JAMIE RENE ROMAN

Administrative Law Judge

Medical Quality Hearing Panel

Office of Administrative Hearings

A Sample of Midwifery Standards as acknowledged by Administrative Law Judge Roman

(with specific reference to Midwife Obsorn or the specific care have been removed)

I.   In 1993, the Legislature enacted the Act (SB 350 (Stats. 1993, c. 1280)). An effect of the legislation was to follow the example of other states and, at the same time, professionalize "lay" midwifery in the State of California as licensed midwives. Until the Act, only physician assistants and registered nurses could, within the scope of their respective license practice acts, obtain additional licensure as midwives; lay persons, practicing midwifery, were subject to penal sanctions. 9

In enacting the Act, the Legislature also sought to serve more Californians who, until this legislation, were being denied or under-served competent medical care in various locations of the state whether due to geography or economics.

In reviewing a statutory scheme, this tribunal must be guided by an interpretation that would further the legislative purpose within constitutional limitations."

Unlike physicians, physician assistants, physician assistant midwives, registered nurses, or certified nurse midwives who practice within the context of a medical model, licensed midwives practice within the context of a midwifery model. Complainant contends that the medical model should function to define the scope of a midwife's practice. This issue arises because the Act provides that a licensed midwife is authorized by his or her license, "under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth. . ..''11 "Normal" within the context of the medical model specifically excludes, inter alia, breech presentation because of the risk for complications. Within the context of the midwifery model, breech presentation is merely a variant of normal childbirth.

While Texas and Florida, possessing statutes which license lay persons as midwives, specifically preclude such licensees from rendering care to mothers presenting breech; Washington does not. The California Legislature's provision is, as aforesaid, limited to normal. "

The medical model of birth, the more prominent model applicable to birth in the United States, "presupposes that birth is a series of risks that medical doctors must systematize, control, and fit into an established time frame." 12   "Physicians determine the need for acute care by calculating the perceived risk; 'the definition of risk is ... central to the medical model of birth.' In the calculation of risk approach, childbirth is seen and described as a life-threatening situation. 13

On the other hand, "[m]idwifery presumes that childbirth is a healthy and normal event." Employing "a holistic approach in which the mind and body are mutually important to the outcome, midwifery recognized that in childbirth, mind and body cannot be separated: 'A woman's body works best when she feels confident, secure, emotionally supported, and on her own ground."' Midwifery involves "socially oriented preventive care, which incorporates prenatal care and a concern for the social and emotional aspects of pregnancy and birth in order to meet the individual needs of each woman."' 5 "Decision making is collaborative. . - - " "

"This model is a far cry from the medical model of childbirth, where the doctor's expertise is all that stands between mother and baby and disaster.' In the medical model, '[c]hildbearing women are viewed as unreliable and often defective machinery.... [D]octors frequently intervene in the normal process, considering their numerous tests and manipulations to be right and necessary to produce a quality " product" (baby)."'

As has been demonstrated to this tribunal, the models differ distinctively:' 8

**Medical Model                                                                  Midwifery Model**

Pregnancy is a "physical condition's                                      Pregnancy is normal

Pregnancy causes "symptoms"                                              Pregnancy includes physical changes

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

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

and is a stressor woman

"Both before and after birth, the medical model conceives of the baby and the mother as conflicting entities with conflicting **needs-the baby needs attention and** feeding; the mother needs rest. In contrast, the midwifery model treats the needs of the mother and the needs of the infant as interlocking, during **pregnancy and labor and after birth.** The midwife interprets the mother's need for 'rest' as the need for relief from activities other than caring for her baby. The baby needs to be with the mother."20 "The midwife spends time teaching in order to remove the mystique surrounding pregnancy and to empower the client. She teaches the woman or couple that pregnancy is a time for 'psychological as well as physical growth and development.' In comparison with obstetrical care, this type of personalized prenatal care results in better client participation and satisfaction."21 M.G.'s testimony tellingly demonstrated the distinction between the models.

