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| Information for the Medical Board of California |
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| History and Background of the Licensed Midwifery Practice Act of 1993  **Legislation and its antecedents,** **background on LMPA**: SB 350, the original midwifery licensing bill, as authored by the midwives (before being gutted and rewritten by the CMA), provided for collaboration between midwives and obstetricians and included a �hold blameless for care not rendered� clause for collaborating doctors. This wisely acknowledges the dramatic difference in training, temperament and practice between hospital-based, high tech obstetrics as provided by medical doctors and high-touch, low-tech midwifery. **Midwifery by statute is not a practice of medicine.** Community-based birth services are non-medical (no use of *artificial, forcible or mechanical* means) and occur in non-medical locations (family�s home or free-standing birth centers). For more than a century, scientifically-valid sources (studies, vital statistics, etc) have documented the safety of midwifery care for healthy women with normal pregnancies in conjunction with access to appropriate medical services for complications.  Regardless of the historic success and logic of this situation, the CMA deleted the original language of SB 350, replacing it with a fatally flawed bill that contained a �poison pill� provision that is a complete stumbling block to the lawful practice of community-based midwifery. This insurmountable barrier to practice was accomplished by repealing the original, 1917 midwifery certification provision (Article 24) that identified the powers and duties of state licensed midwives as independent practitioners in their own right (and therefore **responsible for their own torts**). The CMA version of SB 350 also removed the �hold blameless for care not rendered� clause and replaced physician *collaboration* with mandated physician supervision. These unilateral actions by the CMA **artificially created unnatural and unnecessary vicarious liability for obstetricians.** This results in an **insurmountable barrier to practice for midwives** and for many women, an **unwelcome, unwanted intrusion of physician involvement in their pregnancies**.  After passage of the CMA version of the LMPA, the three doctor-owned malpractice carriers promptly forbid doctors to supervise or have *any other professional association* with community midwives or even to provide care to childbearing women who were seeing a licensed midwife. One carrier (Norcal Mutual) even forbids obstetricians from giving emergency advice or assistance to a professional midwife as they define this as providing �supervision�, which is prohibited by the malpractice carrier�s contract with doctors. Clients of midwives cannot receive concurrent care from an obstetrician unless it is on a �*don�t ask, don�t tell*� basis so that the doctor is unaware of the mother�s plan to labor at home with a midwife unless a problem arises.  Ostracizing physicians that collaborate with LMs can be traced to the opposition and open hostility to community midwifery by the American College of Obstetricians and Gynecologist and the California Association of Obstetricians and Gynecologists. An ACOG policy statement of 1979 (reaffirmed in 1999) defines it as unprofessional conduct for obstetricians to provide out-of-hospital birth services or support midwives who do. Incredibly, it is these very organizations who simultaneously reject all home-based birth services while insisting on the �physician supervision� clause of the LMPA, obviously fully aware that doctors could not and would not provide that mandated supervision. These trade groups continue to characterize home-based birth services as �the earliest form of child abuse�, notwithstanding multiple sources of sound statistical data and scientific studies identifying out-of-hospital maternity care of low risk mothers by professional midwives to be **equally or slightly safer for the baby** and to entail an order of magnitude **reduction in maternal interventions and complications** (induction, narcotic pain medication, epidural anesthesia, episiotomy, forceps, Cesarean section, hemorrhage, neonatal intensive care for the baby, etc).  In public the CMA and ACOG portrays physician supervision as a stepping stone to guarantee access to medical services and therefore crucial to consumer safety. Upon close observation, it is obvious that the American College of Obstetricians and Gynecologists� insisted on a mandatory �physician supervision clause� precisely because it would not work for doctors or midwives.  (exhibit 4 ~ ACOG, CAOG policy statements) This anti-midwife, anti-homebirth agenda by ACOG was documented in public statements made by District IX AGOC representative Dr. Vivian Dickerson in the trade paper *OBGyn.News* (Sept 1993). Dr. Dickerson was quoted as saying:  ��.