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Medical Board of California

Division of Licensing (DOL)

1426 Howe Ave

Sacramento, CA

January 29, 2004

Dear DOL Members,

At each Board meeting or midwifery-related regulatory hearing the question inevitably arises as to whether community-based midwifery is �safe� as defined by the scientific literature. Board members repeatedly state that they either are unfamiliar with the literature or they question whether or not published studies even exist. I assure you that such documentation does exist and that to become familiar with this scientific literature is to redefine the politics of this controversy. The official debate will no long be how to protect the �consumer� by stopping licensed midwives from providing care and but rather how to protect the consumer by helping them access the care of LMs and helping LMs better access medical services in a timely and appropriate manner.

The overwhelming scientific basis for physiological management of normal pregnancy and birth, as published in peer reviewed journals and other types of public records, makes a stack that is wide, tall and impressive. I personally have over 40 three-ring binders which contain historical sources documenting organized medicine�s historical campaign against midwifery, and peer-reviewed studies and science-based reports that validate the safety of physiological principles and emphasize the countervailing risks of medicalizing healthy women. One particularly insightful study on relative safety of place of birth wisely noted that:

Although home and hospital offer different risks and benefits, neither has standard care characteristics. In fact, the range from safe to unsafe practices may be **wider within each location that it is between them**. Addressing what constitutes safe practice at home may be  *a more pivotal concern*  than attempting to quantify the theoretical differences attributed to place of birth. (Perinatal death associated with planned home birth in Australia: a population based study,  BMJ 1998:317:384-388 (8 August) [emphasis added]

The overwhelming consensus of the published research is that community-based maternity care by professionally trained midwives, in conjunction with access to obstetrical services for complications, is statistically equally to that of hospital care under obstetrical management. Physiological management by midwives in non-medical settings is actually protective of both mothers and babies, reducing the operative rate, along with its associated complications, from approximately 37% to approximately 5% with a virtually identical, or even slightly improved perinatal mortality rate. (MCA "Listening to Mothers", 2002)

In an effort to address concerns of safety as voiced by Board members and staff, I have provided about a hundred pound of these studies on a one-by-one basis over the last 11 years. This included many letters to individual Board members in which I quoted studies and included abstracts and excerpts of studies and reports that were highlighted with a bright yellow marker to make scanning easier. However, there has been no mechanism for establishing an institutional memory on this important issue by transferring this information to newly appointed Board members or staff . In response to this problem, I have now compiled an extensive sampling of the research on the efficacy of physiological management and domiciliary care as provided by CNMs and LMs.

Out of approximately a hundred research papers on the relative safety of different providers and/or birth settings, I have photocopied 25 of the major studies. In addition I have reproduced perinatal statistics, abstracts of other research, published editorials and excerpts of pertinent material, including sections from the standard of care document and practice guidelines for community-based midwifery. I have also included a report on the future of midwifery from the Pew Charitable Trust, a survey from the California Senate Office of Research on LM practice and another survey commissioned by the Maternity Center Association entitled *Listening To Mothers*. This sampling represents the most significant research published in the last three decades on the physiological management of normal childbearing and community-based maternity services. This is a total of 500 pages, divided the material into two 3-ring notebooks for easier use.

I�d like to specifically note three of these studies. The first is a �Delphi study� (notebook 2, section 6) called *A Model of Exemplary Midwifery Practice: Results of a Delphi Study* (Jour Midwifery & Woman�s Health, vol 45, Jan/Feb 2000) by a PhD nurse-midwife who is the director of the nurse-midwifery program at the University of Rhode Island. I was a contributor to this study and was quoted on page twelve as the originator of the concept and expression *The Critical Difference: The Art of Doing 'Nothing' Well*. It was my observation that the "work" of a midwife is to provide physiological management and emotionally supportive care as an "educated observer with emergency response capacity" while simultaneously refraining from interrupting or disturbing the spontaneous process of normal labor. I characterized this as mastery in the 'art of doing 'nothing' -- in contrast to the obligatory drive or 'doing-ness' of intervenventional obstetrics. Ultimately, the "*The Art of Doing 'Nothing' Well*" became the title for Dr. Kennedy�s poster presentation.

