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Re: Your letter of Jan 02, 2007 to California licensed midwife Edana Hall

Dear Mr. Iftiniuk,

Ms. Hall forwarded a copy of your January 2007 letter to me. As director of the California College of Midwives, she asked that I look into the issue of physician supervision of LMs, relative to your conversation with Herman Hill, Licensing Operations Analyst for the Medical Board of California. As described in your letter, Mr. Hill's remarks gave a misleading impression about the midwife-physician supervision situation since implementation of the Licensed Midwifery Practice Act (LMPA) 13 years ago.

Mr. Hill is to be forgiven for any lack of familiarity with this complicated historical situation, as he was the seventh staff person assigned to midwifery licensing program since 1994. Understandably, the Medical Board's main regulatory responsibility is the licensing and supervision of its 100,000-plus MD licentiates. There are only about 150 practicing LMs in California, so the staff person in charge of the midwifery program has many other duties and is frequently reassigned as the staffing needs of the agency change, preventing the accumulation of institutional memory. As of December 31, 2006, Mr. Hill elected to transfer to another state agency.

In the interest of accuracy, and preservation of institutional memory relative to the critical topic of physician supervision, the California College of Midwives believes it is important to set the record straight.

But before moving on I want to correct one small area of confusion. In your letter, you referred to the Medical Board's web site as providing information about… "all aspects of a nurse midwife's practice". Actually, the MBC doesn't regulate *nurse* midwives, as that is the responsibility of the Board of Registered Nurses (BRN). Midwives licensed by the MBC are non-nurse practitioners of physiological (i.e., traditional, non-medical) midwifery.

While LMs and CNMs share an "equivalent but not identical" educational curriculum and scope of practice, the experience and practice of the two groups is remarkably different. Nurse midwives are trained and function primarily in hospitals and their duties generally include the provision of medically-based care. In contrast, non-nurse midwives train and practice primarily in independent birth centers and the family's home, and provide only physiologically-based care.

As for the legal relationship between midwives and physicians, all stakeholders agree with your attorney's black letter reading of the law – the LMPA does indeed mandate a supervisory relationship between each midwife and a physician with obstetrical practice privileges. Mr. Hill's

statement that “many California obstetricians throughout the state advocate physician supervision” is true in the narrow sense. Unfortunately, the mere fact that obstetricians ‘advocate’ for supervision does not equate to either a *willingness* or *ability* to provide the mandated supervision.

Apparently Mr. Hill also gave the impression that he didn’t believe the information reported by Edana Hall on the *inability* of physicians who supervise midwives to obtain (or retain) malpractice coverage. I can assure you that Edana Hall’s observation is not in dispute, coming, as it does, from the malpractice carriers themselves. A variety of sources confirm this, including a ruling by an administrative law judge in a midwifery-related case (citation #1). Irrespective of Mr. Hill’s opinion, individual MDs are not able to provide such a relationship without either violating the terms of their own liability insurance OR being assessed huge increases in premiums. In the District of Columbia, imposition of a ‘vicarious liability’ surcharge by malpractice carriers was deemed illegal, since there is no actuarial data supporting such a category of surcharges. (citation #2)

However, these few facts cannot provide a useful grasp of the situation in relation to licensed midwives and the physicians called on to interface with midwifery clients. This letter provides the missing pieces, which include the legislative history, the contemporary legal situation and the circumstances experienced in real time by midwives, the families they serve and the few brave, much maligned physicians who attempt to bridge the gap in our fatally flawed licensing law.

Before addressing the legal and legislative aspects of this problem, a few words about my professional background and experiences with the topic will help. I have been representing California midwives since the 1993 passage of the LMPA. I was present at all seven of the day-long MBC’s Midwifery Implementation Committee meetings in 1994 and 1995, and continue to act as liaison between California licensed midwives and the Medical Board. I administered a professional liability group policy for community-based midwives in three states between 1998 and 2001. More recently I was the lead author of the official Standard of Care for California LMs adopted into regulation by the Medical Board in 2006. Currently I am a member of the MBC’s Midwifery Advisory Council.

I was an L&D and ER nurse for 17 years before cross-training into midwifery. However, I chose not to become a certified *nurse* midwife (CNM) and instead trained as a non-medical midwife. I am licensed and practice under the regulatory authority of the Medical Board. As a licensed midwife (LM), I currently provide home-based birth services and hospital-based support services, thus I am personally familiar with the issue of physician supervision. As with all other licensed midwives in the state who attend planned home births (PHB), I myself do *not* have a physician supervisor. Like Ms. Hall, I have informal relationships with a few obstetricians who, on occasion, permit me to consult with them and who collaborate with me relative to medical evaluation or hospital care of my clients. Midwives have always had informal backup arrangements for their clients, which are identified antepartum and documented in the client’s record.

