MEDICAL BOARD OF CALIFORNIA
Licensing Program

Midwifery Advisory Council

Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

January 15, 2009

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California was called to order by Chair Faith Gibson at 1:08 p.m. A quorum was present and due notice had been mailed to all interested parties.

Members Present:

Faith Gibson, L.M., Chair
Ruth Haskins, M.D., Vice Chair
Barbara Yaroslavsky
Carrie Sparrevohn, L.M.
Karen Ehrlich, L.M.

Members Absent:

Guillermo Valenzuela, M.D.

Staff Present:

Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs (DCA)
Billie Baldo, Management Services Technician, Licensing Operations
Deborah Pellegrini, Chief, Licensing Program
Diane Ingram, Manager, Information Systems Branch (ISB)
Frank Valine, Staff Services Manager I, Licensing Operations
Kurt Heppler, Legal Counsel, DCA
Phyllis Bean, Staff Information Systems Analyst, ISB
Ramona Carrasco, Staff Services Analyst, Central Complaint Unit
Robin Jones, Analyst, Licensing Operations
Sophia Kong, Staff Programmer Analyst, ISB
Susan Cady, Staff Services Manager II, Enforcement Program

Members of the Audience:

Alison Price, L.M.
Andrea Ferroni, L.M.
Ariele Bauers, CSU Sacramento
Claudia Breglia, L.M., California Association of Midwives (CAM)
Candace Diamond, Manager, Office of Statewide Health Planning and Development (OSHPD)
Frank Cuny, California Citizens for Health Freedom
Jennifer Brown, L.M.
Kelly Olmstead
Rachel Fox-Tierney, L.M.
Robyn Strong, Analyst, OSHPD
Tonya Brooks, L.M.

Agenda Item 2 Approval of Minutes of the December 6, 2007 Meeting

The minutes for the October 23, 2008 meeting were approved by consensus.

Agenda Item 3 Licensed Midwife Annual Report

A. Proposed Summary of 2007 Report

Faith Gibson, L.M., Chair, presented her Draft Synopsis of California licensed midwife planned home birth (LM-PHB) statistics for 2007. It was M/S/C (Ehrlich/Yaroslavsky) to attach Ms. Gibson's synopsis to the Council minutes.

It was M/S/C (Ehrlich/Sparrevohn) to attach Ms. Gibson's report to the Medical Board's annual report to the legislature.

Ms. Sparrevohn requested the total number of fetal demises be added to the 2007 Medical Board's annual report to the legislature. It was M/S/C (Sparrevohn/Yaroslavsky) to accept the summary report if it is modified to add the total number of fetal demises and to change the language on the column from "*Complications resulting in the mortality of the infant*" to "*Complications resulting in the mortality of the fetus/infant*."

Concern was expressed that the column for complications resulting in the mortality of the infant/fetus does not separate out the fetus that has died from lethal birth defects at twenty-one weeks. It was M/S/C (Ehrlich/Yaroslavsky) to add a disclaimer, preceding the summary, that states "*Conclusions should not be drawn from this summary as data does not specify whether or not the death is fetal, intrapartum or neonatal; whether the affected perinate was with or without congenital anomalies incompatible with life; or whether the perinate was born in or out of the hospital*."

B. 2008 Report

Phyllis Bean, Staff Information Systems Analyst, ISB, gave a demonstration of the proposed Internet version of the Licensed Midwife Annual Reporting form. A number of suggestions for change were made by those in attendance and discussed in detail. Medical Board staff will incorporate the changes discussed.

C. Recommendations for Change

The subcommittee of Dr. Haskins and Ms. Sparrevohn discussed their revised changes. The survey was presented and reviewed by section and edits and/or revisions were noted and discussed by those in attendance (see attached list of suggested edits).

After discussion, it was recommended certain changes be made to both the paper and electronic report forms. One recommended change included emphasis that this annual report be a requirement for continued licensure as a midwife in California. In addition, suggestions were made to add the licensing number to the bottom of each page of the survey. Discussion concluded at Section G of the report as it became clear that a subcommittee would need to be formed to continue the suggested revisions of the Council.

