Department of
Consumer
Affairs 1020 N Street, Sacramento, California 95814

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AB 1896 - BACKGROUND INFORMATION PAPER
THE MIDWIFERY PARCTICE ACT OF 1978

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 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 Edmond 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 process in 1937, midwives have been denied licensure in California since 1949.

[*Faith's note*: the 1937 date for certification is incorrect – certification was established in **1917 by the original legislation** (AB 1375 -- Assemblyman Lee Gebhart). This is an easy mistake to makes, as the entire body of California statues from statehood in 1876 to 1937 were **codified** for the first time in 1937. This new codification scheme was misinterpreted by the researcher as the initiation of certification, but was merely a restatement of 1917 authorization of the state-certified practice of non-nurse midwifery.]

In 1974, the California Legislature authorized the practice of nurse midwifery. This new program reflected concern over a perceived shortage and mal-distribution of obstetrical services in rural areas and the lack of prenatal care through 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 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.

That court found in Bowland v. Municipal Court, 18 Cal.3d 479 (1976) that a woman who is pregnant 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 and afflicted and so violating the statue. 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 prenatal care under the Medi-Cal, with approximately 27 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 not receive prenatal care under the Medi-Cal program receive on average only two prenatal visits with an obstetrician. To underscore this crisis, Los Angles County has requested legal advice on closing altogether its prenatal services due to fiscal problems.

Against this background of crisis, California 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 hospital 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 populations.

Since most births are uncomplicated and normal, alternative birth practices are safe and reasonable. Because normal birth can be handled in a more natural setting, mother's 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) [editor's note: cost of normal childbirth in Santa Clara County hospital in March 2007 was $32,000], 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 to maternity care services which the mothers of California should be allowed to utilize.

But Why Not License More Nurse Midwives or Physician's Assistants?

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 and 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 3 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 are presently practicing in California speaks to the potency of these structural barriers in limiting the practice of nurse midwifery.

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 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 resident with traditionally less access to educational institutions.

AB 1986 implements the Governor's concern with this type of barrier, for the apprenticeship [editor's note: describes an educational model of one-on-one, non-institutional clinical training] 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 which protecting the public health and safety in licensing competent midwives. Midwives under AB 1896 would thus receive training comparable to the that given nurse midwives at the present time but the arbitrary (missing text – did not Xerox bottom edge of page – probably concluded with statement about the 'arbitrary requirement of nursing school')

Pages 4 to midway thru page 7, which is a line by line examination of AB 1896, were skipped for brevity. However, the text of this document has amply description about the specifics of the proposed legislation. (original pages included at the end)

What effect will this bill have on maternity 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 1,000 percent while the Consumer Price Index rose only 125 percent during the same period. Costs per patient day have risen from $15.62 to $175.08 in 1976. [editor's note: currently in 2007 for normal maternity care after a normal vaginal birth is approximately $1,000 the per day rate]. 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 birth are normal and do not necessarily require hospitalization, the cost of a hospital birth in California ranges from $1,000 to $3,500, averaging $1,500 [in 2007 average hospital birth is $26,000 to $45,000, with $30K+ being 'average' in Bay area]. This situation is particularly burdensome for maternity patients because while they must share the rising hospitals 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 [missing next line due to failure of copy machine] drastically reduce the maternity care bill. Estimates for midwives services as licensed under AB 1896 range from $250 to $400, representing a potential saving of up to 50 percent for each maternity care consumer, depending on their choice of childbirth setting. [2007 figure is approximately $1800 in rural counties to $3,700 in San Francisco Bay area] If only 10 percent of maternity care consumers used midwives, this savings would be approximately $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 the 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 of 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 1986 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 complication in pregnancy and birth. Upon detection of such symptoms, a midwife would be required by AB 1986 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 the midwifery training sufficient to protect the public's health and safety in maternal delivery? The research behind the provisions of AB 1896.

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 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 [NOTE – LMAR for Cal. LM for 2010 is 0.89 neonatal death per 1,000 live births]. 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 a 100,000 cases. He added that a group of 20,000 deliveries by midwives in Holland produced no care 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 birth but midwives delivered almost 67 percent of all home births. What were the result?

In 1973, Holland's infant mortality rate was 11.5 percent per thousand live births, the third lowest national infant mortality rate [birth to 12 months of age] for the Unites 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.

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 as 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.

[Editor's Hx background: The Frontier Service's nurse-midwives traveled on horseback to serve the Appalachian poor in rural counties with high unemployment and little or no medical services – according to conventional obstetrical thinking, they should have had the worst outcomes in the US.]

Considering the data collected in California, researchers from Stanford Medical School looked at the most difficult comparison of doctors and midwives to analyze the safety question. Through 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 [missing text for next sentence due to Xerox failure] ….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 law midwives had little formal training and minimal physician back-up. 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), [less] meconium staining, and fewer episiotomies (only 6.6 percent with experienced 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 as been screened for abnormalities. [a study was conducted by Dr. Lewis Mehl and Dr. Don Creevy – two SF Bay area obstetricians]

Finally, one of the best measures of the effectiveness of new health professionals in 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 all [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, 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 [Pitocin to artificially speed up or induce labor] and analgesia [pain medications].

<u>But can AB 1896's provisions insure the required level of training?</u>

Yes, because the two-tiered tract 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 [i.e. non-institutional clinical training] 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: <u>by watching trained personnel do it</u>

and by practicing under the trained supervision in a clinical setting. Thus, the midwife will receive equal or superior training in dealing with the normal birth process. [emphasis added by editor]

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 at Los Angeles County Harbor General Hospital. Training both lay persons and RNs 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 detained 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.