As for the issue of safety and efficacy of PHB, it must be noted that a consensus of the scientific literature identifies the physiological management of normal birth

(a) in essentially healthy childbearing women
(b) as provided by experienced midwives in independent birth centers and client homes
(c) with access to appropriate obstetrical services for complications
(d) to be <u>equally as safe</u> as obstetrically-managed hospital births for this same healthy cohort

These studies assign all complications and mortality *to the midwifery cohort*, even though the mother may actually have transferred to the hospital at the start of labor, the intrapartum was medical managed and the birth attended by an obstetrician.

As for efficacy of PHB care, the scientific literature identifies a dramatic *reduction* in the

number of obstetrical interventions by a factor of two to ten times, with a CS rate under 4%, while preserving the same level of perinatal wellbeing. When maternity care for healthy women adheres to the principles of physiological management, a non-medical setting is *as safe* as any other location, with the added bonus of conserving expensive medical resources. [encl #1]

These consistently good outcomes are not merely happenstance or due to avoiding potential harm from unnecessary medical interventions. A study of a religious group that eschewed all forms of professional maternity care was reported in the American Journal of Obstetrics & Gynecology (1984). Researchers identified a dramatically *elevated* rate of perinatal and maternal mortality in women who had no antepartum care during pregnancy and no experienced attendant during childbirth.

Maternal mortality for this group was an astounding **ninety-two times higher**. Out of 344 births, there were **six maternal deaths and 21 perinatal losses**. In contrast to these horrific findings, a study of midwife-attended PHB in North Carolina in 1980 found *no* maternal mortality and a rate of perinatal mortality for term pregnancies significantly *below* the rate for the state (3 per 1,000 vs. 7 per 1,000). Sadly, the researchers also identified that planned *unattended* home births had a perinatal mortality rate of 60 to 120 baby deaths per thousand.

As can be seen from these studies, the presence of a skilled and experienced midwife equates to an educated observer with an emergency response capacity, much like a lifeguard at the beach makes swimming safer. The legislative intent of the LMPA was to protect the lives of healthy mothers who choose physiological care and to preserve the wellbeing of their unborn and newborn babies. This licensing law must itself be safeguarded in order to achieve these worthy goals. The alternative is a re-emergence of unlicensed midwifery and increased number of risky unattended births. This is both unnecessary and unethical.

An additional factor is the economic aspect of maternity care for healthy women. Ultimately, our success in the global economy is dependent on the US having an efficient and functional maternity care system that matches the rest of the world. We don't have that at present. The current obstetrical 'package' is associated with an ever-increasing Cesarean section rate. This results in additional maternal deaths, higher medical costs at the time of delivery and from the delayed and downstream complications of surgical birth, which include emergency hysterectomies, secondary infertility, tubal pregnancies and miscarriages, as well as placental abnormalities and stillbirth in subsequent pregnancies. These are human as well as economic disasters. [encl #2]

Worldwide, the negative economic effect of obstetrical interventions used on healthy women, in particular a disproportionately high Cesarean rate, is causing some countries to rethink their national maternity care policy. For example, the Ministry of Health in the UK is reconfiguring the National Health Services so as to reduce the medical costs associated with normal childbirth. By 2009 every expectant mother in the UK will be able to choose among three options:

1. Home birth supported by a midwife
2. Birth in a local midwife-led unit, based in a hospital or community clinic and promoting natural birth
3. Birth at a hospital, supervised by a consultant obstetrician, for mothers who may want epidural pain relief or may need specialist care to deliver safely [Encl #3 The Guardian, Feb 6, 2007]

Many developed countries and all of the developing world already use the cost-effective model of physiological management as their standard of care for healthy women. In industrialized countries, that is approximately 70% of the childbearing population. To successfully compete with the rest of the global economy, the US will have to develop a similarly cost effective maternity care system that relies on physiologic practices.

The influence of third party payers in the US, in combination with a large uninsured population, is already rearranging the landscape of health care. Businesses must pass their employee health insurance costs back into the marketplace by increasing the price of goods and services. To stretch health care dollars, Americans have begun to travel aboard for more affordable medical procedures, dentistry and elective surgery. Another consequence of runaway cost is the growth of medical services in non-acute care settings. Private equity markets in the US have been investing in outpatient surgical centers for two decades. At present the hot investment opportunity is residential and outpatient drug rehab facilities.

