California College of Midwives ~

Defining An Appropriate Standard of Care for Licensed Midwives:

SB 1950 amends the Midwifery Practice Act of 1993. This new provision directs the MBC, the regulatory agency for licensed midwives, to define the �appropriate standard of care for the practice of midwifery�. This offers the opportunity to identify in regulation the basic distinction between the physiologically-based midwifery model of care which addresses the normal biology of healthy childbearing women (as defined in SB 1479) and that of the medical model which addresses pathology, dysfunction and complications.

At issue is a history by the Board�s enforcement division, which regularly utilizes hospital-based obstetricians as consultants and expert reviewers for cases involving quality of care issues for LMs. The problem with identifying obstetricians or even family practice physicians as a source for defining the standards for midwifery practice is two fold. First, standard medical training does not teach or utilize the physiological management of normal labor and birth, which is the foundation of the midwifery model of care. Second is that the legal foundation for medical practice, which is normally based on diagnosing pathology and a subsequent offer to �cure� the patient, is distinctly different from that of community based midwifery. Unlike medical care, midwifery is extended to healthy childbearing women and only at their invitation. The nature of that interaction is a contract in which midwives agree to help the mother deal more successfully with the spontaneous forces of nature which constitute �normal� childbirth. Midwifery practice precludes the use of any �artificial, forcible or mechanical means� which defines a pathological or abnormal labor and medicalized childbirth practices.

**Tort Law versus Contract Law**

**Medical practice under tort law as contrasted with midwifery care under contract law:** Obviously it is inappropriate to use the medical model, which is based on tort law, as the legal basis for midwifery practice, which instead is based on contract law. Tort law, which is what governs medical practice, reflects the fact that laypersons suffering from illness or injury could not normally be expected to know the specifics of medical diagnosis and professional treatment protocols or surgical procedures relative to a cure for their disease state or disability, and thus could not intelligently contract for the appropriate therapeutic regime. For this reason, what is 'standard' for medical practitioners relative to an identified pathological diagnosis is defined under the tenets of common law (the basis of our tort law) by what is regularly done under similar circumstances by other practitioners of the same profession.

There are many other examples of tort law in modern life such as boarding a public bus, hailing a cab or being a passenger on an airliner, in which no specific �contract� exists between the passenger and the driver/pilot. Even though one is a �paying customer�, a passenger has no right to direct or control the actions of the driver or determine the policies of the bus company. Quite to the contrary, the service offered is a standardized, one-size-fits-all. The only option for a 'dissatisfied customer' is to get off the bus if the industry standard is for any reason deemed unacceptable. However, as a passenger one has the right, under common law, to expect �standard� (i.e. safe) care and therefore can sue for monetary and punitive damages based on tort law definitions of the responsibility of the bus, cab or airline company if one should become injured during the trip.

Under the current conventions of tort law the practice of obstetrical medicine requires that obstetricians (and all hospital-based nurse-midwives) conform their practice to the common-law definition of a �community standard,� which is what is commonly done by other practitioners of the same status under the same or similar circumstances. This is not an evidenced-based concept but rather one of **statistical majority and convention**  -- what is regularly done. In hospitals, the industry standard is to define normal birth as a medical procedure. True to the rules of tort law, the hospitalized childbearing woman has no control over how any �medical procedure� is accomplished by the doctor. Once she has presented herself to the hospital as a maternity patient, her role is simply to submit to whatever aspects of the procedure are deemed �necessary� in the professional judgment of the practitioner. In the current medical model childbirth is a �medical procedure�. The only opportunity for the mother to control the course of events (or avoid standardized interventions) is to �get off the bus� (i.e., leave the hospital) -- an option which is not feasible during the birth of her baby.

For instance, if the childbearing woman wants to decline medical admission procedures, wants leave the L&D unit to walk around the grounds of the hospital, labor somewhere other than in her bed or deliver spontaneously in an upright position (for example standing or squatting at the side of her bed), the doctor or hospital staff will usually insist that they �can�t permit� it, as none of these activities are routinely done and therefore are all outside the �standard of care�. Were there to be a problem the doctor or hospital could be held liable for damages.

# **Historical Childbirth under General Anesthesia as the**

**Model for Procedure-Intensive Obstetrical Care**

The conventions of tort law characterize the physician (or by proxy, the labor room nurse) as �captain of the ship� and thus responsible for all aspects of outcome. As such doctors and nurses become quasi-enforcer of obstetrical standards organized more than 90 years ago when childbirth was defined as inherently pathological. Hospitalized mothers were under the influence of powerful narcotics and hallucinogenic drugs (�twilight sleep�), were unable to cooperative due to the effects of serious medical complications or unconscious due to anesthesia and thus unable to be personal responsible or be an agent in their own behalf. All vaginal births were conducted under general anesthesia with the routine assistance of episiotomy and forceps.

While the use of twilight sleep and general anesthesia is rare today, the contemporary medical standard in the United States is still for childbearing women to be immobilized in bed during labor (now the result of continuous electronic fetal monitoring and equipment relative to IVs, Pitocin administration and epidural anesthesia) and for the mother to remain 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 (see *Guide to Effective Care* and *Listening to Mothers* survey).

Once a �procedure� such as vaginal delivery or operative delivery (forceps, vacuum extraction or Cesarean surgery) is successfully completed by the physician, the doctor�s culpability under tort law is concluded and he or she is not liable for complications that may arise at a later date. For example, long term complications of forceps (incontinence or pelvic organ prolapse) or post-cesarean complications (infertility, abnormal placentation such as a previa or percreta in a subsequent pregnancy or a uterine rupture and neonatal death or permanent neurological damage) are not deemed to be the �fault� of the physician performing the original medical or surgical procedure.  This explains why �consent� for these hospital procedures does not routinely reveal the association between these surgical procedures and the pathological sequelae listed above which are well known to the medical profession. Under tort law, the doctor is free from future liability when he puts in the last stitch and writes standard orders for post-delivery/operative care. This principle is similar to the limitations on liability common in product liability law.

