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AB 1896 - BACKGROUND INFORMATION PAPER

THE MIDWIFERY PRACTICE ACT OF 1978

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Introduction

AB 1896 re-establishes the important role that professional midwives can play as maternity care providers in California, combining certified nurse midwives and professional non-nurse midwives into one category -- Certified Midwives. AB 1896 creates an alternative, medically safe approach to broadening the scope of maternal care available in California by allowing a woman and her family to choose among several methods of childbirth. This expanded range of choices, including doctors, hospitals, midwives, clinics, homes, and other alternative childbirth practices, returns to the woman and her family critical control over the most fulfilling and natural expression of a family-centered culture -- the birth of children.

Governor Edmund G. Brown Jr. has provided the resources through the Department of Consumer Affairs to develop this legislative initiative and has extended his support to this important bill. Endorsed by the State Department of Health, AB 1896 is carried by Assemblyman Gary K. Hart (D.-Santa Barbara).

Background

Midwives have traditionally delivered most of the babies born on this planet and, until the early 1950's, were widely used in California. Though the Legislature first recognized midwives in state law in 1917 and established a certification program in 1937, midwives have been denied licensure in California since 1949.

In 1974, the California Legislature authorized the practice of nurse midwifery. This new program reflected concern over a perceived shortage and maldistribution of obstetrical services in rural areas and the lack of prenatal care throughout the state. The nurse midwife is authorized to attend cases of normal childbirth and provide prenatal, intrapartum and postpartum care under the general supervision of a physician. (The physicians need not be physically present, but are responsible for the actions of the nurse midwife.) Regulations have been established to implement the law; but for a number of reasons, including the restrictive nature of the regulations, only about 65 nurse midwives are presently certified in California.

The practice of midwifery envisioned by AB 1896 is presently considered practicing medicine without a license in California. In 1974, the then

Board of Medical Examiners and Santa Cruz County prosecuted midwives in that county for illegally practicing midwifery and practicing medicine without a license. The case went to the California Supreme Court on the issue of whether Section 2141 of the Business and Professions Code, which defines the practice of medicine, prohibits unlicensed persons from treating and assisting a woman in childbirth.

The court found in ^{Kate} Bowland v. Municipal Court, 18 Cal.3d 479 (1976) that a woman who is pregnant or undergoing childbirth is not "sick or afflicted" and that pregnancy is a "normal condition"; but, since the midwives represented themselves as capable of undertaking activities not solely related to normal childbirth, they were treating the sick or afflicted and so violating the statute. The court also held that assisting a woman in birth is treating a physical condition, and the treatment of the condition of pregnancy (though not a disease) violates the act as well.

Why Does California Need Midwives?

Approximately 400,000 women in California will need maternity care annually over the next decade. Current distribution of maternity care providers, including doctors and nurse midwives, will simply not meet this level of demand. Shortages of care for poor pregnant women and rural women are already in a crisis stage. The State Department of Health reported in July, 1977, that only 37 percent of all practicing obstetricians are now accepting Medi-Cal women as patients; and, even worse, 17 counties in California have no practicing obstetricians at all. This shortage of trained maternity care providers has produced a dramatic increase in emergency room and paramedic deliveries in recent years. It has also produced a crisis in prenatal care, with approximately 23 percent of all women receiving little or no prenatal care. According to the State Department of Health in August, 1977, those poor pregnant women who do receive prenatal care under the Medi-Cal program receive on the average only two prenatal visits with an obstetrician. To underscore this crisis, Los Angeles County has requested legal advice on closing altogether its prenatal services due to fiscal problems.]

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Against this background of crisis, California mothers and their families have also demonstrated an increasing interest in new theories about natural childbirth. These new, alternative birthing approaches are generally discouraged in the standard obstetrical/hospital delivery system in California. Today's California hospitals and obstetricians are strongly oriented to caring for the abnormal, complicated birth with drugs, technology, and other forms of medical intervention. Though these advances in medical science have produced dramatic reductions in infant and maternal mortality rates, drugs and medical intervention are not always necessary to births which are uncomplicated, normal deliveries. According to experts at the medical schools of the University of California in San Francisco and Los Angeles, most mothers can be screened in the prenatal period into high-risk and low-risk groups, with 90 percent of all mothers generally falling into the low-risk population.