The second study of note is the *Survey Results on the Practice of Licensed Midwifery in California* (March 2001) by the Senate Office of Research (notebook 1, section 3). Co-incidentally, I also helped the staff in the Senate Office of Research to formulate survey questions to elicit information on the issues of safety and the availability of physician supervision. The survey noted that medical consultation and transfer rates (6%) as well as emergency and non-emergency hospitalizations (4%) for clients of licensed midwives are both low. It also reported that only 3% of California LMs (total of 2) indicated that they had a relationship with a physician that involved the legally mandated supervision. This report also stated that �a number of studies have shown that the outcomes of planned out-of-hospital births are comparable to, or better than, those associated with hospital births�.

The third study that I want to call attention to is a Ph.D. thesis done at Stanford University in 1999 entitled *The Safety of Alternative Approaches to Childbirth* by Peter F Schlenzka, Ph.D. (notebook 2, section 7). Dr Schlenzka accessed computerized records for two consecutive years  for all California birth certificates (a total of 1.2 millions births) and separate hospital discharge records for mother and baby. This resulted in a total of 3.6 million data points. His study is the most powerful (i.e., largest) and also the best triangulated (cross-checking of data by three different sources of records for each birth) of any research comparing birth setting and management style for relative safety of both mother and baby. Of the 1.2 million births in the original cohort, Dr Schlenzka determined that 71% of them met the study criteria for home-based birth services (normal pregnancy in a healthy woman, low to moderate risk labor). For this data, set (which excluded lethal congenital anomalies), the mortality rate was **0.56 %** or 1/5th of the perinatal mortality rate (**2.65** %) for the 29% of the population that was identified as high risk. He concluded the following:

� We conclude that low-risk women who opt for a natural childbirth approach [i.e., physiological management] in an out �of-hospital setting will experience a slightly, though not statistically significant, **lower perinatal mortality** than low-risk women who opt for a hospital birth under the management of an obstetrician. [p.1]

Our data also suggest that **even for the high risk-levels** of our study population the natural approach (including transfers) **produces the same perinatal mortality** outcomes as the obstetric approach. .... Our analyses of the California data for 1989 and 1990 **do not support** the claim by the obstetric profession that for the large majority of low-risk women hospital birth is �safer� with respect to perinatal mortality. [p.1]

�The already apparent disadvantages of the obstetric approach are of such a large order of magnitude, that in any clinical trial it would be considered **unethical to continue** with the obstetric �treatment�. [p.  175]. emphasis added

I have a hard copy of the entire thesis (total 218 pages) and also a 35 page synopsis, either of which I would loan to anyone interested in reading Dr Schlenzka's research.

The two-notebook literature set provided to each DOL Board member will permit easy access to scientific documentation on the historical background, contemporary practice and standards of care for both LMs and CNMs, as well as general safety and efficacy. I have individual copies of these notebooks for each of the seven appointed seats on DOL. As this is a very time-intensive and expensive proposition. I ask that each member retain his or her copy for the foreseeable future. When individual members of the DOL completes their term of office, I ask that the notebooks be returned to the MBC staff so that they can be passed on to the next appointees. For those Board members who received a DVD copy of the �Great Debate�, please add the DVD to the pocket on the front or back covers.

I will also be forwarding this documentation to the AG's Health Enforcement Task Force office and to the Office of Administrative Law (OAL). I know that the MBC provides a 6 hour orientation on video tape to newly appointed OAL judges on the theory behind laws relative to the authorized, unauthorized and illegal practice of medicine, medical terminology and the specialized vocabulary of anatomy, physiology and pharmacology. We request that this process of orientation also apply to the discipline of midwifery and believe this documentation to be a good beginning to this in-service education process.

It has been 11 years since the passage of Licensed Midwifery Practice Act of 1993 (LMPA) and a decade since the midwifery implementation committee meetings were held by the MBC. As a participant in all seven of those day-long meeting chaired by Dr Joas, I and other midwife licentiates assumed that the science-based information on midwifery principles and practice would trickle down naturally to the agency staff and Board members. After a decade, I think we can pronounce that theory a failure. As a result, direct measures seem necessary to assure that agents of the regulatory Board for midwives and those in authority in the AGs office and the OAL are mutually informed about matters that are crucial to their ability to make informed decisions about the practice and regulation of licensed midwifery.

