[**Short Cut to Historical Addendum**](http://docs.google.com/RM%20SB%201950%20Hx%20addemdum%20July03.htm)

**Short Cut  "**[**Remarks on the Employment of Female Practitioners of Midwifery**](http://docs.google.com/RM%20SB%201950%20Remarks%20Female%20Prac%20Jul03.htm)**", published 1820**

**Short Cut to** [**Letter from Norcal Insurance Company May 1999**](http://docs.google.com/legal_legislative01/NorCalLttrMay98.htm) **stating that doctors �cannot supervise, consult**

**with or back-up any midwife for home birth�**

California College of Midwives

3889 Middlefield Road

Palo Alto, Ca 94303

650 / 328-8491

www.collegeofmidwives.org

Medical Board of California

1426 Howe Ave

Sacramento, Ca  95814

  **Navigational Shortcut**   (1) [**Supervision**](#gjdgxs)          (2) [**Standard of Care**](#30j0zll) 

Friday, July 25th 2003

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

**Section 3504 the Board shall adopt regulations defining the appropriate standard of care .... for the practice of midwifery**

The membership of the California College of Midwives, a professional organization representing the legal and legislative interests of California Licensed Midwives, **supports the passage of these proposed regulations**.

**The basis for our support is as follows**

1.      They are protective of consumer interests

2.      They reduce the burden on the regulatory agency to investigate non-meritorious complaints

3.      They are helpful to midwives by assisting them to be in compliance with the LMPA

4.      They met or fulfill the legal criteria for regulations � that is, Necessity, Authority, Consistency, Clarity, Non-duplication and Reference.

5.      In the consideration of 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

# **Point by Point Assessment**

(a) Physician  Supervision:

This provision of the proposed regulation states that: �The requirement for supervision shall be **deemed to have been met if** **a midwife has documentation of any of the following**:

  (1) The client is currently receiving **ongoing care from a physician or clinic**.

(2) The client **is receiving care from a health care service or plan** or other organized health plan.

(3) The client has **refused medical care by a physician in accordance with Section 2063** (i.e., the religious exemptions clause) of the code or in accordance with the **client's right to make an informed refusal of [***medical***] care**

� This proposed regulations modifies and updates the physician supervision provision of the LMPA in two necessary and useful ways.

Point #1.  In the years since the 1993 licensing law was passed, the dominate form of health insurance for almost all Americans has changed dramatically.  Freely transferable health insurance, in which the consumer directs and controls the fee-for-services reimbursement aspect of his or her health insurance plan, has been replaced by health maintenance organizations and preferred provider networks. These limitations on patient choice are an attempt to control or reduce the cost of health care. However, the framers of the LMPA, which was written in the spring of 1993, had no way of predicting this turn of events, which also dramatically alters the functionality of the supervisory clause as written.

At present more than 80% of California families have some form of HMO and another large percentage of families have no health insurance at all. HMO/PPO plans and the AIMS program for uninsured pregnant women all restrict access of physician and the hospital to ones covered by that particular plan. This restricts access to �out of network� providers or requires policyholder to pay out of pocket for all out of network care. In the market economy of today�s health insurance industry, it is virtually impossible for childbearing women to have their pregnancies medically-supervised and treated by physicians who are not a part of their own health care plan. However, the unregulated wording of the LMPA supervisory provision restricts the mother�s choice of medical supervision of her pregnancy to the particular physician who supervises her midwife�s practice.

In theory, the supervisory provision would require this physician/medical supervisor to take on the legal and financial burden of providing pregnancy consultation and/or hospital services to all the clients of that LM who needed obstetrical care, regardless of what each client�s health insurance coverage mandates (and regardless of the client�s ability to pay out of pocket). Neither doctors or childbearing women are willing or able to do this. In point of fact, the arrangements for medical supervision or concurrent care is actually being made independently by expectant women themselves (instead of the Licensed Midwife), based on each pregnant woman�s personal preference and her health insurance requirements.

Unfortunately, this means that the Licensed Midwife is out of compliance with the current unmodified language of the LMPA. This proposed regulation would remedy that situation by acknowledging that the intent of medical supervision is satisfied when the mother is receiving tandem care from a licensed physician or licensed medical facility.

**Point # 2**. At present, all three major malpractice carriers in California are physician-owned and have policies **explicitly preventing** obstetricians from being able to provide the mandated supervision of licensed midwives who provide community-based (non-institutional) birth services **(see attached letter from Norcal, 5/18/99).**

In the face of such formalized roadblocks to medical services, other structures and protocols have been implements by midwives and their clients in order to provide access to medical consultation, medical treatment, transfer of care or hospital-based medical services for mother or baby.

One of the most frequent arrangements made by clients of Licensed Midwives is concurrent medical care in which an expectant woman arranges for the medical supervision of her pregnancy via a physician or licensed facility of her choosing. This makes a known provider (and one covered by her health insurance plan) available to her as a source of medical services should she desire or require medical care during labor or after the birth of her baby.

In contrast to the previously described situation of redundant medical care, a significant number of childbearing women who have chosen community-based midwifery care do so based on religious or philosophical choices that are in striking contrast to those offered by contemporary medical providers. These clients often request care under the religious exemptions clause (Sec 2063) or for other bona fide reasons, eschew the medical supervision of their pregnancy.

No statute of California law mandates that pregnant women to seek out maternity care from a professional provider of any category (either physician or professional midwife) either during pregnancy or the events of labor, birth and the immediate postpartum. Neither does any statute require the State to provide or to pay for maternity care for all its legal residents. Healthy women in California have lawful right to make an informed refusal of medical services or otherwise to decline to have their normal pregnancies medically supervised. In those instances, as in point #1 above, the lawful decisions and acts by the childbearing woman should not be cause for pejorative legal action against the LM.

In a vastly different context, case law (*Thor v. Superior Court*) ruled that it was not constitutional to turn the patient�s �*shield*� (in this case the mother�s lawful right to self-determination regarding pregnancy and the manner and circumstances her normal birth) into a �*sword*� to be used against her (or in this case, the shield-turned-sword is against her lawful caregiver � i.e., triggering disciplinary action against LMs for violating the Licensed Midwifery Practice Act).

Therefore provisions 2 & 3 of the proposed regulations acknowledge that when a mother-to-be makes an informed decline of medical supervision, either under Section 2063 or under the theory of �informed refusal�, **the intent of medical supervision provision of the LMPA is satisfied**

(b) The  standard of care shall be that of the midwifery community.

The legal obligation of the MBC is to license appropriately trained and qualified medical practitioners and to discipline these licentiates if they violate their professional standard of care. For better or for worse, the Board itself does not set the �appropriate� standard for any profession under its authority. That occurs as a result of the findings of an �expert reviewer� -- a bona fide member of the discipline in question � who states that the care provided was �substandard� by the standards of the profession. From this one can appreciate the centrality an �appropriate� standard of care for the practice of midwifery.

Upon first reading, this proposed regulation would seem to fail the �*Necessity*� and the �*Non-duplication*� requirement of the legal review standards for regulations. Like all other professional healthcare disciplines, one would assume that the functional standard for the practice of midwifery was already determined by the community of professional midwives. This would reflect the principle of professional self-determination (i.e., associated with the legal theory of �distinct calling�) that applies to other� healing arts� disciplines such as physicians, psychologists, dentists, nurses and physical therapists.

