

# MEDICAL BOARD OF CALIFORNIA

May 2014

---

## PRACTICE GUIDELINES FOR CALIFORNIA LICENSED MIDWIVES

Annotated by faith Gibson, LM

**Red text** = added by MBC

**Blue text** = ethical concepts accepted by MBC & help us

**STRIKE-THRU – DELETED BY THE MBC pre AB 1308**

The California licensed midwife is a professional healthcare practitioner who offers primary care to healthy women and their normal unborn and newborn babies throughout normal pregnancy, labor, birth, postpartum, the neonatal and inter-conceptual periods.

### I. PURPOSE, DEFINITIONS & GENERAL PROVISIONS

**A.** This document provides a framework to identify the professional responsibilities of licensed midwives, and permit an individual midwife's practice to be rationally evaluated to ensure that it is safe, ethical and consistent with the professional practice of licensed midwifery in California. However, these practice guidelines are not intended to replace the clinical judgment of the licensed midwife.

Sources and documentation used to define and judge professional practice include but are not limited to the following:

1. The international definition of a midwife and the midwifery scope of practice
2. Customary definitions of the midwifery model of care by state and national midwifery organizations, including the Licensed Midwifery Practice Act of 1993 and all its amendments (Business and Professions Code Sections 2505, et seq.)
3. Standards of practice for community midwives as published by state and national midwifery organizations
4. Philosophy of care, code of ethics, and informed consent policies as published by state and national midwifery organizations
5. Educational competencies published by state and national direct-entry midwifery organizations

**B.** The California licensed midwife maintains all requirements of state and, where applicable, national certification, while keeping current with evidence-based and ethical midwifery practice in accordance with:

1. The body of professional knowledge, clinical skills, and clinical judgments described in the **Midwives Alliance of North America (MANA) Core Competencies for Basic Midwifery Practice**
2. The statutory requirements as set forth in the **Licensed Midwifery Practice Act of 1993 ("LMPA")**, all amendments to LMPA and the Health and Safety Code on birth registration.

3. The generally accepted guidelines for community-based midwifery practice as published by state and national direct-entry midwifery organizations

**C.** The California licensed midwife provides care in private offices, physician offices, clinics, client homes, maternity homes, birth centers and hospitals. The licensed midwife provides well-women health services and maternity care to essentially healthy women who are experiencing a normal pregnancy. **An essentially healthy woman is without serious pre-existing medical or mental conditions affecting major body organs, biological systems or competent mental function.** An essentially normal pregnancy is **without serious medical complications affecting either mother or fetus, and is consistent with the definition set forth under Business and Professions Code Section 2507(b)(1).** *[text in RED added by MBC 5-2014]*

**D.** The California licensed midwife provides the necessary supervision, care and advice to women prior to and during pregnancy, labor and the postpartum period, and conducts deliveries and cares for the newborn infant during the postnatal period. This includes preventative measures, protocols for variations and deviations from norm, detection of complications in the mother and child, the procurement of medical assistance when necessary and the execution of emergency measures in the absence of medical help.

**E.** The California licensed midwife's **fundamental accountability is to the women in her care.** This includes a **responsibility to uphold professional standards and avoid compromise based on personal or institutional expediency.**

**F.** California licensed midwife is also accountable to peers, the regulatory body and to the public for safe, competent, ethical practice. It is the responsibility of the licensed midwife to incorporate ongoing evaluation of her/his practice, including formal or informal sources of community input. This includes but is not limited to the licensed midwife's participation in the peer review process and any required mortality and morbidity reporting. The results of these individual evaluations can be distributed to influence professional policy development, education, and practice.

**G.** The California licensed midwife is **responsible to the client, the community and the midwifery profession for evidence-based practice.** This includes but is not limited to continuing education and on-going evaluation and application of new information and improved practices as recommended in the scientific literature. It may also include developing and dispersing midwifery knowledge and participating in research regarding midwifery outcomes.

**H.** The California licensed midwife **uses evidence-based policies and practice guidelines for the management of routine care and unusual circumstances** by establishing, reviewing, updating, and adhering to individualized practice policies, guidelines and protocols appropriate to the specific setting for a client's labor and birth and geographical characteristics of the licensed midwife's practice. Practice- specific guidelines and protocols are customarily implemented through standard or customized chart forms, informed consent and informed refusal documents **and treatment waivers (including the consent required in Business and Professions Code Section 2508),** other formal and informal documents used routinely for each area of clinical

practice, including but not limited to the antepartum, intrapartum, postpartum, newborn periods and inter-conceptual periods.

