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Medical Board of California
1426 Howe Ave
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February 3, 2005

RE: Testimony Supportive to Passage of Section 1379.23 regarding **Standards of Care**, as required by SB 1950 which amended the **Licensed Midwifery Practice Act** of 1993.

Dear Sirs,

California licensed midwives wish to thank the Division of Licensing for its official recognition of a midwifery model of care as the appropriate standard of care for the practice of California licensed midwives. California midwives are committed to promoting the highest level of safety for mothers and babies while protecting and preserving the reputation of midwifery with the public, the Legislature and our regulatory agency, thus ensuring continued access to professional midwifery care for California residents.

The California College of Midwives is a professional organization representing the legal and legislative interests of California licensed midwives. In the opinion of our members, the proposed regulation satisfies the spirit and the letter of its authorizing legislation, SB 1950. The CCM standard of care facilitates midwifery practice that is both safe and competent and consistent with the history and tradition of midwifery in the US, as well as the midwifery model of care as practiced worldwide. This document reflects the art and science of modern midwifery, balancing evidence-based practice parameters with the central role played by the practitioner's clinical judgment. In regard to the legal aspects, the CCM Standard of Care includes statutory and regulatory language excerpted from fourteen other states that license non-nurse midwives. The informed consent / informed refusal policies of the CCM are consistent with documents on those topics as published in the American College of Obstetricians and Gynecologist Compendium of Policies, 2004 (see attachment #1).

The California College of Midwives believe that professional competence can be described and demonstrated and when consistently employed produces a consistent quality of care that preserves the fundamental health of childbearing women and protects mothers & babies from preventable complications. The CCM document does an excellent job of making the professionally competent practice of midwifery visible and understandable by the public, licensed midwives and state regulators. Additionally, the articulated standard of care incorporated by reference is effective at balancing the needs and often conflicting interests of all three major stakeholders:

- Public safety -- childbearing women and their unborn or newborn babies;
- The profession of community-based midwifery as licensed by the MBC
- The organizational needs of that regulatory agency -- the Medical Board of California

The authorizing legislation (SB 1950) offers an important opportunity to identify in regulation the basic distinctions between the physiologically-based midwifery model of care, which addresses the normal biology of healthy childbearing women (as defined in SB 1479; Figueroa, 2000) and that of the medical model. Additionally, the proposed regulation is:

1. Protective of consumer interests
2. Reduces the burden on the regulatory agency to investigate non-meritorious complaints
3. Helpful to midwives by assisting them to be in compliance with the LMPA
4. Meets or fulfills the legal criteria for regulations – that is, Necessity, Authority, Consistency, Clarity, Non-duplication and Reference.
5. In the consideration of all alternatives, there is no alternative which would either be more effective than or as effective as or less burdensome on affected private persons than the proposed language of Section 1379.23, as authorized by SB 1950

Therefore the membership of the California College of Midwives **supports the passage of this proposed regulation in its present form**.

While the CCM firmly believes that the legislative purpose of the LMPA and interests of these groups are appropriately represented in this regulation, the frequently disputed and controversial nature that surrounds the regulation and practice of licensed midwives is inescapable.

As of this date, major areas of dispute are:

1. The opinion of the California Association of Midwives that CAM speaks for all California Licensed midwives and CAM midwives would prefer a nationally generated standard instead of a state standard
2. The opinion by the board of directors of the California Association of Midwives that the term “standard of care” as used in SB 1950 requires the Medical Board to restrict its proposed regulation to the general midwifery standards listed on pages 5 and 6 of the CCM document or as listed in the MANA Standards & Qualifications document
3. The persistent claim by organized medicine that community-based midwifery should be prohibited and that the standard of care for midwives LMs should be determined by obstetrical conventions rather than the tradition of midwifery

However, before addressing the areas of controversy by other stakeholders I’d like to provide the following background and overview of the topic.

The Purpose of the LMPA

The purpose of the LMPA is to provide professional maternity services to essentially healthy childbearing women who for personal, philosophical, cultural, economic or religious reasons have chosen non-obstetrical pregnancy care from a licensed midwife and childbirth care in a non-institutional setting (family home or independent birth center). The functional limitation of physiological care in a domiciliary setting restricts LMs to the provision of non-medical maternity care for healthy mothers with normal pregnancies who do not desire or require induction or augmentation of labor or anticipate a need or desire for narcotic pain medications or anesthesia during labor and birth.