The models, despite the Legislature's intent to provide "a multifaceted, cost-effective approach which includes licensed midwives providing prenatal, delivery and necessary follow up care to families ,,22 nevertheless Conflict.23 Within the context of these models, physicians and surgeons, physician assistant midwives, and certified nurse midwives will not, within the context of the medical model, undertake the delivery of children at home midwives, in contrast, within the context of their midwifery model, will not. Were this tribunal to employ the medical model on licensed midwifery, as Complainant urges, no home births could be competently assisted. Mindful that licensed midwives, with only one exception presented before this tribunal, possess no hospital privileges, the legislation would function to permit lay persons to possess a license that would not be functional anywhere within the State of California. This tribunal declines Complainant's offer.

This tribunal notes that some testifying midwives placed inordinately significant focus on the import of informed consent to presenting cases. While informed consent is mandated within the context of midwifery practice, regardless of model, it does not supplant the requirement placed on California's professional healthcare practitioners, including licensed midwives, to exercise restraint when compelled to do so by patient safety. Complainant, in that regard, persuasively argues that some restrictions should be placed on licensed midwives' capacity to assist in home births. Ile restriction immediately urged would preclude breech presentations, except in emergent situations. Complainant submits that such presentations are not considered "normal" by the medical model and that such definition should apply to the Legislature's undefined term as set forth in Business and Professions Code section 2507(a).

Notwithstanding such submission, Respondent competently acknowledges that, within the context of the midwifery model, breech presentation, a variant of normal birthing, may only be assisted within specific guidelines. A midwife's assistance in a breech presentation that fails to meet such specific criteria violates the midwifery model's standard of care and/or practice and would be unprofessional conduct. The effect of each model posited by the parties is to meet the Legislature's primary interest in the implementation of license practice acts: protection of the public. Sufficient evidence has been provided this tribunal to competently conclude that properly conducted midwife-led home births are as safe as births conducted by physicians in hospitals when effected within standards of practice. Accordingly, without dismissing either model or deferring to either model, protection of the public can be effectuated, and the licensure of -professional lay midwives promoted by this tribunal's adoption of the midwifery model of practice to licensed midwives as referenced in Findings 14, 17 - 21, and 23 to the facts and law herein; particularly where, as here, the Legislature failed to specifically preclude breech presentation and relied, instead and consistent with its deference to developing healthcare models, on professional standards of care.

Accordingly, cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(a)(1) for gross negligence as set forth in Findings 5 - 11, 13 - 15, and 17 - 23.

2. Cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(a)(1) for gross negligence as set forth in Findings 5 - 11, 13 - 15, and 17 - 23.

3. Cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(a)(1) for gross negligence as set forth in Findings 5 - 11, 13 - 15, and 17 - 23.

4. Complainant, cognizant that no physician and surgeon in the State of California, for reasons primarily (and sadly) born of liability or restrictions imposed by their insurance carriers, will supervise a licensed midwife who conducts home births, submits that Respondent has violated the Act for practicing licensed midwifery without physician and surgeon supervision.

The parties readily acknowledge that "supervision" as set forth in Business and Professions Code section 2507(c) does not "require the physical presence of the supervising physician" and does not purport to involve, as set forth in Business and Professions Code section 3 501 (f), the overseeing of activity or acceptance of responsibility for services rendered by licensed midwives as required by such physicians for licensed physician assistants. Clearly, a different standard was intended by the Legislature; however undefined.

In an effort to practice their art, virtually all of California's 109 licensed midwives, including Respondent, have, with the cooperation of physicians sympathetic to their plight and who seek to expand the options available to patients, developed a relationship that involves collegial referral and assistance, collaboration, and emergent assistance without direct or accountable physician and surgeon supervision of licensed midwives. In an effort to promote the efficacy of the Act, this tribunal concludes, at this time, that a licensed midwife who possesses a relationship with a California physician and surgeon as referenced herein has feasibly and reasonably satisfied the ambit of the Act. Accordingly, cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(e), in conjunction with sections 2507(a) and 2507(b), for unprofessional conduct arising from lack of supervision as set forth in Findings 13-14 and 17-23.