Dr. Haskins and Ms. Sparrevohn will discuss further changes to the annual survey at their next sub-committee meeting to be held on January 25, 2009.

D. Timeframe to Implement Changes

The expected timeframe for the changes to be implemented and available online for the 2009 Licensed Midwife Annual Report is December 1, 2009. The staff will bring a task list and due date for the requested changes to the next Midwifery Advisory Council Meeting in April 2009.

Agenda Item 4 Licensed Midwife Complaints – Statistical Data

Medical Board Enforcement staff presented statistical data to the Council. They reported ten complaints were received for licensed midwives for fiscal year 2007/2008 and four additional complaints were received from July 1 through December 2008. All complaints received are registered and categorized whether they are jurisdictional or non-jurisdictional.

Staff was directed to prepare and present updated statistics every six months.

Agenda Item 5 Licensed Midwife Remediation/Re-entry to Practice

Ms. Pellegrini informed the Council members the Medical Board staff memo regarding remediation/re-entry to practice will be presented at the January 30, 2009, Medical Board meeting.

Agenda Item 6 Public Comment on Items Not on the Agenda

Tonya Brooks, L.M., stated the licensed midwives are practicing in a “grey area” as long as there are issues involving physician supervision and she suggested this topic remain on the Council agenda for future meetings.

Agenda Item 7 Agenda Items for Next Meeting

Council members directed Medical Board staff to prepare a document cataloging the history of Senate Bill 1950 (Figueroa 2002) a bill involving physician supervision of Licensed Midwives and bring this forward to the next Council meeting on April 2, 2009.

Agenda Item 8 Adjournment

The meeting adjourned at 4:43 p.m.

****Conclusions should not be drawn from this summary as data does not specify whether or not the death is fetal, intrapartum or neonatal; whether the affected perinate was with or without congenital anomalies imcompatible with life; or whether the perinate was born in or out of the hospital.****

GENERAL SUMMARY OF 2007 *LICENSED MIDWIFE ANNUAL REPORT

Total Number of Clients served as primary caregiver at the onset of care	TOTAL	2,277	
Total Number of Clients served with collaborative care available through or given by a licensed physician and surgeon	TOTAL	704	
Total Number of Clients served under the supervision of a licensed physician and surgeon	TOTAL	159	
Total Number of Fetal Demise**	TOTAL	12	
Number of planned out-of-hospital births at the onset of labor		1,687	
Number of planned out-of-hospital births completed in an out-of-hospital setting:		1,438	
Twin Births	Twins	15	
Multiple Births (other than Twin Births)	Multiples	0	
Breech Births	Breech	14	
VBAC (Vaginal births after the performance of a cesarean section)	VBAC	92	
Complications resulting in the mortality of the mother		0	
Complications resulting in the mortality of the fetus/infant		6	
ANTEPARTUM:			
Primary care transferred to another health care practitioner (Elective)	301		
Urgent or Emergency Transport of Expectant Mother	44		
INTRAPARTUM:			
Elective hospital transfer	226		
Urgent or emergency transfer of an infant or mother	23		
POSTPARTUM:			
Elective hospital transfer	30		
Urgent or emergency transfer of an infant or mother	17		
* Births attended by the Licensed Midwife as the primary caregiver.			
** Updated March 2009 per Midwifery Advisory Council			

Agenda Item #4

Medical Board of California
Licensed Midwife Program

January 15, 2009 MAC

Midwife License Data	**FY 2007/2008**	**FY 2008/2009 (7/1/2008–12/31/2008)**
Current *Total*	**179**	**191**
Delinquent	**5**	**2**
New Licenses Issued	**17**	**14**
Midwife - Complaints		
Received	**10**	**4**
Referred to Investigation	**2**	**0**
Referred for Discipline	**1**	**0**
Midwife – Discipline Activity		
Accusations/Statement of Issues Filed	**0**	**0**
Effective Decisions	**0**	**0**
Probation	**0**	**0**
Surrender	**1**	**0**
Revocation	**0**	**0**
Total Effective Decisions	**1**	**0**