Explicit and implicit in the licensing statute and its amendments is the fact that the safety of professional midwifery care for healthy women with normal pregnancies, in conjunction with access to appropriate obstetrical services for complications, is statistically equal to hospital-based obstetrical care for the same low and moderate risk populations *(see intent section of SB 1479, Figueroa, 2000)*. Public health officials are in agreement that access to professional maternity services by physicians and midwives makes childbirth safer than it would be without access to or use of such care.

It should be noted that California statutes do not require a pregnant woman to obtain prenatal care or to be professionally attended by either a physician or midwife during labor, birth and the immediate postpartum period. Therefore it is the obligation of maternity care professionals to meet the needs of childbearing women – as perceived and defined by the women themselves-- in such a fashion as to induce women to value and seek out professional maternity care.

It can be statistically demonstrated that the professional care of a midwife vastly improves maternal and perinatal outcomes as contrasted to childbirth in women who receive no prenatal care and have unattended births. For example, perinatal loss for unattended birth in women with no prenatal care in a North Carolina study was as high as **60** per 1,000 (compared to only **3** per 1,000 when an experienced midwife was present). The current perinatal mortality rate for the US is **7** per 1,000. According to a large study of more than a million California birth certificates, perinatal mortality for low and moderate risk women is 2 per 1,000 for all three locations – hospital, independent birth centers and the family's home. *[The Safety of Childbirth Alternative, Schlenzka, 1999]*

The appropriate role of midwifery for the consumer and the professional obligations of its practitioners are perhaps best summarized by a statement from American College of Nurse Midwives' (ACNM), which reads in part:

> Every family has a right to a safe, satisfying childbirth experience, with respect for cultural variations, human dignity and the rights as consumers to freedom of choice and self-determination. Decisions regarding midwifery care require client participation in an ongoing negotiation process in order to develop a safe plan of care. This process considers cultural diversity, individual autonomy, and legal responsibilities. It recognizes that the integrity of the mother-child relationship begins in pregnancy and acknowledges the responsibility of professional care providers to provide safe, effective and competent care…"

The proper role of maternity care, regardless of the educational background or licensure status of the caregiver, is to preserve the health of *already healthy* mothers and babies. The goal of midwifery care, regardless of setting, is to benefit the mother-baby dyad, the father and other family members and the community <u>without introducing harm</u> to any of these entities.

Standard of care as a technical category, should conform to the following criteria:

1. A standards of care for California midwifery must be **consistent** with community-based midwifery as defined in state and national professional midwifery organizations and state licensing regulations for jurisdictions that have equivalent forms of direct-entry midwifery.

2. Since the promulgation of regulations is by its very nature inflexible, regulations describing a standard of care must take care to be a floor and not a ceiling -- that is, they should reflect minimum requirements that informs the LM and protects the consumer but does not block the advance of

science-based practice, advanced training by the individual midwife or the development of more expansive or stringent criteria by professional midwifery organizations at the state or national level.

3. A standard of care for California must be **consistent with the educational qualifications** of California LMs -- by statutory definition, the LMPA three year educational requirement is "equivalent but not identical" to the education and scope of practice for CNMs.

4. A midwifery standard of care must be **evidence-based and include mechanisms for being updated** as scientific data is added or changed and should include evidence-based guidelines and protocols to address unusual circumstances or unusual needs, as well as variations of norm and minor or temporary deviations

5. A standard of care for California must recognize and acknowledge the childbearing woman's legal and ethical right to choose the manner and circumstance of normal labor and birth (note Intent language of SB 1479) and that *risk reduction strategies must include the consent of the mother.* This includes an acknowledgment that the mother's permission or **voluntary consent is the least standard that is legally acceptable.** At a minimum, consent must be obtained for routine midwifery care and medical interventions in all but "extremely rare and truly exceptional circumstances". The mother's informed consent or informed decline must be honored except in those emergent circumstances in which there is a clear and present danger or other overriding legal obligations have been placed on the midwife.

6. A standard of care should provide protective guidance to the practitioner by delineating minimum expectations. The goal of this information is to provide safe, "state of the art" care to consumers and protect individual clients from substandard care while also protecting the practitioner from litigation and accusations of unprofessional conduct that may arise out of *a lack of consensus from within the profession*.

