STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – Division of Licensing
1428 Howe Avenue, Suite 56, Sacramento, CA 95825
(916) 263-2382 Fax (916) 263-2567 www.mbc.ca.gov

MEMBERS OF THE COUNCIL

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

MIDWIFERY ADVISORY COUNCIL

December 6, 2007

Medical Board of California
Greg Gorges Conference Room
1424 Howe Avenue
Sacramento, CA 95825
(916) 263-2382

Action may be taken on any item listed on the agenda.

AGENDA

1:00 p.m. – 4 p.m.
(or until completion of business)

Members of the Board who are not members of the Council may be attending the meeting as observers.

1. Call to Order/Roll Call
2. Approval of Minutes of the September 6, 2007 Meeting
3. Report on Midwife Annual Reporting Form and Instructions
4. Midwife Remedial/Re-entry to Practice Training Programs Discussion
5. Schedule of Future Meetings
6. Future Matters for Consideration by the Council
7. Public Comment on Items not on the Agenda
8. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Billie Baldo at (916) 263-2365 or sending a written request to Ms. Baldo at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

Meetings of the Midwifery Advisory Council are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Council, but the Chair may apportion available time among those who wish to speak.

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For additional information, contact the Licensing Program at (916) 263-2382.

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Midwifery Advisory Council

Greg Gorges Conference Room
1424 Howe Ave
Sacramento, CA 95825

September 6, 2007

MINUTES

Agenda Item 1 - Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California was called to order by Chair Faith Gibson at 1:07 p.m. A quorum was present and due notice had been mailed to all interested parties.

Members Present:
- Faith Gibson, L.M., Chair
- Ruth Haskins, M.D., Vice Chair
- Karen Ehrlich, L.M.
- Carrie Sparrevohn, L.M.

Staff Present:
- Billie Baldo, Administrative Assistant, Licensing Program
- Kathi Burns, Manager, Licensing Operations
- Kurt Heppler, Legal Counsel, Department of Consumer Affairs (DCA)
- Mike McCormick, Analyst, Licensing Operations
- Christine Meighan, Office Technician

Members of the Audience:
- Bruce Ackerman, Midwives Alliance of North America (MANA)
- Claudia Breglia, L.M., California Association of Midwives (CAM)
- Tonya Brooks, L.M., Natural Birth and Women's Center
- Mason Cornelius, L.M., Nova Midwifery Service
- Candace Diamond, Manager, Office of Statewide Health Planning and Development (OSHPD)
- Rachel Hansen, CAM
- Diane Holzer, L.M., CAM/MANA
- Lucinda Johnston-Chiszar, L.M. Californians Advocating Licensed Midwifery
- Robyn Strong, Analyst, OSHPD

Agenda Item 2 – Approval of Minutes of the June 12, 2007 Meeting

It was M/S/C (Haskins/Sparrevohn) to approve the minutes of the June 12, 2007 meeting as amended.

Agenda Item 3 – Midwife Annual Report Coding System

MAC members, OSHPD representatives, audience members, and division staff discussed final revisions to the Midwife Annual Report Coding System.

It was M/S/C (Ehrlich/Sparrevohn) to approve the Midwife Annual Report Coding System as amended.

Agenda Item 4 – Midwife Annual Report Form and Instructions

MAC members, OSHPD representatives, audience members, and division staff discussed final revisions to the Midwife Annual Report form and instructions.

It was M/S/C (Ehrlich/Sparrevohn) to approve the Midwife Annual Report form and instructions as amended.

Ms. Ehrlich and other MAC members expressed appreciation to Ms. Burns for her efforts in coordinating the development of the midwife annual report coding system and related reporting documents.

Following the above actions, Ms. Ehrlich re-opened discussion of this item to consider adding a page to allow comments to be included if the "other," "unknown," and/or "information not obtainable" reporting options are used. Discussion ensued.

