Contemporary History ~ California licensed midwives, the LMPA of 1993, its implementation, the challenge mechanism and on-going regulation by the Medical Board of California

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Excerpts taken from expert review complied for an attorney in March 2006
The original issue – the status of students under the preceptor ship of LMs –
has been resolved thru corrective legislation

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 continuously since the passage of the LMPA in 1993. 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.

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 twelve 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 now 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. No bill has been introduced yet that could 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 (4 of the 7 meeting).

Historical Background ~ **Original 1917 & 1949 Midwifery Legislation**

State certified non-medical midwifery already has a long and honorable tradition in California. A 1917 amendment to the 1913 Medical Practice Act (**AB 1375** – Gebhart - attachment # __) created the first state certification for midwives. However, it must be noted that women did not yet have the right to vote or participate in the legislative process in 1917. As a result, the original midwifery provision was conceived and written entirely by physicians, without input from either the public *or* the practicing midwives of the era.

While AB 1375 established educational qualifications and standards of practice for the state-certified midwives, it was not a midwifery practice act, as it did not offer any protection or entitlement to midwives to the exclusive practice of their own profession. The physician-authors of the original statue were primarily concerned with limiting the practice of midwives. The 1917 provision defined the use of any medicines or instruments (i.e., forceps) by midwives to be illegal practice of medicine and it set criminal penalties for any midwife who might do so. 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**." (#__)

Even though the state regulation of midwifery in 1917 was unbidden by the midwives themselves, they were generally compliant with all aspects of its provisions and appreciated the added status of professional credentialing. In the 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. From 1918 to 1950, the Medical Board's Directories of Licentiate recorded only 3 disciplinary actions against midwives-- all three for overstepping the non-surgical scope of midwifery practice established by 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, Italy (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 interest in midwifery and the opinion that "midwifery was a dead class".

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.(#3) This meant that California residents were unable to meet the criteria for licensing, unless the relocated to another state or foreign country for training in one of the 49 out-of-state

midwifery training programs approved by the BME. (#4) 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 for physicians (#5). 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 (#6), the only source for new applicants were either medical students that had completed the obstetrical portion of a medical school curriculum ***or*** foreign-trained immigrants – primarily Japanese – who were licensed by reciprocity from one of Japan's 27 midwifery schools. By far, the largest categories of California certified midwives were Japanese and Italian immigrants (#7).

The US was at war from 1941 to 1945 with Japan and Italy and the Japanese population of California was interned out of state for the duration of WWII. Considering those facts, it is not surprising that there were *only 9 applications* for a midwifery license in the entire decade preceding the request by the Board to eliminate the licensing program. [See historical records of Board Medical Examiners' list of certified midwives – note number of addresses are in internment camps in Arizona and Wyoming for midwifes with Japanese sur names] The last two applications in 1947 and 1948 (both denied) were for licensing by reciprocity from Japan and Italy.

The legal impact of SB 960 on the practice of already certified/licensed midwives was nil and the 46 midwives who held valid licenses at the time were unaffected. The midwifery provisions defining the extent and the non-medical practice of midwifery (Section 2140) and those concerning penalties for unprofessional conduct were left intact (section 2400-08). (# 8) 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**.

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 a democratic form of government, *what is not expressly outlawed is legal*.

A convention of all form of government licensing is exclusive entitlement in both title and scope of practice in the professional 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, a statement that is true today.

The original midwifery statue was primarily concerned with prohibiting and 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 would create for physicians by *not including* exclusive entitlement language for midwives in the 1917 provision.

One practical reason for not addressing this issue is that physicians and midwives share the same 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. That would mean physicians providing normal maternity care to healthy women would be vulnerable, in theory at least, to being charged with the unlicensed practice of midwifery. To prevent this would have required either that physicians train and become licensed in the midwifery principle of physiological management *or* that an equivalent midwifery curriculum be incorporated as part of the medical school education, thus creating *exemption* to the midwifery licensing law. The medical community wished to do neither.

Between 1949 and 1993 the public demand for midwifery care continued on as before, though statistically insignificant as compared to the number of families that chose obstetrical care. The 1949 passage of SB966, which repealed the certificate classification of 'midwife', functionally withdrew the opportunity for future midwives to become state-certified professionals. This demoted 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.

