CALM
CALIFORNIA ASSOCIATION OF LICENSED MIDWIVES

January 7, 2021

To: Medical Board of California

Subject: Medical Board of California Practice Guidelines for California Licensed Midwives

I am writing on behalf of the California Association of Licensed Midwives, the professional association that represents over 300 Licensed Midwives providing community-based maternity care in homes and freestanding birth centers across the state.

CALM does not currently take a position on the proposed revisions to the Medical Board of California Practice Guidelines for California Licensed Midwives. Given that these guidelines were not intended to become regulations; that they did not go through proper APA; and that the **guideline revisions were developed prior to stakeholders reaching agreement on the need to transition to a Licensed Midwife Board**, it is CALM's position that the MBC's time and resources are best directed towards supporting the Licensed Midwife Board Sunrise process.

We appreciate the Midwives Advisory Council (MAC), including MAC task force member Carrie Sparrevohn LM, and Medical Board staff for their professionalism and dedication in developing these guidelines, subsequent revisions and for looking for common-ground solutions. Their work has laid the groundwork for stakeholders and interested parties to come together as we look ahead to sunrising the Licensed Midwife Board.

Sincerely,

Rosanna Davis

Rosanna Davis LM
President
California Association of Licensed Midwives

January 7, 2021

Medical Board of California
2005 Evergreen St, Unit 1200
Sacramento, CA 95815

Sent via: webmaster@mbc.ca.gov

Subject: January 14, 2021 Interested Parties Meeting
to discuss revisions to licensed midwife guidelines

To Whom It May Concern:

We oppose this meeting because this will be the appropriate purview of the Licensed Midwife Board. Additionally, this debate about the guidelines disrupts the clean transition to a Licensed Midwife Board agreed to by all stakeholders.

It is the non-evidence based opinion and agenda of ACOG and CMA to deny access, including VBAC care, to pregnant people served by midwives. We oppose these efforts and we support a non-controversial sunrise of a Licensed Midwife Board, the most effective and efficient way to ensure public safety.

Respectfully,

Jen Kamel
CEO & Founder, VBAC Facts®
President, Californians for the Advancement of Midwifery

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Carrie Sparrevohn Ham, BS, LM
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January 5, 2021

Subject: Interested Parties Meeting
Discussion re: proposed revisions to Licensed Midwife Guidelines

Author's history regarding this subject:

- Consultant and Contributing editor of Standard of Care for California Licensed Midwives (SCCLM) document enacted as regulation1379.19 in September 2005 by the Licensed Midwife Committee of the Medical Board of California. Original document was authored and proposed by Faith Gibson, LM – Executive Director, California College of Midwives. I provided extensive edits together with input from midwifery community leaders; Ms. Gibson; California American College of Obstetricians and Gynecologists, Region IX (California), Representative and Lobbyist; and the Licensed Midwife Committee prior to their adoption.
- President, California Association of Midwives during adoption of SCCLM
- Member, Midwifery Advisory Committee (MAC) 2007 to 2018 including Chair 2012 to 2018
- MAC Chair during conversion of Standard of Care Document to current Licensed Midwife Practice Guidelines
- Expert Reviewer employed by the Board 2007 to 2019; multiple LM cases reviewed
- Expert Witness on behalf of Licensed Midwives, 2007 to present
- Current member, MAC task force for Guideline revisions