One can easily imagine that in five more years venture capitalists will be investing in a national chain of Maternity Homes patterned after the UK model mentioned earlier. This will provide a cost-effective system of physiological management for healthy women, with normal labors and births attended by midwives, family practice physicians and obstetricians who are sick of the high-tech, high volume, malpractice rat race. Like outpatient surgical-centers, each community-based Maternity Home will want to be associated with a cooperative and welcoming acute care facility for transfers of care. Catholic Healthcare West, with its reputation for offering cost-effective and family-friendly care, may find this arrangement very much to its own advantage. This would certainly make licensed midwives an asset to your own organization.

Historical background & the modern dilemma of physician supervision

1876-1993 ~ Beginning with California statehood in 1876, the practice of midwifery was fully lawful but unregulated by the state. In 1917 a law was passed creating the category of state-certified (non-nurse) midwives. Between 1917 and 1949, the medical board licensed 217 midwives. According to a 1949 document from the office of California Governor Earl Warren (*that* Earl Warren!), state-certified midwives "**operate independently and *not* under the supervision of a physician**". [encl #4] Two hundred state licensed midwives practiced safely and successfully during those 32 years, providing normal birth services to healthy women, consulting and collaborating with physicians as indicated. During this time, only three state-certified midwives were subject to disciplinary actions by the Board of Medical Examiners (BME).

However, in 1949 the provision in statute -- Article 9, which authorized the BME to process the *application* for midwifery certification -- was withdrawn at the request of the BME (SB 966), citing a lack of applicants. This reflected two interrelated historical circumstances.

The 1917 provision required midwifery applicants to be graduates of a Medical Board-approved training program. During that period of time, the BME approved 49 midwifery training programs in 6 foreign countries and 7 other states of the US. However, no midwifery schools within California were ever approved. The *only* approved educational route available in California to students of midwifery was the obstetrical training provided in medical schools. No California students were ever accepted into medical school for the purpose of midwifery training. As a result, the vast majority of California certified midwives were Japanese immigrants or Japanese American citizens who traveled back to Japan and graduated from one of the 27 Japanese midwifery schools recognized by the BME.

On February 19th, 1942, Executive Order 9066 was issued, resulting in the internment of virtually all of California's Japanese citizens, including midwives. According to medical board records, Japanese American midwives from California were incarcerated in camps in Arizona, Utah, and Heart Mountain, Wyoming. With the majority of licensed midwives removed from the state, birth registration for midwife-attended births fell to below one percent by the end of the war. Proponents of SB 966 cited the low number of midwife-signed birth certificates and licensing

applications as proof that midwifery was now a “dead class”. Based on these factors, the 1949 Legislature repealed Article 9, thus eliminating the application process. Midwives already certified were unaffected and continued to practice for the next forty years, until the last one retired in 1990.

In 1993 the original midwifery provision was repealed and replaced with the LMPA. At the insistence of the medical profession, the practice of non-medical midwifery was tied to medical supervision by physicians for the first time in the state’s history.

However, this clause of the LMPA has never been able to be implemented. During legislative hearings prior to passage of the LMPA, physician supervision was promoted by the California Medical Association (CMA) as a stepping stone to appropriate obstetrical services and a method to better ensure the safety of California citizens. Unfortunately, supervision has only functioned as a vehicle for creating artificial and unnecessary vicarious liability for physicians. It is a stumbling block and a legal impossibility that has resulted in at least one preventable fetal demise. This occurred when all the physicians in a small town in Northern California refused to order an ultrasound or evaluate a pregnant woman who was 11 days postdates because she was the client of a licensed midwife. They cited liability restrictions imposed by their insurance carriers.

The legal impossibility of physician supervision should come as no surprise to organized medicine, as documents in the public domain indicate that as far back as 1978 at least one California-based mutually-owned malpractice carrier consistently prohibited its physicians from having any professional association with planned home birth or any midwife who provided this type of care. In 1995, NorCal lawyers reaffirmed that their company policy had not changed since the publication the NorCal Mutual News in 1978. It remains the same in 2007.

The impossible nature of this situation became clear to the MBC during the process of implementing the new legislation in 1994-95. During that time, seven 6-hour meetings were held in the conference room of the Medical Board’s Sacramento facility, with representatives from all interested stakeholders attending. One of those present was Judge Cologne, who represented the California professional liability carriers’ trade organization. According to him, he had been a CMA lobbyist and at the request of his former employer, he had personally “killed” earlier midwifery licensing bills. On the topic of physician supervision, Judge Cologne stated repeatedly that none of the physicians insured by the companies he represented (all three California carriers) would permit their physician members to supervise midwives under the terms of their contract.