**Statistical Norms for Medical Care:** A survey of "regularly performed" obstetrical practices in the US was published October 24, 2002 by the Maternity Center Association of New York City (MCA), which is a nationally recognized not-for-profit organization dedicated to improving maternity care since 1918.  The data covered childbirth in the last 24 months among healthy women with term pregnancies and documented that �women who gave birth vaginally experienced high rates of use of many interventions and labor practices with **established** or potential **adverse effects**.� The researcher authors stated that: ��*there were virtually no �natural childbirths� among the mothers we surveyed.  Less then 1% of mothers gave birth without at least one of these interventions, and almost all of these came from the very small group (also less then 1%) of home births in our sample.��*

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, known as �*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. It 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 *Guide to Effective Care* cautions that:

"Practices that limit a woman's autonomy, freedom of choice and access to her baby should only be used 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"

The Maternity Center Association has 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.

The survey revealed that 93% of laboring women were exposed to continuous electronic fetal monitoring (associated with increased Cesarean sections rates *without* improvement in perinatal mortality), 86% had IVs while being prohibited from drinking or eating, 74% were required to give birth lying on their back, 71% were immobilized / confined to bed / not permitted to walk during labor, 67% had artificial rupture of membranes, 63% had labors induced or accelerated with artificial oxytocin (Pitocin), 63% had epidural anesthesia, 58% had a gloved hand inserted into their uterus after birth, 52% had bladder catheterizations (causes an increase in bladder and kidney infections), 35% had episiotomies, 24% had cesarean surgery (2-4 Xs increase in maternal mortality, abnormal placentation/ emergency hysterectomy in subsequent pregnancy) and 13% of babies were delivered via forceps or vacuum extraction, for a total of 37% operative delivery. 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 medical complications.

This accounting 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** (with associated increases in maternal deaths, placenta percreta and emergency hysterectomy) and a **76% drop** in the rate of VBAC births in the year 2001.

The Maternity Center Association recommendations were for �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.

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Physiologically-sound practices (midwifery principles of care) includes: �patience with nature�, continuity of care, full-time presence of the primary caregiver during active labor, social and emotional support, walking, unrestricted access to oral fluids and snacks,  recognition of the non-erotic but none the less sexual nature of spontaneous labor with provision for appropriate psychological privacy, an upright and mobile mother during active labor, non-pharmaceutical pain management such as touch relaxation, help with labor breathing techniques and access to showers and deep water tubs,

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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 midwife to appropriately use "midwifery" (i.e. physiological) management).

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Due to the limitations of tort law individual physicians cannot implement common sense recommendations as provided by the MCA or the *Guide to Effective Care*. At present, doctors are all forced to provide care that is of the same quality and quantity 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, lessen the need to artificially accelerate labor with oxytocin / Pitocin and use narcotics, epidural anesthesia, admission of babies to the NICU and reduce 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 ACOG policies) and the numerical majority of practices used by obstetricians which establish a mathematical mean. 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 �natural� birth and/or wish to avoid these ineffective, counter-productive or harmful methods of medical management must go outside the tort system since doctors are not able to comply with the requests for non-medical physiological management (midwifery model of care) any more than airline pilots or cab drivers can permit passengers to direct the course of their travel. For that reason, these women choose instead to contract with non-physicians to provide non-medical, physiologically-based care as provided under the midwifery model of care.

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

**Professional responsibilities are 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 practice of her profession (see www.collegeofmidwives.org web site for a definition of standard midwifery practice)

            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 � a clear and present danger of death or disability

**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 specific actions taken and of care provided, the content of patient education and instructions given by the midwife and informed consent conversations

d) Obtaining written consent / informed decline of care when applicable and memorializing in writing any formal discussions or consultation with other professionals relative to making decisions on care and medical interface.

These aspects of care make up the appropriate �standard� of care for professional midwives. **The professional midwife who conforms to this standard is judged to be competent.**

The membership of the ACDM/California College of Midwives has developed a comprehensive set of practice guidelines recorded in a document entitled *Characteristics of Clinical Competency*. These standardized guidelines were adopted by the 55 professional midwives -- both CMNs and LMs � who were members of the malpractice consortium covered by professional liability insurances as provided under a group policy through the American College of Domiciliary Midwives.

**The *Characteristics of Clinical Competency* includes**:

1. The international definition of a midwife

2. A definition of the midwifery model of care

3. Standards of practice for community midwives

4. Philosophy of care

5. Code of ethics

6. Informed consent policy

7. Educational competencies

8. Criteria for client selection and preliminary consultation

9. Indications for discussion, consultation and transfer of care during the antepartum, intrapartum, neonatal and postpartum periods

10. Special circumstances informed consent / decline of standard procedures and provision of care under the �Good Samaritan principle�

These standards and guidelines are **supplemented by** **technical bulletins** for:

            Intermittent auscultation

         Episodic electronic fetal monitoring

         Guidelines for postnatal management following birth at home

         Presence of meconium in a vigorous term newborn.

The *Characteristics of Clinical Competency* is available for your review on the ACDM/California College of Midwives Internet web site. A hard copy was provided to the MBC staff in November of 1999. I will also bring a hard copy for each of you to the Midwifery Task Force meeting.