Note to Readers:

I created this annotated PDF by working for 8 hours straight. Can't even describe how many parts of my body hurt and I'm virtually word-blind after spending a whole day looking at a compute screen.

Unfortunately, I need to go over this document again to be sure there are no errors, but I'm racing the stork tonight.

But because this is the first official version of SB 457, and our legal future is on the line, I'm going to post this not-perfect version as a "draft", and will fix any problems later.

Childbearing families have much more to loose than the profession of midwifery, as SB 457 would **eliminate maternal autonomy** (the right to decide) in regard to childbirth. This could even be used to justify 'Court ordered' Cesareans. Unless women have a 'perfect' or "no-risk" pregnancy or labor, they would find themselves ensnared in the mandates of SB 457 that prevent the midwife from providing care until the mother is evaluated by an obstetrician.

If the doctors believes there any kind of "deviation" from norm (a legally ***undefined*** term!), or finds anything else that "could" (not would, but merely *might*) prove problematic during pregnancy or childbirth, it will be illegal for anyone to provide childbirth services in an OOH setting (birth center or parent's home). This includes both physicians and midwives (LMs and CNMs). The would of course result in a resurgence of lay midwifery and unattended births for VBAC women who can get care any other way.

So we are urging clients and former clients of midwives, and their friends and family to call their Legislators (right now just state senators) and tell them to kill this anti-mother, anti-family, anti-midwife, pro-hospital bill.

I also hope all licentiates affected by this disturbing legislation (MDs, LMs and CNM) will read it and call, write or visit the office of your state senator, and stay tuned for additional ideas for how to "kill bill SB 457".

Date Published: 04/17/2017 09:00 PM
BILL START

AMENDED IN SENATE APRIL 17, 2017

CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

SENATE BILL No. 457

Introduced by Senator Bates

February 16, 2017

NOTE frm Faith ^O^- Text in BLUE is the official working for this version, while RED ~~strike-thru~~ text is language to be repealed by this new law

~~An act to amend Section 1248 of the Health and Safety Code, relating to health facilities.~~ *An act to amend Section 2507 of, to add Section 2746.54 to, to add Article 17 (commencing with Section 880) to Chapter 1 of Division 2 of, and to repeal Sections 2508, 2510, 2516 of, the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to out-of-hospital childbirths.*

LEGISLATIVE COUNSEL'S DIGEST

SB 457, as amended, Bates. ~~Health facilities: outpatient settings.~~

Out-of-Hospital Childbirths: physicians and surgeons: licensed midwives: certified nurse-midwives.

(1) Existing law, the Medical Practice Act, provides for ***the licensure and regulation of physicians and surgeons*** *by the Medical Board of California.*

*Existing law, the **Licensed Midwifery Practice Act of 1993**, provides for the licensure and regulation of midwives by the Medical Board of California. A violation of the act is a crime.*

***Existing law authorizes a licensed midwife to attend cases of normal pregnancy and childbirth**, but requires a midwife to immediately refer or transfer a client to a physician and surgeon if there are complications.*

*Under the act, if a **client of a licensed midwife is transferred to a hospital**, the licensed midwife is required to provide records and speak with the receiving physician and surgeon about labor up to the point of the transfer.*

*The act requires a **hospital to report each transfer** of a planned out-of-hospital birth to the Medical Board of California and the California Maternal Quality Care Collaborative using a standardized form developed by the board.*

*Under existing law, **a midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports** that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.*

*Existing law, the **Nursing Practice Act**, provides for the licensure and regulation of **certified nurse-midwives** by the Board of Registered Nursing. A violation of the act is a crime. Existing law authorizes a certified nurse-midwife, under the **supervision of a licensed physician and surgeon**, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to **assist a woman in childbirth so long as progress meets criteria accepted as normal**.*

*Existing law **authorizes a certified nurse-midwife to furnish and order drugs or devices** incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistent with the certified nurse-midwife's educational preparation or clinical competence to specified persons, and only in accordance with standardized procedures and protocols developed and approved by, among others, the supervising physician and surgeon.*

*Existing law establishes the **Office of Statewide Health Planning and Development {OSHPD}** in state government and it has jurisdiction over health planning and research development.*

*This bill would **revise and recast** these provisions by requiring that a **licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife only attend cases of***

pregnancy and out-of-hospital childbirth, as defined, when specified conditions are met.
For purposes of ***determining whether a patient or client satisfies these conditions****, the bill would require the licensed physician and surgeon, licensed certified nurse midwife, or licensed midwife to* ***use a self-screening form to identify patient or client risk factors*** *for out-of-hospital childbirth.*

The bill would ***specify those circumstances when a medical examination by a licensed physician and surgeon is required****, when a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife is* ***prohibited from attending cases of pregnancy and out-of-hospital childbirth****, and when a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife would be* ***required to initiate appropriate interventions, including transfer to a hospital****, when a patient or client's health status changes.*

The bill ***would make it unprofessional conduct*** *for a licensed physician and surgeon, licensed midwife, or licensed certified nurse-midwife* ***to attend to a case of out-of-hospital childbirth after a licensed physician and surgeon determines that the patient or client is at an increased risk*** *due to her health status, as provided.*

This bill would ***require*** *licensed physician and surgeon, licensed midwife, or a licensed certified nurse-midwife attending to cases of out-of-hospital childbirths to* ***make specified disclosures to a prospective patient or client and obtain consent, as provided****.*

The bill would ***also require*** *these licensees to* ***provide the patient or client with the most recent versions of specified documents concerning out-of-hospital childbirths****.*