I. The licensed midwife's policies, guidelines and protocols are consistent with standard midwifery management as described in standard midwifery textbooks or a combination of standard textbooks and references, including research published in peer-review journals.

Any textbook or reference which is also an approved textbook or reference for a midwifery educational program or school is considered an acceptable textbook or reference for use in developing a midwife's individual policies and practice guidelines. When appropriate or requested, citations of scientific source should be made available for client review.

J. The licensed midwife may expand her skill level beyond the core competencies of her training program by incorporating new procedures into the individual midwife's practice that improve care for women and their families. It is the responsibility of the licensed midwife to:

1. Identify the need for a new procedure by taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensure that there are no institutional, state, or federal statutes or regulations that would constrain the midwife from incorporation of the procedure into her practice.
3. Be able to demonstrate knowledge and competency, including:
  - a) Knowledge of risks, benefits, and client selection criteria.
  - b) Having a process for acquisition of required skills.
  - c) Identifying and managing complications.
  - d) Employing a process to evaluate outcomes and maintain professional competency.
4. Identify a mechanism for obtaining medical consultation, **collaboration**, and referral related to each new procedure.

## II. A BRIEF OVERVIEW OF THE LICENSED MIDWIFE'S DUTIES AND SPECIFIC RESPONSIBILITIES TO CHILDBEARING WOMEN AND THEIR UNBORN AND NEWBORN BABIES

**A.** The California licensed midwife engages in an on-going process of risk assessment that begins with the initial consultation and continues throughout the provision of care. This includes continuously assessing for normalcy and, if necessary, initiating appropriate interventions including consultation, referral, transfer, first-responder emergency care and/or emergency transport.

**B.** Within the midwifery model of care, the licensed midwife's duties to women and babies include the following individualized forms of maternity care:

1. Antepartum care and education, preparation for childbirth, breastfeeding and parenthood.
2. Risk assessment, risk prevention and risk reduction.
3. Identifying and assessing variations and deviations from normal and **detection of abnormal conditions** and subsequently communicating that information to the woman and, when appropriate, to other health care providers and emergency responders.
4. Maintaining an individual plan for consultation, referral, transfer of care and emergencies.
5. Evidence-based physiological management to facilitate spontaneous progress in labor and normal vaginal birth while minimizing the need for medical interventions.
6. Procurement of medical assistance when indicated.
7. Execution of appropriate emergency measures in the absence of medical help.
8. Postpartum care to mother and baby, including counseling and education.
9. Maintaining up-to-date knowledge in evidence-based practice and proficiency in life-saving measures by regular review and practice.
10. Maintenance of all necessary equipment and supplies, and preparation of documents including educational handouts, charts, informed consent & informed refusal documents [added by MBC 5-2014] (including the consent required in Business and Professions Code Section 2508), birth registration forms, newborn screening, practice policies, guidelines, protocols, and, morbidity and mortality reports and annual statistics

### III. GUIDELINES FOR COMMUNITY-BASED MIDWIFERY

**ONE:** The licensed midwife is accountable to the client, the midwifery profession and the public for safe, competent, and ethical care.

**TWO:** The licensed midwife ensures that no act or omission places the client at unnecessary risk.

**THREE:** The licensed midwife, within realistic limits, provides continuity of care to the client throughout the childbearing experience [according to the midwifery model of care](#).

**FOUR:** The licensed midwife [respects the autonomy of the mentally competent adult woman by working in partnership with her and recognizing individual and shared responsibilities](#). The midwife [recognizes the healthy woman as the primary decision maker throughout the childbearing experience](#).

**FIVE:** The licensed midwife [upholds the client's right to make informed choices about the manner and circumstance of pregnancy, and childbirth, and facilitates this process by providing complete, relevant, objective information in a non-authoritarian and supportive manner](#), while continually assessing safety considerations and risks to the client, informing her of same.