It was M/S/C (Sparrevohn/Haskins) to include, with the reporting form, an optional page for comments to be included if the "other," "unknown," or "information not obtainable" reporting options are used.

Agenda Item 5 – Midwifery Remedial/Re-entry to Practice Training Programs

Due to time constraints, this item was postponed and moved to the December 6, 2007 MAC meeting.

Ms. Sparrevohn requested staff obtain information regarding whether a process similar to how the MBC uses expert witnesses for educational purposes could be used in situations regarding licensed midwives.

Agenda Item 6 – Schedule of Future Meetings

The document included in the agenda packet related to this item, indicated the December meeting date as the 9th, when, in actuality, it is scheduled for the 6th. It was agreed that the 2008 MAC meetings be held on April 3, 2008, June 19, 2008, and October 9, 2008, all starting at 1 p.m.

Agenda Item 7 – Future Matters for Consideration by the Council

Ms. Gibson requested staff identify reasons for complaints filed and disciplinary actions taken against licensed midwives to determine whether educational activities aimed at reducing identified violations could or should be developed.

Dr. Haskins suggested that the MAC request the DOL to allow it the opportunity to explore ways of educating both professional communities and consumers on the distinction between lay midwives and licensed midwives.

Agenda Item 8 – Public Comment on Items Not on the Agenda

None.

Agenda Item 9 - Adjournment

The meeting adjourned at 4:40 p.m.

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA

LICENSED MIDWIFE ANNUAL REPORT

Pursuant to Business and Professions Code section 2516, all California licensed midwives must report specific information related to birthing services provided when the client's intended place of birth at the onset of care is an out-of-hospital setting. The California Licensed Midwife Annual Report (MBC-CLMAR) form has been developed to allow for such reporting. Please consult these instructions while completing the form to ensure that the proper information is reported.

This form is to be submitted to the Office of Statewide Health Planning and Development (OSHPD) not the Medical Board of California (Board). The OSHPD will report the data collected, in aggregate form, to the Board each year. Your identity will remain confidential. Only the identity of those licensed midwives who fail to file a report with the OSHPD will be reported to the Board for purposes of restricting license renewal until a report is received. For questions concerning this report, you may contact OSHPD at (916) 326-3935 or the Board at (916) 263-2382.

Mail report to: Office of Statewide Health Planning and Development
Patient Data Section
Licensed Midwife Annual Report
400 R Street, Suite 270
Sacramento, CA 95811-6213

Throughout this report there are categories for "unknown," "information not obtainable," and "other." If you use these options, we encourage you to explain the reasons on the optional page that follows the reporting form. Remember, your identity will not be linked to this information. Rather, it will be used to highlight issues that may need the attention of the Midwifery Advisory Council and/or the Medical Board of California or to assist in further improvement of the form.

DEFINITIONS: (The following definitions govern only the responses provided in this report)

Collaborative Care – Midwife receives advice or client receives additional medical care or advice regarding the pregnancy from a licensed physician or surgeon. (The midwife remains the primary caregiver.)

Fetal Demise – The death of a fetus at 20 weeks or more of gestation or a weight of 500 grams or more.

Healthcare Practitioner – An individual practitioner (of midwifery or medicine) or a medical facility.

Information not Obtainable – An attempt was made to acquire the information, either from the client or the transfer facility, but it was not provided or received.

Intrapartum – Midwife has begun to monitor/attend woman in labor, regardless of cervical dilation or contraction pattern.

Non-medical Reason – Client preference, relocation, insurance issues, other inability to pay, lost to care/unknown.

Other – No other option applied.

Postpartum – After infant has been born.

Primary Caregiver – Licensed midwife contracted by client to provide primary care midwifery services during her pregnancy and/or out-of-hospital delivery.

For services provided in a group practice, one licensed midwife must be designated as the primary caregiver for each client for reporting purposes. The practice may determine which midwife will report on a client as the primary caregiver in a variety of ways: for example, the primary caregiver is the licensed midwife who a) meets the client first, b) does the client intake, c) provides a majority of the services, d) delivers the infant, etc.