The bill would also require the Medical Board of California and the Board of Registered Nursing to ***make those same documents publicly available on their Internet Web sites****.*

If a patient or client is transferred to a hospital, this bill would ***require*** *the licensee to* ***provide specified records and speak with the receiving physician*** *and surgeon about the labor up to the point of the transfer. The bill would provide that* ***the failure to comply with this requirement shall constitute unprofessional conduct****.*

The bill would ***also require the hospital****, within a specified period of time,* ***to report to the Office of Statewide Health Planning and Development each transfer of a patient****, as specified.*

The bill would ***require*** *the Office of Statewide Health Planning and Development to* ***develop a form, subject to specified criteria****, including that patient identifying information is protected, for purposes of implementing the hospital-reporting requirement.*

This bill would ***require each licensee*** *caring for a patient or client planning an out-of-hospital birth* ***to submit, within a specified period of time, a form to the Office of***

***Statewide Health Planning and Development indicating the initiation of care**. The bill would **also require** each licensee who attends an out-of-hospital childbirth **to annually submit a specified report** to the Office of Statewide Health Planning and Development.*

*The bill would **require** the Office of Statewide Health Planning and Development to, among other things, **maintain the confidentiality** of this information.*

*For consistency with the above provisions governing out-of-hospital childbirths, the bill would **make conforming changes to the Licensed Midwifery Practice Act of 1993** and the **Nursing Practice Act**.*

*The bill would specify that a **certified nurse-midwife** is authorized to attend cases of out-of-hospital childbirth **without physician** and surgeon supervision when the provisions governing out-of-hospital childbirths are complied with.*

*The bill would also **authorize a licensed midwife and a certified nurse-midwife to administer, order, or use certain drugs and equipment**. Because a violation of these requirements by a licensed midwife or certified nurse-midwife would be a crime under their respective acts, the bill would impose a **state-mandated local program**.*

*(2) Under existing law, an **alternative birth center** that is licensed as an alternative birth center specialty clinic is required to, as a condition of licensure, and a primary care clinic providing services as an alternative birth center is required to, meet specified certain requirements including **requiring the presence of at least 2 attendants at all times during birth**, one of whom is required to be **a licensed physician and surgeon, licensed midwife, or a certified nurse-midwife**.*

*This bill would **require the client to be informed orally and in writing** when no licensed physician and surgeon is present.*

*(3) Existing constitutional **provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.***

This bill would make legislative findings to that effect.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law prohibits the operation, management, conduct,~~

~~or maintenance of an outpatient setting unless the outpatient setting is accredited by an accreditation agency that is approved by the Medical Board of California, licensed by the State Department of Public Health, as specified, or meets other criteria. Existing law defines an outpatient setting, in part, as a facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined, that uses anesthesia, as specified.~~
~~This bill would make technical, nonsubstantive changes to those provisions.~~

DIGEST KEY
Vote: majority Appropriation: no Fiscal Committee: ~~no~~*yes* Local Program: ~~no~~*yes*

BILL TEXT
THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.
Article 17 (commencing with Section 880) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 17. Out-of-Hospital Childbirths {NOTE – 2 asterisks (**)next to a section indicate that is contains one or more unworkable requirement

880. *(a) Notwithstanding any other law and except as provided in subdivisions (c) and (d), a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife shall* ***only attend*** *cases of pregnancy and out-of-hospital childbirth when all of the following conditions are met:*

***(1) There* *is no increased risk to the patient or client because of a disease or condition that could adversely affect the pregnancy and childbirth**.*

> **This is a **decision to be** properly (and ethically) **made by the CB woman after she receives fully-informed consent** and signs **appropriate informed consent/decline documents.**
>
> **This provision would **violate** the *North American Free Trade Act* (NAFTA). **NAFTA** prevents passage of professional licensed laws that constitute "*unnecessary barriers to trade*". To avoid being illegal under NAFTA, state licensing requirements must:
>
> "**not** constitute a **disguised restriction** of the **provision of service** .. Requirements should be **based on competence**"

***(2) The patient or client has* *not had prior uterine or abdominal surgery, including, but not limited to, myomectomy, hysterotomy, or prior caesarian section.*

** This is properly a **decision that is to be made by the CB woman after she receives fully-informed consent** and signs **appropriate informed consent/decline document**s

** It also does **not provide** for women who are seeking care under the **religious exemptions clause** and those who are suffering from **PTSD** from a previous traumatizing hospital birth and say to their midwife "**I just can't make myself return to the scene of the crime"**.

(3) There is a singleton fetus.

(4) There is a cephalic presentation by $36^0/_7$ completed weeks of pregnancy.

(5) The gestational age of the fetus is greater than $37^0/_7$ weeks and less than $42^0/_7$ completed weeks of pregnancy.

(6) Labor is spontaneous or manually induced after 39 weeks gestation.

***(7) **Transfer to a hospital setting can occur within 20 minutes** from the initiation of the transfer.*

** This is properly a **decision that is to be made by the CB woman after she receives fully-informed consent** and signs **appropriate informed consent/decline document**s

*** (b) The licensed physician and surgeon, licensed certified nurse midwife, or licensed midwife, acting within their scope of practice, shall use a self-screening form to identify patient or client risk factors for out-of-hospital childbirth.*

** This is a function of the **professional Standard of Care** the these licentiates (MD, LM or CNM already function under)

(c) If the patient or client meets the conditions specified in paragraphs (3) to (7), inclusive, of subdivision (a), but fails to meet the conditions specified in paragraph (1) or (2) of subdivision (a) based on the risk factors identified by the self-screening form, the patient or client shall obtain a medical examination by a licensed physician and surgeon with privileges to practice obstetrics or gynecology.