The ethical basis for an appropriate Standard of Care for California Licensed Midwives:

In the Midwifery Model of Care, the professional midwife must live up to the following responsibilities and duties to:

A.) Safeguard the physical health and psychological well being of the mother
B). Safeguard the physical health and psychological well being of the baby
C). Safeguard the personal and professional well being of the midwife
D). Safeguard the reputation of midwifery

Professional Duties are to:

1. Have up-to-date knowledge of the standards of care for her profession
2. Have the education, skills and equipment needed to provide standard midwifery care
3. Communicate those standards to the client and negotiate an informed consent contract for community-based non-medical midwifery care
4. Provide full information to the client/family in the context of the midwifery care being offered and obtain the mother's/or other parent's voluntary consent before implementing the various discrete observations, actions, and interventions associated with standard midwifery care in a non-institutional setting
5. Document the informed decline of standardized care and memorialize in writing the circumstances and associated conversations with parents and others leading to this choice

6. Provide ‘first-responder’ and emergent care to mother or baby when necessary
7. Initiate access to appropriate emergency services in the presence of an evident need based on parental request, the licensed midwife’s recommendation or in response to a clear and present danger

An articulated standard identifies a uniform obligation for the following areas of practice:

a. Criteria for client selection / consultation, referral, elective transfer of care, emergency transport
b. Responsibilities of the professional midwife and nature of the caregiver-client relationship, including the specific responsibilities of the client and her family
c. Minimum practice requirements for advice and education offered by the licensed midwife, including labs, genetic testing, coping skills, scheduling pediatric care of the neonate, etc
d. Technical skills and minimum practice requirements for the clinical areas of prenatal, intrapartum, postpartum, neonatal and follow-up care, including skills in the management of emergency situations
e. Procedures for & content of informed consent / decline and for withdrawal of services by the midwife
f. Record keeping and charting characteristics
g. Drugs and equipment used and maintained
h. Timely filing of birth certificates and other necessary documentation

The basic foundation for standard care consists of:

a. Offering such midwifery care as is appropriate to the mother or baby’s situation
b. Performing such observations/actions/treatments/protocols with due diligence and in a timely manner (including recommendations for medical evaluation or transfer of care and/or institution of emergency measures pending transport)
c. Documenting all pertinent facts, including a chronology of the specifics of care provided, the content of patient education and instructions given by the midwife and informed consent conversations
d. When applicable, obtaining written consent/decline of care and memorializing in writing any formal discussions or consultation with other professionals relative to making decisions on care and medical interface.

CCM Standards of Care for California Licensed Midwives

Collectively, the above listed criterion equates to a safe, effective and competent standard of care for professional midwives. The CCM document identifies the characteristics associated with such competency and distills them into a specified standard of care that is appropriately flexible and yet maintains its inner congruity. It uses elements from the WHO “*Care in Normal Birth - a Practical Guide*”, Dr. Koostermen’s list of client selection criteria for domiciliary midwives in Holland and the College of Midwives of British Columbia (Canadian direct-entry midwives) as a source for universally applicable principles of practice. The scientific values and the range of biological norms (e.g. the normal range of newborn respirations per minute, etc) used in making clinical judgments are data driven, having been taken from recognized textbooks and peer reviewed journals. This information represents a general consensus on the biology of childbearing and the neonate by the scientific community. Specific sources include Varney’s Pocket Midwife”, Constance Sinclair’s “A

Midwife's Handbook", Penny Simpkin's "The Labor Progress Handbook", "Assessment & Care of the Well Newborn" by Thureen *et al* and informed consent/decline principles from the ACOG Compendium 2004, a book of policy statements.

The CCM document supports the need for the law to be stable while remaining able to evolve and change as the science and customs of society change. The standard of care as published in the CCM document includes the various professional obligations, guidelines, and minimum practice requirements necessary to meet the legal definitions of standard midwifery practice in California. The professional midwife who conforms to this standard is judged to be competent. Furthermore, we believe that professional midwives owe a duty to their clients to provide an identified minimum standard of care, the characteristics of which are plainly and publicly described, so that 'informed consent' becomes a meaningful concept for all women receiving care from licensed midwives.