Since most births are uncomplicated and normal, alternative birthing practices are safe and reasonable. Because normal births can be handled in a more natural setting, mothers' dissatisfaction with current hospital practice, which in the vast majority of hospitals discourages alternative birth styles, coupled with consumer dissatisfaction and dismay at rapidly escalating maternity care costs (averaging \$1500 in California in July, 1977, according to the State Department of Health), has resulted in a steadily rising percentage of births delivered by lay midwives and others outside the hospital since 1970. California mothers and their families are demanding adequate maternity care providers and styles of their own choosing at a reasonable cost. Midwives represent a safe and popular alternative maternity care service which the mothers of California should be allowed to utilize.

But Why Not License More Nurse Midwives or Physicians' Assistants?

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The difficulty of becoming an effective nurse midwife in California has been clearly documented. The Board of Registered Nursing, the state licensing body for nurse midwives, has chosen to delegate fully the responsibility for standards of certification to the American College of Nurse Midwives, an organization which has certified temporarily two nurse midwifery training programs in the state. Furthermore, by limiting the practice of midwifery to only those situations under a doctor's supervision and by limiting a doctor's supervision to only three nurse midwives, the practice of nurse midwifery has been effectively limited to large metropolitan hospitals where obstetrical services are most abundant. The fact that only 65 nurse midwives are presently practicing in California speaks to the potency of these structural barriers in limiting the practice of nurse midwifery. *an in hosp. not at home.*

However, a more fundamental structural flaw limits nurse midwifery as an effective response to the demand for midwifery services. Nurse midwives must be registered nurses, though the skills acquired in nursing school are not necessarily required for the effective practice of midwifery. This threshold requirement for an R.N. certificate stands as a substantial barrier to those persons wishing to practice solely midwifery, a barrier more often felt by ethnic minorities and rural residents with traditionally less access to educational institutions.

AB 1896 implements the Governor's concern with this type of barrier, for the apprenticeship route to licensure as a midwife would open this health care profession to those without the financial resources for institutional education or to those who traditionally have been excluded from the state's educational structure. This apprenticeship program is designed to provide maximum flexibility in learning while protecting the public health and safety in licensing competent midwives. Midwives under AB 1896 would thus receive training comparable to that given nurse midwives at the present time, but the arbitrary barrier of an R.N. certificate would be eliminated.

As the Assembly's Subcommittee on Health Personnel concluded in its analysis of AB 1896:

"Thus it appears at this time neither nurse midwives nor physicians assistants are in a position to augment the availability of obstetrical services in California or to provide alternative birth settings for those women who desire them."

What Does AB 1896 Actually Say?

Combination of Midwives and Nurse Midwives

1. The categories of non-nurse midwives and nurse midwives that exist under current law would be merged to provide a single midwifery expert in normal childbirth. In this way, the maternity care consumer would have a clear definition of what services a "midwife" could legally offer in California. The new "Certified Midwife" would have training comparable to that currently required of a nurse midwife, and he or she would not face the same obstacles presently inhibiting the effective use and practice of nurse midwives in California.

The program proposed in AB 1896 for certification of midwives would have the following elements:

Scope of Practice

1. The practice of midwifery would be defined as "the obstetrical management and care of a woman and her infant during the pre-natal, intrapartum and postpartum periods of normal childbirth". (Section 4907)
2. The certified midwife would be required to:
 - a. Practice in "consultation" with a licensed physician (consultation does not require the physical presence of a consulting physician). (Section 4908)
 - b. Secure the immediate services of a licensed physician whenever any "abnormal signs or symptoms of complications appear either in the mother or the child". (Section 4908)
 - c. Practice pursuant to protocols established by the certifying committee concerning standards for:
 - the supervision of a physician when practicing in a health facility.
 - the safety of infants and mothers.

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certified if the examining committee determined the requirements for obtaining the certificate in the other jurisdiction are "substantially equivalent" to those of this state and that person passed the California certification examination. (Section 4939)

4. "Grandmother" Clause - An individual providing proof satisfactory to the certifying committee of having had primary management in the care of mother and infant through the prenatal, intrapartum and postpartum periods of 100 births over at least a two-year period would be certified if that person also passed the California certification examination. (Section 4939)
5. All applicants would be required to complete a certifying examination prior to practicing. The examination would cover 15 specified subjects in the general areas of anatomy, physiology, management and care in pregnancy, labor, birth injuries, hygiene, medications, diseases of the newborn, complications, and all other legal requirements pertaining to birth. (Section 4933)