*Under these circumstances, the licensed physician and surgeon, licensed midwife, or certified nurse midwife may **only attend** cases of out-of-hospital childbirth if a licensed **physician and surgeon** **with privileges to practice obstetrics or gynecology** determines, at the time of the examination, that the patient or client is **not at an increased ris**k due to a disease or condition, that could adversely affect the pregnancy and childbirth.*

** This is properly an informed consent/decline **decision a made by the CB woman after the licentiate (MD, LM or CNM) provides all available information about the identified issue or condition.**

ACOG Committee Opinions #166, #214 and #669 all acknowledge the autonomy of all childbearing women (such ethical principles would not just apply those receiving obstetrician services) to provides her consent to be:

(a) evaluated by said physician & surgeon
(b) decline to be so medicalized
(c) agree to be evaluated
(d) if evaluated, either decline OR accept said physician's recommendation or via the customary mechanism for **fully-informed consent or decline-of-recommended-treatments** and sign appropriate **informed consent/decline documents,** which are to be included in the woman's **chart**.

*(d) The licensed physician and surgeon, licensed midwife, or licensed certified nurse-midwife attending cases of pregnancy and out-of-hospital childbirth under this article ** **shall continuously assess the patient or client for any evidence of a disease or condition** that could adversely affect the pregnancy and childbirth.*

This is **already the Standard of Care for all professional maternity care providers; inserting this into black-letter law is both unnecessary & insulting.

*If any evidence of a disease or condition that **could** adversely affect the pregnancy and childbirth arise, the patient or client shall obtain a medical examination by a licensed physician and surgeon with privileges to practice obstetrics or gynecology or the licensed physician and surgeon, licensed midwife, or licensed certified nurse-midwife, shall initiate appropriate interventions, including transfer, first-responder emergency care or emergency transport.*

** "**COULD" is inappropriate concept in this legal context.** The word "*could*" fails to make the *critical legal distinction* between what is merely "*possible*" from that which is **probable.**

The word **"could"** also does not take into account the critical distinctions either of frequency or severity. These important differences must be addressed *differently* as legal concept that identifies it as **discriminatory** when *different* circumstances are treated as if they are the *same,* while laws that treat the *same* circumstances *differently* are legally regarded ***arbitrary***.

A legal obligation already exists for licentiates to fully inform clients about known risks – both frequency AND severity -- as delineated by our professional standard of care. Circumstances with a low level of risk, or risks that are substantial but rare are dealt with differently by licentiates that provide normal childbirth services in OOH settings.

In addition to maternal and fetal health, OOH providers must also factor in *driving distances, traffic/time-of-day, weather, local road conditions* and whether the hospital preferred by the parents (or their health insurance arrangements) is able to provide sufficiently comprehensive care for at-risk mothers and babies, and if not,

to have an appropriate alternative arranged. All these distinctions are properly the topic of **informed consent conversations** btw the primary birth attendant (MD, LM or CNM) and the childbearing family.

When the birth attendant has identified a **substantial level of risk in *combination* with a substantially increased frequency** of occurrence for either mother or baby during the process of providing full decision-making information to the parents, the initial option of a planned OOH is mutually eliminated by family and primary provider.

It should be noted that licensed professionals such as MDs, LMs and CNMs all have a vested interests maximizing good outcome and preventing bad outcomes. This is especially true when planned place-of-birth would be seen as contributing to the problematic outcome.

At a practical level, and with rare exception, the final decision maker (ethically and legally) should be the childbearing woman. The experience of LMs is that when women are fully informed about any risk factors that apply specifically to them, they often but no always decide that tolerating a relatively minor risk, or even one that is substantial but ***rare***.

In these instances, they will **continue with their plans** for a professionally-attended OOH, which they believe is **in their best interest,** given the high level of **iatrogenic and nosocomial complications** that are associated with hospital-based obstetrical management of normal labor and birth in a healthy population.

After an appropriate informed consent/decline, these mothers-to-be maintain their plan to remain in an OOH during normal labor and birth. This "Plan A" is always contingent on her being (a) an essentially healthy women with a normal pregnancy, (b) having a spontaneous onset of labor at term, (c) making suitable progress in labor, (d) while both she and her fetus continue to tolerate labor without any significant diminution of well-being.

This provision also **violates ACOG Committee Opinions #166, #214 and #669,** which clearly acknowledges the ***autonomy of all childbearing women****, even when they have serious medical situations***.** These principles provides for women with identified risks factors to consent to be:

(a) evaluated by said physician & surgeon
(b) decline medical evaluation
(c) agree to be evaluated
(d) if evaluated, either decline OR accept said physician's recommendation or via the customary mechanism for **fully-informed consent or decline-of-recommended-treatments** and signing appropriate **informed consent/decline documents,** which is to be included in the woman's **chart**.

*(e) For the purposes of this article, "**out-of-hospital childbirth" means** childbirth in the home setting, an alternative birth center pursuant to pursuant to paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or **any other setting other than a facility** as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, or a facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.*

*(f) It **shall constitute unprofessional conduct** for a licensed physician and surgeon, licensed midwife, or licensed certified nurse-midwife to attend to a case of out-of-hospital childbirth after a licensed physician and surgeon with privileges in obstetrics or gynecology, pursuant to a medical examination under subdivision (c) or (d),** **determines that the patient or client is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth**.*

Notwithstanding any other law, a violation of this section shall not be a crime.