**The Official Role and Function of the Scientific Literature**

Next to God and President Bush, the seven members of the DOL have the first and last word on policies regarding the practice of licensed midwifery in a state that represents the 5th largest economy in the world. With the exception of the two public members of the DOL, each member has a Ph.D. in medical science and is therefore an �expert� schooled in assessing technical information relative to making medical diagnosis and planning complex medical treatments or surgical operations.

As Ph.Ds, physicians are also particularly skilled in reading and digesting the technical and statistical aspects of research articles and scientific studies published in professional journals. The duties of DOL members also include the weighty responsibilities of analyzing documents relative to MBC licentiates accused of unprofessional conduct. These sophisticated fact-processing abilities are also required to properly present the activities of the Board to the public and other state agencies. Frankly, I assume that the same level of intellectual inquiry and critical thinking skills will be utilized when analyzing midwifery-related research and when considering any form of testimony or other communication that bears on the efficacy (or lack thereof) of the professional discipline of midwifery.

It may come as a surprise to some members of the Board that persons in leadership roles within organized medicine are actually very well aware of the safety of domiciliary midwifery, most especially when provided by professionally trained midwives. If not, the medical association and its predecessors would not have gone to such great lengths over the last 50 years to keep the Office of Vital Records from accurately registering midwife attended home births. If organized medicine *really believed* its own negative account, its representatives would be hiring lawyers and going to court to force midwives and state agencies to accurately record each and every midwife-attended home birth, since doing so would establish its claim of medical superiority and midwifery inferiority.

However, the inverse is actually true. In 1957 organized medicine lobbied to take the word �midwife� out of the 1915 birth registration law. Since then the medical association has gone to great lengths to prevent the accurate documentation of midwife-attended births, as it would provide indisputable validation of the scientific literature � that professionally attended labors and births in domiciliary settings have outcomes equal (or superior) to those of hospital deliveries.

The historical and on-going campaign by organized medicine to conceal the efficacy of midwifery care can only lead one to conclude that the obstetrical profession is not nearly as interested in safety of mothers and babies as it is in maintaining control over women�s reproductive biology. This control is especially focused in unnecessarily medicalizing normal birth in healthy women.

Healthy families seek out home-based midwifery services ***not*** *because they are indifferent to the safety of their babies* but because it offers the only access to the safe and scientifically sound principles of physiological management � non-interventive methods that facilitate spontaneous labor and normal birth. Unfortunately, our tort laws currently force doctors to provide interventionist care irrespective of the health status or the stated desires of the mother. It should be noted that this creates an asymmetrical burden of risk that falls unfairly on the childbearing woman, in which the mother is exposed to the actual pain and potential harm of medical and surgical interventions in order to *reduce the risk of lawsuits for the obstetrician*. Many women feel that this is totally unacceptable.

A �reality check� in regard to the actual dangers of normal childbirth for healthy women may be useful. It is a serious misunderstanding to assume that normal biology is itself dangerous. For healthy women who are enjoying a normal pregnancy with a healthy baby (often confirmed thru ultrasound), the typical �risk� she faces today is *not normal labor* but the routine use of uterine stimulants to accelerate progress, narcotic drugs for pain and the use of anesthesia so that surgical procedures or instruments can be used.

The litany of immediate complications from the use of these interventions, such as hemorrhage and infection, and downstream complications such as pelvic organ prolapse and incontinence, are amply documented in the literature. According to Dr. Peter Bernstein, MD, MPH, Associate Professor of Clinical Obstetrics & Gynecology at the Albert Einstein College of Medicine in NYC:

**These adverse side effects may be more the result of how current obstetrics manages the second stage of labor**. Use of episiotomy and forceps has been demonstrated to be associated with incontinence in numerous studies. Perhaps also vaginal delivery in the dorsal lithotomy position [lying flat on the back] with encouragement from birth attendants to shorten the second stage with the Valsalva maneuver [prolonged breath-holding], as is **commonly practiced in developed countries**, **contributes significantly to the problem.** emphasis added

However, many who are antagonistic to midwifery typify the choice of a �natural birth� as self-centered and hedonistic. Nothing could be further from the truth. Choosing to abstain from pain medication and anesthesia in the middle of labor or birth is very difficult -- a courageous thing to do. Women take this hard road because they know that it is actually safer. At the same time, they are equally willing to be medicalized or consent to surgical intervention should such things become necessary for their baby�s safety. Hospital labor rooms are the only area of life that I can think of in which just-saying-no to narcotics and other potent drugs by a pregnant woman is interpreted as a callous disregard for the well-being of her unborn baby.