However, it is been the custom of the medical profession to assume that physicians (and not midwives) should define and arbitrate the practice of midwifery. For example, the majority of complaints received by the Medical Board against licensed midwives come *not from consumers or other licensed midwives*  but rather from physicians. Complaining physicians routinely insist that any decision, action or inaction by the midwife that is different from those which would have been applied by an obstetrician must, *ipso facto*, be **substandard care**. Physicians assume this to be grounds for revocation of the midwife�s license and their testimony and expert review has been instrumental in disciplinary actions taken against licensed midwives since passage of the 1993 LMPA.

The fundamental problem with this concept is that historically medical practice is an entirely different and in many ways, an opposing discipline and therefore an illogical choice to define standards of care for the distinct calling of midwifery. Physicians are educated, trained, and experienced in the distinct calling of medicine (which by law midwives are prohibited from practicing) while physicians are *not* educated, trained or experienced in the principles, the body of technical knowledge and the skill sets of midwifery. Many physicians assume there is (or should be) no difference between these two disciplines but unfortunately, this erroneous opinion is usually arrived at by *those most unfamiliar* with the history and practice of traditional midwifery and *least able* to have an informed view point.

The reasons for this disconnect between the reality of modern midwifery practice (i.e., physiologically-based maternity care) and the generally negative opinions of the medical community are quite complex, with roots in past history and contemporary politics. For the last hundred years, organized medicine has focused considerable official attention and effort on denigrating the reputation of midwifery in the eyes of the lay public and in attempting to obliterate the non-institutional practice of midwifery by all means available.

Appropriate Standard of Care for Community-based Midwifery � Who Decides?

The question before us is whether contemporary members of the medical profession are a superior or better source for defining the �appropriate� standards of practice for domiciliary (non-institutional) midwifery than the profession of midwifery itself as represented by community of California licensed midwives.

At the heart of this issue is whether midwifery and medicine are two seperate disciplines, with each functioning under the legal category of a �distinct calling�. This theory recognizes that the duties of each profession may, in certain areas, overlap, but in the main, they are two seperate disciplines, each with a different history, philosophy, principles and a unique body of knowledge and skill sets and providing a vastly different type of care to different populations of childbearing women.

So what are the facts bearing on this question?

The background of this controversy is more fully examined in an attached document -- the historical addendum -- which is a �must read� if one is to appreciate the true nature of midwifery practice and its contemporary conflict with the medical profession. But to maintain clarity of the narrowly drawn issue of a legally appropriate standard of care for the practice of community-based midwifery under the 1993 LMPA, we will repeat only the most elemental historical facts. This information bears directly on the relationship of each discipline (medicine and midwifery) to acknowledged safe childbearing practices at the beginning of the 20th century and where each of them is in the context of safe maternity practices now, at the beginning of the 21st century.

# **Modern Medicine, Modern Childbirth and a Modern Midwife?**

All agree that historically-speaking, midwifery as an organized body of knowledge and set of skills preceded the modern discipline of medicine by more than 5,000 years. This fact was grudgingly acknowledged by physicians in the early decades of the 20th century.

~ 1925 �The practice of midwifery is as old as the human race. Its history runs parallel with the history of the people and its functions antedate any record we have of medicine as an applied science. **Midwives, as a class, were recognized in history from early Egyptian times**." [1925-A; Dr. Hardin, MD; p. 347]

~ 1913 �The **diagnostic ability of midwives is generally good and in the case of many, remarkable excellent**. In this respect, the average midwife is fully the equal of the average physician." [Dr. Van Blarcom, MD; 1913]

However, there is much disagreement about the contemporary relationship between physicians and midwives. At the core of this question is yet another question -- what is the relationship of �modern medicine� to �modern� childbearing?  Has the obstetrical knowledge of the 20th century fundamentally changed the nature of childbirth (which is a natural biological act) the way medical science fundamentally changed the course of human illness, disease, deformity and accidental injury (all forms of pathology).  If the answer is yes, it can be assumed that the medical profession has rightly re-configured an undependable, unsatisfactory and unsafe biological function of the childbearing body and made it dependable, safe and more satisfactory and thus has permanently displaced the *traditional (or  non-nurse)* practice of midwifery.

For the better part of 200 years organized medicine in the US has promoted the idea that midwives were not temperamentally, intellectually or educationally qualified to provide birth services as independent practitioners (See *�Remarks on Female Practitioners�*). The only legitimate role accorded to midwives by the obstetrical profession was a dependent one, providing care under the authority of an MD. (See the Historical addendum)

If that is the case, it would be safe to assume that the long tradition of midwifery as a distinct calling would be moot and the medical profession would have a proprietary claim on the �value added� obstetrical services as provided by physicians. The only appropriate role for midwives under these circumstances would be to offer medical care only in the role of a �physician-extender�.

For the last 100-plus years, it has been the opinion of the obstetrical profession that traditional (non-medicalized) midwifery was a relic of a by-gone era in which mothers and babies suffered and all too frequently died as a result of �normal� birth while midwives stood by helplessly, unable to prevent preventable deaths because they lacked the training of a physician-surgeon. In the minds of the medical profession that was brought to an end in the early 1900s when doctors forced midwives out of the �childbirth business� and convinced childbearing women to have their babies delivered in hospitals by physicians. This perspective was encapsulated in an article contrasting modern obstetrical services versus midwifery care that was published in the New York Times Magazine in 1975. It characterizes physicians as saving mothers from the �dangers� of midwifery care:

~ 1975 "In the United States ... in the early part of this century, **the medical establishment forced midwives** -- who were then largely old-fashioned untrained "grannies" **-- out of the childbirth business**. Maternal and infant mortality was appallingly high in those days. As the developing specialty of obstetrics attacked the problem**, women were persuaded to have their babies in hospitals, and to be delivered by physicians**.... Today it is rare for a women to die in childbirth and infant mortality is (*low*)..." [Steinmann, 1975]

For the last eight or nine decades, this negative characterization of midwives has dominated the thinking of the lay public and medical profession both. It associates midwifery with an �appallingly high� death rate for mothers and babies while obstetrical care is portrayed as purely heroic. However physicians and government health officials who lived during �the early part of this century� reported facts that were diametrically opposed to both assumptions. For example, testimony on the efficacy of midwifery care was presented in 1931 to the White House Conference on Child Health and Protection by the Committee on Prenatal and Maternal Care. Its author, Dr. Reed, concluded:

~1932 �...that untrained midwives approach and *trained midwives surpass* (emphasis in original text) the record of physicians in normal deliveries has been ascribed to several factors. Chief among these is the fact that the circumstances of modern practice induce many **physicians to employ procedures which are calculated to hasten delivery, but which sometimes result in harm** to mother and child. On her part, the midwife is not permitted to and does not employ such procedures. She waits patiently and lets nature take its course."

Another exemplary source of information from the �early part of this century� came from research done for his employer by Dr. Louis Dublin, President of the **American Public Health Association** and the Third Vice-president and Statistician of the **Metropolitan Life Insurance Company**. After analyzing the work of the Frontier Nurses� midwifery service in rural Kentucky, Dr Dublin made the following public statement on May 9, 1932:

~ 1932 �The study shows conclusively that the type of] service rendered by the Frontier Nurses *[i.e. domiciliary midwifery by professionally-trained midwives]* safeguards the life of the mother and babe. If such service were available to the women of the country generally, there would be **a savings of 10,000 mothers� lives a year in the US, there would be 30,000 less stillbirths and 30,000 more children** alive at the end of the first month of life."