** Same issue with word "**could**" as discussed above, and also same issue with the **unethical and unnecessary elimination of maternal autonomy** in violation of ACOG's own policies on the topic.

It should be noted that were this same language used in a regulation under the authority of the *Office of Administrative Law* (AOL), the use of this word would **fail** on ground of *not having a consistent or functional understanding* of its meaning.

880.2.

(a) A licensed physician and surgeon, licensed midwife, or a licensed certified nurse-midwife authorized to attend to cases of out-of-hospital childbirths pursuant to this article shall disclose in oral and written form to a prospective patient or client seeking care for a planned out-of-hospital childbirth, and obtain consent for, all of the following:

*(1)** All of the provisions of Section 880.*

** Burdensome, unnecessary and discriminatory, as obstetricians are not required to disclose any of the laws regulating the practice of medicine to their patients

As mentioned above, this same wording, were it part of a *proposed regulation*, which ***not*** be able to meet 4 out of the 6 standard requirements for regulatory language:

(1) Necessity (3) consistency (4) clarity (i.e. *easily understood by those directly affected by it*), (5) non-duplication (i.e. many aspect of these requirement are already present in the professional standards of care by these three categories of licentiates.

*(2)**The type of license held by the licensee and licensee number.*

** *Is* Easily available on the internet
** Burdensome, unnecessary and discriminatory, as obstetricians are not required to disclose any of the laws regulating the practice of medicine to their patients
** Also reiterates the previous statement of "burdensome" as not meeting the commonsense standards used for regulations.

*(3)**A licensed midwife or certified nurse-midwife who attends cases of out-of-hospital childbirth without physician and surgeon supervision shall provide notice that the care being provided is not being supervised by a physician and surgeon.*

** Burdensome, unnecessary and discriminatory, as obstetricians are not required to disclose any of the laws regulating the practice of medicine to their patients

** ***Not*** be able to meet requirements for regulatory language:

(1) Necessity (3) consistency (4) clarity (i.e. *easily understood by those directly affected by it*), (5) non-duplication (i.e. many aspect of these requirement are already present in the professional standards of care by these three categories of licentiates.

*(4 **The practice settings in which the licensee practices.*

** Burdensome, unnecessary, discriminatory and *nonsensical, as families seeking OOH childbirth services are specifically choosing a particular MD, LM or CNM because he or she provide such care*

(5) If the licensee does not have professional liability coverage for the care being provided in an out-of-hospital birth setting, he or she shall disclose that fact.

*(6) ** The acknowledgment that if the patient or client is required to obtain an examination with a licensed physician and surgeon pursuant to subdivision (c) or (d) of Section 880, failure to do so may affect the patient or client's legal rights in any professional negligence actions against a physician and surgeon, a healing arts licensee, or hospital.*

** **Burdensome, inconsistent and discriminatory**: This information, if and when it applies to a specific obstetrician, should be **provided by that specific physician** in the course of his or her consultation with a childbearing women referred to him/her for evaluation.

*(7) ** There are conditions that will result in an examination from, or transfer of care to, a licensed physician and surgeon and if these conditions exist, the licensee will no longer*

be able to care for the patient or client in an out-of-hospital setting, beyond continuing care during the transition period to the physician and surgeon.

** **Unethical and unnecessary elimination of maternal autonomy** in violation of ACOG's own policies on the topic (see expanded explanation earlier in document)

(8) The specific arrangements for examination by a physician and surgeon with privileges in obstetrics or gynecology for examination. The licensee shall not be required to identify a specific physician and surgeon.

** **Deficient Concept,** as many problems that arise in pregnancy are not obstetrical in origin or nature, and would be best and most cost-effectively addressed by MDs that are not obstetricians. This would include GPs, family practice physicians, and those that specialize in endocrinology, perinatologists, and other medical specialties. Under this scheme, CB women would first have to see an obstetrician and then get referred to the appropriate specialty.

Unethical and unnecessary elimination of maternal autonomy in violation of ACOG's own policies, as the childbearing woman has an ethical right to decide for herself which type of physician she will see, to decline this recommendation at the particular time or under those particular circumstances. (See expanded explanation ACOG's principles delineated earlier in document)

*(9)** The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for patient or client and newborn, if necessary, and recommendations for preregistration at a hospital that has obstetric emergency services and is most likely to receive the transfer.*

** **Redundant and burdensome**, already part of the LMPA and is already required by the professional Standard of Care for MD, LM and CNM birth attendants whenever they provide OOH childbirth services

(10) If, during the course of care, the patient or client has or may have a condition indicating the need for a transfer to a hospital, that the licensee shall initiate the transfer.

(11) The availability of the text of laws regulating out-of-hospital childbirth and the procedure for reporting complaints to the appropriate licensing entity.

** **Redundant and burdensome**, already part of the LMPA and is already required by the professional Standard of Care for MD, LM and CNM birth attendants whenever they provide OOH childbirth services

*(12) **Consultation by a licensee with a consulting physician and surgeon does not alone create a physician-patient relationship or any other relationship with the consulting physician and surgeon. The licensee shall inform the patient or client that he or she is an independent healing arts licensee and is solely responsible for the services he or she provides.*

** **Discriminatory**, as no other category of health or medical service providers are required to "disclose" such obvious information

(b) The disclosure and consent form shall be signed by both the licensee and patient or client and a copy of the signed disclosure and consent form shall be placed in the patient or client's medical record.