Controversies and Disagreements

> (1a) An assertion by the California Association of Midwives that they alone speak for all California Licensed midwives and (1b) that CAM midwives would prefer a nationally generated standard instead a state standard

1a. Of the148 licensed midwives with current addresses in California, 52 are CAM members, with about half belonging to both CAM and CCM. LMs who *do not agreed* with CAM's official opposition to the proposed regulation were concerned that our viewpoint would not be given the consideration it merits. In order to address this issue, an advocacy group -- *California Advocates for Licensed Midwifery* (CALM) — is conducting a survey by mail of all 148 California LMs, regardless of their organizational affiliation. As of this date, more than 50% of LMs have replied, with **82.5 % supporting** the regulation and **17.5 % opposing.**

1b. Another issue is a preference by CAM that any standard adopted for California LMs should originate from the national organization (the Midwives Alliance of North America). MANA would like to see the states that use the NARM licensing exam replace their practice regulations with MANA standards. The MANA standards (see attachment #2) define most parameters of practice with the adjective "appropriate". MANA standards do *not* incorporate by reference any definition of terms, guidelines or minimum practice requirements identifying the parameters of 'appropriate'.

As founder of the CCM and a member of both CAM and MANA for twenty years, I don't oppose anyone's efforts *to improve the profession of midwifery*, or to make it safer and more accessible to women. However, the train already left the station in regard to the current regulation. Were these other groups able to agree on a *superior version or a better design at some time in the future* and propose that the Board replace the CCM document, I would welcome it. In the mean time, I believe that the proposed regulation is the best choice for LMs, the best way to promote and protect consumer safety and the most satisfactory way for the Medical Board to fulfill its regulatory function.

> (2) An opinion by the board of directors of the California Association of Midwives (CAM) that the term "standard of care" as used in SB 1950 requires the Medical Board to restrict its proposed regulation to the general statement of midwifery standards listed on pages 5 and 6 of the CCM document or the MANA Standards (see attachment #2)

The common legal definition of a standard of care is how practitioners would have managed a client's care under the same, or similar, circumstances. The dictionary defines *guidelines* as "a standard or principle by which to make a judgment or determine a course of action". Both of those definitions seem compatible with a broadly defined and comprehensive standard of care.

While admitting that in California there is no published definition of the term 'standards' relative to the adoption of standards for a profession, CAM none-the-less posits that the Board lacks authority for the proposed regulation and therefore must delete all background information, definition of terms, explanations, guidelines, policies and minimum practice requirements. Their theory is based on the use of the term 'standard of care' in SB 1950, while words such as 'guideline' or 'definition of terms' do not appear.

We believe this is a disingenuous position, since it would leave us with undefined & over broad concepts like "provides appropriate care", "makes appropriate medical referrals & transfers" and "keeps appropriate records". This would render the passage of these regulations useless from the standpoint of a regulatory agency. But worse yet, it would offer no protection to the midwife in a disciplinary situation, as she also faces great difficulty proving that she fulfilled a professional obligation defined by vague terms like "appropriate". In regard to the issue of competency, one is unable to "connect the dots" because *there are no dots*.

However, SB 1950 did not direct the MBC to adopt "Midwifery Standards" as vague language from a state or national publication, but rather to adopt regulations *defining* the appropriate standard of care for the practice of midwifery. Unless a term is specifically defined in the authorizing legislation, the interpretation is common usage at the time the law was passed. In my mind, the main and the plain meaning of "standard of care" is the field of practice for midwives. If I had been a legislator in 2002, I would have assumed that the authority to pass regulations defining the appropriate standard of care would refer broadly to the professional field of endeavor and that was what I was voting for in the passage of SB 1950.

> (3) The persistent claim by organized medicine that community-based midwifery should be prohibited and that the standard of care for midwives LMs should be determined by obstetrical conventions rather than the tradition of midwifery

Since the passage of the midwifery licensing law in 1993 (a bill long opposed by organized medicine) organized medicine has continued to insist that home birth is irresponsible and the MBC should prevent midwives from providing such care. ACOG was able to produce one poorly conducted and non-representational study (Pan*g et al*) that made it appear that community-based midwifery resulted in a slight increase in perinatal mortality (equivalent of 1 per 1,000 as compared to hospital care). However, the vast majority of reputable studies on midwifery published in the last 20 years (75-plus) identify comparable perinatal outcomes for low and moderate risk women in all three locations – about 2 per 1,000 for hospital, home and birth centers alike, with a dramatic reduction in medical interventions in the planned home cohort (including the hospital transfers). Scientifically speaking, physiological management is the safest and most efficacious method of care for healthy women with normal pregnancies and it is this model used worldwide by midwives and in some locations, by physicians.
While organized medicine has been unsuccessful in eliminating domiciliary care, they have had greater success in bringing pressure on MBC staff to impose a medical rather than midwifery definition when conducting investigations of LMs. In response to this decade-long problem, SB1950 directed the MBC *" to pass regulations defining the appropriate standard of care for the*