Infections from �childbed fever� or puerperal sepsis � a particularly virulent form of septicemia often fatal to both mothers and babies -- occurred far less among the population cared for by midwives who did not attempt to hasten the birth with internal manipulations (podalic version) or instruments (forceps). An obstetrician from NYC (Dr Ira Wile) reported that:

~ 1911 "In NYC, the reported cases of death from puerperal sepsis **occur *more frequently* in the practice of physicians than from the work of the midwives�**". [Dr. Ira Wile, 1911-G, p.246]

The reason that the �work� of midwives, as Dr Wile referred to it, was safer than that of physicians was simply that midwives did not routinely use �artificial, forcible or mechanical means� � no drugs, no hands introduced into the uterus to pull baby or placenta out, no instruments, no surgery. According to a comment by Dr Alan Guttmacher:

~ 1937 �Midwives have small practices and time to wait; they are expected to wait; this what they are paid for and there they are in no hurry to terminate labor by ill-advised operative haste." [1937-A]

Doctors Dublin, Wile and Guttmacher were all referring to the physiologically-sound practices now also known as �midwifery principles of care�, **which includes access to obstetrical services for complicated pregnancies**. These time-tested methods are the same ones used today, and they are the same regardless of the setting for childbirth � home, hospital or birth center. They included:

�patience with nature�, continuity of care, full-time presence of the primary caregiver during active labor, social and emotional support, walking, unrestricted access to food and water, appropriate psychological privacy, an upright and mobile mother during active labor, non-pharmaceutical pain management such as touch relaxation, labor breathing techniques and access to showers and deep water tubs; absence of arbitrary time limits, vertical postures and the right use of gravity -- maternal mobility and upright positions during second stage -- which includes pushing on the toilet or a supported squat and physiological or �self-directed� pushing without prolonged breath holding or artificial time limits.

One does not have to be a woman or a midwife to appropriately use physiological management. For a professional midwife or physician these principles include appropriate prenatal care during pregnancy, monitoring the vital signs of mother and baby (fetascope or Doppler) during labor and the use of aseptic techniques and sterile supplies when examining the mother and during the birth. For the last 200 years, during which statistical outcomes have been tracked in Europe and elsewhere, these methods have proven both cost effective and safe.

# **Black is White, White is Black**

However, the medical profession has always insulated itself from objective sources that documented the safety of physiologically-based care as provided independently by midwives in non-institutional setting.  Through out the entire 20th and into the 21st century, organized medicine has reiterated the type of propaganda published in the *NY Times* article as the rationale for the medical profession to define and arbitrate the standards of practice for both nurses and professional midwives.

According to their popular explanation, the medical profession was directly responsible for the historical improvement in maternal-infant outcomes *by eliminating midwives* and re-configuring normal childbirth into a surgical procedure performed by an obstetrical surgeon in an operating room environment with the help of anesthesia and forceps. Birth as a physiological act that depended on the mother�s undependable biology (and the dangerously out-dated ministrations of midwives) was seen as the problem to which a nice safe surgical procedure was the solution.

Even though the origin of this controversy is remote in time, this obstructionist history and the obstetrical profession�s current irrational attachment to an interventionist model of care for healthy women is at the center of the modern-day conflict between medicine and midwifery and negatively effects the modern relationship between the two professions. It is particularly relevant to who and how an �appropriate� standard of care for licensed midwives is arrived at. At the core of that controversy is **the historical decision by the medical profession to re-defined care provided during a normal birth as a �surgical procedure� performed by the physician**, an exclusionary practice that has no equivalent in the discipline of midwifery.

The issue of whether or not the type of care for normal birth is ideally a �surgical procedure performed physicians� is central to the type of professional education offered to students of each discipline and the �standards� for each distinct calling (medicine and midwifery). To clarify this issue we are providing a through synopsis of these historical events as an addendum. However, the specific history surrounding the move to define normal birth as a surgical procedure is included in this document. After this brief digression, we will return to the issues associated with defining the �appropriate� standard of care within the regulatory framework and its association with the medical convention of normal childbirth as a surgical procedure.

The Historical Move to Re-define Childbirth as a Surgical Procedure

Part 1 ~ The original medical definition of �surgery� was to �sever or penetrate human tissue�. Since the discovery of microbes and the development of the germ theory of disease, this definition was expanded to include the use of sterile techniques or entering into a sterile body cavity through a natural body orifice. The mouth, nose, ear, vagina and rectum are not normally �sterile� and thus excluded from that definition. Only three sterile organs can be accessed thru a natural body orifice -- the lungs, the bladder and the uterus.  A medical treatment is functionally a �surgical procedure� if it occurs under general or regional anesthesia and utilizes �sterile� technique. This would apply to changing burn dressings in the OR or inserting a bronchoscope into the lungs. In the early years of the 20th century, surgical sterility and anesthesia was also applied to �normal vaginal birth�.

The idea of surgical �sterility� itself is little more than a 100 years old. It was not until 1881 that a French physician, Dr. Louis Pasterur, established the central role of microbes -- commonly known as �germs� or �pathogens�-- in causing illness and infection. On a chalk board at a prestigious medical meeting Dr. Pasteur drew a graphic representation of what the streptococcus bacteria looked like under a microscope -- rectangular microbes that resembled a string of box cars on a train track -- and said �Gentlemen, this is the cause of Childbed Fever�. With this discovery, Dr. Pasteur delivered the fatal blow to the **erroneous and dangerous doctrine of �spontaneous generation�** -- the theory held for 2000 years that life could arise spontaneously in organic materials. This was a natural conclusion for Louis Pasteur as his father was a vintner and techniques to achieve bacteria-free surfaces are basic to wine making. In order to prevent mold from growing on the fermenting wine, the bottles must be sterilized by boiling and their sterility maintained until filled with wine and sealed. Dr Pasteur also developed "pasteurization", a process by which harmful microbes in perishable food products are destroyed using heat, without destroying the food.

It was not until the discovery of anesthesia in the 1840s to control the inevitable pain of surgery and then 40 years later, the germ theory of disease and use of sterile technique to control the infection that surgery became a reasonably effective form of medical treatment.  According to history, the first-ever obstetrical operation -- a Cesarean -- was done in first century Rome to extract a living child from its dead or dying mother. Anesthesia made it possible to do Cesareans on living women and sterile technique made it possible for women to survive the operation. Other obstetrical surgeries such as episiotomy and the use of forceps were greatly enhanced by anesthesia and sterile technique. It did not take long for operative obstetrics to become the new �wave of the future� � for the decade of 1900 to 1910, operative deliveries in one famous NYC hospital were already up to 20% or **one out of five births**.

By the early 1900s, �enlightened� obstetrical care was based on the idea that surgical interventions provided a superior form of care. One of the titans of the obstetrical world in the first decade of the 20th century was Dr. Joseph DeLee. Dr DeLee was famous (or perhaps infamous!) for insisting that childbirth, from the mother�s standpoint, was about as �natural� as falling on a pitchfork.  He likewise insisted that every baby�s head was subjected to pathological forces during even the most normal labor by being repeated bashed into the mother�s unyielding (�iron�) perineum. The take-home message in 1910 was that a �generous� episiotomy saved both mother and baby from the malevolent forces of her �iron� (i.e., intact) perineum and that the routine use of forceps �saved� the baby from being battered and bruised as it was pushed down thru an intrinsically dangerous birth canal by unpredictable forces of nature.