**SIX:** *[added by MBC 5-2014]* [The licensed midwife immediately refers the client to a physician, as required by law, if at any point during a pregnancy, childbirth, or postpartum care the client's condition deviates from normal.](#)

**SEVEN:** The licensed midwife confers and collaborates with other health care professionals, including other midwives, as is necessary to professionally meet the client's needs. [When the client's condition or needs exceed the midwife's scope of practice or personal practice guidelines, the licensed midwife consults with and refers or transfers the client to a physician or other appropriate health care provider.](#)

**EIGHT:** [Should the pregnancy deviate from normal](#) and primary care be transferred to a physician, the licensed midwife may continue to counsel, support and advise the client at her request.

**NINE:** The licensed midwife maintains complete and accurate health care records.

**TEN:** The licensed midwife ensures confidentiality of information except with the client's consent, or as required to be disclosed by law, or in extraordinary circumstances where the failure to disclose will result in immediate and grave harm to the client, baby or other immediate family members or professional care providers.

**ELEVEN:** [Where geographically feasible, the licensed midwife makes a good faith effort to ensure that a second midwife, or a qualified birth attendant certified in neonatal resuscitation and cardiopulmonary resuscitation, is available during the delivery.](#)

**TWELVE:** [The licensed midwife orders, uses or administers only those drugs, supplies, devices and procedures that are consistent with the licensed midwife's professional](#)

Comparison of SOCCLM (OAL-approved Mar 2006 & Practice Guideline edited by MBC May 2014

training as described in 16 CCR 1379.30, community standards and the provisions of LMPA and does so **only in accordance with the client's informed consent**.

**THIRTEEN:** The licensed midwife orders, performs, collects samples for, or interprets those screening and diagnostic tests for a woman or newborn which are consistent with the licensed midwife's professional training, community standards, and provisions of the LMPA, and **does so only in accordance with the client's informed consent**.

**FOURTEEN:** The licensed midwife participates in the continuing education and evaluation of self, colleagues and the maternity care system.

**FIFTEEN:** The licensed midwife critically assesses evidence-based research findings for use in practice and supports research activities.

## IV. CRITERIA FOR CLIENT SELECTION [originally “part A”]

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

- Healthy mother without serious pre-existing medical or mental conditions
- History, physical assessment and laboratory results within limits commonly accepted as normal and *[added by MBC 5-2104]* consistent with Business and Professions Code Section 2507(b)(1) with **no clinically-significant evidence** of the following, including but not limited to:
  - a. cardiac disease
  - b. pulmonary disease
  - c. renal disease
  - d. hepatic disease
  - e. endocrine disease
  - f. neurological disease
  - g. malignant disease in an active phase
  - h. significant hematological disorders or coagulopathies
  - i. essential hypertension (blood pressure greater than 140/90 on two or more occasions, six hours apart)
  - j. insulin-dependent diabetes mellitus
  - k. serious congenital abnormalities affecting childbirth
  - l. family history of serious genetic disorders or hereditary diseases that may impact on the current pregnancy
  - m. adverse obstetrical history that may impact on the current pregnancy
  - n. significant pelvic or uterine abnormalities, including tumors, malformations, or invasive uterine surgery that may impact on the current pregnancy
  - o. iso-immunization
  - p. alcoholism or abuse
  - q. drug addiction or abuse
  - r. positive HIV status or AIDS
  - s. current serious psychiatric illness
  - t. social or familiar conditions unsatisfactory for **community-based** birth services
  - u. other significant physical abnormality, social or mental functioning that affects pregnancy, parturition and/or the ability to safely care for a newborn
  - v. other as defined by the licensed midwife

**NOTE:** The “Client Selection Criteria” in the original (52-page) *Standard of Care* was paired with a “Part B” (included below). It provided for physician consultation or referral for clients with minor pathologies or other conditions listed above that were not likely to affect the outcome pregnancy, normal childbirth, or the neonate AND it acknowledged the right of childbearing woman to decline such advise.

**Attention** ~ added for discussion ~ never was part of the 2006 Standards or the MBC's May 2014 revision & renamed "Practice Guidelines"

---

## IV-B ~ Obstetrical Consultation or Referral

(Taken from the original, 52-page CCM version)

When a prospective client has pre-existing medical issues, the midwife routinely consults with a physician, or refers the perspective client to a physician for evaluation prior to determining if the pregnant woman is an appropriate candidate for community-based birth services:

