**Mother**�**s Day**,

May 9th 1999

**RE: Expert Reviewers --**

**"Generally Accepted Practices"**

**~ Clinical competencies for professionally licensed practitioners**

**Dear Friend**,�

I am hoping to interest you in volunteering a little of your time and expertise to a worthy cause. I’d like you to read and critique the enclosed/posted documents on Characteristics of Clinical Competencies. But before giving you details, let me give you a bit of the background information.

I and a few other California midwives have organized a state chapter of the American College of Domiciliary Midwives, known as the *California College of Midwives.* The major purpose is to unify and professionalize community-based or domiciliary midwifery as licensed by the Medical Board of California.  Seventeen percent of all American births occur in California, so we can assume that our state is a leader in setting policy for the nation. To have any change of achieving the lofty goal of unity and professionalization, it seem evident that we must together draw the various different (and at times opposing) philosophies and diverse practice styles and practice settings represented by California licensed direct-entry midwives and still, in the final frame, create a unified profession that is in step with both the science and the politics of our time.

It is my sincere belief that one of our first activity must be to define and achieve consensus on a definition of the midwifery model of care, philosophy, code of ethics, standards of practice, normative scope of practice and characteristics of competency for licensed midwives and simultaneously, within the same context, to identify the legal autonomy and ethical right of the parents to make elemental decisions about their care (including the right to decline interventions or make medically unpopular decisions). The finished product, it is hoped, will be an integration of the best of the oral tradition of midwifery with the **best of evidenced-based practice parameters.**

I have combed various practice protocols of other professional midwifery groups (Holland, British Columbia, MANA, NARM, homebirth guideline from ACNM, etc) by going over them line by line and combining that information, along with the general experience of homebirth midwives, to create the draft version of the enclosed document, which is also currently available on our web site. Using the Delphi model of a consensus of expert midwives, hard copies of this material have been sent to experienced midwives and other "experts" for review, critique and commentary. Opinions, criticisms, suggestions and other forms of constructive feedback from all these sources will be incorporated into a second version and posted on the ACDM/CCM web site. After it is generally circulated among the membership, it will be put to a vote.

The question will be  **if each voting member can agree to at least 90% of the material**  and believes that she would be able to practice under this criteria in spite of any specific aspects she may find objectionable. If ratified by a super-majority of the membership (60%), it will become the official guideline for members of the College. As with any evidenced-based instrument of this kind, it is in actuality a slowly moving train in need of constant modification and so will be amended accordingly as scientific evidence warrants and submitted to ratified by the membership every 3 years thereafter. I will web-wife interim additions and amendments.

It is this document that I am asking you to review as an "expert" in midwifery or a related field that deeply effects or is affected by the practice of midwives and/or the obstetrical management of normal childbirth.

A somewhat less democratic version of this method is used by ACOG when developing its own legal definitions of the obstetrical standard of care . The product of this process (the series of ACOG technical bulletins) is then utilized in all manner of decision-making including the malpractice definition of "substandard" care, negligence and incompetency in court cases. In fact, it is this very process that defines a "profession", as t**he practitioners of a technical discipline join together to create a distinguished identify to which they subsequently "profess" allegiance**.

The concept of a "profession / professional" arises from the Middle Ages in which nuns and monks participated in a "profession of vows" (i.e. professed their allegiance) to follow the Rules of their religious order as defined by its founder and adopted by the members of the religious community. After this ritual the newly "professed" nuns and monks became known as "professionals" (some who professed to follow an ethically-based standard). As medical guilds arose in the 1500 & 1600s this process was imitated by them. Like religious orders, they developed a code of ethics and standardized activities and then required all the members of the guild to swear or profess allegiance to them, thus creating the status of a "professional" in the secular world. The historical background of exclusive title (or license to use a title such as "medical doctor", etc) was granted by a royal decree of the king. From this come the concepts of a professional "standard of care" and professional licensure utilize to this very day.

The problem is that non-nurse midwives have by and large been left out of this loop. Without ever having attended a spontaneous labor and/or ever being present at a home birth (or studied the principles of normal midwifery care or becoming familiar with the non-interventive techniques of midwives), the obstetrical community is enthusiastically applying their definitions of "professional" standards for hospital-based obstetrical practice to community-based midwifery. It is crucial that this tactic, which is being used to eliminate the independent practice of midwifery, be stopped. The legal parameters of the practice of licensed midwifery must be defined ***by*** licensed midwives, hopefully with the constructive criticism of parents and consumer groups, and of obstetricians, pediatricians, perinatalogists, CNMs, lactation counselors and other professionals. Only in this way can independent, community-based midwives become true "professionals" in control of our own profession.