Supervision – Midwife is supervised by a licensed physician or surgeon who will go on record as being the midwife's supervisor for a particular case.

Transfer of Care – The receiving health care practitioner becomes the primary caregiver.

Unknown – Not known.

Section A – LICENSEE DATA

You must provide your name and your California Licensed Midwife license number. All other information in this section is voluntary; however, it will assist the OSHPD in contacting you if questions arise relating to your report.

Section B – REPORTING PERIOD

Indicate the calendar year for which this report pertains. In this report, include outcomes for *all births* occurring in the reporting year, even if the outcome event occurred the next reporting year.

Section C – SERVICES PROVIDED

Line 12 – If the answer is "No," because no qualifying services were performed during the year, skip all further questions and go to the last page. Sign, date, and mail the form to OSHPD. **You must submit a report, even if no qualifying services were performed during the reporting year.** Pursuant to Business and Professions Code section 2516(d), failure to submit this report to the OSHPD will delay the renewal of your midwife license until receipt of the report.

If the answer is "Yes," proceed to the next section. The entire report must be completed and submitted in order to satisfy the reporting requirements.

Section D – CLIENT SERVICES

Line 13 – Enter the total number of clients (include any client, regardless of year initially booked) you provided midwifery services to in this reporting year, as the primary caregiver *whose intended place of birth* ***at the onset of care*** was an out-of-hospital setting. This includes clients who may have left your care at some point for a non-medical reason and clients for whom collaborative care or supervision occurred.

Line 14 – Enter the total number of clients (include any client, regardless of year initially booked) who left care for non-medical reasons rather than being transferred to another healthcare practitioner. DO NOT include these clients in any further categories on this report. If there were none, enter zero (0).

Line 15 – Enter the total number of clients (regardless of year initially booked) who were pending on the last day of this reporting year (i.e. those who have yet to give birth).

Line 16 – Enter the total number of clients you served (regardless of year initially booked) *when the intended place of birth* ***at the onset of care*** was an out-of-hospital setting and who also received collaborative care.

Line 17 – Enter the total number of clients you served (regardless of year initially booked) under the supervision of a licensed physician and surgeon *when the intended place of birth at the* ***onset of care*** was an out-of-hospital setting.

Section E – OUTCOMES PER COUNTY

Include all births that occurred during this reporting year, regardless of year client was initially booked. Use one line for each county where a birth you attended as primary caregiver occurred. Use additional paper if necessary.

Lines 18(a-g) – In **Column A**, enter each county (using the county codes listed below) where you attended a birth as the primary caregiver.
– In **Column B**, enter the actual number of live births attended as primary caregiver in that county.
– In **Column C**, enter the number of births attended in each county as primary caregiver where the fetus died.

County Codes:

1	Alameda	21	Marin	41	San Mateo
2	Alpine	22	Mariposa	42	Santa Barbara
3	Amador	23	Mendocino	43	Santa Clara
4	Butte	24	Merced	44	Santa Cruz
5	Calaveras	25	Modoc	45	Shasta
6	Colusa	26	Mono	46	Sierra
7	Contra Costa	27	Monterey	47	Siskiyou
8	Del Norte	28	Napa	48	Solano
9	El Dorado	29	Nevada	49	Sonoma
10	Fresno	30	Orange	50	Stanislaus
11	Glenn	31	Placer	51	Sutter
12	Humboldt	32	Plumas	52	Tehama
13	Imperial	33	Riverside	53	Trinity
14	Inyo	34	Sacramento	54	Tuolumne
15	Kern	35	San Benito	55	Tulare
16	Kings	36	San Bernardino	56	Ventura
17	Lake	37	San Diego	57	Yolo
18	Lassen	38	San Francisco	58	Yuba
19	Los Angeles	39	San Joaquin	59	Out-of-state
20	Madera	40	San Luis Obispo		

Section F – OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Include all births that occurred during this reporting year, regardless of year client was initially booked. (It is understood that for this section each birth experience or infant born may be included on one or more lines.)