The California Supreme Court's *Bowland Decision*, 1976

For the first time in California state history, the practice of midwifery, without the protection of its licensing scheme (repealed in 1949 by SB 966), was declared to be an illegal practice of medicine in 1976. The *Bowland* Decision by the California Supreme Court was unique in two ways. First it was solicited by the State as a legal opinion, rather than an appeal of a trial verdict. The case was never tried in court prior to the Bowland Decision and the state dropped the case afterwards, so the actual facts were never legally established. This was important because one part of the state's case was its characterization of the midwives as 'doing things that only a physician was authorized to do'. This was actually a reference to a self-help type of well woman healthcare, in the style that was currently being popularized in book "Our Bodies, Ourselves" by the Boston Women's Health Collective. It recommended such things as the use of yogurt as a home remedy for a vaginal yeast infection, which was the issue in the *Bowland* case.

The other aspect that make the *Bowland* Decision unique is that it did not (and could not) point to any California statue as having created the 'public offence' (i.e. crime) of an 'illegal practice of midwifery'. There was and is no California law making the practice of midwifery a crime, not then and not now. Instead the *Bowland* Court reached its conclusion using a legal theory based on the newly declared US Supreme Court decision *Roe v. Wade* (1973). Abortion-related law was applied to non-nurse midwifery on the generally accepted (but incorrect) assumption that care by midwives in a non-medical setting, as contrasted to physicians in a hospital, put the unborn or newborn infant at great risk, including a materially-increased risk of death. In that way, *Roe v Wade* and *Bowland* pondered the constitutional right of women, both as mothers and as midwives, to take actions that predictably resulted, even if accidental, in the death of viable fetuses or newborns.

In dismissing the argument for a US Constitutional right of privacy (1st, 4th, 5th, 9th and 14th amendments), the *Bowland* Court noted "**that the right of privacy has never been interpreted so broadly as to protect a women's choice of the manner and circumstance in which her baby is born**. Indeed, *Roe, supra,* appears specifically to exclude the right to make such choices from the constitutional privacy right. . ….More significantly, the Court held that at the point of viability of the fetus, the state's interest in the life of the unborn child supersedes the woman's own privacy right…" **see note below [Dec 6,1976, page 638 - 134 California Reporter, 18 Cal.3d 494]

Roe v Wade established the constitutional right of women to have an abortion *before* the stage of viability. Once fetal viability had been identified as the ethical principle and essential criteria for determining the right to abort, it opened the way, logically-speaking, for the state to control or prohibit abortions *after* viability. The *Bowland Decision* extended the watershed idea of fetal viability relative to abortion to include the state's assumed right to have control over childbirth, occurring, as it does, to a post-viable fetus.

Thus the *Bowland* Court, using the theories in *Roe v Wade,* declared, for the first time, that the practice of midwifery was an illegal or unauthorized practice of medicine in California *unless or until* the Legislature passed laws creating state licensing for the traditional or non-medical practice of midwives. This created the unassailable legal status of '*stare decisis'*, which could only have been reversed by the US Supreme Court. As a result, California mothers and midwives had no choice but to seek a legislative remedy. From 1976 to 1993, there were six different attempts to get midwifery licensing laws passed. Finally in 1993, the LMPA, complete with its 'poison pill' of physician supervision, was passed and signed into law by the Governor Pete Wilson.

Below is a list of the six bills as introduced in the Legislature from 1978 to1993. In addition to legislation, an OSHPD midwifery pilot project was proposed in 1979 but never implemented. In 1985 state-wide hearings on the "Alternative Birth Methods Study" were held in several locations.

AB 1896	**The Midwifery Practice Act of 1978** (Assemblymen Hart)
1979-1980	**Midwifery Practice Pilot Project** OSHPD
SB 1829	**The Professional Midwifery Practice Act of 1980**
SB 670	**The Midwifery Practice Act of 1981** (Sen Barry Keene)
AB 3655	**The Lay-Midwifery Practice Act of 1986** (Assemblymen Vasconsellos)
Jan 1985	**Alternative Birth Methods Study**
SB 1190	**Licensed Midwifery Practice Act of 1991** (Senator Killea)
SB 350	**The Licensed Midwifery Practice Act of 1993** (Senator Killea)

[** Sen. Figueroa's amendment to the LMPA in 2000 -- SB 1479 – contains language that for the first time acknowledges that: "**that every woman has a right to choose her birth setting from the full range of safe options available in her community**". In the same section, SB 1479 identifies that home birth for low-risk women is equally safe as hospital birth and that "The midwifery model of care is an important option within comprehensive health care for women and their family and should be a choice made available to all women who are appropriate for and interested in home birth".