Examining Committee

1. A Midwifery Examining Committee would be established in the Division of Allied Health Professions of the Board of Medical Quality Assurance. The Committee would have its own rule-making power.
2. The Committee would consist of eleven (11) members:
 - a. Three (3) physicians (two (2) Ob/Gyns, one (1) Pediatrician)
 - b. Two (2) nurse midwives
 - c. Two (2) certified midwives (the first two (2) midwives must be certified under the "grandmother" clause)
 - d. One (1) educator involved in training midwives or nurse midwives.
 - e. Three (3) public members
3. The duties of the Committee would include:
 - a. Approve schools for the training of midwives
 - b. Establish certifying and apprentice examinations
 - c. Establish protocols of conduct pertaining to safe practice, normal childbirth, consultation with physicians, use of drugs, continuing education, definition of emergencies and procedures for safe practice
 - d. Carry out discipline activities
 - e. Maintain a register of midwives (Section 4928)

- evaluation of normal childbirth.
 - when a midwife must consult a physician.
 - defining emergency situations to allow the use of drugs. (Sections 4910 and 4928(d))
3. The practice of midwifery would not include assistance of childbirth by an artificial, forcible or mechanical means. If authorized by the regulating committee it would include:
- a. Administration of drugs, medications and therapeutic agents under prescription from a consulting physician. (Section 4909)
 - b. Administration of drugs, medications and therapeutic agents in an "emergency situation" without prescription. (Section 4909.5)

Qualifications To Become A Midwife

A midwife could be certified under one of four options:

1. Formal Education - The applicant would complete a program of not less than 12 months, if a registered nurse, and 18 months, if a non-registered nurse at a school of midwifery, hospital school of midwifery or clinic school of midwifery with instruction in: chemistry, anatomy, physiology, obstetrics, pathology detection and screening, pediatrics, gynecology, psychology, applied pharmacology, sociology and social medics, ethnics, family planning, home birth practice, hospital labor and delivery room procedures. Under supervision, the student would be required to take primary responsibility for the prenatal, intrapartum and postpartum management and care of 50 mothers and infants. (Section 4930)
2. Apprentice Training - As an alternative to formal education, the person could apprentice under the immediate supervision of a certified midwife or physician pursuant to rules established by the certifying committee. The apprentice would observe 50 births and then be required to pass an apprentice exam in the subjects taught in the formal training programs. Upon passage of the apprentice exam, the apprentice would take primary, hands-on responsibility under supervision for 50 more births. (Section 4931(1)(b))

The minimum period for apprenticeship would be 12 months if the applicant were a registered nurse and 24 months if a non-registered nurse.

No M.D. or midwife could supervise more than three (3) apprentices.

3. By Reciprocity - A midwife certified or licensed in another state, by the federal government or by a foreign country, could be

Financing

A Midwifery Fund would be created in the Board of Medical Quality Assurance based upon a fee schedule.

Discipline

Grounds for unprofessional conduct would include gross or repeated acts of negligence, incompetence, violation of protocols, practicing medicine without a license and other traditional grounds. (Article 7, Section 4942 et. seq.)

Medi-Cal

The bill requires the Medi-Cal program to provide reimbursement for services provided by midwives. No level of reimbursement is specified. (Section 4913)

Hospital Privileges

The bill requires that provision be made by hospitals to give privileges to midwives. It prohibits hospitals from discriminating against midwives as a class. (Section 4, p. 23)

What Effect Will This Bill Have on Maternal Care Costs?

Ninety-nine (99) percent of all children born in California in 1974 were born in hospitals. Though this represents a decline in hospital births since 1970, hospitals remain the primary center for birthing in this state. However, since 1950 the cost of hospital care has risen more than 1000 percent while the Consumer Price Index rose only 125 percent during the same period. Costs per patient day have risen from \$15.62 in 1950 to \$175.08 in 1976. This increase in cost per patient day is responsible for nearly all of the rise in the per capita expenditure on hospital care.

Though 90 percent of all births are normal and do not necessarily require hospitalization, the cost of a hospital birth in California ranges from \$1,000 to \$3,500, averaging approximately \$1,500. This situation is particularly burdensome for maternity patients because, while they must share the rising hospital costs with others, health insurance policies have typically excluded or minimized maternity care coverage. Yet, although the use of the hospital for these patients undoubtedly provides added convenience to physicians, the major reason for hospitalization is that most private and public medical insurance systems will not pay their part of the claims unless the patient is admitted to a hospital.

Since maternity care consumers must pay from 2/3 to 3/4 of childbirth expenses directly, the use of midwives' services and a mix of hospital, home, or birthing clinic settings for childbirths would

drastically reduce the maternity care bill. Estimates for midwives' services as licensed under AB 1896 range from \$250 to \$400, representing a potential savings of up to 50 percent for each maternity care consumer, depending on their choice of childbirth setting. If only 10 percent of maternity care consumers use midwives, this savings would reach \$20 million annually.