History of Licensed Midwife Practice Guidelines Document

The original document, Standard of Care for California Licensed Midwives (SCCLM), was adopted through a formal regulatory process in 2004 and 2005 culminating in Title 16 California Code of Regulations section 1379.19 in September 2005. Between 2005 and 2014 no revisions were made to the SCCLM. In December 2013, subsequent to the passage of AB 1308, which removed statutory authority for section 1379.19, I was asked by Board staff as the MAC Chair to help revise the SCCLM document to comply with this new legislation so that the document could be retained as "Guidelines" on the MBC website. Given the amount of effort that went into the creation of the SCCLM I was loathe to lose it all together and so worked with staff to create those changes. I was assured at the time that the resulting document would not have the force of law behind it and would be nothing more than a guideline for licensed midwives to refer to.
The revised document was reviewed and adopted in the March meeting of the MAC in 2014. It is important to note that a new document was not created, as implied by the current Board staff report included in the materials for the current meeting. No new wording was created, except what was needed to bring the document into compliance with the changes to statute. The SCCLM was not revised with regards to standard of care changes that had occurred between its adoption in 2005 and the revisions of 2014. The removal of key parts of the SCCLM, specifically Section V (B), rendered it inappropriate as a midwifery standard of care (see changes in attached document: "*Original wording for SCCLM and changes made to convert it to Guidelines for Licensed Midwives"*)
The MAC was advised by legal counsel at the 2014 March meeting that the re-named standard of care document, now Guidelines for California Licensed Midwives, would not have the force of law behind it. This was reaffirmed on multiple occasions since then by Board legal staff. Licensed Midwives were assured that it would not be used as an enforcement tool.

Current Use of the Licensed Midwife Practice Guidelines

The section of CCR that created the Standard of Care for Licensed Midwives, section 1379.19 (attached) has not, to date been repealed. The board legal staff noted in March of 2020 that it was in a queue to be recommended to be repealed. To my knowledge that has not yet moved forward. A link to the regulation remains on the MBC website with no mention that there is no longer any statutory authority for this regulation. The original SCCLM document that the regulation references is not available anywhere on the MBC website except in its revised form as the Guidelines document. This creates confusion for licensed midwives, physicians and the public.

In the summer of 2018, I was made aware that the Guidelines document was being used by physician reviewers of LM complaints as if it were the Licensed Midwife Standard of Care as evidenced in their reports to the Board which I was privy to in my role as an expert witness for the licensed midwives under investigation. I asked, and was told by legal staff, that not following the Guidelines was not in and of itself cause for discipline; though not following the standard of care was cause for discipline. Realizing that physician reviewers of LM complaints could not possibly know or understand the Licensed Midwives Standard of Care, I was concerned the Guidelines document was being used in that way. This began the MACs decision to revise the Guidelines, as well as my involvement on the task force.

Pertinent History of Implementation of AB 1308 Changes

AB 1308 brought about a number of changes to the Licensed Midwife Practice Act (LMPA). The most significant to this issue is the removal of physician supervision of Licensed Midwives and the following section:

> 2507(b)(3) states: The board shall adopt regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part of 1 of Division 3 of Title 2 of the Government Code) specifying the conditions described in subparagraph (A) of paragraph (1).

This change effectively directs the Board to create a list of conditions for which a licensed midwife must refer a particular client to a physician for evaluation. The Board, to date, has not proceeded with this directive. Using the Guidelines as essentially a list to this end could be seen to constitute an underground regulation, as defined by California Code of Regulations: Title 1, Division 1, Chapter 2. Underground Regulations.

Given this and the Boards inaction on crafting regulations pursuant to AB 1308 as described above, a recommendation was made to the MAC and subsequently to the Board in October 2020 to make the revisions outlined in the document made available in the materials for this Interested Parties meeting. These recommended revisions were approved by the MAC in August of 2020. While leaving the tenets of licensed midwifery practice in the Guidelines it was recommended that all lists of conditions be removed.

The reasons were two-fold. Removing the lists of conditions would remove public/physician confusion regarding the scope of practice/standard of care for licensed midwives and maintaining a document that could no longer be mis-construed as possibly being an underground regulation.

Additionally, while other professions the Board regulates have Guidelines posted by the Board and not adopted through the formal regulatory process, none have an all-encompassing scope for the profession as do the Licensed Midwife Practice Guidelines. Guidelines for other professions single out particular aspects of a professions practice, such as guidelines for cannabis recommendation or guidelines for use of psychotropic medication in children, but none go into the details covering standard practices that the LM Guidelines do.