Line 19 – In Column A, enter the total number of out-of-hospital births you planned on attending as the primary caregiver ***at the onset of labor.***

Line 20 – Out of the total number of out-of-hospital births you planned on attending as the primary caregiver ***at the onset of labor*** (as indicated in line 19), enter, in Column A the number of those births that actually did occur in an out-of-hospital setting.

Lines 21 and 22 – Enter the number of planned births you attended (in an out-of-hospital setting) as the primary caregiver that involved twins or higher order multiple births. Include the number of actual infants delivered out-of-hospital in Column A and the number of sets of twins or higher order multiples in Column B.

Lines 23 and 24 – In Column A, enter the number of planned births you attended (in an out-of-hospital setting) as the primary caregiver that were breech births and/or vaginal births after prior caesarian section (VBAC). For these lines count each infant delivered.

FOR THE REMAINING SECTIONS
CHOOSE ONE CATEGORY THAT BEST FITS EACH CLIENT TRANSFER

Section G – ANTEPARTUM TRANSFER OF CARE, ELECTIVE

Lines 25- 43 – For each reason listed, enter the number of clients who, during the antepartum period, were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

Section H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 44-53 – For each reason listed, enter the number of clients who, during the antepartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

Section I – INTRAPARTUM TRANSFER OF CARE, ELECTIVE

Lines 54-66 – For each reason listed, enter the number of clients who, during the intrapartum period, were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

Section J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 67-74 – For each reason listed, enter the number of clients who, during the intrapartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

Section K – POSTPARTUM TRANSFER OF CARE, ELECTIVE

Lines 75-83 – For each reason listed, enter the number of clients who, during the postpartum period, were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

Section L – POSTPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 84-92 – For each reason listed, enter the number of clients who, during the postpartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

Section M – INFANT TRANSFER OF CARE, ELECTIVE

Lines 93-99 – For each reason listed, enter the number of infants who were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each infant.

Section N – INFANT TRANSFER OF CARE, URGENT/EMERGENCY

Lines 100-111 – For each reason listed, enter the number of infants who were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each infant.

Section O – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Lines 112-118 – For births occurring after the transfer of care of the mother or infant (from the licensed midwife to that of another healthcare provider) for urgent reasons in the antepartum period, or for any reason in the intrapartum or postpartum periods, indicate whether the birth was vaginal or caesarian by using Columns A or B for each outcome listed as it pertains to the mother.

Lines 119-127 – For births occurring after the transfer of care of the mother and infant (from the licensed midwife to that of another healthcare provider), indicate whether the birth was vaginal or caesarian by using Columns A or B for each outcome listed as it pertains to the infant.

Section P – COMPLICATIONS LEADING TO MATERNAL/INFANT MORTALITY WITHIN SIX (6) WEEKS

Lines 128-134 – For each complication listed, in Column A, enter the total number of mothers who died during the pregnancy or within six (6) weeks after the end of a pregnancy as a result of that complication. Of the total entered in Column A, indicate in Columns B or C the numbers that were out-of-hospital births or transfers. Report only the primary complication for each client.

Lines 135-142 – For each complication listed, in Column A, enter the number of infants who were live born and subsequently died within six (6) weeks after birth as a result of that complication. Of the total entered, indicate in Columns B or C the numbers that were out-of-hospital births or transfers. Report only the primary complication for each client.

Mail report to: **Office of Statewide Health Planning and Development**
Patient Data Section
Licensed Midwife Annual Report
400 R Street, Suite 270
Sacramento, CA 95811-6213

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

Completion/submission of this form by all licensed midwives in California is required pursuant to Business and Professions Code section 2516(c). Your midwife license will not be renewed unless and until the requisite data is submitted.