For these reasons it was natural to obstetricians of the early 1900s that childbirth should henceforth be considered a surgical procedure. Technically-speaking, childbirth is considered �operative� delivery when forceps (& now vacuum extraction) are used or a Cesarean section performed. Strangely, an episiotomy, which impacts only the mother, is not statistically categorized as operative.  By 1910 it was considered �standard� to utilize sterile technique, anesthesia, episiotomies and outlet forceps at every birth, to manually remove the placenta (this required the doctor to reach up inside the uterus and sheer the placenta off the uterine wall with is fingers) and then suture the perineal wound. These surgical procedures and operative techniques were routinely used 95% of the time and quickly equated to the formal obstetrical �standard of care�.

Doctors also assumed that childbirth conducted under these sterile operating room conditions would eliminate the great killer of childbearing women and newborns -- a fatal streptococcal infection of the blood stream known as puerperal sepsis or �childbed fever�. It was the streptococcal bacteria which caused septicemia after childbirth that Dr Pasteur used as an example of the germ theory of disease on that famous day in 1881. In the minds of obstetricians 2 decades later, surgical techniques represented a permanent cure for this scourge, one so important to public health that it called for 100% hospitalization and 100% care of childbearing women by obstetrical surgeons.

While their intentions were good, the idea that normal childbirth should be abandoned and replaced by the routine use of surgical procedures was actually **an experimental hypothesis**, that is an "theory" instead of a proven fact. The application of any unproven hypothesis would be considered, under the ethical guidelines for scientific "discoveries", to be a **medical** **experiment**. The obstetrical profession was proposing that thousands of years physiological management be abandoned and replaced by the hospitalization of healthy women under surgical conditions and the interventionist care of obstetrical surgeons. This massive change was purported by the obstetrical profession to make childbirth 'safer'. Normally it would be up to the group that is proposing such a dramatic change to establish that their theoretical basis was accurate and the new methods it generated were safe and effective. However, this most central aspect of good science, which is to put new theories to test in a well-conducted research phase, was skipped entirely in the rush to medicalized normal birth. Instead the obstetrical profession went **straight to the whole-sale implementation of this untested experimental model**, which was turned directly into a wide-spread clinical practice within a single decade and without a single study to verify its efficacy.

The reason that no studies and no vital statistics could validate to the superiority of normal birth as a surgical procedure was because it was associated with a dramatic increase in complications, which at times were fatal to childbearing women. Unfortunately the frequent pelvic exams associated with laboring in a hospital, combined with episiotomy, forceps, manual removal of placenta and suturing of the perineum, created the ideal conditions to  **carry virulent hospital pathogens up into the sterile cavity of the uterus** where the raw surface of the recently delivered placenta offered bacteria the perfect pathway into the mother�s blood stream.

The stress of anesthesia and the added blood loss associated with episiotomy, operative delivery and manual removal of the placenta all weakened the mother�s immune system and made her more vulnerable to this lethal infection. The lack of effective antibiotics sealed her fate in all too many cases -- in 1918 there were 23,000 maternal deaths, the majority cause by or complicated by streptococcal septicemia. Unfortunately for the childbearing women of the era,  **surgical birth vastly increased the rate of puerperal sepsis and the rate of maternal deaths.**

Other Unintended Consequences

But this 20th century convention of birth as a surgical procedure influenced more that just the way the baby was delivered and went far beyond the singular experience for any one childbearing woman, more even than the sum total of  fatalities from surgical complications. There was an impressive and exhaustive list of special arrangements that had to precede the wholesale provision of childbirth as a surgical service. For the last 100 years these special arrangements have molded and eventually defined the institutions of society in regard to maternity care.

More influential than the 30 minutes surgical procedure of �delivery� were the many other areas this new concept impacted -- public opinion, medical education, the design of hospital maternity wards, the rigid, gender-based roles of health care professionals and the dramatically increased professional fees charged for this type of medicalized maternity care. These social changes molded public opinion and national policies for health care so even if an individual woman never personally gave birth under �surgical� conditions, her choices in regard to normal childbearing (i.e., physiological management and non-medicalized birth) were eclipsed by this historical turn of events.

First off, birth as a �surgical procedure� changed both the public and the medical profession�s fundamental relationship to childbearing. Doctor, nurse, mother, husband, lay person -- status didn�t matter, as everyone began to see a sharp (if artificial) split between �labor� and �delivery� -- the mother labored and the doctor �*delivered*�. Attention was directed away from the mother and her labor and instead shined a spotlight on the artificially created, very brief event of �delivery�, during which the obstetrician, instead of the mother, becomes the most essential person in the room and the one credited with bringing about the birth of the baby. Birth as a surgical procedure was (and is) divorced from labor, which was historically characterized by the obstetrical profession as merely the �waiting period�.  All of this resulted in a very different expectation of where and how to give birth, and what the proper roles of the participants were -- the mother and her family, the doctor and his assistants. It also promoted a drastically different type of hospital architecture that isolated the mother and the events of childbirth from all forms of social oversight and accountability.  (See Hx Addendum)

Maternity Care ~ on a Metaphoric �San Andreas Fault� after the �Big One�

With childbirth redefined as a surgical procedure performed by physicians, the hospital quickly replaced the home, the nurse displaced both family and midwifery care during labor, the doctor displaced the midwife during the birth/delivery and his surgical skills displaced the mother�s spontaneous efforts. Under �surgical� conditions, the mother�s central role was reduced to a passive, usually unconscious vessel, out of which a baby was extracted by the physician who then received the accolade of the father for having �safely� delivered his wife of the longed-for son or daughter. While the doctor was giving the good news to the family in hospital waiting room and they were admiring the baby in the nursery window while handing out cigars to passing strangers, the mother was vomiting her way out of the fog of anesthesia in the �No-Admittance� labor ward.

Birth as a surgical procedure also leads to an entirely different focus in medical education. Medical students �observed� deliveries -- not labors. They studied interventions, not normal biological processes. They practiced surgical techniques, not methods to avoid the necessity of their use. They dissected cadavers and performed autopsies, which required them (in emotional self-defense) to distance themselves, and objectify the �body� as an inert and unemotional machine.

The fashion of surgical dominance spilled over into other areas and influenced nursing school education, which now taught students nurses a surgical style for childbirth and prepared them to be good technicians who carefully served *the hospital system* and faithfully carried out the doctor�s orders. While the ratio of midwifery caregiver to mother has always been (and remains) *one* midwife to *one* mother, the ratio of nurse to laboring patients (that is patients plural) is one nurse to several labor patients � anywhere from two to six women in all stages of labor, plus new admissions, emergency surgeries and covering for other nurses while they take meal breaks. This made labor room nursing a very different entity from the traditions of midwifery care. Nurses primarily administered potent drugs while �waiting� for the mother to be completely dilated so she could be prepared for �delivery� and of course, the nurse assisted the doctor during the surgically conducted procedure of childbirth. The obstetrical care system itself, that is the needs of the doctors and the hospital, were the central focus of L&D nursing.