*(c) (1) **The licensee shall provide the patient or client with the most recent versions of the following documents:*

(A) The American College of Nurse-Midwives Clinical Bulletin entitled "Midwifery Provision of Home Birth Services."

(B) The American College of Obstetricians and Gynecologists on Obstetric Practice Committee Opinion #669: Planned Home Birth.

(C) Society of Maternal Fetal Medicine and the American College of Obstetricians and Gynecologists document entitled "Obstetrics Care Consensus: Levels of Maternal Care."

(2) The Medical Board of California and the Board of Registered Nursing shall make the most recent version of the documents specified in paragraph (1) publicly available on their Internet Web sites.

** (a) **Massively burdensome! AND (b) massively discriminatory** -- unless the obstetrical profession is likewise required to provide all obstetrical patients with a similar list of publication promoting midwifery care and OOH birth. It's not appropriate for midwifery professionals to be forced by a competing profession to promote the ideas and perspective those other, non-midwifery professions.

In my opinion, ALL those provisions marked with double asterisks (**) also **violate** the *North American Free Trade Act* (NAFTA). **NAFTA** prevents passage of professional licensed laws that constitute "*unnecessary barriers to trade*". To avoid being illegal under NAFTA, state licensing requirements must:

"**not** constitute a **disguised restriction** of the **provision of service** .. Requirements should be **based on competence**"

880.4.

(a) If a patient or client is transferred to a hospital, the licensee shall provide records, including prenatal records, and speak with the receiving physician and surgeon about the

labor up to the point of the transfer. The failure to comply with this section shall constitute unprofessional conduct. Notwithstanding any other law, a violation of this section shall not be a crime.

(b) The hospital shall report, in writing on a form developed by the Office of Statewide Health Planning and Development, within 30 days, each transfer of a patient who attempted a planned out-of-hospital childbirth to the Office of Statewide Health Planning and Development.

The standardized form shall include:

(1) Name and license number of the licensed physician and surgeon, certified nurse-midwife, or licensed midwife who attended the patient's planned out-of-hospital childbirth or out-of-hospital childbirth attempt.

(2) Name and license number of the accepting or admitting physician and surgeon or certified nurse midwife who assumed care of the patient.

(3) Name of the patient and patient identifying information.

(4) Name of the hospital or emergency center where the patient was transferred.

(5) Date of report.

(6) Whether the person or persons admitted was pregnant, the delivered mother, or newborn newborns.

(7) Whether there was a verbal handoff or if any prenatal records were obtained from the out-of-hospital childbirth attendant.

(8) Gestational age of the fetus or newborn in weeks and method of determination.

(9) Events triggering transfer including, but not limited to, pain management, excessive bleeding, fetal intolerance of labor, prolonged or non-progressive labor with time in labor, maternal request for transfer, or the clinical judgment of the out-of-birth childbirth attendant.

*(10) Presence of significant history and risk factors including, but not limited to, preterm less than $37^0/_7$, post-term greater than $42^0/_7$, prior uterine or abdominal surgery including prior cesarean section, Group B strep, multiple births, IUGR, IUFD, chorioamnionitis, bleeding, non-cephalic presentation, gestational diabetes, **morbid obesity (BMI >40), or preeclampsia.*

> ** ***This simply doesn't below here*** – *obesity is not a treatable condition on the part of maternity care providers and many women believe that such a focus on it is discriminatory. To avoid this, women who are concerned about this issue will refuse to be weighed at prenatal appointment.*

(11) Method of delivery.
(12) Whether a caesarian section was performed.
(13) Place of delivery.
***(14) FHR tracing on admission.*
***(15) Fetal presentation on admission.*
(16) APGAR score of the newborn.
***(17) Cord gases.*
(18) Whether the newborn suffered any complications and was placed in the NICU.
(19) Whether the mother suffered any complications and was placed in the ICU.
(20) Duration of hospital stay for the mother and the newborn and newborns as of the date of the report and final disposition or status, if not released from the hospital, of the mother and newborn or newborns.

> ** **Burdensome:** While the data itself is not a particular problem, the length and particularity of this data would create a huge burden on hospitals, as these forms are generally filled out by secretarial staff who simply don't have or understand the fine points of this information.
>
> ** **Redundant**: So much of this data is already being collected by the Licensed Midwives Annual Report. Personally, I'd like to see more detailed information provided within the LMAR for transferred mothers and babies, such as gestational age, weight, etc.
>
> ** **Waste of Time and Money** for hospitals and OSHPED both, unless this data is going to be published so it can be used to evaluate and when necessary, improve care. However, this system, which has been in effect since AB 1308 was implemented Jan 1st, 2014, is a PAPER-BASED. Since paper forms are being used, all the data must be typed by hand into a database if we were to create a dataset that could be accessed for research.

(c) The form described in subdivision (b) shall be constructed in a format to enable the hospital to transmit the information in paragraphs (4) to (20), inclusive, to the Office of Statewide Health Planning and Development in a manner that the licensees and the patient are anonymous and their identifying information is not transmitted to the office.

The entire form containing information described in paragraphs (1) to (20), inclusive, of subdivision (b) shall be placed in the patient's medical record.

(d) The Office of Statewide Health Planning and Development may revise the reporting requirements for consistency with national and standards, as applicable.

880.6. **(This section was copied from the current** LMPA and most of it the same**. However** it does create a prospective (rather than retrospective) collection of this data, which is also what the Midwifery Advisory Council has advised. It also seems (not sure**) that it would quite dramatically increase the level of detail associated**

with each transfer, therefore making it quite burdensome, especially for birth attendants who have a large practice.)