Judge Cologne frequently noted that it would be a violation of federal anti-trust laws for malpractice carriers to ‘discriminate’ against the lawful activity of planned home birth. As a lawyer himself, Judge Cologne had apparently been involved with the Justice Department’s Anti-trust Division. He assured us that he was very knowledgeable in this area and that his employers were very careful not to violate antitrust laws.

Referring to the legal right of insurance carriers to limit their risks, he said malpractice carriers could *require a vicarious liability surcharge* for any insured physician who supervised midwives. When asked how much that might be, he estimated that it would be approximately *double* the obstetrician’s regular premium. He also noted that the malpractice carriers legally *could and no doubt would* decline to renew the policy of any individual physician who manifested ‘questionable judgment’ by supervising midwives in the “risky business of home deliveries”.

When asked to provide the actuarial data supporting this assertion, Judge Cologne stated that it was “just common sense” that home births were riskier than hospital births. Their idea that PHB represented an unacceptable liability risk was reflected in the official policy of the boards of directors of all three carriers. None of the parties felt the need for any further ‘proof’’ and he did not anticipate that any of his employers could be persuaded to reconsider.

Dr Thomas Joas (committee chair) and Stewart Hsieh, governor-appointed members of the

Medical Board, agency Deputy Director Doug Laue, MBC senior counsel Anita Scuri, Linda Whitney, other MBC staff members and CMA lobbyist Joan Hall and Tim Shannon, all participated in the conversations about the anti-homebirth policies of all three malpractice carriers.

Dr Joas and Mr. Laue frequently acknowledged the legal impossibility of LMs complying with the supervisory provision, citing the issue of vicarious liability and the political positions taken by organized medicine as the reason. On several occasions they both stated that the Medical Board would not take disciplinary action against LMs solely based on the inability to find a supervising physician. Dr Joas repeatedly described the LMPA as a "bad law that needed to be fixed". Audio recordings for 4 of the 7 meetings exist and written transcripts of pertinent testimony are available on the internet. They include Judge Cologne's comments on the liability carriers' refusal to permit physician supervision of LMs and his 'kill-bill' role as a lobbyist for the CMA.

1997~ In response to a request from the California College of Midwives to Ron Joseph (former director), the Medical Board's July 1997 newsletter "The Action Report", included an article about the practice of California licensed midwives under the LMPA. It concluded with information on the mandated physician supervision relationship and urged interested physicians to contact the MBC. Sadly, not a single one of the 100,000 California licensed physicians responded to the Board's offer to connect them up geographically with LMs looking for a supervising physician. When the request was repeated in the Action Report a few months later, again not one physician responded.

1998 -99 ~ In 1998 a disciplinary action against a licensed midwife by the Board tangentially involved the issue of physician supervision. The Assistant Attorney General prosecuting the case requested that the midwife's license be revoked or suspended relative for her failure to be in technical compliance with the physician supervision clause. The case went to hearing in 1999 before an administrative law judge, who ultimately ruled in favor of the licensed midwife. (citation #1)

In his decision, Judge Roman acknowledged two different models of maternity care for healthy women -- the midwifery and the medical models -- and noted the striking philosophical and functional difference between them. He observed that within the medical model, neither physicians, physician assistants, nurse practitioners nor nurse midwives are able to provide the traditional services of physiological management in a non-medical setting, in which childbirth for a healthy woman is related to as a normal biological process. It was Judge Roman's belief that the Legislature's intent for the LMPA was to replace the original 1917 provision by creating a new category of state licensed non-medical midwives who would be available to families who desired a non-medical form of maternity care. In regard to the safety of that choice Judge Roman stated:

> "Sufficient evidence has been provided this tribunal to competently conclude that properly conducted midwife-led home births are as safe as births conducted by physicians in hospitals when effected within standards of practice." [emphasis added]

As to the legislative intent relative to the supervisory clause, he stated that

> "supervision" as set forth in Business and Professions Code section 2507(c) does not "require the physical presence of the supervising physician" and does not purport to involve, as set forth in Business and Professions Code section 3 501 (f), the overseeing of activity or acceptance of responsibility for services rendered by licensed midwives, *as is required by such physicians for licensed physician assistants*. Clearly, a different standard was intended by the Legislature; however undefined. [emphasis added]

In regard to physician supervision and the MBC's official knowledge that supervision was unavailable, Judge Roman declared that the Medical Board was:

> " … cognizant that no physician and surgeon in the State of California, for reasons primarily (and sadly) born of liability or restrictions imposed by their insurance carriers, will supervise a licensed midwife who conducts home births …" [underline added]