Based on the amended LMPA, the basic right of childbearing women to have control over the manner and circumstances in which her baby is born was extended to all California citizens.]

Contemporary Midwifery Licensing:

SB 350 was passed in September and signed into law as the Licensed Midwifery Practice Act in October of 1993. It repealed the 1917 provision and 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 Hsieh, MBC agency deputy director Doug Laue, 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). Those 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) a professional curriculum and clinical experience 2) testing on those educational parameters and 3) state licensing. Either the LMPA was inconsistent and contradictory OR the MBC interpretation of the statutory scheme created an internal conflict that was 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 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 directly criminalized the practice of midwifery by persons not holding a state-issued midwifery license. None of these three statutes ever extended *exclusive entitlement to licensed midwives* relative to their identified scope of practice – maternity care to healthy women with normal pregnancies.

Had any aspect of the law done that, physicians would either have been barred from providing the physiological form of maternity care provided by midwives to healthy women) OR been forced to include this type training in their medical school curriculum. With that in mind, it will not come as a surprise that exclusive entitlement language for midwives was also not included in the LMPA. Only thru the conventional definitions of the Medical Board and its case against Kate Bowland in 1976 (decided by the California Supremes Court in the Board's favor) that generates the 'crime' of practice midwifery without such a license, which is brought about by charging the midwife with the illegal practice of *medicine*. (Even Medical Board members and staff still speak of the "illegal" practice of midwifery, in actual, technical fact, there is no such 'crime' – any prosecution would fall under the *unauthorized practice of medicine*.)

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 an appropriate knowledge base and technical skills 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 (i.e. testing out of their 3 year curriculum) and administering the newly-minted California 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 believed 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 by the legislatively mandated deadline.

With the exception of two midwives licensed by reciprocity from Washington State, all California LMs licensed before 2002 qualified under the challenge process. In 2002 the MBC approved several out-of-state three-year midwifery 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 involved.

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. This type of *expos facto* liaison between a single individual midwife (usually me) and the Board for purposes of administering the entire midwifery licensing program has always seemed inadequate and results in predictable and frequent breakdowns, as we lurch from one mini-crisis to the next.

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 <u>to develop clinical judgment</u>; 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 do <u>might</u> 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 but the Board continues to have an open case against the midwife (I'm not sure what the basis of it is).

Need for Midwifery Representation/Participation in the administration of the LMPA

Since the passage of the LMPA I have ceaselessly advocated for necessary legislative changes which would permit midwifery representation on current Board (this would require changing the law) ***or*** for forming a separate, in-house midwifery committee: At present, licensed midwives are still in the dubious category of "regulation without representation". An advisory committee is necessary to provide advice to the MBC when dealing with the licensing program and matters pertaining to disciplinary action. This would include the creation of **panel of 5 midwives to determine "quality of care" issues**, and additional representation from consumers who are familiar with community-based midwifery care.

This is particularly important, since midwifery education and practice are not standardized in the same manner as is the medical school curriculum or hospital-based obstetrical practice. While we are currently working to bring about a greater degree of agreement on "usual and customary practices" thru the *Midwifery Standard of Care* adopted by the Board in March 2006, many technicalities (even small things such as the style of charting employed by each midwife or the number of cylinder of oxygen carried, etc), will remain highly eclectic for a long time to come.

In addition, community-based midwifery practice is non-medical with distinctly different protocols than those commonly used in allopathic medicine. There is a great potential for controversy in that community midwives provide care to families that have chosen to exempt themselves from

standardized care – both midwifery and medical. Midwives must obtain consent for all the care they render unless it is under emergency conditions. The principles of informed consent and informed refusal play a much larger part in midwifery care (absent an emergency) than in hospital-based obstetrical management. All these facts must be known and taken into account in determining quality of care issues.

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 legislation to authorize the formation of a 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 controversies such as this one about the relationship between LMs and midwifery students.

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 Article 9 -- 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 – with or w/o licensing -- was never directly identified as a practice of medicine (either legal or illegal) 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 Bill 1479 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***.

Future Areas of Concern

There are many areas of future concern – physician supervision conundrum, the appropriate gathering of statistics, etc and also the basic policies of the Medical Board in other areas.

In my opinion, the best place to start is with a robust and appropriate interface between the agency and the midwifery licentiates, by formalizing some regular method of communication, between the State's licensed midwives, consumers of normal birth services and the Agency, such as a Midwifery Advisory Council.

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