VBAC Criteria for California Licensed Midwives under Article 3.5

Compliance by LM#041 Faith Gibson with Section 1379.19; (b), item 2

> "A description of the licensed midwife's level of clinical experience and history with VBACs and nay advanced training or education in the clinical management of VBACs:

Faith Gibson is a California licensed midwife (LM #041) and a nationally Certified Professional Midwife (CPM #96050001). Prior to cross training in midwifery she was a labor & delivery room & emergency room nurse. She's had a private practice on the San Francisco peninsula since 1983, providing midwifery care for planned home birth (PHB). In addition she has provided labor support at home and in the hospital for mothers planning hospital births. The majority of this patient population had unusual obstetrical circumstances such as twins, breech, VBAC, IVF pregnancies or older first-time mothers.

Nursing Employment History:

Seventeen years vocational nursing in acute-care institutions;
Emergency room/trauma medicine, labor & delivery room staff
Hospital-based childbirth educator
Office nurse for family practice physician
Visiting maternity nurse for postpartum home care

Advanced Training and Education relative to VBAC:

Current certificate in **Neonatal Resuscitation** (2007)
Current certificate in **Cardio-pulmonary Resuscitation** for infants and adults (2005)
ICAN workshop analyzing the scientific literature relative to various classifications and categories of post-cesarean patients and outcome statistics for VBAC and neonatal morbidity and mortality (2005)

Professional History with a Post-Cesarean Patient Population:

I have worked with post-cesarean women who desired to have VBACs in hospitals or at home since 1982. I was the facilitator for a VBAC moms group that met every two weeks from 1982 to 1990. During that time I attended approximately 50 VBAC labors and births of mothers who planned hospital VBACs. This included pre-hospitalization labor support at home until active labor was fully established and then electively transfer to the hospital for the balance of their labor and vaginal birth or repeat C-section. The vaginal birth rate was approximately 90% for this patient population. There was no morbidity or mortality in the hospital cohort for either mothers or babies.

In addition, I have attended approximately 35 planned VBAC at home over the last 25 years, with a vaginal birth rate of approximately 95%. There was no morbidity or mortality for mothers or babies when labor and/or birth was planned to occur at home.

In addition to the MBC Standard of care regulations also use the Moderate-Risk labor & Birth guidelines as published in the *California College of Midwives* Standard of Care / Special Circumstances:

California College of Midwives

State chapter ~ American College of Community Midwives

Section One

MODERATE-RISK LABOR & BIRTH ~ Protocols & Criteria for Midwives providing domiciliary birth services in "**Special Circumstances"**

Special circumstances of pregnancy or parturition require special training, special skills and special preparation on the part of the licensed midwife, as well as a willingness by the midwife to take on potentially complicated or litigious legal and/or political consequences. It also requires special arrangements and a special informed consent or decline of standard care waiver from the client and her family and a similar willingness on the part of the client's to expose herself to potential complications of unknown severity and the legal consequences of a unpopular choice.

In a perfect world, neither the client nor the midwife would have to make these difficult choices. In the mother-friendly Dutch system, this would be resolved by what Dutch midwives call a "relocated home birth", that is, routine physiological management by midwives in a low-tech hospital environment with immediate access to obstetrical care and surgery. In this integrated system, mothers and babies get the "best of both worlds."

Unfortunately our obstetrical system does not offer this opportunity. In the US, doctors and hospital do not offer or even permit the childbearing women to choose physiological management in certain moderate risk situations due to fear of lawsuits. At present pregnant women with moderate risk factors are frequently forced to decide between multiple unwanted medical interventions and/or physiologically unnecessary Cesarean surgery *or* to labor at home unattended. However, childbearing women and their unborn or newborn babies are always safer with an experienced professional present than they would be giving birth *unattended*.

Risk vs. Complication: The *Licensed Midwifery Practice Act of 1993* prohibits providing care to childbearing women with any significant medical *complication*. However, the LMPA is silent about the topic of "*risk*." The scope of practice for California midwives legally defines midwives as being authorized to attend "normal childbirth."

Normal Birth Defined: The term 'normal', as used in the LMPA and the both previous California statutes relative to midwifery, equates with a natural or spontaneous birth process, that is, one *not* requiring the use of any "artificial, forcible or mechanical means." Thus 'normal' would encompass all spontaneous physiological processes characteristic of healthy reproductive biology in healthy childbearing women that can reasonably be expected to lead to normal healthy conclusions.