Draft - Synopsis of California LM-PHB stats for 2007

Prepared by Faith Gibson, LM, Chair, Midwifery Advisory Council
December 24, 2008

Legislative Background: In 2006 Senator Figueroa carried a bill that amended the Licensed Midwifery Practice Act of 1993 (LMPA); Senate Bill 1638 was enrolled as Section 2516(c) of the Business & Professions Code. It requires all California licensed midwives (LM) to report annually the total number, a specified set of outcomes for all midwifery clients seeking care for planned home birth (PHB), and the statistics for a specified set of maternal-infant outcomes for PHB and all hospital transfers. The legislative intent of SB1638 was to make accurate data available to consumers and professionals relative to PHB, and to assist California's LMs in evaluating appropriate policy changes in midwifery education, scope of practice, and/or standards of care.

SB 1638 also authorized the creation of a six-member Midwifery Advisory Council, which convened for the first time in March of 2007, and meets each quarter. Currently it is comprised of three licensed midwives, two obstetricians and one Medical Board consumer member.

First Annual LM Report - 2007: The MBC requested that the Midwifery Advisory Council develop a questionnaire for collecting the data required by Section 2516(c). The Council worked on drafts of this document in public meetings held between March and November of 2007. The version that was sent to midwives who held active licenses in calendar year 2007 was developed during those meetings. As stipulated in the law, all completed confidential questionnaires were returned to the Office of Statewide Health Planning and Development (OSHPD). Candace L. Diamond, Manager, OSHPD Patient Data Section, is in charge of creating and maintaining the agency's database for the LM annual reports.

Assessing the First Year's Results: The majority of California LMs completed the questionnaire in a timely manner and returned them to OSHPD as instructed. The data provided were generally complete and informative. However, several instances of confusion were identified which included missing, incorrect, or redundant data (i.e., the same outcomes recorded in more than one place). In particular, Midwifery Council members identified data from two LMs that were so unlikely that Candace Diamond was asked to contact those midwives for clarification. In both instances, the numbers stated were mistakes and Ms. Diamond was able to correct the record. Council members and OSHPD staff noted other instances of confusing or inadequate instructions and imprecisely worded questions. The Midwifery Advisory Council will address these concerns during future meetings, and will monitor and respond to the feedback submitted by LM responders.

OSHPD Feedback: In spite of these identified problems, Candace Diamond complimented the Midwifery Council and LM responders for a successful launch of a complex data collection process. She noted that her agency tracks information from all categories of medical professionals and facilities including hospitals, clinics, home health services, and hospice services. She assured us that the performance of the LM responders was in line with responses by other segments of the healthcare field.

Definition of Mortality in Midwifery Cases: By centuries of convention, all mortality in midwifery cases is attributed to the midwife, even when the laboring woman is transferred to obstetrical care

many hours before the birth, or the adverse event occurred after an extensive period of hospital treatment.

Effects of Congenital Anomalies on Mortality Rates: Families who plan home births often decline perinatal screening for birth defects. When a serious defect is discovered during routine testing, this cohort of childbearing women is less likely to terminate an affected pregnancy during the pre-viable stage. This has been documented to contribute to a slightly higher rate of perinatal mortality in the home birth population. Since place of birth has no impact on congenital anomalies incompatible with life, the perinatal mortality rate for this report was calculated twice: once including deaths from birth defects, and once excluding them.

Statistical Overview for 2007: There were 164 LMs who submitted reports to OSHPD, 110 of whom provided midwifery services to 2,277 childbearing women (Section D, Line 13) whose intention was to give birth out-of-hospital. Of that initial cohort, 172 women left midwifery care for non-medical reasons and 46 women terminated midwifery care due to pregnancy losses (39 miscarriages prior to 20 weeks and 7 fetal demises or medical terminations after 20 weeks).