An example of how important this is can be seen in a case currently being pursued a against a licensed midwife. If successful dangerous precedents that are an anathema to the independence of midwifery and parental informed choice will result. This case would require every midwife to force laboring women into the hospital for a CS after 2 hrs of complete dilation. Failure to be so would be, *ipso facto*, proof of negligence and incompetency. Mind you this is not 2 hrs of hard pushing or because of any distress on the part of mother or baby or to be voluntarily hospitalized for non-surgical assistance but the expectation of a CS at 2 hrs post 10 cm dilatation!. Failure to conform to this would be grounds for revocation of one’s midwifery license. Heavy-handed methodology of this sort denies the natural autonomy of the mother or her right to make *any determinations* about birth care that are medically unpopular. We can only stop this if we come up with a strategy that is respected by the scientific community and will  **stand up in the court of public opinion as well as a court of law**.

The historical practice of obstetrics has not, in the main, been scientifically well-founded. Current obstetrical practices, while "usual and customary", are *still not* evidence-based. Childbearing families would be best served by the creation of a single standard of maternity care -- a broad continuum which honors the Midwifery Model of Care at one end and the highest level of obstetrical and perinatology interventions at the other. This system would strongly encourage (and provide incentives) for doctors to recommend midwifery care for healthy moms who didn’t plan on medication or anesthesia. Of course, midwives will continue to recommend obstetrical care for complicated pregnancies or women who are planning to have pain meds or anesthesia or prefer physician-only care.

This model also assumes that medical students and interns will learn normal birth from midwife educators and that the non-invasive skills that are the hallmark of midwifery care will be learned and routinely employed by physicians before they use the high risk interventions. For instance, common sense would decree that physicians first use gravity by getting the laboring women up, helping her to squat or take advantage of other ‘midwifery’ ticks before using forceps. The same would apply to the use of the Gaskin maneuver, i.e., hand and knees, to resolve a shoulder dystocia (assuming of course that the mother did not have an epidural or other medical complications preventing their use) before using a Zanvanelli maneuver (push the baby back in and perform as CS). However, the first order of business is far more modest -- it is just to write an evidenced-based Characteristics of Competency which includes an acknowledgment of the rights of parents to make crucial determination about their care.

Clearly our first choice of these guideline would be absolutely conservative criteria above reproach from *all* quarters. However, it is very clear to those of us who have practiced for any length of time, that  **tight and narrowly drawn criteria only results in a vast increase of mothers who either choose unlicensed, unregulated midwives or give birth unattended.** The research by Peter Schlenzka identifies that, in general, community-based birth services are of equal or greater safety as measured by perinatal mortality and morbidity and that these number hold *even when applied to pregnancies with identified risk factors*. In the absence of an actual medical complication, obstetrical treatments appears not to offer much improvement over the outcomes achieved OOH via non-interventionist approach of midwives. With this in mind, I have  **made every attempt to protect childbearing families, their midwives and the reputation of midwifery with tightly drawn criteria** requiring recognition of all identifiable risks and either consultation and/or referral OR very tight informed consent /decline of standardized care for those families who cannot be convinced that medical care is best for them. Naturally, this does not apply to circumstances of evident and immediate danger.

For the last 30 years, approximately 1% of mothers in California have chosen to give birth OOH. This number was steady for decades before the first midwifery licensing law (CNMs in 1974), after 20 years of CNM practice and the same after 6 years after passage of the Licensed Midwifery Practice Act (1993). It does not go up, or down and it won’t go away. For the unborn and new babies in those families, having their mother’s labor and birth attended by a skilled, experienced and regulated midwife is a human rights issue.

Since the dangers of hospital over-treatment are generally greater than those of under-treatment (via midwifery model of care) for healthy pregnancies with risk factors, it seems to be a better tactic to avoid forcing medical services on people via threats of abandonment if they don’t comply. And especially from the baby’s standpoint, it seems crucial to avoid forcing families into choosing between an unattended birth or inexperienced uncredentialed caregivers who are disarticulated from medical backup.

So the result is enclosed. If you are unable or unwilling to review, would you be so kind as to return the manuscript to me so I may send it on to another expert. Specific directions are in the front sleeve of the document itself.

TIA, Warm Regards,

faith Gibson, LM, CPM

Licensed Community Midwife #041

Executive Director, ACDM/CCM

**go on to** [**Instructions**](http://docs.google.com/lttr_instruction_ccc_99.htm) **for Expert Reviewers**

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