1. Physical and mental conditions or diseases of **clinical significance** that require ongoing use of medical treatment or Rx medications
2. Family history of **clinically-significant** genetic disorders, hereditary disease, or congenital or genetic anomalies likely to affect the pregnancy or unborn/newborn baby
3. History of 3 or more sequential spontaneous abortions and/or 2 or more **late** miscarriages
4. History of preterm birth of **VLBW infant, unexplained stillbirth, or neonatal mortality** associated with maternal disease, a GBS infected newborn, serious congenital or genetic anomalies
5. History of significant fibroids or **uterine surgery involving an incision into its musculature**
6. Previous **unexplained** antepartum or postpartum hemorrhage **requiring transfusion in spontaneous labor** (i.e., previous labor was not induced or augmented; previous PPH was a non-repeating pathology such as placenta previa)

This list is not exhaustive, as other medical or mental conditions not identified above may require medical evaluation before a client is accepted for community-based childbirth services.

Nor is the list meant to be an absolute contra-indications to midwifery care. There are circumstances in which fully informed parents have an ethical right to choose physiologically-managed childbirth in an OOH setting in spite of a specific identified risk factor. Examples include history of repeat miscarriages or previous Cesarean, family history of hereditary disease, or unexplained fetal or neonatal death, and other issues may continue to be possible but have a low *probability* of reoccurrence.

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

Wording as edited by MBC at Dec 5<sup>th</sup>, 2013 Mfry Council meeting, & published May 2014

### Responsibility of the Licensed Midwife

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

(read strike out of “medical practitioners” to mean we cannot refer to CNM, nurse-practitioner or PA)

### ~~Client’s Rights to Self-Determination~~

~~In recognition of the client’s right to refuse that recommendation as well as other risk-reduction measures and medical procedures, the client may, after having been fully informed about the nature of the risk and specific risk-reduction measures available, make a written informed refusal.~~

~~If the licensed midwife appropriately documents the informed refusal in the client’s midwifery records, the licensed midwife may continue to provide midwifery care to the client consistent with evidence-based care as identified in this document and the scientific literature.~~

With respect to the care of a client **who deviates from a normal pregnancy** as identified by the client selection criteria in section IV or other science-based parameters, **the licensed midwife informs the client that her situation must be evaluated** by a licensed physician who has current training and practice in obstetrics and gynecology.

If the physician determines that the client’s condition or concern has been resolved such that the risk factors presented by a woman’s disease or condition are not likely to significantly affect the course of pregnancy, the licensed midwife can continue to provide primary care.

The client should further be informed that **unresolved significant risk factors will limit the scope of the midwife’s care to concurrent care with a physician, regardless of whether the woman has consented to care or refused care by a physician.**

It is recognized that the client has the right to refuse the recommended referral; however, pursuant to the law, **the licensed midwife cannot continue care.** The licensed midwife will document refusal of the referral in the client’s record.

## VI. ANTEPARTUM REFERRAL

### • To define and clarify minimum practice guidelines for the safe care of women and infants in regard to ANTEPARTUM PHYSICIAN CONSULTATION, REFERRAL & TRANSFER OF CARE

The licensed midwife consults with a physician and/or other health care professional whenever there are deviations from normal (including abnormal laboratory results) during a client's pregnancy. If a referral to a physician is needed, **pursuant to Business and Professions Code Section 2507**, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern.

The following conditions, occurring after acceptance of care with a licensed midwife, require client referral to a physician and may require transfer of care of the client to a medical health care provider. A referral for immediate medical care does not preclude the possibility of care with a licensed midwife if a physician who has current training in obstetrics and gynecology determines, after an examination, 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.

### **Antepartal conditions that deviate from normal pregnancy conditions include, but are not limited to:**

#### **Maternal:**

- a. positive HIV antibody test
- b. threatened or spontaneous abortion after 14 weeks
- c. significant vaginal bleeding
- d. persistent vomiting with dehydration
- e. symptoms of malnutrition or anorexia
- f. protracted weight loss or failure to gain weight
- g. gestational diabetes, uncontrolled by diet
- h. severe anemia, not responsive to treatment
- i. severe or persistent headache
- j. evidence of pregnancy induced hypertension (PIH) or pre-eclampsia (2 blood pressure readings greater than 140/90, 6 hours apart)
- k. deep vein thrombosis (DVT)
- l. urinary tract infection (UTI)
- m. significant signs or symptoms of infection