**physicians held out for a guarantee of supervision rather than a more �collegial� sort of relationship, which was, we felt, an invitation to home births. �.� �What this means in practical terms, is that instead of the midwife being in charge and telephoning the physician to consult or for referrals, the physician is ultimately responsible for the patients**�� In the letter from Norcal (malpractice carrier) dated 5-18-99, this is reiterated as �**The M.D. has the ultimate responsibility, liability and authority**.�  Irrespective of the affirmation in SB 1479 of the right of healthy childbearing women to choose the manner and circumstance of normal birth, ACOG continues to acts as if it is up to obstetricians to determine whether or not childbearing women have the choice of safe home-based maternity care. ACOG may believes that if they make it more difficult for women to engage a trained professional attendant, mothers will abandon their otherwise appropriate plans and have obstetrically-managed hospital births. But this is not the case. For the last 30 years a consistent 1% of mothers in California have choose out of hospital birth � this was before there was any midwifery legislations, after passage of the nurse midwifery act in 1974 and after the passage of the LMPA in 1993. This means that approximately 6,000 babies are born OOH each and every year, about one-half of them by LMs. **For the 36,000 babies delivered by LMs since the 1993 passage of the LMPA, it is a human rights and a public safety issue that their mothers have access to professional birth attendants**, regardless of where the mother has chosen to labor and give birth.  Obstetricians Refusal to provide Concurrent Care to Childbearing Women  The physician supervision clause has the opposite effect to its stated purpose (that of assuring appropriate access to medical services) and actually endangers childbearing women. As an example, I have included a copy of a letter from an obstetrician sent to a client of mine who had been receiving �concurrent� care from their OB group. (exhibit 5 ~ client letters documenting refusal of medical care) When she was only 7 months pregnant, this insured and medically compliant pregnant woman (who could was even not eligible for home-based birth care for another 2 � months) was summarily discharged from obstetrical care. This happened after the mother-to-be mentioned to the nurse midwife that she was hoping to give birth at home if her pregnancy remained healthy and her labor at term was normal.  The letter explained that the obstetrician�s malpractice insurance contract prevented them from even providing prenatal care to any pregnant woman known to be seeing a midwife, **due to the physician supervision provision of the midwifery practice act**. Doctors fear that any professional relationship with either the mother or the midwife might be interpreted as creating a  �supervisory� relationship (which would result in �vicarious liability� for the physician) and therefore they might be sued for care rendered by a midwife. The woman was instructed to go to �any emergency room� should she need medical care.  Please note that these same malpractice carriers do not prevent obstetricians from consulting, collaborating or providing concurrent care to pregnant women who are seeing other types of practitioners -- physicians, chiropractors, acupuncturists or nutritionists or other healthcare providers. Malpractice carriers do not prevent obstetricians from accepting referrals of the *very highest-risk mothers* who may be drug addicted, non-compliant teenagers who are HIV-positive, or women carrying triplets, in premature labor or suffering from complex medical problems such as cancer, kidney or heart disease.  It does not prevent obstetricians from utilizing all manner of interventions or off-label use of drugs (Cytotec or trebutaline) or performing medically unnecessary (�maternal-choice�) cesareans.  In theory doctors �could� be (and often have been) sued in any and all of these complicated circumstances but *only the small theoretical risk of vicarious liability attributed to community-based care by licensed midwifery* (one not substantiated by any actuarial data) spurs this **drastic lock-out of medical interface between healthy childbearing women and obstetrical services**. The answer to this seeming conundrum is that doctors, chiropractors and other healthcare providers are not subsumed under the supervision of another medical care provider. As independent practitioners they (and not the obstetrician!) are responsible for their own torts and as a result, the obstetrician is not prevented from being available to consult with them or to provide services to patients in need of medical care  It should be noted that nurse midwives prevailed in a lawsuit against a doctor-owned malpractice carrier in the Washington DC area it regard to the imposition of a large �surcharge� for them and their physician associates. It was determined by the judge that all risks are already included in the current price structure for obstetrical liability