**The Surgical System ~ a galaxy light-years away in its own orbit**

Labor and delivery was organized around ideas of surgical sterility which first required admission to an acute care hospital and second required isolation of the �patient� within the hospital. Laboring women were hidden way behind those ubiquitous swinging doors with a sign that read *�No Admittance -- Authorized Personnel Only*� in big black letters. Surgical procedures required special preparations of the mother�s body (pubic shaving and enemas) and administration of sleeping pills, narcotics and other drugs that altered her consciousness. As a �pre-op� patient she was NPO � *non per os* or �nothing by mouth�, no food or water. In some hospitals, IV fluids were given if the labor was unusually long. The narcotic and amnesic drugs, combined with the L&D protocols, restricted her to lying horizontal a hospital bed, listening to other women in the labor ward moan and cry out with each contraction. She was isolated her from friends and family and prevented from walking about or socializing during labor. Under these circumstances the drugs were a blessing, even though they depressed newborn respirations. Needles to say, virtually all of the standard techniques of midwifery care, such as psychological support, walking and right use of gravity, were impossible in this medialized environment devoted to assembly-line childbirth.

Birth as a surgical procedure also required a specially trained professional staff, special clothing for the staff and special arrangements for changing clothes -- a place where doctors and nurses could exchange street clothes for special OR clothing. It required a variety of other special preparations and rituals for the staff such as a surgical cap to hide the hair, shoe covers to hide the feet, a surgical mask to block exhaled air and a prolonged form of hand washing called a �surgical scrub�.  The OR team (surgeon and scrub nurse) were all required to perform a ritualized cleaning of nails and scrubbing of fingers, hands and forearms for 5 full minutes with a special antibacterial soap, rinsing hands with fingers pointing up so that the water (and germs from skin) flowed off the fingers and hands and water dripped off the elbows. Then the scrubbed hands and arms must be dried with a sterile towel while being held in this fingers-up, elbows down position.

The last steps in this particular ritual were special techniques for physicians and scrub nurses to don sterile OR gowns and gloves without �breaking technique� -- that is, scrubbed and dried hands must be kept directly in front of the body, in sight and above waist level at all times, and touch nothing that isn�t itself sterile, all surfaces must be keep dry, etc. With hands in this stilted position, the doctor and scrub nurse must each don a sterile �doctor�s� gown and surgical gloves (while  the circulating nurse tied their gowns, as scrubbed hands can�t go behind the body or out of sight).

One of the most �special� aspects of birth as a surgical procedure was the special location designed for the surgical procedure of �delivery� -- an operating or �delivery� room itself. The operating room of an acute care hospital functions under special rules, which included restricted access and the ability to maintain sterility of the environment (no cloth or other type of porous surfaces, sealed flooring, etc) and non-sparking electrical equipment. It also required very special furnishings -- stretcher, operating table, operating room lights, instrument table, surgical instruments, drugs, equipment cabinets, oxygen, anesthesia machine, etc.

Next was the need for a special OR staff -- circulating nurse and �scrub� nurse, other assistants and on occasion, specially trained nursery nurses and the most �special people� of all -- licensed physician-surgeons as obstetrician, anesthesiologist and sometimes a pediatrician. Physicians and physician-extenders (Physician Assistants or certified nurse midwives acting under the authority of an MD) were (and still are) the only people with the special technical skills and legal authority to provide surgical procedures of any kind, including normal childbirth defined as a surgical event.

The special role for the mother relative to a surgical �delivery� was to be especially passive, compliant, horizontal, pushed thru space on a conveyance such as a stretcher or special type of intensive care bed. In order for the doctor to properly perform the �delivery� the mother had to be positioned on a operating room table (or specially equipped bed) in lithotomy stirrups. She would be naked from the waist down, with her buttocks hanging slightly off the table over empty space. This unstable position on the delivery table required special restraints -- the mother�s arms were confined by leather cuffs at each side so she wouldn�t fall off the high narrow delivery table or touch any of the sterile drapes, her legs were strapped into the lithotomy stirrup on each side of the table.

Since these all these surgical functions were strictly segregated from the public, the very architectural design of the hospital was deeply changed by this re-defining of care for normal childbirth. Birth as a surgical procedure meant that women labored in a different setting and under different conditions than they �delivered�, hence the now familiar expression �the Labor *and* Delivery Room�. What had been an integrated maternity ward (with mother�s laboring, giving birth and recovering in the same place) was now divided into four separate classifications � (1) labor room, (2) operating/delivery room, (3) postpartum hospital room for the new mother, (4) nursery care for the new baby.

The childbearing woman (and eventually her baby) experienced musical beds and conveyances as she went by wheelchair from hospital admitting desk to her labor bed, then by stretcher to the delivery table, by stretcher again to a recovery room or temporary holding area until she regained consciousness and then she was rolled out via stretcher to her to postpartum bed. During this time her baby had already been sent to the nursery to reside for several days in a cot (or incubator).

Needless to say, this plethora of specialty arrangements added greatly to hospital overhead and thus greatly increased the basic cost of maternity care. Patients (or third party payors) were billed for the special staff and surgical environment by the quarter hour and for the patient room and nursery by the day. These special services also provide an excellent opportunity for professionals to charge a very handsome fee for the advanced technical skills associated with the surgical procedure of �delivery�.

Fast Forward � Childbirth in the Year 2003

While the use of twilight sleep and general anesthesia is rare today, the contemporary obstetrical standard in the United States is still a surgical model for normal childbirth, with a philosophy and a style of care remarkably faithful to the 1910 model, only now days we usually bring the delivery room to the mother through surgically equipped LDR rooms that have special (and especially expensive) motorized labor beds which turn into a waist-high delivery �table� with stirrups at the press of a button.

Epidurals have replaced general anesthesia but childbearing women are still required to be NPO (no food or drink) with the exception of ice chips and they are still immobilized in bed during labor. The 21st century woman is now held hostage in bed by the � dozen (or more) the medical devices that she is hooked up to -- IV fluids and Pitocin administration equipment, 2 continuous electronic fetal monitoring leads, epidural anesthesia catheter and administration pump, automatic blood pressure cuff, Foley catheter, pulse oximetry, and for many, an oxygen mask when the inevitable signs of fetal distress are noted, the frequent result of a supine position and the depressive effect of multiple drugs.

Obviously maternal mobility, right use of gravity and other aspects of physiological management are still not a recognized part of obstetrical care. Meeting the social and psychological needs of the mother are still not acknowledged to have any real importance in regard to safe, satisfying and non-surgical outcomes.

The physician is still the �captain of the ship� and the nurse is still a �borrowed servant�, loaned to the physician by the hospital as his assistant. She is out of the labor room 79% of the time, serving the �system� instead of the mother. According to this study of L&D nursing, only 6% of the nurse�s time is devoted to the personalized care of the mother.

Normal childbirth is still conducted as a �surgical procedure� (complete with a surgical billing code that charges by the quarter hour) that must be performed by and billed for by a licensed physician (or physician extender). It is still the nurse�s job to keep the mother from pushing so that the baby will not be born spontaneously before the physician arrives, as the doctor can�t bill for the surgical procedure of �delivery� if he wasn�t scrubbed in and the hospital can�t bill for the nurse�s services as a birth attendant since she is not a licensed practitioner. This makes an �easy� birth a big problem for everyone but the new mother.

Unless her baby is born precipitously, the mother is still expected to be prone and passive during delivery, which is assumed to be accomplished by the doctor while the mother lies on her back in some version of a lithotomy position. The physician will still be �scrubbed in� and wearing a surgical gown, scrub cap, shoe covers and face mask (with splash guard), with ready access to an array of gleaming surgical instruments at his side. And the mother still assumes, for the most part, that she could not have �done it� without the physician�s advanced technical skills and thus is grateful to the doctor for �delivering� her. And as soon as the physician puts in the last stitch, his/her official duties as a surgeon are completed and the mother�s �post-op� recovery will be assigned to the nursing staff.