By providing for midwives to practice in hospitals and to be reimbursed under Medi-Cal for their services, the state's Medi-Cal program would achieve substantial savings on childbirth costs. Based on 1976 figures and assuming only 10 percent of all Medi-Cal maternity patients utilize midwives' services, the state would save \$10 million on its annual Medi-Cal bill.

It is interesting to note that these conservative estimates of costs savings have been recognized on the federal level, even by conservative planners. The Nixon Administration's proposal for National Health Insurance specifically provided for payments for nurse midwives and pediatric nurse-practitioners whose training is comparable to that anticipated by AB 1896. These two were singled out on the basis of the high need for maternal and child health services nationally. This proposal demonstrates a conservative conviction that midwives or similarly-trained maternity care providers can practice safely enough to warrant the great boost to utilization which massive federal reimbursement would certainly bring.

What About the Health and Safety Aspects of Midwifery as Authorized by This Bill? Is the Training Adequate?

AB 1896 authorizes the practice of midwifery within the scope of normal childbirth. Though leaving the precise technical definition of "normal childbirth" to the public hearing and rule promulgation process to be conducted by the Midwifery Examining Committee, this bill authorizes midwives to deal with childbirth as a condition of "wellness", not pathology. Midwives would be trained to conduct prenatal screening and to detect the symptoms which lead to complications in pregnancy and birth. Upon detection of such symptoms, a midwife would be required by AB 1896 to refer the mother to a physician. [Practicing in consultation with a physician, the midwife would be responsible for care of the mother and her infant through the prenatal, intrapartum, and postpartum periods.]

Is this scope of practice and midwifery training sufficient to protect the public's health and safety in maternal care delivery? The research behind the provisions of AB 1896 says yes.

The Netherlands provides the most graphic evidence of the effectiveness of midwifery practice. Professor G. J. Kloosterman, Chief of Obstetricians and Gynecologists at the University of Amsterdam Hospital, believes that, through basic training in simple diagnostic procedures, the midwife can divide women into categories of high risk or good health and pass high-risk mothers on to physicians. It is Kloosterman's opinion from experience that over 70 percent of all pregnant women, thus screened, would deliver naturally and

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should be attended only by midwives. Further, he stated that during delivery only 3 to 5 percent of the healthy mothers would ever require consultation from a doctor. Given such midwife care for healthy, low-risk mothers, the infant mortality rate would be 2 to 4 in 1,000, Kloosterman explains, a figure markedly lower than any other birth statistics in the world. So, too, would the maternal mortality rate be lower, as Kloosterman explained, since for midwife-attended, low-risk mothers the mortality rate is less than 5 in 100,000 cases. He added that a group of 20,000 deliveries by midwives in Holland produced no case in which an obstetrician could have done any better than the midwife.

Do Professor Kloosterman's conclusions stand up in light of practice? According to a Joint Study Group of the International Federation of Gynecology and Obstetrics and the International Confederation of Midwives, 47 percent of all deliveries in Holland took place in health facilities and 53 percent took place at home in 1973. Obstetricians attended 63 percent and midwives attended 37 percent of all births, but midwives delivered almost 67 percent of all home births. What result?

In 1973, Holland's infant mortality rate was 11.5 per thousand live births, the third lowest national infant mortality rate in the world. By comparison, the national infant mortality rate for the United States in 1973 was 17.7 per thousand live births. The figure for Holland stands in stark contrast to the infant mortality figure for the County of Los Angeles for 1975 -- 14.5 per thousand live births.

The various studies from the United Kingdom, where 80 percent of all children are delivered by midwives, have shown that properly screened home births can be as safe or safer than in hospital delivery, with an infant mortality rate as low as 2.83 per 1,000.

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In contrast, the trend in the United States, as in most other countries, has been toward 100 percent in-hospital delivery. Despite this fact, since 1950 there has been a considerable decrease in the rate at which infant mortality has been lowered. From 1955 through 1960, only three of the largest United States' cities showed any decrease in infant mortality. In comparison, Kentucky's Frontier Nursing Service's midwives, with training comparable to that envisioned by AB 1896, consistently achieved maternal and perinatal mortality results which were comparable or better than those for the total United States during the same period.