insurance. Therefore the �surcharge� added to the regular malpractice premium relative to midwifery was �double dipping� and therefore illegal. MBC informed by Med-Mal LobbyistWhy Supervisory Provision is Unworkable During MBC Midwifery Implementation committee meetings in 1994, Judge Colonge, lobbyist for the Doctors, Skippy and Norcal Mutual insurance companies, referred to the language of the midwifery original bill (which a identified the physician-midwife relationship as �consulting� before being amended at the request of the organized medicine lobby to read �supervision�), saying**:** *�we [malpractice carriers] weren�t opposed to it because it was consulting and the doctor was given immunity except for bad advise. Now its totally different [since its] been amended and made him a supervisor. He is liable whether he gives bad advise or not�*. Judge Colonge goes on to say: **�I�m �talking about the one who is taking on the role of supervisor. That�s a very significant legal issue here, because if you�re a supervisor, you have vicarious liability. �What we�re concerned about is the vicarious liability that a doctor assumes when the doctor takes on the special relationship as a supervisor**�. In short ACOG purposely put its obstetricians uninvited into the position of having unnecessary and unnatural liability and then points to that vicarious liability to establish why doctors can�t possibly provide the very supervision their own professional organizations insisted upon.  There has already been one documented stillbirth directly attributable to this artificially created road block which keeps both midwives and mothers from timely access to medical services. Two physicians (one OB and another a perinatalogist) and the director of nursing for the only Chico hospital all refused the request over a 3 day period of time by a licensed midwife to provide a non-stress test (NST) to a mother who was 41 � weeks pregnant. The baby died in utero of placental insufficiency before the parents could make arrangements in a near-by town. This is the very condition a fetal NST is designed to reveal so interventions can be implemented in time to prevent a bad outcome. This and similar events represents an extreme escalation of an already pernicious situation, as the majority of obstetricians are now denying both essential and preventive services to childbearing women they know to be receiving care from a licensed midwife and in some many instances, are actively hostile and even take retaliatory actions against both mother and midwives.  **Senate Office of Research �LM Survey� Documents Situation**  In the fall of 2000 the Senate Office of Research conducted a statewide �Licensed Midwives Practice Survey�. This 16-page survey has the most comprehensive data on LM practice to date and confirmed that physician supervision is not available or workable for California LMs who provide community-based birth services. Its conclusion by Peter Hansel states:  �The findings indicate that licensed midwives generally make appropriate arrangements for medical consultation, referral, transfer of care, and hospitalization of clients. Additional study of California birth records would help in affirmatively establishing the safety and efficacy of midwife-assisted births in California. SB 1479, with its requirement that licensed midwives register live births, should begin to produce the data needed to do that. In the meantime, the Legislature may wish to consider implementing a pilot project to test the idea of requiring physician consultation rather than supervision. The pilot would examine birth outcomes and changes in relationships between midwives and physicians associated with the revision of the supervision requirement.� �A Collaborative Relationship with Physicians �. Satisfies the Ambit of the Law� I believe the following quotes from the *Alison Osborn* decision by Judge Roman are both informative and instructive. Judge Roman noted, �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**\*.�  His finding of fact goes on to identify that the:   �the medical community of obstetricians is hostile to licensed midwives�. �The evidence presented this tribunal further establishes that, with the exception of one licensed midwife who is also a licensed physician assistant, no California licensed midwife, despite efforts for supervision, possesses a supervising physician except as referenced in Finding 14.  �  �[she] avidly seeks, along with other midwives, to be part and parcel of the healthcare team that serves the residents of California.�  �    �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.� �."[m]idwifery presumes that childbirth is a healthy and normal event. � 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.�  �Decision making is collaborative.�    **�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 .. persons to possess a license that would not be functional anywhere within the State of California. This tribunal declines Complainant's offer.