American College of Domiciliary Midwives

3889 Middlefield Road, Palo Alto, CA 94306

February 7, 1997 Public Hearing

Medical Board of California

Division of Licensing

Submitted in conjunction with Oral Testimony

RE: Opposition of Proposed Supervisory Regulation 1379.21

We oppose adoption of this regulation for the following reasons:

Necessity --the Board has not demonstrated for the record substantial evidence of the need for each part of this regulation.

Authority -- the Legislature has not delegated to the agency the power to adopt this regulation.

Consideration of Alternative -- The Division has not determined that the "alternative" (i.e., no supervisory regulation) would be more effective than, as effective as and/or less burdensome on affected persons than the proposal regarding 1379.21, physician supervision.

Medical Board policies must preserve the ability of midwives to shield physicians from unnatural liability by not creating an artificial relationship of "agency" between physicians and midwives and/or the legal principle of "close supervision".

Pertinent Background and the History of SB 350

-- Licensed Midwifery Practice Act of 1993

Senator Killea, sponsor of the Licensed Midwifery Practice Act of 1993, records in plain language that is was her intention that midwives not be burdened with any further limitations via the imposition of regulations regarding physician supervision over and above the limitation already imposed by section 2507. [enclosures 1,2,3,4,9,20] In Senator Killea’s own words in a letter to the MBC dated 11/3/93: " *As you know, the bill does not require the Board to promulgate regulations except to update the educational requirements in four years to reflect the national standards of midwifery education"*  [9]. Physician supervision as defined by Senator Killea was specifically noted to be the same arrangement required by law for certified nurse-midwives. CNMs are ***not*** required to have any written agreements, written practice guidelines, written communication arrangements or other impediments to practice in regard to physician supervision. [1, 14]

Senator Killea repeated these statements in oral testimony before the Medical Board of California on 11/3/94, again insisting that it violated her expressed intent for the MBC-Division of Licensing to burden direct entry midwives with regulations which *"have been tested and proved to discourage collaboration between physicians and midwives".* This comment refers to nearly identical supervisory regulations (section 1464 and 1465) passed by the Board of Registered Nursing in 1974 and repealed in 1985. [1]

As recorded in the Minutes of the DOL 11/3/94 meeting, Senator Killea stated that "the intent of this legislation is to provide affordable prenatal and delivery care... ...that in the legislative process, the representatives from California Medical Association (CMA) wanted an identical scope of practice (for direct-entry midwives) as were already defined for certified nurse midwives, which includes practicing under the supervision of a physician*. The idea of a written agreement was rejected by the Legislature. It should be left up to the physician as any other relationship.* This was testified to by a physician who is very active in utilizing midwives and finds that the idea of a written agreement would depend on the individual situation. The [malpractice] insurance companies can independently require written agreements, depending on circumstances.. *So this should not be written into the regulations and it was not included in the actual bill that became law".*  Senator Killea "asked the members to honor the work of the midwifery committee. Certified nurse midwives or licensed midwives working under the reasonable state guidelines should allow them to provide the equivalent high quality services...." [20]

A letter by Dr. Schumacker, MD, appointed board member of the MBC, to Greg Gorges, Legal Counsel, DCA, dated 8/11/93, [5] states Dr. Schumacker’s official opinion on SB 350. It states his "objection to this legislation center(s) around inadequate supervision, a lack of any mandated review process, ....and a failure to interface with the established systems of care". The list of his suggestions includes "... *a written contract with any licensed midwife under his/her supervision*". Clearly some members of the medical board held strong opinions prior to the passage of SB 350 for this legislation to be modified to include written protocols. However, the Legislature did not agree with these requests.

The Assembly Committee Hearing on Health chairman, Burt Margolin, noted that "This bill does *not require that the supervisory relationship be confirmed in writing or that protocols for patient case review be established."* [6] It was also noted in Senator Killea’s 11/3/93 letter to Jackie Trestrail, then president of the MBC [9], that "opponents repeatedly asked for amendments to require a written agreement between the supervising physician and the midwife. *That agreement was defeated each time by committees in both houses*". **[***emphasis added***]**

A professional publication -- OB-GYN NEWS, 9/15/93 -- quoted Dr. Vivian Dickerson, chairman of District IX (California) of the American College of Obstetricians and gynecologists, saying that ACOG "*held out for a guarantee of supervision*  rather than a more collegial relationship, which was, we felt, *an invitation to home births*". The article goes on to say "ACOG has been strongly opposed to home births for more than a dozen years. California, along with Illinois, requires that certified nurse midwives be supervised by physicians, unlike states which license "lay" or certified nurse-midwives. What this means, in practical terms, is that instead of the midwife being in charge and telephoning physicians for consults or referrals, the physician is ultimately responsible for the patient and sets protocols in a formal (*and most likely written) relationship*." The article further quotes Dr. Milton Estees, saying: "Certain malpractice carriers won’t insure anyone who has anything to do with home births." [7]

An analysis of the legislation undertaken by the MBC to determined what actions needed to be taken by the Board subsequent to the October 1993 passage of the bill directly supports this assessment. A letter written by Deputy Director Doug Laue, dated 2/7/94, outlines seven specific activities, none of which had anything to do with supervisory regulations. [12] In fact, the words "supervision" and "written agreement" do not appear in any of the seven bulleted paragraphs contained in this letter to Dr. Del Junco (former president of the Medical Board).