Considering data collected in California, researchers from Stanford Medical School looked at the most difficult comparison of doctors and midwives to analyze the safety question. Though the practice of midwifery has recently been declared illegal by the California Supreme Court, lay midwives nonetheless practicing in California have been able to secure self-instruction from a few cooperating nurse-midwives and obstetricians. In analyzing the practice of midwifery under these conditions, the Stanford researchers analyzed 287 home births attended by lay midwives between 1971 and 1973. These births constituted 10 percent of all Santa Cruz County births performed

during that period. The population of mothers was self-selected by interest in home birth and screened by the midwives for symptoms of complications. The lay midwives had little formal training and minimal physician backup. If midwifery practice were dangerous, it should have shown up in this study. Instead, there was significantly less infant mortality (3.2 per 1,000 as compared with 15.1 in Santa Cruz County), meconium staining, and fewer episiotomies (only 6.6 percent with experienced lay midwives compared to a U.S. episiotomy rate of 73 percent). The study shows that neonatal mortality and morbidity is lower in a population which has been screened for abnormalities.

Finally, one of the best measures of the effectiveness of new health professionals is their performance on standard outcome measures compared to accepted professionals in the field. In a paper to be presented to the American Public Health Association this fall, ¹⁹⁷⁷ Dr. Lewis E. Mehl, of the Institute for Childbirth and Family Research in Wisconsin, (the most widely quoted expert on midwives and home birth) will report his research on midwives and obstetricians in comparisons of obstetrical outcomes obtained with matched low-risk populations. Dr. Mehl, to determine the effectiveness of lay midwives in attending non-complicated deliveries, compared the delivery outcome statistics of 500 deliveries attended by trained midwives to 500 deliveries attended by obstetricians. These deliveries were matched randomly on a case-by-case basis for age, parity, risk factors, total risk factor score, socioeconomic status, and length of gestation. Analysis of the data revealed that the lay midwife group had a lower incidence of intrapartum fetal distress, infants requiring resuscitation, postpartum hemorrhage, low Apgar scores, birth injuries, and neonatal infections. All other outcome parameters were equivalent. Statistical tests of the differences obtained were performed and those differences were found to be associated with a greater use of obstetrical technology by the obstetricians, including forceps, oxytocin, and analgesia.

But can AB 1896's provisions insure the required level of training? Yes, because the two-tiered track to licensure requires the level of nurse midwifery training without the often irrelevant requirement of R.N. training, leading to completion of the required course of study in less time. As a graphic case in point, according to Dr. J. M. L. Phaff of the Ministry of Public Health in the Netherlands, only 20 percent of all midwives in Holland have previous nursing training. The apprenticeship route requires hurdling two major examinations as well as satisfactory completion of a substantial clinical experience under trained and licensed supervision.

A comprehensive comparison in 1974 of the training offered to midwives versus that completed by persons achieving generic licensure as physicians demonstrated the favorable comparisons. Most lectures received by the medical students were on complications in birth and how to treat them. The midwives do not treat complications; they are required merely to recognize such complications and refer the woman involved to a doctor or admit her to a hospital for attendance by an obstetrician or licensed physician. The medical students received only one lecture on the conduct of normal pregnancy, labor,

delivery and puerperium, and maternal mortality. Midwives concentrate on the normal pregnancy. However, while medical students wrote reports on pathology in the hospital setting, they learned how to deliver babies in exactly the same way that AB 1896 anticipates training midwives: by watching trained personnel do it, and by practicing under trained supervision in a clinical setting. Thus, the midwife will receive equal or superior training in dealing with the normal birth process.]

The key to this training lies in the midwife's ability to learn and identify potential complications and abnormalities. The medical research literature says that complications can be identified and dealt with effectively, and midwives can learn these techniques, as indicated in a study done at Los Angeles County's Harbor General Hospital. Training both lay persons and R.N.s to be women's health care specialists in the physician assistant/nurse practitioner mold, Harbor General found that both types of persons could be trained to be effective, competent practitioners -- lay persons simply required a longer, more detailed plan of study.

The education and training envisioned by AB 1896's two-tiered track to licensure emphasizes the preparation of a person highly skilled in the normal birth situation and effectively prepared to identify those complications which require medical attention, including emergency situation training.

Conclusion

AB 1896 is a carefully drafted legislative initiative that draws upon the cumulative experience of other state and nations in midwifery licensure. The combination of nurse midwives and non-nurse midwives into one category -- Certified Midwife -- provides a professional expert in normal childbirth as an alternative childbirth care provider to complement the existing resources to meet the coming demand in maternity care services in California. This bill represents the input of doctors, nurse midwives, lay midwives, nurses, childbirth educators, scholars, government administrators, hospital administrators, and many mothers from many California communities.

[The basic question facing the health care industry today is whether a woman and her family have the right to decide the manner and place in which she gives birth to their baby.] AB 1896 demonstrates that the health care community can be truly responsive in providing alternatives that meet community maternity care needs.