�    �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.  \*underline emphasis added  Asking medical doctors to create an unnecessary and unnatural vicarious liability for themselves by volunteering to supervise practitioners of an entirely different and non-medical discipline is a very curious thing to do and in the final frame, a fatally flawed strategy that is not consistent with its goal of consumer safety. Physicians are neither educated or licensed in the non-medical discipline of midwifery, they are not professionally familiar with community-based birth services, have never attended or even been present during a domiciliary labor or birth and have no interest in ever providing home-based services themselves. In addition to this natural tension is also the undeniable reality that physicians and midwives are economic competitors and this fact of life prejudices obstetricians against cooperating with midwives. For the last hundred years the balance of power has been extremely weighted toward organized medicine and away from midwifery, to the determent of the public safety .  **Request** ~ And the second request is that, in the name of consumer safety and the legislatively acknowledged right of childbearing women in California to choose the �safe option� of a licensed midwife and home-based maternity care, the *Osborn Decision* be accepted as the operative foundation for medical board policy. A Midwife�s Plea for a �conspiracy of cooperation� It appears that Judge Roman�s finding in the Osborn case provided the Board with ample information and instructions to resolve this impasse. These legal theories were subsequently reiterated and expanded upon in the Figueroa amendment to the LMPA (SB 1479) and it�s finding that normal childbirth is not a medical condition and identifying midwifery as protective and preventive health care. (exhibit 8) Judge Roman identified that midwifery is distinctly different from medicine as it is based in a social relationship between mother and midwife that is quite different from the remedial medical therapies offered by physicians, physician assistants and nurse midwives. Legal issues should therefore be judged by midwifery and not medical criteria. (see accompanying report to 1994 MBC Midwifery Implementaion Committee)  The practice of medicine is the science of forcing something to happen that otherwise would not, could not happen on its own. In general this is achieved through the prescribing of powerful drugs or use of surgery designed to trick Mother Nature or to overcome what are deemed to be her mistakes. The practice of medicine is an active use of forceful interventions. For example, I have never known an appendix or gallbladder to take itself out before the surgeon arrived. However, as a nurse and midwife have seen a many, many laboring mothers with babies who �took� themselves out before their doctors or midwives arrived.  In medicine, the physician is the �essential� ingredient. *In midwifery, it is the mother who is essential*. In the latter equation, the skilled midwife is engaged in the art of working with the natural characteristics of healthy biology. In many areas of modern life we engage the services of healthcare professional depending on what we hope to achieve. We expect their knowledge base and skills as a practitioner to be perfectly tailored to the demands of their specific professional discipline. For example, we would not go to a orthopedic surgeon for back pain if what we wanted was a chiropractic adjustment or acupuncture treatments. Hospital-based ob-gyn surgeons excel in interventive medical and surgical interventions but have little or no first-hand experience or skills in physiological management of unmediated labor and spontaneous birth. Their 20-plus % CS rate is evidence that the expertise of obstetricians lays elsewhere. Logically a healthy childbearing woman who has chosen to employ the subtle systems of normal biology and who is seeking physiological (instead of medical) management of her pregnancy and parturition, would need to have unfettered access to a licensed community midwife in order to achieve her goals.  In regard to the issue of physician supervision, Judge Roman identified that �it satisfies the ambit of the law� when midwives have made a good faith attempt to secure a supervisory relationship and failing that, to have a method identified for physician collaboration. Since the passage of the amended LMPA, this would extend to the documentation of medical interface arrangements as mandated in 2508. According the Senate Office of Research, 83% of respondent midwives (84.7% of LMs practicing in the state) LMs have some combination of collaborative and/or consultative medical relationship (i.e. �working arrangements�) either with individual physicians or with teaching/tertiary care hospitals. (exhibit 8 ~ SB 1479 LMPA amendment /  Intent section, Informed Consent UCSF Home Birth transfer + 9 sample letters to midwives from physicians or institution) |
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