Other findings in the case included an acknowledgment that:

> 25. Respondent has presented competent and credible evidence in the form of witnesses and documents attesting to her experience, competency, devotion, dedication, concern, and professionalism for both midwifery and patients. She avidly seeks, along with other midwives, to be part and parcel of the healthcare team that serves the residents of California.
>
> A. Midwives employ a midwifery model of practice distinct from the medical model of practice. The testimony of Complainant's witnesses as to the medical model's applicability to midwifery is inapposite and summarily dismissed.
>
> B. Respondent, residing and laboring in an area where the medical community of obstetricians is hostile to licensed midwives, has been unable to gain supervision by a physician and surgeon. As a consequence of such hostility, unsupervised by any physician except as set forth in Finding 14, she lacks a specific physician to whom she might regularly brief regarding clients undergoing midwifery care and treatment, or who might provide care for complications in a hospital.
>
> The evidence presented this tribunal further establishes that, with the exception of one licensed midwife who is also a licensed physician assistant, no California licensed midwife, despite efforts for supervision, possesses a supervising physician .... Nevertheless, the evidence further established that Respondent uses at least one physician for collaborative consult, collaborative assistance, and emergent issues. Respondent, consistent with the extant midwifery standard of care (Findings 17 - 21), transfers patients to physicians or hospitals as necessary. [emphasis added]

The judge noted that:

> "Were this tribunal to employ the medical model on licensed midwifery, as Complainant urges, no home births could be competently assisted. Mindful that licensed midwives, with only one exception presented before this tribunal, possess no hospital privileges, the legislation would function to permit lay persons to possess a license that would not be functional anywhere within the State of California. This tribunal declines Complainant's offer." [emphasis added]

Judge Roman's ruling also acknowledged the functional sufficiency of collegial referral and assistance, collaboration and emergent assistance without direct or accountable physician supervision:

> "In an effort to practice their art, virtually all of California's 109 licensed midwives, including Respondent, have, with the cooperation of physicians sympathetic to their plight and who seek to expand the options available to patients, developed a relationship that

> involves collegial referral and assistance, collaboration, and emergent assistance without direct or accountable physician and surgeon supervision of licensed midwives.
>
> In an effort to promote the efficacy of the Act, this tribunal concludes, at this time, that a licensed midwife who possesses a relationship with a California physician and surgeon as referenced herein has feasibly and reasonably satisfied the ambit of the Act. Accordingly, cause does not exist to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(e), in conjunction with sections 2507(a) and 2507 (b), for unprofessional conduct arising from lack of supervision as set forth in Findings 13-14 and 17-23. [emphasis added]

In spite of this ruling, the bias against planned home birth and the many stumbling blocks to any form of supervisory relationship continues on unabated. In recent years, malpractice carriers have extended their prohibition to include consultation and collaboration. NorCal also prohibits insured physicians from consulting or collaborating with midwives, citing the supervisory clause in the LMPA as their rationale (NorCal letter 05-18-99). They claim that the courts might interpret such collaboration as a *de facto* form of supervision and find the physician and his/her malpractice carrier to be vicariously liable.

A letter from the California Association of Professional Liability Insurers (CAPLI) to the MBC in 2005 confirms, in unambiguous terms, that all its member organizations prohibit supervision of LMs relative to PHB. This is the same trade organization for California carriers that in 1994 employed Judge Cologne as their lobbyist. The 2005 CAPLI letter was written by Tim Shannon, current CAPLI representative who was also one of the CMA lobbyists who attended the Midwifery Implementation Committee meetings in 1994-5. [encl #4 – CAPLI letter 2005; NorCal letter 05-18-99; NorCal Mutual Newsletter; 1978].

It must be emphasized again that the original language for the 1993 LMPA was provided to Senator Killea by the CMA and AGOC (American College of Obstetricians and Gynecologists). Both organizations verbally threatened to "kill" the licensing law unless it *required* physician supervision. Senator Killea stated this in my presence and it is confirmed by official documents. While she deemed this to be regrettable, she still believed that "bad legislation is better than no legislation at all".

At the time, this appeared to be a reasonable compromise, since the CMA lobbyist promised Senator Killea that if she acceded to their demand for legislatively-mandated physician supervision, the CMA would "see to it that physicians provided the required supervision". [Nancy Chavez, Aide, Sen Killea 1993] The CMA has never been able to deliver on this promise. As a result, no California obstetrician has ever been able, under the terms of his/her professional liability contract, to supervise a licensed midwife who provided planned home birth services. According to published reports from the obstetrical community [encl #5- ObGynNews 09-15-93], preventing PHB by denying licensed midwives access to the essential service of physician supervision was the intended effect of the legislative clause demanded by organized medicine.