practice of (licensed) midwifery" by July 2003. According to correspondence from the bill's author (Senator Liz Figueroa), this provision was to settle the question by identifying in regulation that the appropriate criteria for California licensed midwives was a midwifery-based standard of care.

Another aspect of this long-standing disagreement between organized medicine and midwifery centers on the issue of autonomy by the childbearing woman and her constitutional right to have control over the manner and circumstances of normal childbirth. The functional autonomy of the healthy, mentally competent pregnant women is a compelling human rights issue that encompasses her right, via an informed consent mechanism, to decline risk-reduction protocols *even when that results in a medically unpopular choice.*

Without recognition of this right, childbearing women -- especially those with special circumstances-- can and frequently are forced into extensive medical interventions for non-medical reasons even though these mothers can otherwise be expected to labor normally and give birth spontaneously to healthy neonates. This occurs because our current obstetrical system denies physiological management of labor to women in many circumstances -- post-dates pregnancies, babies in a breech position or assumed to be larger than average, twins or post-cesarean pregnancies. In many of these situations the health issue is increased *risk* and *not* a present tense *complication*. The mother can, from a mechanical standpoint, deliver normally were it not for policies of the American College of Obstetricians and Gynecologists that are designed to reduce the litigious risk to the provider.

It must be noted that the current unwillingness or inability of the obstetrical profession to provide vaginal birth services to women with an identified risk factor creates an asymmetrical burden of risk that *falls directly and unfairly* on the childbearing woman. This risk-shifting process reduces the litigious exposure of the physician by passing it on to the mother as the risk of complications and the physical pain of major surgery. Cesarean delivery is associated with many delayed or downstream complications including reproductive difficulties in future pregnancies, such as abnormal placental conditions and medical conditions arising later, such as infertility or miscarriage.

For example, the risk of cesarean includes fifteen well-known complications (including a 13-fold increase in emergency hysterectomies) compared to the 3 specific risks identified for normal vaginal birth. Research recently published in the New England Journal of Medicine is illustrative of this point. In a study described as the largest and most rigorous to date (34,000 births at 19 academic hospitals from 2000 to 2003), maternal-infant outcomes of planned vaginal birth after cesarean (VBAC) are compared with elective repeat Cesareans. Among the 16,000 elective repeat Cesareans, **7** mothers died. In the larger 18,000 VBAC mothers (a bigger cohort by 2,000 women), there were only **3** maternal deaths and two infant deaths. The study concluded that elective Cesarean was associated with *increased maternal deaths* (7 versus 3), while VBAC was associated with a small increase in perinatal deaths (0 vs. 2).

Other studies on the VBAC risk to the neonate show that planning a normal labor in post cesarean pregnancies results in neonatal mortality no higher than that of a first-time pregnancy (as compared to the birth of a second or third baby, which has a statistically better outcome than a first delivery). This is in contrast to a planned Cesarean, which *does not substantially improve perinatal outcomes* and yet is still associated with 15 long and short -term complications, including a doubling of maternal mortality. Under these circumstances, the mother alone should make the decision to risk her life or reproductive abilities on behalf of her unborn baby and only after fully informed consent.

In recognition that all the childbirth choices made by parents are associated with specific risks of some sort, the ethical response is to acknowledge that risk reduction must always be implemented *with the consent of the parents*. For mentally competent women, legal principles of body integrity already acknowledge their right to refuse medical treatments, procedures and surgery, even when the decline of these interventions may, as perceived by medical authorities, disadvantage the fetus. The quote below identifies a case law precedent for maternal consent:

> "In 1990 District of Columbia Court of Appeals, in a strongly worded opinion, essentially *adopted the American College of Obstetricians and Gynecologists'* statement as law, holding that **the decision of the pregnant women must be honored in all but "extremely rare and truly exceptional" cases"**.