The pain medication most widely used in obstetrics today is fentanyl, a synthetic narcotic that is a 100 more powerful than morphine. It is administered as a pain shot and also is the standard epidural anesthetic. Fentanyl was the drug used by the Russian army in their ill-fated attempt to end the terrorist take-over of the Moscow Opera. Unintentional overdose with an aerosol form of fentanyl resulted in the accidental death of 130 of the freed hostages and permanent neurological damage to many other victims.

The other area that the obstetrical profession considers just-saying-no to be irresponsible is continuous fetal surveillance via electronic fetal monitoring. The obstetrical profession has long promoted the idea that continuous EFM prevents birth complications and that it is irresponsible not to use it. Since continuous electronic monitoring is not routinely employed in a domiciliary setting, obstetricians insist that it is unacceptably dangerous for a healthy woman to labor at home or freestanding birth centers. For the last three decades representatives for American College of Obstetricians and Gynecologists (ACOG) have used some version of this argument in the public press, with the legislature and in testimony at MBC regulatory hearings to advance their opposition to community-based midwifery, which they characterize as a dangerous and technologically-outdated form of care.

However, no less an entity than ACOG has recently concluded that they were mistaken about the ability of continuous electronic monitoring and liberal use of cesarean section to reduce the rate of cerebral palsy and other neurological disabilities. The failure of EFM and cesareans to prevent these neonatal complications has recently been documented in a July 2003 report by ACOG *Task Force on Neonatal Encephalopathy & Cerebral Palsy,* which stated that*:*

**Since the advent of fetal heart rate monitoring, there has been no change in the incidence of cerebral palsy.**

**�. The majority of newborn brain injury does not occur during labor and delivery. Instead, most instances of neonatal encephalopathy and cerebral palsy are attributed to events that occur prior to the onset of labor.**"

This ACOG task force report had the endorsement and support of six major federal agencies and professional organizations, including the Center for Disease Control & Prevention (CDC), the March of Dimes and the obstetrical professions in Australia, New Zealand and Canada. It is described as the "most extensive peer-reviewed document on the subject published to date."

An August 15, 2002 report in *Ob.Gyn.News* stated that:

**�performing cesarean section for abnormal fetal heart rate pattern in an effort to prevent cerebral palsy is likely to cause as least as many bad outcomes as it prevents."**

.... A physician would have to **perform** **500 C-sections\*** for multiple late decelerations or reduced beat-to-beat variability to **prevent a single case of cerebral palsy**. [\*\* n.n.t. or �numbers needed to treat�] emphasis added

The September 15, 2003 edition of *Ob.Gyn.News* stated that:

**The increasing cesarean delivery rate that occurred in conjunction with fetal monitoring has *not* been shown to be associated with *any reduction* in the CP rate**...

**... Only 0.19% of all those in the study had a non-reassuring fetal heart rate pattern.... If used for identifying CP risk, a non-reassuring heart rate pattern would have had a 99.8% false positive rate...."** emphasis added