SECTION A – LICENSEE DATA

1a. First:	1b. Middle:	1c. Last:
2. License Number: ☐☐☐☐☐		
Numbers 3-10 are voluntary, but will assist OSHPD in contacting you if questions arise relating to your report		
3. Street Address 1		
4. Street Address 2		
5. City:	6. State:	7. ZIP Code:
8. Phone 1: ☐☐☐-☐☐☐-☐☐☐☐	9. Phone 2: ☐☐☐-☐☐☐-☐☐☐☐	
10. E-mail Address:		

SECTION B – REPORTING PERIOD

Line No.	Report Year
11	☐☐☐☐

SECTION C – SERVICES PROVIDED

Line No.		Yes	No
12	Did you, or a student midwife supervised by you, perform midwife services during the year when the intended place of birth at the onset of care was an out-of-hospital setting?		
	If "yes," continue with completion of the report. **If "no," go to the last page, sign and date the report and mail it to:** Office of Statewide Health Planning and Development Patient Data Section Licensed Midwife Annual Report 400 R Street, Suite 270 Sacramento, CA 95811-6213		

SECTION D – CLIENT SERVICES

Line No.		Total #
13	Number of clients you served as primary care giver whose intended place of birth, at the onset of care, was an out-of-hospital setting.	
14	Number of clients you served as primary care giver whose intended place of birth, at the onset of care, was an out-of-hospital setting and who left care for a non-medical reason. (DO NOT include these clients in any further categories on this report)	
15	Number of clients pending on the last day of this reporting year.	
16	Number of clients you served who received collaborative care.	
17	Number of clients you served while you were under the supervision of a licensed physician and surgeon.	

SECTION E - OUTCOMES PER COUNTY

Line No.	(A) County (see instructions for county code list)	(B) # of Live Births	(C) # of Cases Fetal Demise
18a			
18b			
18c			
18d			
18e			
18f			
18g			

SECTION F – OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Line No.		(A) Total #	(B) # of Sets
19	Number of planned out-of-hospital births **at the onset of labor**		
20	Number of completed births in an out-of-hospital setting		
21	Twins		
22	Multiples (Other than twin births)		
23	Breech		
24	VBAC		

SECTION G – ANTEPARTUM TRANSFER OF CARE, ELECTIVE

Line No.	Code	Reason	Total #
25	G1	Medical or mental health conditions *unrelated* to pregnancy	
26	G2	Hypertension developed in pregnancy	
27	G3	Blood coagulation disorders, including phlebitis	
28	G4	Anemia	
29	G5	Persistent vomiting with dehydration	
30	G6	Nutritional & weight loss issues, failure to gain weight	
31	G7	Gestational diabetes	
32	G8	Vaginal bleeding	
33	G9	Suspected or known placental anomalies or implantation abnormalities	
34	G10	Loss of pregnancy (includes spontaneous and elective abortion)	
35	G11	HIV test positive	
36	G12	Intrauterine growth restriction, fetal anomalies	
37	G13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	
38	G14	Fetal heart irregularities	
39	G15	Non vertex lie at term	
40	G16	Multiple gestation	
41	G17	Clinical judgment of the midwife (where a single other condition above does not apply)	
42	G18	Client request	
43	G19	Other	

SECTION H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
44	H1	Non pregnancy-related medical condition	
45	H2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	
		Reasons continue on next page	

46	H3	Isoimmunization, severe anemia, or other blood related issues	
47	H4	Significant infection	
48	H5	Significant vaginal bleeding	
49	H6	Preterm labor or preterm rupture of membranes	
50	H7	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)	
51	H8	Fetal demise	
52	H9	Clinical judgment of the midwife (where a single other condition above does not apply)	
53	H10	Other	