~ The Final Frontier -- Safe Maternity Practices for the 21st Century ~

The last and most crucial question in regard to the issue of an �appropriate� standard of care is whether or not modern day obstetrics for healthy women is a �superior� system that rightly displaces the traditional practice of midwifery. If that be the case, obstetrically-based practice would logically replace the non-medicalized from of care used by midwives and thus the obstetrical profession would have earned the right to define the �appropriate� standard of care for California licensed midwives. There are two excellent, well-respected sources that we may turn to for an objective determination on this question. The first is a scientifically researched publication known as �*A Guide to Effective Care in Pregnancy and Childbirth*� and the second is a survey of contemporary maternity care practices entitled �*Listening To Mothers*� that was commissioned by the Maternity care Association of New York City and conducted by Harris Poll Interactive.

(1) The determination of scientifically predicated, evidence-based practice parameters is based on the published work of Drs Ian Chalmers and Murry Enkins, the bible of evidenced-based maternity care entitled �*A Guide to Effective Care in Pregnancy and Childbirth*�(GEC). It is a compilation of all pregnancy and childbirth related studies published in the English language in the last 30 years.

The *Guide to Effective Care* identifies six levels effectiveness/efficacy, ranging from the positive end of �clearly beneficial� (category 1) to the negative end (category 6) of �likely to be ineffective or harmful�. Using the preponderance of available evidence, Drs Chalmers and Enkins rated each �standard� maternity-care practice and regularly used medical/ surgical interventions for safety and efficacy. Based on these categories, the *G E C* cautions that:

"Practices that **limit a woman's autonomy**, freedom of choice and access to her baby **should be used only if there is clear evidence that they do more good than harm**"

"Practices that **interfere with the natural process** of pregnancy and childbirth should only be used if there is clear evidence that they do more good that harm"

As measured by the 6 categories established by *Guide to Effective Care*, the �standard of care� presently provided by obstetricians is **extremely discordant when measured by scientific principles** (both in practice and in *interpretation* of scientific studies) and evidence-based practice parameters. Contemporary obstetrics reverses the recommended safe practices, with those identified as most beneficial and least likely to cause harm (List #1) being the *last or least used* and those identified as most likely to be ineffective or harmful (List #6) being the primary or routinely used methods. This vastly increases the number of medical and surgical interventions used and the complications occurring, both immediately and downstream.

(2) *�Listening to Mothers: Report of the First National US Survey of Women�s Childbearing Experiences*� by the Maternity Center Association ~ October 2002, as conducted by the Harris Interactive Polling Service. This is a survey of healthy mothers with normal pregnancies (no premies, multiple gestations, no sick mothers) who gave birth in the last 24 months. The full report (some 60 pages long) is available on the Internet at [www.maternitywise.com](http://www.maternitywise.com/)).

This important national survey from an impeccable source -- the well-respected Maternity Center Association (MCA) of New York City, a non-profit organization established in 1918. It promotes safer maternity care and develops educational materials for expectant parents on �evidenced-based� maternity practices -- that is, policies that are based on a scientific assessment of the safety and effectiveness of commonly used methods and procedures.

The Maternity Center Association documented a significant gap between scientific evidence and standard obstetrical practice. Healthy, low-risk women in the United States often receive maternity care that is **not consistent with the best research**. According the MCA, many people are not aware of the following major areas of concern:

~ The under-use of certain practices that are safe and effective

~ The widespread use of certain practices that are **ineffective or harmful**

~ The widespread use of certain practices that have both benefits and risks without enough awareness

             and consideration of the risks

~ The widespread use of certain practices that have not been adequately evaluated for

    safety and effectiveness

According the MCA's �**Listening to Mothers**� survey, the majority of childbearing women did not receive the safer and more satisfactory type of care delineated in the top 3 categories (those established as beneficial) and instead were exposed to a plethora of practices in the bottom 3 categories which were rated as of unknown or unproven effectiveness, unlikely to be effective or known to be harmful.

This document notes that in the last 24 months there were **virtually NO �natural� births occurring in hospitals. This entire population of childbearing women was subjected to one or more major interventions.** The only women who had a normal birth without medical or surgical interventions were those who had their babies in a domiciliary setting � home or free-standing birth centers.

 The basic stats for healthy women reflect the following routine medicalizations of normal birth:

**93%** continuous electronic fetal monitoring;

**86%** IV fluids and denial of oral food and water;

**74%** immobilized or confined to bed due to physician preference,

         hospital protocols or the limitations imposed by multiple medical

         devices (EFM, IVs, epidural catheter, Foley bladder catheter, etc);

**71%** push and deliver with mother lying flat on her back;

**67%** artificial rupture of membranes;

**63%** epidural anesthesia,

**63%** Pitocin induced *or* accelerated uterine contractions;

**58%** gloved hand inserted up into the uterus after the delivery

         to check for placenta or remove blood clots;

**52%** bladder catheter;

**35%** episiotomy;

**24%** Cesarean delivery (**12.6%** planned/**12.4%** in labor;

**11%**  operative � one-half forceps the other half via vacuum extraction.

In a population that was essentially healthy (95% +/-), an astounding **55%** **of women had some form of surgery performed � episiotomy, forceps, vacuum extraction or Cesarean section**. Using the classical definition of operative delivery (CS+ forceps/vacuum extraction) the rate for 2002 for California would be **38% or 2 out of five** or twice the operative deliveries reported by physicians in the early 1900s who merely performed operative procedures on one out of five.

Please note these statistics are for healthy women at term with normal pregnancies. Intervention **rates would be much higher for women with premature labor, multiple pregnancies or frank medical complications**.

The Maternity Center Association survey is consistent with data from the CDC�s National Center for Health Statistics Vol. 47, No 27, *The* *Use of Obstetric Interventions 1989-97,* which documents a steady annual increase since 1989 in each of these interventions. A press release dated June 6, 2002 based on the NCHS report �Births: Preliminary Data for 2001�; NVSR Vol. 50, No. 10. 20 pp. for the year 2001 <http://www.cdc.gov/nchs/releases/02news/birthlow.htm>), documents a **24.4% CS rate** (exactly the same rate as identified by the MCA/Harris Poll survey). Statistics for the **year 2002 show an even higher Cesarean rate � 26.1** in the US and **26.8 in California**.

Childbearing women are **three times more likely to die from the intra-operative, post-operative or downstream complications of Cesarean surgery than from normal vaginal birth.** These dangers don�t go away simply because the mother survived the surgery, as potentially-lethal complications and protracted difficulties extend into the postpartum period, post-cesarean reproduction, post-cesarean pregnancies and post-cesarean labors.

New mothers who were delivered by Cesarean experience an increased rate of serious postpartum depression, low self-esteem and breastfeeding failures and report post-operative pain lasting up to 6 months.