Fortunately, there is an effective alternative method to EFM that is easily used by midwives in a non-institutional setting. Intermittent auscultation or (IA) describes regularly listening to fetal heart tones with a fetoscope or an electronic Doppler for one full minute immediately following a uterine contraction and counting in twelve (or more) 5-second samplings to determine the baseline beats per minute (bpm). Using IA, one can detect the presence of normal heart rate variability and accelerations and, one hopes, document the absence of pathological decelerations. The baby is considered to have a �reassuring� fetal heart rate pattern if there is a normal baseline rate (110 to 150 bpm), normal variability (6 to15 bpm variation in rate), normal accelerations (increase of 15 bpm, lasting at least 15 seconds & occurring two or more in 40 minutes) and absence of repetitive pathological decelerations (decrease of 15 bpm, lasting longer than 15 seconds). In the presence of a reassuring fetal heart tone pattern, the likelihood of hypoxic states (i.e., fetal distress) occurring within the next 120 minutes of normal labor is statistically insignificant (i.e., the baby's well-being is assured). [*"Fetal Monitoring In Practice"* by Dr David Gibbs & S. Arulkumaran, MD; published in the UK]

It is interesting to note that this method of beat-by-beat auscultation was the theoretical basis underpinning the development of electronic fetal monitoring. The original theory and method of fetal surveillance comes from the work of Dr. Joseph DeLee, one of the titans of modern obstetrics, who described counting and graphing fetal heart tones in 5-second sampling in his 1924 obstetrical textbook. [Principles and Practice of Obstetrics; DeLee, 4th edition, ch. 8, p. 144]. Most people wrongly assume that EFM is the equivalent of an electrocardiogram (EKG) for the unborn baby but this is a serious misunderstanding of the technology. Electronic monitoring is simply an elaborate mechanism to count the unborn baby's pulse. The machine merely transposes the acoustic signal of heart rate into a printed paper graph and video display of the four auditory markers of fetal well-being. While IA is more time-intensive, it is equally as effective as continuous EFM for low and moderate-risk labors, with the added benefit of a greatly reduced cesarean rate (4% vs. 26%). This is, in part, because it *unhooks* healthy mothers from machines and permits laboring women to move around freely. No longer tethered to the bed by electronic wires, the mother is able to change positions frequently, walk, use hot showers or deep water for pain relief and make �right use of gravity� These practices reduce fetal distress and failure to progress and  the need for Pitocin-augmentation of labor, pain medication, anesthesia and instrumental and operative delivery.

In spite of the significant benefits of intermittent auscultation, the obstetrical profession has dismissed the use of IA for what they claim is the �unacceptably great expense involved in providing the one-on-one nursing that is almost mandatory to perform intermittent fetal heart rate auscultation.� [Obstetrics: normal and problem pregnancies, Gabbe et al; 1992, p. 457]. This is a strange objection, since many hospitals bill, and insurance companies reimburse, $400 an hour for the use of continuous EFM, far less than the average L&D nurse�s hourly salary. Luckily for the clients of midwives, one-on-one is the standard caregiver-client ratio so IA is a natural, safe and cost-effective extension of the midwife�s full time presence during active labor.

The majority of laboring woman in the US apparently do not object to the limitations of medical management and increased cesarean rate associated with continuous EFM. However, there is a significant minority of families who are unwilling to tolerate an obstetrical �standard of care� that cannot delivery on its promise of safety and satisfaction and for which the main feature is protecting institutions from litigation by passing the risk on to the mothers and babies.

The best, perhaps the only solution to the on-going (and all consuming) home birth controversy is to make maternity care in homes and hospitals equally safe and equally satisfactory so that families are not forced to choose home birth for want of appropriate, compassionate and cost effective care in hospitals. Obviously, it is beyond the scope of the MBC to rehabilitate obstetrical care for healthy women or change our entire tort system. However, the intent language of SB 1479 (2000 amendment to the LMPA) acknowledges the right of healthy women to have control over the manner and circumstance of normal childbirth, which includes not being forced into non-consensual obstetrical treatment. While working for the rehabilitation of normal maternity care, women must continue to have a reliable mechanism that permits them to avoid the pain and potential harm of unnecessary medical and surgical interventions without having to choose between an unattended labor or untrained, inexperienced, or unregulated birth attendants. The intent language of SB 1479 specifically addresses these issues. It states:

(a)    Childbirth is a normal process of the human body and not a disease.

(b)   Every woman has a right to choose her birth setting from the full range of safe options available in her community.

(c)    The midwifery model of care emphasizes a commitment to informed choice, continuity of individualized care and sensitivity to the emotional and spiritual aspects of childbearing and includes monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, prenatal care, continuous hands-on assistance during labor and delivery and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention.