5. Having determined that a breech presentation is a variant of normal within the context of the midwifery model; cause, accordingly, does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code sections 2519(e), in conjunction with sections 2507(a) and 2507(b), for unprofessional conduct arising from undertaking a case outside the scope of licensed midwifery practice as set forth in Findings 5 11, 13 - 14 and 17 - 23, and Legal Conclusion 1

6. Cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(e), in conjunction with section 2507(b),"for unprofessional conduct arising from failure to refer as set forth in Findings 5 - 11, 13 - 14 and 17-23.

7. Cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(e), 'in conjunction with section 2508(b), for unprofessional conduct arising from failure to refer complications to a physician as set forth in Findings 5 - 11, 13 - 14 and 17 - 23.

8. Having determined the relationship required by a licensed midwife with a physician and surgeon to permissibly engage in his or her licensed activities; cause, accordingly, does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(e) for unprofessional conduct arising from failure to consult or collaborate as set forth in Findings 5 - 11, 13 - 14 and 17 - 23, and Legal Conclusion 4.

9. Business and Professions Code section 125.3 provides for an award to Complainant of reasonably incurred investigative and enforcement costs when a licentiate is found to have committed a violation or violations of the licensing act. No violation having been found as set forth in Legal Conclusions I - 8, and each of them; no costs, notwithstanding their reasonableness as set forth in Finding 27, are awarded to Complainant

**ORDER**

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

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

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

B. Fostering the delivery of safe and satisfying care.

C. Recognizing that childbearing is a family experience.

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

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

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

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

H. Performing duties within professional competence.

18. Respondent further submits that midwifery duties and responsibilities include, but are not limited, to:

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

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

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

(1) Educational background,

(2) Level of experience,

(3) Types of services rendered,

(4) Licenses, certifications, and professional affiliations,

(5) Midwifery expectations of clients, and

(6) Financial charges.

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

E. Requiring laboratory tests.

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

G. Using and maintaining aseptically clean equipment.

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

1. Employing newborn screening within three days of delivery.

J. Referring and/or consulting with healthcare professionals as required by each client presentation. Within this obligation to refer or consult, the standard of practice compels obstetrical referral or consult for a client who exhibits:

(1) Active syphilis, gonorrhea, or chlamydia.

(2) Unresolved signs of PIH.

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

(4) Persistent glucosuria.

(5) Diabetic symptoms.

(6) Third trimester vaginal bleeding.

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

(8) Familial history of congenital abnormalities.

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

(10) Polyhydramnios or oligohydramnlos.

(11) A Class III or greater PAP.

(12) Size incompatible with date.

(13) Suspected malpresentation.

(14) Suspected twins or breech.

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

(16) Rh negative mother with positive titers.

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

(18) Gestation past 43 weeks.

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

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

(21) Abnormal FHTs.

19. Respondent acknowledges that within the scope of midwifery practice, planned home birth may be contraindicated and is specifically precluded in the following instances:

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

B. History of thrombophlebitis and/or pulmonary embolism

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

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

E. Excessive use of alcohol.

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

G. Unresolved anemia.

H. 1UGR.

I. Preeclampsia.

J. Placental previa or abruption.

K. Active herpes when commencing labor.

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

20. Respondent further acknowledges that the midwifery model includes, during labor and delivery,

that a licensed midwife:

A. Monitor the mother and baby.

B. Coach the mother.

C. Assist in the delivery.

D. Examine and assess the newborn.

E. Manage any third stage bleeding.

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

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

H. Repair lacerations, as necessary.

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

J. Transport or referral upon any of the following:

(1) Signs of preeclampsia.

(2) Fever over 100.4 degrees.

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

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

(5) Abnormal bleeding or blood loss.

(6) Significant meconium with birth not imminent.

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

(8) Signs of maternal shock.

(9) Retained placenta or placental parts.

(10) Unexplained pain.

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

(12) maternal desire.

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

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

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

B. Flexed head.

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

D. Sonogram to rule out anomalies.

E.Proximity to hospital.