Complications of post-cesarean *reproduction* include a higher rate of infertility, tubal pregnancies and miscarriage. (Ob.Gyn.News �Elective C-Section Revisited� Dr. L. Elaine Waetjen; August 1 2001 � Volume 36 � Number 15)

Babies in post-cesarean pregnancies suffer a higher rate of fetal demise and stillbirth. (Ob.Gyn.News �C-Section Linked to Stillbirth in Next Pregnancy� May 15 2003 � Volume 38 � Number 10)

Mothers in post-cesarean pregnancies face a significant increase in placenta previa, placenta accreta and placenta percreta (types of abnormal growth of placenta into the wall of the uterus) as well as uterine rupture, emergency hysterectomy and the need for extensive blood transfusions (Ob.Gyn.News Vol 36, Aug 1, 02). The rate of **emergency hysterectomy** within 14 days of giving birth is **13 times higher** for women delivered by Cesarean surgery. (Obstet Gynecol. 2003 Jul;102 (1):141-5. Route of delivery as a risk factor for emergent peripartum hysterectomy)

These delayed and down-stream complications elevate mortality in post-cesarean pregnancies for both mothers and babies -- up to 10% for women who develop placenta percreta and about 1/2% for newborns. **The risks of Cesarean rise with each successive surgery as the operation becomes more technically difficult as a result of surgical adhesions.** (Ob.Gyn.News Vol 36, Mar 1, 01 & Vol 36, Sept 15, 01; *Elective Cesarean: An Acceptable Alternative to Vaginal Delivery*? Peter Berstein, MD, MPH).

By contrast, only 10% of the healthy women with normal pregnancies who choose home-based midwifery transfer to obstetrical hospital care during labor. The over-all **Cesarean rate** for mothers who **planned a homebirth is about 4%** with approximately 2% forceps or vacuum extraction. [extrapolated from 7,000 midwife-attended home labors documented in "Outcomes of Planned Home Births in Washington State" by Dr Pang, MD et al, ACOG journal, Aug 2002] This means nine out of ten women deliver naturally at home without the risks of the medical and surgical procedures listed above and without fear of downstream complications, which can cast a dark shadow over a future pregnancy. **The protective nature of physiological care is one of the most important reasons people seek out community-based midwifery**. Letters to Editor, ACOG Green Journal (*Obstetrics and Gynecology*) Jan 2003; *Safety of Alternative Approaches to childbirth* � PhD � Stanford University, Dr. Peter Schlenzka, 1999

The Maternity Center Association�s recommended �more physiological and less procedure-intensive care during labor and normal birth�. The beneficial practices identified by the *Guide to Effective Care* are protective and reduce medical and surgical interventions, At present these are absent for the majority of women giving birth in this country under obstetrical management. These helpful practices are based on the physiological management of labor and birth, which requires a **respect for the normal biology** of reproduction and a commitment **not to disturb that natural process**. The elements of success for normal labor and spontaneous birth are the same for home or hospital and include the tried and true methods of non-pharmaceutical pain management and promotion of a spontaneously progressive labor.

## Tort Law � One Size Does Not Fit All

Due to the restriction of tort laws on individual physicians, **doctors cannot independently implement common sense recommendations** as provided by the MCA or the *Guide to Effective Care*. At present, obstetricians are forced to provide care that is of the same quality as is the statistical norm for other obstetricians, even when that institutionalizes sub-optimal care as the 'standard.' As can be seen from these numbers, the majority of doctors impose a daunting array of interventions that are (to quote the authors of the GEC, p. 265) �ineffective, inefficient or counter-productive,� while failing to use many measures that have been documented to shorten labor, increase the mother�s satisfaction and self-esteem while reducing the frequency and severity of postpartum depression. According to the tenets of tort law, what constitutes the �standard� is initially established by the profession itself (as reflected in contemporary ACOG policies) and the numerical majority of practices used by obstetricians which establish the �customary practice�. Illogical as it sounds, **failure to utilize these harmful interventions is to provide �substandard� care** according to the conventions of tort law.

Practically speaking, what this means is that childbearing women who are strongly committed to a spontaneous labor and a �normal� birth and/or wish to avoid the �ineffective, counter-productive or harmful� methods of medical management must go outside the obstetrical care tort system. **Physicians are no more able to comply with the mother�s unique request for physiological (i.e., non-medical) management** (midwifery model of care) any more than an airline pilot or bus driver can permit a passenger to change the course of the company�s scheduled travel or otherwise take exception to the company policy. In response to the constraints placed on physicians by tort law as it pertains to obstetrical practice, a small number of childbearing women purposely choose to contract with *non*-physicians to provide *non*-medical, physiologically-based care as provided under the midwifery model of care. Tort law as it pertains to the competence and *due diligence* of the professionally licensed midwife would be determined by the historical standards applying to the distinct calling of community-based midwifery.

Conclusion ~ Midwifery is a Distinct Calling Authorized By

the LMPA to Provide Physiologically-based Care

Objective sources of scientific evidence supports the traditional practice of midwifery, effectively answering in the negative the question of whether modern obstetrical practices are safer than the physiological management of midwives. They are not and the obstetrical profession cannot claim to extinguish the traditional practice of midwifery based on the idea of �safety�. As amply documented, the medicalizing of healthy women with normal pregnancies does not improve outcomes for either mother or babies. Home-based maternity care is fundamentally non-medical, although it is neither unscientific or anti-medical and includes emergency medical responses and articulation with hospital services. It would be counter-productive to medicalize midwifery practices in the name of greater safety.

The *Licensed Midwifery Practice Act* and the Word �Appropriate�

The only topic left is the role of *Licensed Midwifery Practice Act* in determining *how* the word �appropriate� is applied to the standard of care for licensed midwifery practice. The questions are whether the LMPA acknowledges the traditional practice of midwifery as a safe and satisfactory form of maternity care, whether the LMPA and its amendments support the practice of non-nurse midwifery as a distinct calling and how, if at all, the supervisory clause of the LMPA impacts on the principle of self-determination in regard to an �appropriate� standard of care for community-based midwifery.

(1) **Self-Determination**: This speaks to legislative intent. The question is �Did the People of California intend to authorize and license the traditional (non-nurse, non-medicalized) practice of midwifery as a form of beneficial care for childbearing women that here-to-fore was unavailable ***OR*** did they merely authorize yet another form of proxy medical care (physician extender and/or �borrowed servant�) to serve at the pleasure of the obstetrical profession?� As a distinct calling, the profession of licensed midwifery would be self-determining, a category of practitioner that is the obverse of the "borrowed servant" concept. Under the theories of a "distinct calling", each caregiver is independently liable for his or her own "torts". The inverse would be the status of a proxy caregiver or physician-extender, which always exposes the physician to vicarious liability and thus creates the opportunity for greater control by the physician.

The Licensed Midwifery Practice Act on its face creates the distinct calling of professional midwifery that is �equivalent but not identical� to nurse-midwifery. We note that it was not titled the �***Obstetrical******Assistants******Licensing*** ***Act***� but rather the �Licensed **Midwifery Practice** Act�, which would legally create the category known as a �practitioner�.  The LMPA identifies a comprehensive educational curriculum unique to the profession of midwifery that could be expected to produce a fully qualified practitioner who possessed a body of technical knowledge, capacity for educated judgment and the necessary skill sets to function as a practitioner. These attributes include the ability to recognize obstetrical or pediatric complications that require referral and to initiate a transfer of care to medical services in a timely manner.

(2) **The traditional practice of midwifery acknowledged by the LMPA as safe and defined as unique:**

In September of 2000, SB 1479 amended the original LMPA. It further advanced the recognition of the unique nature of midwifery (its status as a distinct calling), it defined many of the characteristics of traditional midwifery care and noted the science-based nature of physiological (non-medicalized) care, including home-based midwifery. Last but not least, it declared the intention of the People of California, through their elected representatives, to make a safe alternative to hospital-based obstetrical care available to childbearing women who reside in the state.