During the 2007 calendar year, California licensed midwives provided childbirth services to an aggregate population of 3,374 -- 1,687 mothers who began labor at home and their unborn/newborn babies. There were no maternal deaths. There were six perinatal deaths from all causes. When the two infants with fatal birth defects are included, the perinatal mortality (PNM) rate was 3.3 per 1000 births; excluding congenital anomalies, the PNM rate was 2.4 per 1000. The total cesarean section rate for this population was 7.7%. The national rate of cesarean births for the most recently reported year (2006) was 31%.

There were 633 undelivered clients at the end of the reporting period.

Interpretation of Maternal and Perinatal Mortality: An accurate record of mortality is clearly an important aspect of the data collection for out-of-hospital labors and births, including all hospital transfers. Because the current version of the questionnaire does not collect case-specific details, our ability to evaluate each instance of perinatal mortality in 2007 is less than satisfactory. Fortunately mortalities in the home birth population are rare, making it feasible to include an additional section at the end of the current questionnaire identifying specific circumstances and contributing factors for each death. This is consistent with the intent of SB 1638, which anticipates the use of LM-PHB data to make appropriate changes in midwifery education, standards of care, guidelines of practice, etc.

Future Expectations: Ms. Diamond assured Council members that data collection and processing errors of this sort are inevitable at the beginning of any large statistical project and that corrections are always necessary in a new program. She estimates that it will take three years to perfect the data-collection instrument, and to process and amass a sufficiently large database to generate statistically significant numbers.

Planned Home Birth at Onset of Labor ~ 1,687	**Total Completed Home Births ~ 1,438**		

	Elective	**Urgent**	**Total**	G.T
Intrapartum Transfers	226	23	**249**	
Postpartum Transfers	30	17	**47**	
			Total women transferred IP+PP > **296**	
Newborn Transfers	17	26	43	

Total elective transfers - all categories	**273**

Top 5 reasons / complications for transfers of care or urgent transport to hospital

Antepartum Dx + number or 'other' & fetal demise prior to labor

Total AP transfers: 141	**Elective**	**Urgent**	
Spontaneous or elective abortions	**39**		
Non vertex lie at term	16		
PPROM (water break)	16		
Hypertension	15		
Clinical judgment of midwife	14		
[category of 'other'	**26***		this category needs to be expanded to better match the responses]
Fetal demise after 20 wks	5		

Total Intrapartum transfers: 249

Lack of progress	**125**		
Client request /pain relief	36		
Prolonged rupture of membranes	18		
Non-reassuring FHT, distress		14	
Clinical judgment of midwife	13		
[category of 'other' was zero]			

Postpartum transfer: 47

Repair of laceration	**14**		
Retained placenta w/bleeding		9	
Uncontrolled hemorrhage		4	

Retained placenta without bleeding	6
Signs of infection	3

[category of 'other' was zero]

Neonatal transfers: 43

	Elective	**Urgent**
Cardiac or respiratory distress		**9**
Clinical judgment of midwife	7	
Congenital anomalies T.7	3	4
Abnormal vital signs		5
Poor transition extra-uterine life	4	
category of 'Other':	**2**	

Total combined patient population of mothers and babies began labor at home 3,374

Total urgent transfers – all categories 66

Global Transfers for All Categories 339

Transfer rate women during labor, birth or postpartum **15%** IP/PP rate

NB transfer rate after birth **2.6%** NB rate

Breech Twin and VBAC Births completed out of hospital:

Sets of Twins	5
Breech	14
VBACs	92

Total Cesarean Sections out of 1,687 PHB ~ delivery in hospital 130 7.7%

Total Vaginal Births ~ all birth settings 1,548

Total maternal mortality all settings, all routes of birth zero

Total perinatal deaths 6

Perinatal mortality rate per 1,000:

All causes, including birth defects 3.3

Excluding congenital anomalies 2.4