Given my history with the MAC, the Board and the original Standard of Care Document and Guidelines, it is my opinion that the safety of the public is best served by the removal of any recommendations for physician referral from the Guidelines and the crafting and adoption of the regulations pursuant to AB 1308 which to date the Board has failed to do.

Additionally, it is inappropriate for physicians to be involved in creating Guidelines for licensed midwives. AB 1308 removed from the LMPA the requirement for physicians to supervise licensed midwives. Most

physicians have little or no knowledge of the licensed midwife's standard of care, the restraints of practicing in an out of hospital setting or frankly the training and knowledge licensed midwives have with regards to the care of clients seeking a non-medically managed pregnancy, labor and birth. Since physicians no longer have authority to supervise licensed midwives it is inappropriate for their profession to continue to influence the practice of midwifery in California anymore than physicians influence the practice of Chiropractic in California.
Continuing to involve physicians in interested parties meetings for matters that only pertain to licensed midwives, such as Guidelines for their profession, confounds the board's ability to accept recommendations from the Midwifery Advisory Council and assumes that the medical model of obstetric care is congruent with or superior to the midwifery model of care. The legislature has delineated this distinction multiple times as did administrative law judge, Jaime Roman, in Osborn vs MBC 1999. In all instances, midwifery care has been legally defined as distinct from medical care.

For the reasons delineated above, I urge the Board to accept the recommendations of the MAC as they are put forth in the materials for this interested parties meeting, striking all lists of conditions for referral.

Sincerely,
Carrie Sparrevohn Ham, BS, LM
License Number 25

Article 3.5. Midwifery Practice.

1379.19. Standards of Care for Midwives.

(a) For purposes of Section 2507(f) of the code, the appropriate standard of care for licensed midwives is that contained in the "Standard of Care for California Licensed Midwives" (September 15, 2005 edition) ("SCCLM"), which is hereby incorporated by reference.

(b) With respect to the care of a client who has previously had a caesarean section ("C-section") but who meets the criteria set forth in the SCCLM, the licensed midwife shall provide the client with written informed consent (and document that written consent in the client's midwifery record) that includes but is not limited to all of the following:

(1) The current statement by the American College of Obstetricians and Gynecologists regarding its recommendations for vaginal birth after caesarean section ("VBAC").

(2) A description of the licensed midwife's level of clinical experience and history with VBACs and any advanced training or education in the clinical management of VBACs.

(3) A list of educational materials provided to the client.

(4) The client's agreement to: provide a copy of the dictated operative report regarding the prior C-section; permit increased monitoring; and, upon request of the midwife, transfer to a hospital at any time or if labor does not unfold in a normal manner.

(5) A detailed description of the material risks and benefits of VBAC and elective repeat C-section.

NOTE: Authority cited: Sections 2018 and 2507, Business and Professions Code. Reference: Section 2507, Business and Professions Code.

IV. CRITERIA FOR CLIENT SELECTION

Criteria for initial selection of clients for community-based midwifery care assumes:

- History, physical assessment and laboratory results within limits commonly accepted as normal with no clinically significant evidence of the following pre-existing maternal diseases or conditions likely to affect the pregnancy:

  a. cardiac disease
  b. pulmonary disease
  c. renal disease
  d. hepatic disease
  e. endocrine disease
  f. neurological disease
  g. malignant disease in an active phase
  h. significant hematological disorders or coagulopathies
  i. essential hypertension (BP >>140/90 on two or more occasions, six hours apart)
  j. insulin-dependent diabetes mellitus
  k. serious congenital abnormalities affecting childbirth
  I. family history of serious genetic disorders or hereditary diseases that may impact on the current pregnancy
  m. adverse obstetrical history that may impact on the current pregnancy
  n. significant pelvic or uterine abnormalities, including tumors, malformations, or invasive uterine surgery that may impact on the current pregnancy.
  o. isoimmunization
  p. alcoholism or abuse
  q. drug addiction or abuse
  r. positive HIV status or AIDS
  s. current serious psychiatric illness
  t. social or familiar conditions unsatisfactory for domiciliary birth services
  u. other significant physical abnormality, social or mental functioning that affects pregnancy, parturition and/or the ability to safely care for a newborn
  v. other as defined by the licensed midwife