(d)   Numerous studies have associated professional midwifery care with safety, good outcomes and cost-effectiveness in the United States and other countries. California studies suggest that low-risk women who choose natural childbirth in an out-of-hospital setting will experience as low a perinatal mortality as low-risk women who choose a hospital birth under management of an obstetrician, including unfavorable results for transfer from the home to hospital.

(e)    The midwifery model of care is an important option within comprehensive health care for women and their families and should be a choice made available to all women who are appropriate for and interested in home birth.

Any action taken by regulatory boards that prohibits or seriously restricts the ability of professional midwives to provide this form of safe and non-interventive care ultimately denies the constitutional right of healthy women to have control over the manner and circumstance of their own normal childbearing experience.

The basic conflict between the mother�s right to choose what many consider �unconventional� care from a midwife and the policies of the Board was recently illustrated at a Medical Board settlement conference. In this instance, a representative of the Board characterized the midwifery standard as �dangerous� and insisted that the Board �would have no part of it� and that the proper standard of care for midwives should be the �same standard used by obstetricians�. Since midwives are neither trained or authorized to practice medicine or surgery, there is no question that potentially dangerous obstetrical interventions should to be used only by physicians and only in an institutional setting with emergency drugs and equipment at hand. Because of the inherent dangers in obstetrical standards of care, it would be legally impossible for home-birth midwives to use the same �standard� as hospital obstetrics. More to the point, women choose community midwifery *precisely because* it doesn�t entail the restrictions, interventions and complications of hospital based obstetrical care.

The appropriate relationship between the mother, the professional midwife and the State of California should lie in making certain that (1) midwives provide technically competent, non-negligent midwifery care, (2) the childbearing woman be provided with fully transparent information on all identified risks associated with midwifery services and the planned domiciliary labor and birth, (3) the childbearing woman and her midwife document written consent for all routine care, (4) *special* informed consent with appropriate documentation be employed for *special circumstances* in which the mother declines standardized care, protocols or advice. In the absence of �extremely rare and truly exceptional" circumstances that present a clear and immediate danger, the legal standard requires voluntary consent by the childbearing woman prior to any medicalization of labor. (ACOG case, District of Columbia Court of Appeals // *In Re* A.C.. 573 A. 2d 1235 (D.C. App. 1990) Any lesser standard propels mothers-to-be with certain moderate-risk circumstances into either unattended or lay-attended labors or non-consensual and medically unnecessary cesarean surgery.

I believe the chronic misunderstanding of the Board and its agents about midwifery and its standard of practice reflects the historical prejudice of the obstetrical profession, which has seeped into the general consciousness. For example, Dr. Thomas Joas, former president of the MBC and chairman of the Midwifery Licensing Implementation Committee, stated repeatedly during the seven committee meetings that he as a PhD/physician was a scientist who made all his professional decisions solely on the most rigorous scientific evidence -- unlike homebirth midwives who �had only had 2nd class empirical experience and unscientific anecdotal evidence� upon which to opine. His opinion, based according to him on solid science, was that �home delivery was only for pizzas�.

On many such occasions, I had a sense that the testimony of women, as mothers and midwives, was considered inferior to that of men and physicians. Unfortunately, this type of bias is like a computer virus that spreads from obstetricians to lobbyists to the press and the MBC staff and members of the AG's office. The universal antidote for this type of unconscious prejudice has always been corrective knowledge.

In my opinion, the legislatively mandated mission of the Medical Board � to protect the consumer � includes an obligation to carry out the legislative intent of the LMPA. This would mean protecting access to professional midwifery care in a domiciliary setting for California residents. It would be virtually impossible to carry out that mission and make intelligent decisions relevant to the oversight of the licensed midwifery program without having knowledge of the historical and contemporary science of evidence-based maternity care practices, which are the essence of the midwifery model of care.