Criteria for Moderate Risk Circumstances: When client and midwife both agree that the risk-benefit ratio is acceptable, the following criteria must *also* be satisfied in order for the Midwife to provide domiciliary birth services to women with moderate risk circumstances:

Criteria for the Midwife: (per OAL decision by Judge Roman)

1. Must have attended at least 75 births as the primary midwife following licensure
2. Must have advanced training that clearly identifies her experience, skills and comfort to represent an elevated level of professional knowledge and ability beyond "entry -level" midwifery
3. Must be current in neonatal resuscitation and have training and skills in emergency or “first-responder” abilities for mother and baby
4. Must have had advanced experience via attendance of moderate risk labors at home, hospital or a birth center, with supervised hands-on experience in the specific circumstance that applies to the specific client
5. "Special Circumstances // Moderate-Risk Informed Consent Waiver of Standard Midwifery Advice” must be read, agreed to, signed by the client and retained in the client’s chart a (see samples of Informed Consent/Special Circumstances Decline of Standard Care waivers)

Criteria for the Client:

A. Normal pregnancy with reasonable expectation of the normal birth of a healthy baby:

1. ‘Normal’ is functionally defined as a healthy pregnancy that naturally advances to term with a live, growth-appropriate fetus/fetuses in a vertical lie and which can reasonably to expected to culminate with a spontaneous onset of labor that will progress normally to the spontaneous live birth of a viable neonate, with **conservation of the health of the mother and well-being of the baby being the desired outcome and goal**.

2. ‘Normal’ requires a baby in a longitudinal lie that engages in the pelvis before or during early labor and which establishes its ability to fit by advancing sequentially through the stations of the pelvis in a timely manner while displaying no evidence of significant or persistent fetal distress.

B. Circumstances of fetal demise or fetus with documented lethal untreatable congenital anomalies (incompatible with life such as anencephaly, etc) for which medical care is unable to influence outcome and for whom the parents have declined hospitalization with appropriate informed consent/decline of medical advice waiver.

ADVANCED MIDWIFERY SKILLS ~ For Specific Circumstances in Moderate Risk Parturition in Domiciliary Setting (list is not exhaustive)

A. All moderate risk labor situations call for the highest level of fetal monitoring with intermittent auscultation at a minimum of q 20 minutes in active labor, q ten minutes in second stage and q 5 minutes or every other contraction while actively pushing; alternative method - episodic or continuous electronic fetal monitoring.

B. A moderate risk labor calls for a high level of emergency transport plans, including less than 30 minutes to a tertiary care hospital which offers 24/7 in-house obstetrical and anesthesia coverage with access to a fully staffed operating room and other services such as lab and blood banking.

Criteria and guidelines for Physiological management of post-cesarean vaginal birth (based on the model identified by the OAL decision)

1. Documentation of one low transverse incision without serious post-op morbidity/infection
2. Strong recommendation for greater than 18 months between births
3. Adequate pelvis for size of baby
4. Distance to hospital less than 30 minutes
5. Signed informed consent / topic-specific special circumstances decline of medicalization (see special circumstances VBAC informed consent for other VBAC-specific criteria)
6. Once *active* labor begins, progress must be straightforward
7. Highest level of fetal monitoring with intermittent auscultation, episodic or continuous electronic fetal monitoring

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Reading List for Post-Cesarean pregnancy / planned OOH~VBAC clients:

Copy of Article 3.5 Midwifery Practice ~ Section 1379.91
Medical Board of California ~ Standard of Care Regulations adopted OAL ~ March 2006

Informed Decision Making, Informed Consent or Refusal
Copyright © 2006 Childbirth Connection., updated 3/10/2006

Options: VBAC or Repeat C-Section
Copyright © 2006 Childbirth Connection. updated: 4/5/2006

ACOG's policy "Vaginal Birth After Cesarean Delivery"
Practice Bulletin No. 5, published July 1999 Edition #1 / Printed August 2006

Enforcing and Promoting the Rights of Women Seeking Vaginal Birth After Cesarean (VBAC): A Primer by Katherine Prown, Ph.D.
web site ~ International Cesarean Awareness Network (ICAN)

VBAC ~ History, Economics, Hospital Staffing ~ Dr Ronald Cyr_ *American Journal of Obstetrics and Gynecology* Sept 2002 (Volume 187, Number 3)

Not safer and not cheaper? Letter to the Editor on Elective Cesarean
By Michael Klein, MD Centre for Community Child Health Research, BC Child and Family Research, Institute, Vancouver, BC // CMAJ • November 7, 2006; 175 (10) © 2006