A discussion paper written by the MBC program staff [14] during the Midwifery Implementation Committee meetings also noted that similar regulations had been tried by the Board of Registered Nursing and "*these regulations were repealed in 1985\*****.* Per Board staff these regulations were no longer needed. The (Nursing) Board does not have any guidelines on the role, responsibilities or relationship of the supervising physician.** *The (Nursing)Board assumes an accepted standard of practice.****"***[*emphasis added*]

A specific formula for regulatory process used by the MBC occurs in a document entitled "Initial Statement of Reasons" (dated 2/28/94) which exists for other regulations passed by the DOL (1379.1-3) but *not* for 1379.21. [9] Where this formula of the MBC to be applied by the Division of Licensing to proposed 1379.21, we believe that it would be clear that the MBC lacks statutory authority for this proposed regulation.

In a letter from the Center for Public Interest Law, dated 6/24/94, by attorney Julianne D’Angelo [15] who regularly attends MBC meeting, states her legal opinion that "...the Division of Licensing is *not* authorized to adopt a regulation requiring a written supervisory agreement between a supervising physician and a midwife". She also lists areas of regulation in which the legislature did grant authority to the MBC and none of those six topics deal in any way with additional supervisory regulations.

We believe a memorandum by the DCA to bureau chiefs, dated 9/4/92, to be to give pertinent background information. [10] This request by the Governor’s Trade Representative asks each state agency to prepare a plan of implementation for the North American Free Trade Agreement. This letter defines the "anti-competitive" impact of NAFTA which specifically *disallows* any licensing or certification statues, regulations or procedures which are not based on objective and transparent criteria, competence and the ability to provide the service or which are more burdensome than necessary to ensure the quality of the service."

This is reiterated in a letter from the Federation of State Medical Boards by Dorothy Harwood, dated 1/11/94,.[11] which says that "State medical board licensing standards are not pre-empted. NAFTA’s objective in relation to licensing is to prevent licensing requirements from being "unnecessary barriers to trade," stating that any state licensing requirements "*not* constitute ***a disguised restriction***  *of the provision of services*.... Requirements should be based on competence" Approval of this proposed regulation would result in a "disguised restriction of the provision of services" and an insurmountable barrier to practice for direct entry midwives licensed under the LMPA. [*emphasis added*]

Included in the documentation is a letter, dated 7/7/94, by homebirth mother and midwifery client, Cameron Radke, which documents the refusal of an obstetrician to provide any medical services to her unless she first agreed to stopped seeing her midwife "as their insurance forbid them to provide care to anyone seeing a midwife". Clearly, the issue of written documents creates a situation of "vicarious liability" for the supervising physician, thereby becoming an undue burden to practice and a disguised restriction on the provision of the service. [16]

And lastly, we observe that a letter by the American College of Obstetricians and Gynecologists (ACOG), dated 8/11/94, also by Dr. Vivian Dickerson [17] appears to provide the missing piece to the puzzle. While neither the text of the statute nor the expressed intent of the Licensed Midwifery Practice Act author mentions *any form* of a "written practice guidelines/ protocols" ACOG’s letter specifically requests that the MBC further burden the supervisory relationship between midwives and their supervising physicians with such written practice guidelines.

A side-by-side comparison [see enclosures 18 & 19] contrasts the wording of Section 2507, the ACOG letter and the proposed test of 1379.21. Enclosure 16 contrasts the language of the LMPA with the actual text of 1379.21 and finds that the statute itself contain NO instances of the words "written practice guideline" while the proposed regulation contains 4 instances. Enclosure 19 contrasts the request by ACOG with the proposed text of 1379.21 and finds it to be a virtual blueprint for 1379.21, using the exact words, syntax and word order. Out of a total of 122 words communicating the professional desires of ACOG, 54 words appear in the proposed text of 1379.21 (underlined), which itself contains 53 words reiterating the language of the ACOG letter.

**Shielding Supervisory Physicians from Unnatural Liability**

Medical Board policies must preserve the ability of midwives to shield physicians from unnatural liability by not creating an artificial relationship of "agency" between physicians and midwives and/or the legal principle of "close supervision". When a relationship of agency or "close" supervision exists, the physician is *unnecessarily* exposed to vicarious liability under the "captain of the ship/borrowed servant" theory. Except when purposely created, this "captain of the ship" theory is an obsolete legal doctrine.