- n. isoimmunization, positive Rh antibody titer for Rh-negative mother, or any other positive antibody titer which may have a detrimental effect on mother or fetus
- o. documented placental anomaly or previa p. documented low lying placenta in woman with history of previous cesarean
- q. preterm labor (before 37 0/7 completed weeks of pregnancy)
- r. premature rupture of membranes (before 37 0/7 completed weeks of pregnancy)
- s. pregnancy with non-reactive stress test and/or abnormal biophysical profile or amniotic fluid assessment
- t. Post-term pregnancy defined as gestation greater than 42 0/7 weeks [added by MBC 5-2014]
- u. other as defined by the Midwife

### **Fetal:**

- a. lie other than vertex at term
- b. multiple gestation
- c. fetal anomalies compatible with life which are affected by site of birth
- d. marked decrease in fetal movement, abnormal fetal heart tones (FHTs), non-reassuring non-stress test (NST) e. marked or severe poly- or oligo-hydramnios (too much or too little amniotic fluid)
- f. evidence of intrauterine growth restriction (IUGR)
- g. significant abnormal ultrasound findings h. other as defined by the licensed midwife

## VII. INTRAPARTUM REFERRAL

### • To define and clarify minimum practice guidelines for the safe care of women and infants in regard to **INTRAPARTUM PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT**

The licensed midwife consults with a physician and/or other health care professional whenever there are deviations from normal during a client's labor and birth, and/or with her newborn. If a referral to a physician is needed **pursuant to Business and Professions Code Section 2507**, the licensed midwife will, if possible, remain in consultation with the physician in accordance with the client's wishes, remain present throughout the birth and resume postpartum care if appropriate.

**A.** The following conditions require referral to a physician and may require transfer of care. Referral does not preclude the possibility of return to care with a licensed midwife if a physician who has current training in obstetrics and gynecology 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.

Intrapartum Conditions - Serious medical, obstetrical or perinatal conditions, including but not limited to:

#### Maternal:

- a. prolonged lack of progress in labor
- b. abnormal bleeding, with or without abdominal pain; evidence of placental abruption
- c. rise in blood pressure above woman's baseline (more than 30/15 points or greater than 140/90) with proteinuria
- d. signs or symptoms of maternal infection
- e. signs or symptoms of maternal shock
- f. client's request for transfer to obstetrical care
- g. active genital herpes lesion in labor
- h. gestation greater than 42 0/7 weeks**

#### Fetus:

- a. abnormal fetal heart tones (FHT)
- b. signs or symptoms of fetal distress
- c. thick meconium or frank bleeding with birth not imminent
- d. lie not compatible with spontaneous vaginal delivery or unstable fetal lie

## VII. INTRAPARTUM REFERRAL [continued]

### Emergency Transport:

If on initial or subsequent assessment during the 1st, 2nd or 3rd stage of labor, one of the following conditions exists, the licensed midwife initiates immediate emergency transfer to medical care. Transport via private vehicle is an acceptable method of transport if, in the clinical judgment of the licensed midwife, that is the safest and most expedient method to access medical services.

- a. prolapsed umbilical cord
- b. uncontrolled hemorrhage
- c. preeclampsia or eclampsia
- d. severe abdominal pain inconsistent with normal labor
- e. chorioamnionitis
- f. ominous fetal heart rate pattern or other manifestation of fetal distress
- g. seizures or unconsciousness in the mother
- h. evidence of maternal shock
- i. presentation not compatible with spontaneous vaginal delivery
- j. laceration requiring repair outside the scope of practice or practice policies of the individual licensed midwife
- k. retained placenta or placental fragments
- l. neonate with unstable vital signs
- m. any other condition or symptom which could threaten the life of the mother, fetus, or neonate as assessed by the licensed midwife exercising ordinary skill and knowledge

### C. Emergency Exemptions Clause - Business and Professions Code Section 2063 - Medical Practice Act

The California licensed midwife may deliver a woman with any of the above complications or conditions, or other bona fide emergencies, if the situation is a verifiable emergency and no physician or other equivalent medical services are available.

**EMERGENCY** is defined as a situation that presents an immediate hazard to the health and safety of the client or entails extraordinary and unnecessary human suffering.

**D. The California licensed midwife provides records, including prenatal records, and consults with the receiving physician about labor up to the point of transfer to a hospital. [Added by MBC 5-2014]**

## VIII. POSTPARTUM REFERRAL

- To define and clarify minimum practice guidelines for the safe care of women and **newborns / infants** in regard to **POSTPARTUM PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT**

The licensed midwife **consults with a physician and/or other health care professional whenever there are deviations from normal** (including abnormal laboratory results) during the postpartum period. If a referral to a physician who has current training and practice in obstetrics and gynecology is needed, the licensed midwife may resume postpartum care if the physician determines that the client's condition or concern has been resolved such that the risk factors presented by a woman's disease or condition are not likely to affect the client's postpartum care.