Absence of Actuarial Data for Vicarious Liability

Bleak as all this is, a tiny minority of brave physicians is still interested in supporting women who choose midwifery care by offering to supervise licensed midwives in their area. However, their liability carriers inform them that it is prohibited or that a substantial vicarious liability surcharge will be required. In addition to the expense, any obstetrician formally identified by his/her

malpractice carrier as supervising community-based midwives faces the high probability that he will lose his insurance at the end of the contract. Judge Cologne predicted this reprehensible practice during the MBC meetings 1994.

However, the custom by insurance carriers of requiring a surcharge for midwives has not been validated by actuarial data. This was documented in Washington, DC when a vicarious liability surcharge was imposed on a group practice of certified nurse midwives and obstetricians by the National Capital Reciprocal Insurance Company. The NCRIC was a malpractice mutual company owned and controlled the DC Medical Society. Faced with an increased premium of more than 4,000 percent, the nurse midwives filed a complaint with the DC Superintendent of Insurance. After a two day hearing the Superintendent rejected the surcharge as excessive and discriminatory and rolled the rates back to the previous nominal annual premium. Furthermore, he prohibited the insurer from increasing rates unless it could demonstrate a valid actuarial basis for the increase.

The explanation was straightforward. All insurers share the data they collect about malpractice claims with various national insurance organizations or associations. Insurance premiums are then calculated on the basis of statistical probability, which are derived from data compiled, in aggregate form, for each physician specialty. The aggregate claim data for each specialty category are then compared with each other. This results in a weighted average factor that is used to determine premium rates for members of that specialty group. Those with the fewest and/or lowest claims play the lowest premiums, while a high claim groups, such as Ob-Gyns, might pay premiums five times higher.

Within the specialty area of Ob-Gyn, all claims – direct and vicarious -- are grouped together. No one knows how many reflect direct liability for the physician's own actions versus claims reflecting 'vicarious' liability. The liability insurance industry has never collected (or at least, never made public) any such data breakdowns. As a result, the total set of all claims against the surgical specialty of obstetrics and gynecology serves as the basis upon which their premiums are determined. In other words, the premium charged reflects *both direct liability and vicarious liability* claims, to the extent that *any* vicarious claims exist. All OBs pay this rate, which **already accounts for any risk of vicarious liability**. At the time of the NCRIC case, no vicarious claims for obstetricians involving care provided by midwives were known to have occurred.

To the extent that any true vicarious liability exists, it has already been covered by the direct premium. In fact, a surcharge represents "double dipping", as all litigation-related costs have already been factored in initially. This was the basis for rejecting a surcharge as excessive and discriminatory by the DC Superintendent of Insurance.

Malpractice insurance companies that impose surcharges are in violation of state insurance laws, unless they can demonstrate that they have differentiated between actuarial data that accounts for direct liability differently from vicarious liability. However, all insurers use essentially the same data as the NCRIC, so they will not have differentiated data and their surcharges can be challenged as excessive, discriminatory and without adequate actuarial support.

Furthermore, there is no category of actuarial data collected or made available for obstetricians who supervise midwives utilizing the principles of physiological care. Were such data available, physicians who provided physiological management themselves, or supervised midwives who do, would enjoy considerable savings on their malpractice premiums, as the outcomes for this type of care are excellent, with a corresponding low rate of complications.

Reliable sources, including a recent Wall Street Journal article on reducing malpractice costs for normal birth, identify that 50% of all obstetrical malpractice claims involve the administration of artificial hormone Pitocin to induce or speedup labor. In one study, 27% of obstetrical inductions

were being performed *before the term of the pregnancy*. In particular, those pre-due date inductions had a remarkably higher rate of complications, including fetal distress and Cesareans. [encl #6].

Midwives *never* administer artificial hormones or other powerful drugs in a domiciliary setting that induce or accelerate labor. Obviously these safer practices would lower the rates of litigation for any obstetrician associated with licensed midwives. However, practices that reduce the litigations risk and other positive factors are not taken into account when med-mal carriers set premiums for obstetrical liability coverage. Potential savings to the insured physician (or reduced revenue to the carrier) may explain why undifferentiated data continues to be used.