For instance in the case of *Truhitte v. French Hospital*;, 128 Cal.App.3r 322, 348 (1982) the court stated that "We question whether the 'captain of the ship' has any remaining independent existence; the vicarious liability of a surgeon for the independent negligence of nurses and other assistants is determined in the cases under the general rule of agency" ('agency' is a legal term indicating that an individual is acting on behalf of another as "agent" for the first, known legally as the 'principal' ). Such courts indicate that in the modern healthcare marketplace, a physician will be liable on a DIRECT negligence theory ONLY where a physician, in fact, controls that actions of a health professional or otherwise breaches a specific duty imposed on the physician.

**Control & "Close" Supervision versus an Autonomy**

The only situation in which a physician is likely to be found liable for the negligence of a professional midwife is when she is a bona fide employee of the physician. An employer is almost always held liable for the negligence of its employee when those acts or omissions occurred within the scope of the employment. 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 is: 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. Clearly, a midwife independently attending to the needs of her own clients in a domiciliary setting would NOT be the employee of the physician who has merely agreed to provide medical consultation and ordinary (ie. not close) *medical* supervision. Consultation, collaboration and supervision defined by 2507e does not have the attributes of "close" supervision which burdens the physicians with vicarious liability.

**The Doctrine of Distinct Calling**

The other category that exposes a supervising physician to vicarious liability is the doctrine of "agency" -- whether or not the midwife is acting as an agent for the physician or, in contrast, each are independent contractors providing the benefits of their "distinct calling" to the same client, depending on the needs and the situation. Again, the factors that courts consider when deliberating on liability is whether one party has the right to control the actions of the other, the nature and extent of that control and whether the contractor is engaged in a distinct calling which traditionally is *not* closely supervised. The principle here hinges on the *expert* or "distinct" nature of the skill 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 from both 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 setting. They do *not* qualify as "close" supervisors as they do not have a greater mastery of home-based midwifery care than the midwife herself.

To avoid incurring unnecessary liability, a physician would not contract to provide "close" supervise (i.e., purport to exercise control) over the practice of midwifery but would instead defer to the "distinct calling" of the midwife in regard to the conduct of normal midwifery service as authorized by the LMPA. While home-based maternity care includes the rare use of emergency medical procedures , it is fundamentally non-medical by nature and may best be described as a bio-social specialty that is historically distinct from the bio-medical discipline of obstetrics. Under section 2746.5 of Chapter 6 (nursing statutes) the "supervisorial" relationship as defined for nurse-midwifery practice exists only in the realm of medical *inter*dependence and *dependen*t. Supervision would be those areas of medical *inter*dependency or dependency *outside the scope of independent practice* (i.e.. not specified in professional midwifery statute for nurses, nurse midwives and direct entry midwives). Physician liability would appertain only to direct actions or omission of the physician in regard to the quality of his medical care -- *not* the quality of the midwife's care.

By this criteria, professional midwives are obviously *independent* contractors who normally provide ante, intra, postpartal and postnatal midwifery care *without* "close" supervision. The reduction of risk resulting from a dynamic interface with the professional discipline of medicine is provided to client families when the professional midwife enters into a contractual agreement with a physician who agrees to provide MEDICAL (NOT midwifery) supervision. This arrangement not only increases the quality of care to clients but results in the equally important advantage of reducing liability concerns for the physician, who is, in fact, functioning in the familiar realm of his or her formal education while providing institutionally-based, technologically-enriched obstetrical medicine. These "supervisory" physicians are neither attending home births in the capacity of midwives themselves nor taking on vicarious liability for the midwife's domiciliary practice through relationship of agency, close supervision or otherwise placing themselves in unnecessary legal jeopardy by practicing outside the "standards for the California community of physicians". Physician care rendered to the midwife's client takes place in an institutional setting following transfer of care from the midwife who provided care at home to the doctor who provides care within the hospital.

Proposed regulation 1379.21, which would mandate "written protocols" "approved by the physicians" inappropriately forces physicians and midwives into an artificial relationship of agency and "close" supervision, thereby creating the unnatural and unnecessary burden of vicarious liability which becomes an insurmountable burden to practice for licensed midwives, thus rendering the LMPA inoperative and denying the citizens of California the very kind of care that SB 350 was passed to create.

Summary

We believe that any regulations which further define and limit the supervisory relationship between midwives and physicians function as a disguised restriction of the services of midwives and produce an insurmountable barrier to practice under the LMPA of 1993. It was never the intent of the sponsor of this legislation nor is a regulation such as 1379.21 authorized by the language of section 2507. We respectfully request that this proposed regulation be disapproved by the MBC, Division of Licensing as failing the legal review standards of "authority", "necessity" and "consideration of alternatives".

Original documents supporting this written testimony are attached as well as synoptic list of the same documents with pertinent quotes as referred to in this testimony.

Faith Gibson, Certified Professional Midwife#96050001

Executive Director, American College of Domiciliary Midwives

Synoptic List of enclosures 1--22

Photocopies of enclosures 1--22

Verbatim transcription of [MBC-Midwifery Committee Meeting](http://docs.google.com/jun94mfr.htm),

June 6, 1994, tape two on physicians supervision with

obstetrician Shelly (from Oakland), Steve Keller, JD, Judge Cologne, JD

and Senator Killea as participants

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