**The intend language of SB 1479 reads**:

Section 4 ~ THE LEGISLATURE FINDS AND DECLARES THAT:

(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 in other countries. California studies suggest that low-risk women who choose a natural childbirth approach 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 the 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.

(3) **The Physician Supervisory Clause of the LMPA *does not* entail �Close supervision� or control of midwifery standards**

Section 2507 (c) of the LMPA notes that supervision **�shall not be construed to require the physical presence of the supervising physician**�. The loose affiliation between the physician and the LM described by 2507 (c) would preclude the idea that midwives were intended by the legislature to be �closely supervised�. Additional evidence that both midwifery and medicine retain their �distinct calling� classification comes from the functional nature of �close supervision�. The principle here **hinges on the expert or �distinct� nature of the skills in question, as close �supervision� can only be exercised when the �supervising� authority has a greater mastery of the skill than the �agent� or employee**.

By statute, midwifery is NOT the practice of medicine (section 2507e). Midwifery is distinct in origin, in philosophy, in training and in practice both from nursing and from the practice of medicine. Physicians, while trained, skilled and licensed to practice medicine, are NOT themselves midwives and are neither trained or experienced in midwifery, most especially as it has been traditionally practiced in a domiciliary (or non-medical) setting.  **Obstetricians do not have ordinary mastery in the discipline of community-based midwifery** and most certainly  **do not have the requisite �greater mastery� necessary for providing �close supervision**�.

The only situation in which a physician would have legitimate control over a professional midwife�s standard of care would be if the LM was a bona fide employee of the physician. Since an employer can be held liable for the negligence of its employee when those acts or omissions occurred within the scope of the employment, the physician-employer would be authorized to determine the specific standard of care provided by his/her employee. This doctrine is called *respondeat superior* (Latin for "let the superior or master respond" for the wrong that was done). Courts usually define the term "employee" in the same manner as the Internal Revenue Service and the courts in workers compensation cases.

 The salient question would be: Does the employer control (or have the right to control) not only the work done but also **the manner in which the employee does the work**? The courts also take into consideration which individual supplies the instrumentalities, tools, place of work, and the method of payment. Obviously a midwife independently attending to the needs of her own clients in a domiciliary setting is in control of the manner in which she provides care. Since the LMPA does not require the supervising physician to either be present, be consulted or to have ever met the childbearing women (unless she had a complication of pregnancy), the physician is not involved in any form of control over the midwife or the process of normal labor and spontaneous birth. The licensed domiciliary midwife certainly is NOT the employee of the physician who has agreed to provide medical consultation and, *if appropriate*, medical supervision or transfer of care for complications.

The other category that exposes a supervising physician to vicarious liability, and thus authorizes the external imposition of midwifery standards by a non-midwifery practitioner, is the doctrine of "agency" � whether or not the midwife is acting as an agent for the physician or, in contrast, are each independent contractors providing the benefits of their �distinct calling� to the same client, depending on the needs and the situation.

By this criteria, professional midwives are obviously independent contractors statutorily authorized to provide normal antepartal, intrapartal, postpartal and postnatal midwifery care without "close" supervision. When a midwife enters into a contractual arrangement with a physician, this dynamic interface with a medical provider is to the advantage of client families by creating continuity of care between the two professions, medical consultation, and access to back-up care and emergency services. This is a free agent contractual arrangement in which the physician agrees to provide **MEDICAL supervision** as the practice of medicine (not midwifery) is the areas of his/or her �**greater mastery�**. It is only the physician's �greater mastery� in the practice of medicine that qualifies him to exercise �close supervision� and that is only in the arena of medical care.

The licensed midwife is a *non-medical* �practitioner�, educated in a holistic discipline, trained to provide full-spectrum maternity care to healthy women with normal pregnancies and licensed to act independently on her own educated judgment. We know these to be statements of fact as midwives are neither �borrowed servants� or �agents� for obstetricians. Unlike nurses loaned to physicians, midwives cannot conveniently blame the doctor if they fail to use appropriate judgment in regard to their professional duty. When it comes to �due diligence� the buck starts with the midwifery model of care as determined by history and defined by the larger �community� of professional midwives and it stops with the individual midwife who violates those standards of care only at her own peril.

Physicians are educated and trained to provide a medicalized form of maternity care that is based on the idea that normal childbirth is a surgical procedure. Due to this restricted focus on �delivery� and their lack of exposure to and experience in applying the principles of physiological management to all stages of labor (first, second and third stage � i.e., labor, spontaneous birth of the baby and the placenta), obstetricians are not knowledgeable in the art and science of community-based midwifery.

 Thus the obstetrical community is not an appropriate source to define the �appropriate� standard of care for the practice of midwifery. Only the community of California Licensed midwives can appropriately define the standard for safe and cost-effective maternity care in a domiciliary setting as provided by LMs.

The members of the California College of Midwives respectively request the **passage** of Section 1379.23 regarding **Supervision and Standards of Care**, as required by SB 1950 which amended the **Licensed Midwifery Practice Act** of 1993 **as proposed**.

 Faith Gibson, LM,CPM

California Licensed Midwife 041

Executive Director, California College of Midwives/ACDM

Attachments:

[**Addendum � Historical Background**](http://docs.google.com/RM%20SB%201950%20Hx%20addemdum%20July03.htm)

            �[**Remarks on the Employment of Females as Practitioners in Midwifery**](http://docs.google.com/RM%20SB%201950%20Remarks%20Female%20Prac%20Jul03.htm) - 1820

            May 18, 1999 Letter from Norcal Mutual Insurance Company (medical malpractice carrier)

            **Short Cut to** [**Letter from Norcal Insurance Company May 1999**](http://docs.google.com/legal_legislative01/NorCalLttrMay98.htm) **stating that doctors**

**�cannot supervise, consult with or back-up any midwife for home birth�** or provide any

             assistance in an emergency

Cc:

Senator Liz Figueroa,

            Frank Cuny, California Citizens for Health Freedom,

            Division of Licensing, MBC members

            George Annas, JD; Chair of Health Law Department, Boston University School of Health

Obstet Gynecol. 2003 Jul;102(1):141-5.

Route of delivery as a risk factor for emergent peripartum hysterectomy.

a case-control study.

Kacmar J, Bhimani L, Boyd M, Shah-Hosseini R, Peipert J.

Women & Infants Hospital, Providence, Rhode Island, USA

Conclusion:

Cesarean delivery is a significant risk factor

for postpartum hysterectomy.

To evaluate whether cesarean delivery is a risk factor for emergent

postpartum hysterectomy. We performed a case-control study of patients

who delivered at Women & Infants Hospital between January 1989 and

February 2000. Fifty cases of emergent postpartum hysterectomy performed

within 14 days of delivery met our inclusion criteria. Using a

computer-generated list, two patients admitted to the labor department

at a time point similar to that of each case patient were selected as

controls (n = 100). We reviewed medical records for demographic data,

route of delivery, labor characteristics, surgical history, and

indication for hysterectomy. Cases and controls were compared, and logistic

regression was used to calculate the odds ratio (OR) and the 95%

confidence interval (CI) for the association of delivery route and

emergent hysterectomy. **Cesarean delivery was associated with a 13-fold**

**increased risk of emergent hysterectomy when we controlled for previous**

**cesarean delivery, dilation and curettage or abortion before the index**

**pregnancy, use of prostaglandin, and use of pitocin** (OR 12.9; 95% CI

5.2, 32.3).

Cesarean delivery is a significant risk factor for postpartum hysterectomy.