(a) Each licensee caring for a patient or client planning an out-of-hospital birth shall submit, within 30 days of initial acceptance of a patient or client, a form indicating the initiation of care to the Office of Statewide Health Planning and Development. The office shall develop a standardized form.

(b) Each licensee who attends an out-of-hospital childbirth, including supervising a student midwife, shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted no later than March 30, for the prior calendar year, in a form specified by the office and shall contain all of the following:

(1) The licensee's name and license number.
(2) The calendar year being reported.
(3) The following information with regard to cases in California in which the licensee, or the student midwife supervised by a licensee, attended or assisted during the previous year when the intended place of birth at the onset of care was an out-of-hospital setting:
(A) The total number of patients or clients served as primary caregiver at the onset of prenatal care.
(B) The number by county of live births attended as primary caregiver.
(C) The number, by county, of cases of fetal demise, infant deaths, and maternal deaths attended as primary caregiver at the discovery of the demise or death.
(D) The number of patients or clients whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.
(E) The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.
(F) The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.
(G) The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.
(H) The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.
(I) The number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:

(i) Twin births.
(ii) Multiple births other than twin births.
(iii) Presentations other than cephalic.
(iv) Vaginal births after cesarean section (VBAC).

(J) A brief description of any complications resulting in the morbidity or mortality of a mother or a neonate.
(K) Any other information prescribed by the Office of Statewide Health Planning and Development in regulations.

(c) The Office of Statewide Health Planning and Development shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivisions (a) and (b) for any purpose, including, but not limited to, investigations for licensing, certification, or any other regulatory purposes.

(d) The Office of Statewide Health Planning and Development shall report to the appropriate board, by April 30, those licensees who have met the requirements of this section for that year.

(e) The Office of Statewide Health Planning and Development shall report the aggregate information collected pursuant to this section to the appropriate board by July 30 of each year. The Medical Board of California and the Board of Registered Nursing shall include this information in its annual report to the Legislature.
(f) The Office of Statewide Health Planning and Development, with input from the appropriate licensing boards, may adjust the data elements required to be reported to better coordinate with other reporting systems, including the reporting system of the Midwives Alliance of North America (MANA), while maintaining the data elements unique to California. To better capture data needed for the report required by this section, the concurrent use of systems, including MANA's, by licensed midwives is encouraged.

(g) A failure to report under this section shall constitute unprofessional conduct. Notwithstanding any other law, a violation of this section shall not be a crime.
SEC. 2.
Section 2507 of the Business and Professions Code is amended to read:

2507.

(a) ~~The~~ *Notwithstanding any other law, the* license to practice midwifery authorizes the holder to attend cases of ~~normal pregnancy and childbirth, as defined in paragraph (1) of subdivision (b),~~ *** out-of-hospital childbirth pursuant to Article 17 (commencing with Section 880),* and to provide prenatal, intrapartum, and postpartum ~~care, including **family planning care, for the mother,~~ *care related to the out-of-hospital childbirth for the client* and **immediate care for the newborn.

> ** This dramatically and drastically **redefines the historical definition of the practice of midwifery** from "*attend cases of normal pregnancy and childbirth*", to the greatly restricted version defined in the out-of-hospital childbirth pursuant to Article 17 (commencing with Section 880)
>
> ** This repeals the historical ability of professional midwives to provide family planning services, and this to work in doctors' offices and clinics (such as Planned Parenthood) the provide women's reproductive services to healthy women (aside from prenatal and postpartum care.

This is an **economic issue** to childbearing families, as these services would no longer be available as a part of the midwifery care and thus increase the cost to them by being obligated to pay additional professional fees other types of providers. It is also an **economic issue to midwives,** whose *livelihoods* would be drastically ***reduced***

** If understood literally, the idea of "immediate" care of the newborn would again restrict the LM's scope of practice to limit just the hours immediately after the birth. Traditionally midwives make two or more house calls in the days following the birth, and provide care (evolution of well-being and interventions as needed) for both mother and her newborn baby.

If LMs were to be prevented from providing comprehensive care, the family would either have no care for their baby or they would have to leave their home to make what are otherwise unnecessary trips to a pediatrician's office. This would greatly increase the cost to the family

This clearly is in **violation** of the *North American Free Trade Act* (NAFTA). **NAFTA** prevents passage of professional licensed laws that constitute "*unnecessary barriers to trade*". To avoid being illegal under NAFTA, state licensing requirements must:

"**not** constitute a **disguised restriction** of the **provision of service** .. Requirements should be **based on competence**"

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife to assist a ~~woman in childbirth as long as progress meets criteria accepted as normal.~~ *client in an out-of-hospital childbirth pursuant to pursuant to Article 17 (commencing with Section 880).*

Most of the RED section below has already been incorporated often with significant changes, in the Section 880.

