery student. According to Constance, the investigator told her that if she was not able to establish by Monday that it was *legal* for midwives to have a student, then she would be served with a *cease and desist* order and her license would be immediately confiscated. And yes, I again insisted that this must be a mistake and told Constance to call Teri Kizer and work it out.

Sometime in the next few weeks I personally talked to Teri and was shocked when indeed she insisted that it was illegal for a licensed midwife to have a student. So I asked that Cindy James, the person in charge of the licensing division, call me. Eventually I had the chance to talk to Cindy who started out using the same phrase: "illegal to have a student". I asked her to read me the exact words in the LMPA that brought her to that conclusion, which of course she couldn't do. After a bit more wrangling, she corrected her statement to say that "some things that students did might be illegal", thus the preceptor midwife would be guilty of aiding and abetting the unlicensed practice of midwifery. I asked again that she spell out in detail exactly what "things" the MBC defined as "illegal'. She didn't have any specific answer and so we ended our conversation.

I followed up this phone call with a letter to Ms James (August 2004) asking the Licensing Division to identify exactly what statutory authority they based their assertion on and to provide a list of exactly what activities they considered to be 'illegal'. In early September I talked to Liz Smith, the staff person in Senator Figuero's office in charge of midwifery legislation and she reiterated the idea that it must be a misunderstanding. She offered to ask the Legislative Counsel for a legal opinion on the topic and I gladly accepted.

I finally received a reply to my August letter to the Medical Board in December 2004. The letter was sent to all LMs and formally notified them that the Board believed the LMPA to be fatally flawed in regard to the clinical training of midwifery students. Until a legislative remedy could be negotiated, it informed LMs that provision of any "clinical" midwifery care by a student was an unlicensed practice of midwifery and that preceptor LMs would be charged with aiding and abetting this illegal practice if we should permit any students to provide midwifery care.

In January 2005 Senator Figueroa's office received the opinion of the Legislative Council which directly contradicted the opinion of the Medical Board. It stated, among other things, that clearly the LMPA intended for midwifery students to receive appropriate clinical training and that routine caregiver activities such as taking blood pressures and listening to fetal heart tones would be well within the intent of the law, and therefore, the licensed midwife could not be construed to be 'aiding and abetting'.

Subsequent to all these events, Linda Whitney, legislative analyst for the MBC, spoke to me about efforts within the agency to correct the problem thru legislation. Legislation authoring the clinical provision of midwifery care by students matriculated in a Board-approved training program was passed later in the year. We all assumed it would bring this matter to a close.

Synopsis of MBC policies relative to this issue:

During the first eleven years of the LMPA --1993 to December 8, 2004 -- the relationship between licensed professionals (including LMs and nurse-midwives) and students of midwifery were informal – that is to say, not defined by any official source or any formal policies or protocols. The LMPA was silent on the topic, there were no regulations establishing protocols and no published policies by the Medical Board. The Implementation Committee Meetings had not dealt with the topic, nor had any of the quarterly Board meetings.

During this decade-plus period of time the most contentious and provocative issue for the MBC was the continuing unavailability of physician supervision for LMs. The major focus of MBC relative to administrating the midwifery licensing program was a 3 ½ year effort to promulgate new regulations (mandated by SB 1950), which required the adoption of a standard of care (formally approved on March 9th by the OAL). The on-going need so far not addressed is the Midwifery Advisory Committee, so that continuity and institutional memory can provide a logical foundation for guidance to LMs. We all hope this will help to avoid issues such as this one.

Conclusions:

Direct-entry midwifery as an educational discipline, a practical application of historically valuable skills and a vital service to childbearing families, was inappropriately truncated for 44 years due to a 'glitch' in the law – the repeal of the legislative authority by the Board of Medical Examiners to process applications for midwifery licensure. It was the passage of SB 966 in 1949 that eventually resulted in the 1976 Bowland Decision. *Bowland* judicially criminalized midwifery in case law by upholding the BME's contention that the practice of midwifery could be considerer to be an unauthorized practice of medicine, even though midwifery was never directly identified as a practice of medicine in statutory law.

However the 1917 and 1993 midwifery licensing laws both expressly forbid the holder of a midwifery license to "practice medicine and surgery", leading one to reasonably conclude that direct-entry midwifery is intrinsically non-medical and fundamentally *something "other" than the practice of medicine*. Hence the case law conclusion commonly ascribed to *Bowland* – midwifery as an illegal practice of medicine -- is oddly discordant with black letter law, both historical and contemporary.

Functionally speaking, the LMPA was a "legislative remedy" for the *Bowland Decision*. The passage of the LMPA addressed comments by the Bowland court in many areas, including that "… *arguments as to the safety of home deliveries are more properly addressed to the Legislature than to the courts, particularly since the Legislature, by its recent enactments pertaining to midwifery has shown continuing interest in the area.*" The enactment of the LMPA acknowledged that planned home birth (PHB) with a trained attendant was a safe and responsible option for healthy women.

As for the observation in *Bowland* that *"the Legislature had never gone so far as to recognize the right of women to have control over the manner and circumstance of normal birth"*, Senate bill1479 by Senator Figueroa remedied that oversight in the year 2000. SB 1479 acknowledges that birth is a normal process and not a disease and that every woman has a right to choose her birth setting from the full range of safe options.

It defines the midwifery model of care, identifies that numerous studies associate professional midwifery care with safety, good outcomes and cost effectiveness and reports that research on planned home birth (PHB) in California strongly suggests that low-risk women who choose PHB will experience as low a perinatal mortality as low-risk women under obstetrical management in a hospital, including unfavorable results for transfer from home to hospital. Last but not least SB 1479 identifies the midwifery model of care as an important option with comprehensive healthy care for women and their families and notes that it should be a choice available to all women who are appropriate for and interested in planned home birth.

The LMPA (and its subsequent amendments) acknowledged the Legislature's intention that direct-entry (community-based) midwifery and planned home birth (PHB) be available to the public. For safety's sake, the Legislature recognized in the LMPA that California citizens deserve to have professional birth attendants legally available to them who are trained and qualified. In pursuit of that goal it offers practicing midwives the opportunity to 'challenge' the educational curriculum by demonstrating their knowledge, experience and clinical skills via the challenge mechanism and it offers interested citizens the opportunity to become professionally licensed by completing a formal 3-year midwifery training program.

It appears, at least to this author, that the LMPA and its amendments has **laid to rest the odd and limiting definition of midwifery as *an illegal practice of medicine***.