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

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

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

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

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

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

executed the waiver which further provided, "After careful evaluation of the above information I am exercising my right to choose to birth my breech baby at home and waive referral to another provider. This decision is made of my own free will and I absolve and hold harmless my attending midwife,

22. Respondent, possessing experience in vaginal breech births and examined by Respondent on February 19, 1998, presented with a frank breech, flexed head, adequate pelvics space for the fetus, appropriate psychosocial factors, and within the appropriate gestation period. Her location for delivery of the baby in Nevada City was approximately 20 - 25 minutes from the hospital in Grass Valley by vehicle. The sonogram. provided Respondent was taken at 22 weeks and one day; however, a (external) version under sonogram attempted only weeks earlier clinically ruled out hydrocephaly,

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

Breech presentation is a variant of normal birth presentation. It occurs in approximately 3 - 4% of pregnancies and possesses particular risks for both mother and baby during the labor and delivery process"-9. Such risks, however, no longer necessarily compel C-section.8 Within particular criteria, a vaginal breech birth effected by a properly trained, experienced, and knowledgeable healthcare provider is, with the informed consent of the mother, not contraindicated.

M.G.'s presentation, combined with a review by Respondent of her Great Beginnings' healthcare records, was neither abnormal nor, upon the inception of labor, lacking in normal progress and, concomitantly lacking in complications, did not compel immediate or emergent physician referral during the labor and delivery.

**Supervision/ Unavailability**

(California licensed midwives) avidly seek ...  to be part and parcel of the healthcare team that serves the residents of California.

"It is also a requirement of my license to have a **'specific OB informed of your pregnancy who is prepared to take** your

case if transport becomes necessary.'  Despite all reasonable efforts to have a relationship thus described, no obstetrician cares to have that kind of relationship with a homebirth midwife; however, many are happy to continue as we have been working for the past  11 years--they will receive cases if / when a transport becomes necessary or when a referral needs to happen."

No California physician supervises licensed midwives who undertake home births for reasons related primarily to liability exposure (i.e., malpractice insurance does not extend to cover physicians who undertake such supervision). It is also established that a small minority of California physicians object to licensed midwives and will not undertake their supervision on philosophical grounds. Respondent, nevertheless, has repeatedly and unsuccessfully sought physician supervision. As a consequence of the risks posed to physicians who undertake licensed midwife supervision in home births, a relationship has developed between the community of licensed Midwives (including Respondent) and particular physicians and surgeons of collegial referral and assistance, collaboration, and emergent assistance, that does not involve direct or accountable physician super-vision of licensed midwives engaging in home births.

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8 See Christian, M.D., Stefanie Schupp; et al; "Vaginal breech delivery: A five-year prospective evaluation of a protocol using computed tomographic pelvimetry", Am J Obstet Gynecol (September 1990), p. 848; Schutte, M.F., et al; "Perinatal mortality in breech presentations as compared to vertex presentations in singleton pregnancies; an analysis based upon 57819 computer-registered pregnancies in The Netherlands", 19 Europ. L Obstet. Gynec. 391 (1985); Croughan-Minihane, Ph.D., et al; "Morbidity Among Breech infants According to Method of Delivery", 75 Obstetrics & Gynecology 821 (May 1990)

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14 , Suarez, [bid at p. 318. 15 Suarez, Ibid at pp. 346 - 347. 16 Kitzi, Matt, "Can Missouri Catch Up? Why Missouri Laws Work Unconstitutional Discrimination Against Lay Midwives and What Can Be Done to Stop It", 67 UMKC L. Rev. 427, 429. 17 Kitzi, Ibid. is Suarez, Ibid at p. 335; Kitzi, Ibid. 19 *Bowland, supra* at pp. 488 - 489. 20 Suarez, Ibid at p. 336.

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21 Suarez, Ibid at p. 348. 22 SB 350 (Stats. 1993, c. 1280, � 1(k)). 23 Pike, Ibid; Kitzi, Ibid.

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