Additional changes begin at "(c) (1)" below

~~(1)Except as provided in paragraph (2), a licensed midwife shall only assist a woman in normal pregnancy and childbirth, which is defined as meeting all of the following conditions:~~
~~(A)There is an absence of both of the following:~~
~~(i)Any preexisting maternal disease or condition likely to affect the pregnancy.~~
~~(ii)Significant disease arising from the pregnancy.~~
~~(B)There is a singleton fetus.~~
~~(C)There is a cephalic presentation.~~
~~(D)The gestational age of the fetus is greater than 3707 weeks and less than 4207 completed weeks of pregnancy.~~
~~(E)Labor is spontaneous or induced in an outpatient setting.~~

~~(2)If a potential midwife client meets the conditions specified in subparagraphs (B) to (E), inclusive, of paragraph (1), but fails to meet the conditions specified in subparagraph (A) of paragraph (1), and the woman still desires to be a client of the licensed midwife, the licensed midwife shall provide the woman with a referral for an examination by a physician and surgeon trained in obstetrics and gynecology. A licensed midwife may assist the woman in pregnancy and childbirth only if an examination by a physician and surgeon trained in obstetrics and gynecology is obtained and the physician and surgeon who examined the woman determines that the risk factors presented by her disease or condition are not likely to significantly affect the course of pregnancy and childbirth.~~
~~(3)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).~~

(c) (1) If at any point during pregnancy, childbirth, or postpartum ~~care a client's condition deviates from normal, the licensed midwife shall immediately refer or transfer the client to a physician and surgeon.~~ *** care, there is any evidence of a disease or condition that could adversely affect the pregnancy and childbirth arise, the client shall obtain a medical examination by a licensed physician and surgeon with privileges to practice obstetrics or gynecology pursuant to paragraph (b) of Section 880, or the licensed midwife shall initiate appropriate interventions, including immediate transfer, first-responder emergency care, or emergency transport.* The licensed midwife may consult and remain in consultation with the physician and surgeon after the ~~referral or~~ transfer.

> ** Many of these issues were addressed in the first half of this document (Section 880). They include the same violation of ACOG's own policies as amply detailed earlier in this document.
>
> Earlier comments about the *North American Free Trade Act* (NAFTA) also apply. **NAFTA** prevents passage of professional licensed laws that constitute "*unnecessary barriers to trade*". To avoid being illegal under NAFTA, state licensing requirements must:
>
> "**not** constitute a **disguised restriction** of the **provision of service** .. Requirements should be **based on competence**"

(2) ** If a physician and surgeon 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 or childbirth,~~ *client is not at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth,* the licensed midwife may resume ~~** primary~~ care of the client and resume assisting the client during ~~** her~~ *the* pregnancy, childbirth, or postpartum care.

> ** Another example of **ACOG violating its own policies on maternal autonomy**, as amply detailed earlier in this document.

** Why strike out "primary" from the care of the midwife when we are indeed describing her as a practicing an "independent healing arts profession"?

** When discussing care to an individual client/woman, "her" would be the specific pronoun.

(3) If a physician and surgeon determines the client's condition or concern has not been resolved as specified in paragraph ~~(2),~~ *(2) and is at an increased risk due to a disease or condition, that **could** adversely affect the pregnancy and childbirth,* the licensed midwife may provide concurrent care with a physician and surgeon and, if authorized by the client, be present during the labor and childbirth, and resume postpartum care, if appropriate. A licensed midwife shall not ~~resume primary care of the client.~~ *attend an out-of-hospital childbirth of the client.*

** See detailed discussion of the legal problems associated with the use of the word "**could**" in the context of legislation that may **wrongly restricts care to families** if misinterpreted AND may result disciplinary action against midwives for unprofessional conduct they are "*second-guessed*" at a later time.

(d) A licensed midwife shall not provide or continue to provide midwifery care to a ~~woman with a risk factor that will significantly affect the course of~~*client if a licensed physician and surgeon with privileges to practice obstetrics or gynecology determines, at the time of the examination, that the client is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth as described in Article 17 (commencing with Section 880)* pregnancy and childbirth, regardless of whether the ~~** woman~~ *client* has consented to this care or refused care by a physician or surgeon, except as provided in paragraph (3) of subdivision (c).

** Only the **female gender** (women) get pregnant and give birth. "woman" is the right word for this occasion.

(e) The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version of these means.

~~(f)A midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.~~

(f) A licensed midwife may administer, order, or use any of the following:
(1) Postpartum antihemorrhagic drugs.
(2) Prophylactic opthalmic antibiotics.
(3) Vitamin K.
(4) RhoGAM.
(5) Local anesthetic medications.

(6) Intravenous fluids limited to lactated ringers, 5 percent dextrose with lactated ringers, and heparin and 0.9 percent sodium chloride for use in intravenous locks.
(7) Epinephrine for use in maternal anaphylaxis pending emergency transport.
(8) HBIG and GBV for neonates born to hepatitis B mothers, per current Centers for Disease Control guidelines.
(9) Antibiotics for intrapartum prophylaxis of Group B Betahemolytic Streptococcus (GBBS), per current Centers For Disease Control guidelines.

*(10) Equipment incidental to the practice of out-of-hospital childbirth, **specifically, dopplers, syringes, needles, phlebotomy equipment, suture, urinary catheters, intravenous equipment, amnihooks, airway suction devices, neonatal and adult resuscitation equipment, glucometer, and centrifuge.*
(11) Equipment incidental to maternal care, specifically, compression stockings, maternity belts, breast pumps, diaphragms, and cervical caps.

** It's not a good idea to limit the usual and customary equipment to black-letter law, as it makes it impossible to include newer and better devices that would greatly enhance the safety of services provided to California families by LMs.

(g) This article does not authorize a midwife to practice medicine or to perform surgery.

END

@@@@@@@@@@@@@@@@@@@@@@@@@@

The remainder of this document is only contains sections of the LMPA that have are being deleted *in toto*, with the replacement language in the earlier sections (i.e. no new content). I only included them as a reference, in case of questions about the original the language.