**Expectation of Due Diligence by Board members**

**Relative to Licensed Midwives and Maternal-Infant Safety**

I believe the level of due diligence that can be expected of physician board members, who are PhD scientists in medicine, is the same as one would expect in any other area of health care. In my opinion, the Board has a due diligence obligation to be thoroughly familiar with the relevant politics of medicine and midwifery and the last hundred years of scientific literature on evidence-based maternity care, the principles of physiological management of childbirth in a healthy population and the relative safety of various birth settings. This would acknowledge that the consensus of published research has established that community-based maternity care, as provided by professionally trained midwives in conjunction with obstetrical referral for complications, is statistically equally to that of hospital care under obstetrical management.

I am impressed by the aptness of a quote in the foreword of *Davis� Gynecology And Obstetrics* textbook. It states: "**There is no alibi for not knowing what is known**." (J. Rovinsky, MD, FACOG, 1968). I believe this advice applies to professional midwives and obstetricians in regard to their knowledge of evidence-based practice parameters and to Board members who exercise regulatory authority over community-based midwifery. One hopes that �knowing what is known� about this topic would bring to a close all those conversations about whether or not domiciliary midwifery was �safe�.

The licensed practice of midwifery is not only lawful in California but is historically and currently recognized in statute as a safe and cost effective form of maternity care for healthy women. Mothers and midwives and other interested parties are asking for the enthusiastic assistance of the Board to help preserve access to this important form of maternity care. The only other alternative is to turn back the clock, so that once again the only way for families to receive, and midwives to provide, domiciliary midwifery care would be under the religious exemptions clause (section 2063), which has already been established as a lawful method for non-regulated practice of midwifery. It should be noted that midwifery practice under section 2063 **does *not* require physician supervision**.

As a Mennonite midwife, I could easily resume my former caregiver activities as a religious practitioner.  However, I am convinced that what best serves mothers and babies and the State of California are well-trained, experienced, fully-equipped professional midwives who are properly articulated with medical services, so that complications can be promptly and appropriately addressed.

For this and other reasons we need the LMPA to be protected from attempts by the medical lobby to encroach on its functionality or to eviscerated its authority. We need the MBC to support the right of healthy women with normal pregnancies to make informed consent decisions about the manner and circumstance of normal childbearing, even if some of those decisions are medically unpopular. We need the MBC to robustly implement the Licensed Midwifery Act of 1993.

A useful example of the "right relationship" between the midwifery and medical professions, one that serves the long-term interests of society, is encapsulated by the **Society of Obstetricians and Gynaecologists of Canada'** **Statement on  Midwifery**, No 126, March 2003. Midwifery in Canada is an independent profession, in which registered midwives are required by law to provide care **both in home and in hospitals.** These statements on midwives and community-based midwifery care are in sharp contrast to the policies of the American College of Obstetrics and Gynecology .

Passages from the Society of Obstetrics and Gynaeology of Canada  read:

The Society of Obstetricians and Gynaecologists of Canada (SOGC) supports the continuing process of establishing midwifery in Canada as a regulated, publicly-funded profession with access to hospital privileges.  �. The SOGC will extend membership to registered midwives and offer them access to ongoing educational experiences.

�. The SOGC recognizes that women will continue to choose the setting in which they will give birth. All women should receive information about the risks and benefits of their chosen place for birth, and should understand any identified limitation of care at their planned birth setting. The SOGC endorses evidence-based practice and encourages ongoing research into the safe environment of all birth settings.

The SOGC believes midwives should be integrated members of the maternity care team in their community and hospital.  .... (2) Development of policies and procedures to ensure smooth integration of patient care between midwives and other obstetrical care providers. **The SOGC is confident that the integration of midwifery into the obstetrical health-care team is fostering excellence in maternity care for Canadian women and their families, which is the goal of our organization**.

I believe the scientific literature I am providing to DOL members and agency staff will be an important tool for the Board in achieving these worthy goals.

Thank you for your attention to these matters. I look forward to an improved and dynamic relationship between midwives and the Medical Board of California.

 Faith Gibson, LM, CPM Executive Director,

ACCM/California College of Midwives

 CC: Letter and two-notebook set of scientific literature sent to:

            Each members of the MBC/DOL,

            Executive Director, MBC,

            AG / Health Enforcement Office

            Senator Figueroa�s Office

            John Kennedy, Attorney

            Frank Cuny, CCfHF

            Carrie Sparrevohn, CAM

            Renee Anker, CALM