In the meantime, no statistical or actuarial data exist that could justify the imposition of a surcharge for physicians who supervise professionally-licensed midwives providing physiologically-based midwifery care in any setting, including planned homes births. (citation #2)

2000-2007 ~ Since the passage of the LMPA in 1993, consumers and midwives and other grassroots organizations have, with the help of Senator Figueroa and Assemblywomen Strom-Martin, made three separate legislative attempts to remove or modify the poison pill of physician supervision from the LMPA. That also included an effort to eliminate the vicarious liability aspect of physician supervision by adding a "hold blameless for care not rendered" clause. This common sense remedy was opposed by the trial lawyers' lobby. While these bills had the support of forty organizations, they all failed due to opposition of *four* organizations -- the CMA, CAPLI, ACOG and CAOC (the trial lawyers lobby).

However, coordinated efforts by midwifery and consumer groups were able to improve the situation for licensed midwives and make their care more satisfactory for consumers through passage of three amendments to the LMPA. In 2000, SB 1479 added language acknowledging that spontaneous childbirth is a normal process and not a disease, that every childbearing woman has a right to choose her birth setting from the full range of safe options on her community and that PHB with a trained attendant is a safe and responsible option for healthy women. SB 1479 also made licensed midwives responsible for documenting specific medical interface arrangement for each PHB client.

In 2002, a second amendment (SB 1950) required the Medical Board to adopt a midwifery-based standard of care to be used in judging any quality of care complaint against LMs. And in 2006 a third amendment (SB 1638) authorized the formation of a MBC/Midwifery Advisory Council. It also provides for LMs to collect and report statistics and other practice data on the number and outcomes of PHB to the Office of Statewide Health Planning and Development (OSHPD). Aggregated data is to be provided to the MBC each year on the number and outcomes of PHB, which in turn must be included in the Board's annual report to the Legislature.

Ms Hall's Compliance of with the LMPA

Now that necessary background information has been communicated, I would like to turn your attention back to the letter of Jan 2007 and clear up two remaining issues relative to Edana Hall's relationship with French Hospital. In the second paragraph of your letter, you wrote: "Other legal requirements that you apparently do not meet consistently include the obligation to disclose to your clients the specific arrangement you have made for the transfer of care during the prenatal period, hospital transfer during intrapartum and postpartum and access to appropriate emergency care". You continue on, stating that you assume compliance with this requirement is dependent on "reliable access to a physician supervisor at all times", and therefore, Ms Hall must be out of compliance, since she doesn't have a supervising physician.

This interpretation is a misunderstanding of section 2508(b) of the LMPA. This section is of particular interest, since it is one of the first changes made to the midwifery licensing law and was triggered by the very physician supervision conundrum discussed throughout this letter.

In 2000 legislation carried by Senator Figueroa amended the LMPA for the first time since its passage in 1993. SB 1479 repealed section 2508 (b), which originally required each midwife "to disclose to each of her clients that a specific physician was being briefed regularly concerning that client's pregnancy and was prepared to take care of complications in the hospital if necessary".

SB 1479 replaced that wording with a clause that instead requires the midwife, in conjunction with the client, to determine and document the specific arrangements arrived at for medical interface for that particular client. The statute purposefully doesn't stipulate or specify *what the nature* of those arrangements is to be, only that they must be determined *a priori* and properly documented. This information must be in writing, signed by both client and LM and made part of the client's permanent record. This constitutes an effective plan for interfacing with the medical community whenever such care is desired by the mother, is necessary as determined by the clinical judgment of the LM, or is required by the scope of practice of the LMPA.

The amended section 2508 also requires that LMs provide the client with a copy of the midwifery scope of practice, which includes the information that midwives are not authorized to practice medicine or surgery, and the phone number / web site for the Medical Board, should the client wish to make any inquiry or complaint. The LM must also disclose whether or not she carries professional liability insurance.

These changes in the law were brought about by two things. First, all stakeholders in this arena, including organized medicine and the Medical Board, had to admit that physician supervision, functionally speaking, was a legal impossibility. So the new language for Section 2508 insures that each client cared for by a licensed midwife has full information relative to the midwifery law, the midwife's practice, access to the regulatory agency and, most important of all, that she has an effective plan for medical interface in all three areas of pregnancy, childbirth and neonatal care.

The second reason for amending section 2508 was the change in health insurance reimbursement since 1993, when the classic form of medical compensation-- private practice, fee-for-service arrangements -- was supplanted by 'managed care' - HMOs, PPO, etc. Even if a midwife were to have a supervising physician, many client families, for geographical and/or health insurance reasons, would not be able to be cared for by the midwife's supervising physician or hospitalized in the facility at which he had privileges.