In 1999 a disciplinary case was brought against a licensed midwife by the MBC for providing care to a mother whose baby was breech and who, with fully informed consent, declined the medical advise of her obstetrician to have an elective cesarean delivery. The mother-to-be discovered that all the OBs in her area would not do or *did not know how* to delivery a breech baby vaginally and found instead a licensed midwife who was trained and experienced in managing breech births. For reasons not associated with the breech position, the baby was stillborn. Eventually this case came before Judge Roman in an administrative hearing.

His decision confirmed the right of the childbearing woman to decline the risk-reduction procedures of obstetrical care (in particular, the elective performance of a cesarean section) and to choose physiological management under the care of a licensed midwife. The OAH decision also acknowledged that breeches and other variations of norm can be attended by LMs without accusations of 'unprofessional conduct' <u>provided</u> the midwife has appropriate advanced training, additional experience and written protocols that included specific criteria for selection of such clients and specific parameters of care, including referral and emergency transport arrangements. This was based on the recognition that these pregnancies are still anticipated to result in a normal childbirth, even though they have a clearly identified risk factor.

While it is true that 'normal' birth is not specifically defined by the LMPA, its inverse-- abnormal birth – is. Any labor or delivery in which there is a need to use "<u>artificial, forcible or mechanical means</u>", (e.g. drugs to stimulate labor, obstetrical forceps, Cesarean delivery) is specifically prohibited by this statute. In addition, the use of "artificial, forcible and mechanical means", i.e. drugs and surgery, is defined by other sections of Chapter five of the Business and Profession Code as the *unauthorized* practice of medicine.

This inferred definition recognizes that normal equates with natural (i.e., not artificially stimulated) and refers to spontaneous physiological processes that are characteristic of the healthy reproductive biology of childbearing women and can reasonably be expected to lead to normal conclusions. Normal is associated with **a state of irreducible risk –** that is, **all other responses *add* rather than subtract risk**. Functionally speaking, this may be distilled into the following definition:

> Normal as used in the LMPA would refer to a pregnancy that naturally advances to term with a live, growth-appropriate fetus, and culminates with a spontaneous labor that leads to a spontaneous live birth of a viable neonate and conservation of the health of the mother and wellbeing of the baby.

The OAH judge's decision upheld as lawful the standard of care used by a California licensed midwife that included guidelines, protocols and special informed consent for healthy women with moderate risk situations.

That said, the best relationship to pregnancy risks of this sort would start with a paradigm shift in the historical hostility of organized medicine towards midwives and move on to the out-of-control liability insurance situation so that *none* of these parties were forced to choose between the devil and the deep blue sea. Under these political improvements the mother's desire for a physiologically managed labor and normal vaginal birth could be met with what is called in Holland a "relocated home birth" – i.e. physiological management by the professional midwife in a low-tech hospital environment with immediate access to medical services if desired or required. Personally I hope to live long enough to testify on behalf of regulations that would define the California licensed midwife's duties relative to arranging for and conducting a "relocated home birth" in her local hospital.

In Conclusion:

In closing I return to the American College of Nurse Midwives statement to summarize the goal of maternity care:

> Every family has a right to a safe, satisfying childbirth experience, with respect for cultural variations, human dignity and the rights as consumers to freedom of choice and self-determination. Decisions regarding midwifery care require client participation in an ongoing negotiation process in order to develop a safe plan of care. This process considers cultural diversity, individual autonomy, and legal responsibilities. It recognizes … the responsibility of professional care providers to provide safe, effective and competent care…"

There is every reason to believe that proposed regulation incorporating the CCM Standard of Care for California Licensed Midwives will greatly assist families in their right to a safe, satisfying childbirth experience. The CCM document is protective of the consumer, protective of the professional status of the LM and protective of the regulatory agency, reducing the disciplinary burden by lowering the number of incidents that must be investigated and potentially prosecuted by the MBC. The achievement of these vital goals clearly establishes the functional quality of midwifery standards and guidelines to be an "appropriate" standard of care for the practice of midwifery in California.

Therefore the membership of the California College of Midwives **supports the passage of this proposed regulation in its present form**.

Faith Gibson, LM, CPM
Executive Director, ACCM/ California College of Midwives

cc: Senator Figueroa's office

Enclosures: 1) ACOG policy statements on Informed Refusal & Patient Choice and the Maternal-Fetal Relationship; 2) MANA Standards and Qualification, October 1997 edition