SEC. 3.
Section 2508 of the Business and Professions Code is repealed.

~~2508.~~
~~(a)A licensed midwife shall disclose in oral and written form to a prospective client as part of a client care plan, and obtain informed consent for, all of the following:~~

~~(1)All of the provisions of Section 2507.~~
~~(2)The client is retaining a licensed midwife, not a certified nurse-midwife, and the licensed midwife is not supervised by a physician and surgeon.~~
~~(3)The licensed midwife's current licensure status and license number.~~
~~(4)The practice settings in which the licensed midwife practices.~~
~~(5)If the licensed midwife does not have liability coverage for the practice of midwifery, he or she shall disclose that fact. The licensed midwife shall disclose to the client that~~

~~many physicians and surgeons do not have liability insurance coverage for services provided to someone having a planned out-of-hospital birth.~~
~~(6)The acknowledgment that if the client is advised to consult with a physician and surgeon, failure to do so may affect the client's legal rights in any professional negligence actions against a physician and surgeon, licensed health care professional, or hospital.~~
~~(7)There are conditions that are outside of the scope of practice of a licensed midwife that will result in a referral for a consultation from, or transfer of care to, a physician and surgeon.~~
~~(8)The specific arrangements for the referral of complications to a physician and surgeon for consultation. The licensed midwife shall not be required to identify a specific physician and surgeon.~~
~~(9)The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for mother and baby if necessary, and recommendations for preregistration at a hospital that has obstetric emergency services and is most likely to receive the transfer.~~
~~(10)If, during the course of care, the client is informed that she has or may have a condition indicating the need for a mandatory transfer, the licensed midwife shall initiate the transfer.~~
~~(11)The availability of the text of laws regulating licensed midwifery practices and the procedure for reporting complaints to the Medical Board of California, which may be found on the Medical Board of California's Internet Web site.~~
~~(12)Consultation with a physician and surgeon does not alone create a physician-patient relationship or any other relationship with the physician and surgeon. The informed consent shall specifically state that the licensed midwife and the consulting physician and surgeon are not employees, partners, associates, agents, or principals of one another. The licensed midwife shall inform the patient that he or she is independently licensed and practicing midwifery and in that regard is solely responsible for the services he or she provides.~~
~~(b)The disclosure and consent shall be signed by both the licensed midwife and the client and a copy of the disclosure and consent shall be placed in the client's medical record.~~
~~(c)The Medical Board of California may prescribe the form for the written disclosure and informed consent statement required to be used by a licensed midwife under this section.~~

SEC. 4.

Section 2510 of the Business and Professions Code is repealed.

~~2510.~~
~~If a client is transferred to a hospital, the licensed midwife shall provide records, including prenatal records, and speak with the receiving physician and surgeon about labor up to the point of the transfer. The hospital shall report each transfer of a planned out-of-hospital birth to the Medical Board of California and the California Maternal Quality Care Collaborative using a standardized form developed by the board.~~

SEC. 5.

Section 2516 of the Business and Professions Code is repealed.

~~2516.~~

~~(a)Each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted no later than March 30, for the prior calendar year, in a form specified by the board and shall contain all of the following:~~
~~(1)The midwife's name and license number.~~
~~(2)The calendar year being reported.~~
~~(3)The following information with regard to cases in California in which the midwife, or the student midwife supervised by the midwife, assisted during the previous year when the intended place of birth at the onset of care was an out-of-hospital setting:~~
~~(A)The total number of clients served as primary caregiver at the onset of care.~~
~~(B)The number by county of live births attended as primary caregiver.~~
~~(C)The number, by county, of cases of fetal demise, infant deaths, and maternal deaths attended as primary caregiver at the discovery of the demise or death.~~
~~(D)The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.~~
~~(E)The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.~~
~~(F)The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.~~
~~(G)The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.~~
~~(H)The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.~~
~~(I)The number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:~~
~~(i)Twin births.~~
~~(ii)Multiple births other than twin births.~~
~~(iii)Breech births.~~
~~(iv)Vaginal births after the performance of a cesarean section.~~
~~(J)A brief description of any complications resulting in the morbidity or mortality of a mother or a neonate.~~
~~(K)Any other information prescribed by the board in regulations.~~
~~(b)The Office of Statewide Health Planning and Development shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.~~
~~(c)The office shall report to the board, by April 30, those licensees who have met the requirements of subdivision (a) for that year.~~
~~(d)The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of subdivision (a). Failure to comply with subdivision (a) will result in the midwife being unable to renew his or her license without first submitting the requisite data to the Office of Statewide Health Planning and Development for the year for which that data was missing or incomplete. The board shall not take any other action against the licensee for failure to comply with subdivision (a).~~

~~(e)The board, in consultation with the office and the Midwifery Advisory Council, shall devise a coding system related to data elements that require coding in order to assist in both effective reporting and the aggregation of data pursuant to subdivision (f). The office shall utilize this coding system in its processing of information collected for purposes of subdivision (f).~~

~~(f)The office shall report the aggregate information collected pursuant to this section to the board by July 30 of each year. The board shall include this information in its annual report to the Legislature.~~

~~(g)The board, with input from the Midwifery Advisory Council, may adjust the data elements required to be reported to better coordinate with other reporting systems, including the reporting system of the Midwives Alliance of North America (MANA), while maintaining the data elements unique to California. To better capture data needed for the report required by this section, the concurrent use of systems, including MANA's, by licensed midwives is encouraged.~~

~~(h)Notwithstanding any other law, a violation of this section shall not be a crime.~~