For example, families who have Kaiser or other HMO coverage must use their own network physicians and resources. If they don't, they would be forced to pay thousands of dollars out of pocket or, worse yet, be *unable to pay* out-of-network care providers/facilities for their professional services. It was the opinion of the Legislature that the amended section 2508 was an important contribution to consumer safety, as well as an advantage to providers such as your own hospital and its professionals. It is conceivable that SB 1479 has benefited CHW, since families are free to pick the physician and hospital of their choice or ones covered by their insurance plan.

As for Ms Hall's compliance with section 2508(b), she assures me that, as with all LMs, she provides each client with the necessary information and together they formulate an effective plan for medical interface, should it become necessary. Ms. Hall uses the midwifery-medical interface form created by the California College of Midwives, which has been deemed acceptable to the MBC. This is signed by both client and midwife and included in the patient's permanent record.

Last but not least is the issue of Ms. Hall's ability to get ultrasound or non-stress tests done for her clients whenever indicted. You stated in your letter to her that:

> "…even if you were to arrange for reliable physician supervision at all times, we would *remain disinclined to honor an order from you* because we would consider ourselves obligated to protect the interests of patients by *confirming your experience, training and competency* to properly order and interpret data and tests. We do not believe that this would be a worthwhile expenditure of the Hospital's scarce recourses. [emphasis added]

According to your letter, you believed your hospital's legal responsibility to be equivalent to that of "credentialing of certified nurse midwives who are **authorized to practice at the hospital**" [emphasis added]. However, Ms. Hall is not asking for *practice privileges* within your institution. The contrast is quite striking, since a CNM working under institutional authority is authorized to provide medical services such as labor-inducing drugs, IV antibiotics, narcotics and delivery instrumentation such as vacuum extraction. It seems quite reasonable that a standard vetting process should precede the extension of such privileges.

But relative to obtaining ultrasound exams for midwifery clients, Ms. Hall would not the one to perform the ultrasound. She is only asking that agents of your institution, who are trained and licensed in ultrasound technology, perform whatever diagnostic procedure is necessary and provide a written report with the standard information.

French Hospital is not "obliged to protect the interest of patients" by confirming Ms. Hall's "competency to order and interpret the data and tests". The Medical Board of California is responsible for determining training and competency as established by the LMPA. Currently, Ms Hall has a valid midwifery license in good standing. Having qualified as a state-certified midwife, she is able to perform all the duties of a professionally trained midwife. This includes the ordering of tests and interpretation of data, as stated in Medical Board regulations defining the midwifery standard of care for California licensed midwives.

The idea that your institution would be responsible for her interpretation of a test report would no more apply to Ms Hall's situation than it would to an obstetrician who might misinterpret data provided to him by one of your ultrasound technicians. Common sense tells us that the Timex corporation would not responsible for a counting mistake that a doctor or nurse might make in using one of its wristwatches to take a patient's pulse.

You quoted Mr. Hill as confirming that there is "no legal requirement that compels a hospital to respond to orders from a licensed midwife" and that "a hospital is absolutely within its rights to decline to honor such orders." In the narrow sense, this statement is also true. As a private corporation, no California law can compel your hospital to offer any service or privilege to licensed midwives, licensed physicians or other professionals. But as a facility owned and operated by Catholic Healthcare West, I must tell you that I and many others believe your institution has ethical as well as practical responsibilities to implement the idea of 'protecting patients' in a realistic fashion that actually achieves the stated goal. A lot of questionable practices attributed to 'protecting patient safety' do not actually make people safer. One perfectly lovely family has already suffered a preventable loss of their second baby on Easter Day 2004 because each medical care provider, as well as the local hospital, used the neutral status of California law as an excuse to refuse non-emergent but necessary assistance.

As a religiously-oriented person myself, I take my ethical obligations seriously. In that tradition, I also expect the very best from Catholic Healthcare West. Given this high standard, I am sure that your facility could meet its own operational needs, while still protecting the unborn babies of women being cared for by licensed midwives in your area.

The basic premise of midwifery, as it relates to medical care, is best described by a little-known story told about First Lady Eleanor Roosevelt. When asked who she put first in her life, her husband (then president of the United States), or their children, she replied that "together with my husband, we put the children first". I believe that midwives and physicians and medical institutions should all follow this example -- together, we should put mothers and babies first. In this way, the wellbeing of society is also put first.

My prayer is that your institution will join me in furthering that worthy goal.

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Enclosures:

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* Myth of the Ideal C-Section Rate; Dr RM. Cyr, MD Am Jour Obstet Gynecol 2006
#3 The Guardian, United Kingdom; Feb 6, 2007;
#4 Legislative Memorandum, Office of California Governor Earl Warren, 1949
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#7 New Practice Reduce Childbirth (Litigation) Risks; Wall Street Journal; 2006 J