### A. Immediate Postpartum Conditions.

The licensed midwife arranges for immediate referral and transport according to the emergency plan identified in the informed consent document if the following abnormal conditions are present:

- uterine prolapse or inversion
- uncontrolled maternal hemorrhage
- seizure or unconsciousness
- sustained on-going instability or abnormal vital signs
- adherent or retained placenta
- repair of laceration(s)/episiotomy beyond licensed midwife's level of expertise
- anaphylaxis
- other serious medical or mental conditions

### B. Extended Postpartum Condition.

The licensed midwife arranges for physician consultation, client referral and/or transport when/if:

- signs or symptoms of maternal infection
- signs of clinically significant depression
- social, emotional or other physical conditions as defined by the licensed midwife and outside her scope of practice

## IX. NEONATAL REFERRAL

### • To define and clarify minimum practice guidelines for the safe care of women and infants in regard to **PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT OF THE NEONATE**

The licensed midwife consults with a physician or other health care practitioner whenever there are deviations or complications relative to the newborn. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician.

The following conditions will prompt referral to a physician and may require transfer of care.

**A. Neonatal Conditions:** The licensed midwife arranges for immediate referral and transport according to the emergency plan identified in the informed consent document if the following conditions exist:

- a. Apgar score of 6 or less at five minutes of age, without significant improvement by 10 minutes
- b. persistent respiratory distress
- c. persistent cardiac irregularities
- d. persistent central cyanosis or pallor
- e. persistent lethargy or poor muscle tone
- f. prolonged temperature instability
- g. significant signs or symptoms of infection
- h. significant clinical evidence of glycemic instability
- i. seizures
- j. abnormal bulging or depressed fontanel
- k. birth weight <2300 grams
- l. significant clinical evidence of prematurity
- m. clinically significant jaundice apparent at birth
- n. major or medically significant congenital anomalies
- o. significant or suspected birth injury
- p. other serious medical conditions
- q. parental request

### **B. Postnatal Care:**

The licensed midwife arranges for referral or transport for an infant who exhibits the following:

- a. abnormal cry
- b. diminished consciousness
- c. inability to suck
- d. passes no urine in 30 hours or meconium in 48 hours after delivery or inadequate production of urine or stool during the neonatal period

- e. clinically significant abnormalities in vital signs, muscle tone or behavior
  - f. clinically significant color abnormality-cyanotic, pale, grey g. abdominal **distention**, projectile vomiting [spelling error in MBC on-line version]
  - g. jaundice within 30 hours of birth
  - h. significant signs or symptoms of infection j. abnormal lab results k. signs of clinically significant dehydration or failure to thrive other concerns of l. family or licensed midwife
- 

### Faith's Helpful Definition of Terms

**Selection criteria and/or continuation of midwifery** for parents with the expectation of having a planned, OOH labor and birth:

**A.** Normal pregnancy with reasonable expectation of a normal childbirth birth of a healthy baby:

1. Gestational *normalcy* is functionally defined as a healthy pregnancy that naturally advances to term with a live, growth-appropriate fetus in a vertex position that can reasonably be expected to culminate with a spontaneous onset of labor that will progress normally to the spontaneous live birth of a viable neonate, with **conservation of the health of the mother and well-being of the baby being the desired outcome and goal.**

**B.** Normal Birth Defined:

1. The term *normal* as it is used in the LMPA and both previous California statutes relative to midwifery (1917 & 1974) equates the concept of 'normal' with a natural or spontaneous birth process that **does not require the use of any "artificial, forcible or mechanical means."** – that is, not requiring medical, surgical or pharmaceutical treatments.

2. Thus *normal* would encompass all spontaneous physiological processes characteristic of healthy reproductive biology in healthy childbearing women that can reasonably be expected to lead to normal, healthy conclusions.

*Normalcy also* requires a fetus in a longitudinal lie that engages in the pelvis before or during early labor and establishes its ability to fit by advancing sequentially through the stations of the pelvis in a timely manner while displaying no evidence of *significant or persistent fetal distress.*