V. RISK FACTORS IDENTIFIED DURING THE INITIAL INTERVIEW OR ARISING DURING THE COURSE OF CARE

A. Responsibility of the Licensed Midwife

Original Standard of Care wording:

> With respect to the care of a client with a significant risk factor as identified by the client selection criteria in section IV or other science-based parameters, the licensed midwife shall inform the client about the known material risks and benefits of continuing with midwifery care relative to the identified risk factor and shall recommend to the client that her situation be evaluated by a medical practitioner and if appropriate, to transfer her primary care to a licensed physician who has current training and practice in obstetrics.

Guidelines wording:

> With respect to the care of a client who deviates from a normal pregnancy as identified by the client selection criteria in section IV or other science-based parameters, the licensed midwife informs the client that her situation must be evaluated by a licensed physician who has current training and practice in obstetrics and gynecology. If the physician determines that the client's condition or concern has been resolved such that the risk factors presented by a woman's disease or condition are not likely to significantly affect the course of pregnancy, the licensed midwife can continue to provide primary care. The client should further be informed that unresolved significant risk factors will limit the scope of the midwife's care to concurrent care with a physician, regardless of whether the woman has consented to care or refused care by a physician.

B. Client's Rights to Self-Determination – This section was eliminated in the Guidelines

In recognition of the client's right to refuse that recommendation as well as other risk-reduction measures and medical procedures, the client may, after having been fully informed about the nature of the risk and specific risk-reduction measures available, make a written informed refusal. If the licensed midwife appropriately documents the informed refusal in the client's midwifery records, the licensed midwife may continue to provide midwifery care to the client consistent with evidence-based care as identified in this document and the scientific literature.

CALIFORNIA MEDICAL ASSOCIATION

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

January 7, 2021

Ms. Lisa Toof
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Written Comments to the Proposed Revisions to the Practice Guidelines for California Licensed Midwives

Dear Ms. Toof:

On behalf of the American College of OB/GYNs District IX and the California Medical Association, we would like to thank you and members of the Medical Board of California for the opportunity to comment and express our concerns on the proposed revisions to the practice guidelines for California licensed midwives prior to the Interested Parties meeting on January 14, 2021.

While we do have concerns with several of the revisions as proposed, we want to make clear that our concerns with the practice guidelines are not limited to just the revisions. We have identified significant concerns with the existing guidelines as a whole, including sections that appear inconsistent with the licensed midwives' current statutory authority, which we already view as vague and insufficient. These inconsistencies are further exacerbated by the proposed revisions.

A few examples of our concerns with the proposed revisions are as follows:

- Section I (H) – The proposed revision replaces care provided during the inter-conceptional period with "well woman care." This type of care does not exist within the statute pertaining to licensed midwives, and we are concerned that this broad definition that could be interpreted to authorize licensed midwives to provide care outside of the legal scope of midwifery practice and into the practice of medicine.

- Section III (8) – This proposed revision recasts in this section the ability of licensed midwives to provide any care in an emergency. While this definition currently exists in the guidelines, this revision does highlight the use of the definition of emergency. We recommend a clearer definition of what should happen during an emergency, including inserting appropriate safety measures to ensure safe transfer.

- Section IV - IX – These proposed revisions delete Sections IV-IX in their entirety, which included proper criteria for "client selection" and when they should refer to and consult with a physician. We are concerned that striking these sections from the guidelines, in their entirety, sends the wrong message that such proper protocols are no longer unnecessary.

Again, thank you for allowing us to present our concerns on the proposed revisions and we look forward to future dialogue.

Sincerely,

Ryan Spencer
Legislative Advocate
ACOG District IX

Yvonne Choong
Vice President
California Medical Assocation