SECTION I – INTRAPARTUM TRANSFER OF CARE, ELECTIVE

Line No.	Code	Reason	Total #
54	I1	Persistent hypertension; severe or persistent headache	
55	I2	Active herpes lesion	
56	I3	Abnormal bleeding	
57	I4	Signs of infection	
58	I5	Prolonged rupture of membranes	
59	I6	Lack of progress; maternal exhaustion; dehydration	
60	I7	Thick meconium in the absence of fetal distress	
61	I8	Non-vertex presentation	
62	I9	Unstable lie or mal-position of the vertex	
63	I10	Multiple gestation	
64	I11	Clinical judgment of the midwife (where a single other condition above does not apply)	
65	I12	Client request; request for medical methods of pain relief	
66	I13	Other	

SECTION J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
67	J1	Preeclampsia, eclampsia, seizures	
68	J2	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor	
69	J3	Uterine rupture	
70	J4	Maternal shock, loss of consciousness	
71	J5	Prolapsed umbilical cord	
72	J6	Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress	
73	J7	Clinical judgment of the midwife (where a single other condition above does not apply)	
74	J8	Other life threatening conditions or symptoms	

SECTION K – POSTPARTUM TRANSFER OF CARE, ELECTIVE

Line No.	Code	Reason	Total #
75	K1	Adherent or retained placenta without significant bleeding	
76	K2	Repair of laceration beyond level of midwife's expertise	
77	K3	Postpartum depression	
78	K4	Social, emotional or physical conditions outside of scope of practice	
79	K5	Excessive or prolonged bleeding in later postpartum period	
80	K6	Signs of infection	
81	K7	Clinical judgment of the midwife (where a single other condition above does not apply)	
82	K8	Client request	
83	K9	Other	

SECTION L – POSTPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
84	L1	Abnormal or unstable vital signs	
85	L2	Uterine inversion, rupture or prolapse	
86	L3	Uncontrolled hemorrhage	
87	L4	Seizures or unconsciousness, shock	
88	L5	Adherent or retained placenta with significant bleeding	
89	L6	Postpartum psychosis	
90	L7	Signs of significant infection	
91	L8	Clinical judgment of the midwife (where a single other condition above does not apply)	
92	L9	Other	

SECTION M – INFANT TRANSFER OF CARE, ELECTIVE

Line No.	Code	Reason	Total #
93	M1	Low birth weight	
94	M2	Congenital anomalies, birth injury	
95	M3	Poor transition to extrauterine life	
96	M4	Insufficient passage of urine or meconium	
97	M5	Parental request	
98	M6	Clinical judgment of the midwife (where a single other condition above does not apply)	
99	M7	Other	

SECTION N – INFANT TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
100	N1	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing	
101	N2	Signs or symptoms of infection	
102	N3	Abnormal cry, seizures or loss of consciousness	

Reasons continue on next page

103	N4	Significant jaundice at birth or within 30 hours	
104	N5	Evidence of clinically significant prematurity	
105	N6	Congenital anomalies, birth injury, other medical conditions of an emergent nature	
106	N7	Significant dehydration or depression of fontanelles	
107	N8	Significant cardiac or respiratory issues	
108	N9	Ten minute APGAR of less than seven (7)	
109	N10	Abnormal bulging of fontanelles	
110	N11	Clinical judgment of the midwife (where a single other condition above does not apply)	
111	N12	Other	

SECTION O – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Line No.	Reason	(A) Total # of Vaginal Births		(B) Total # of Caesarian Deliveries	
MOTHER		Code		Code	
112	Without complication	O1		O8	
113	With serious pregnancy/birth related medical complications resolved by 6 weeks	O2		O9	
114	With serious pregnancy/birth related medical complications not resolved by 6 weeks	O3		O10	
115	Death of mother	O4		O11	
116	Unknown	O5		O12	
117	Information not obtainable	O6		O13	
118	Other	O7		O14	
INFANT/FETUS					
119	Healthy live born infant	O15		O24	
120	With serious pregnancy/birth related medical complications resolved by 6 weeks	O16		O25	
121	With serious pregnancy/birth related medical complications not resolved by 6 weeks	O17		O26	
122	Fetal demise diagnosed prior to labor	O18		O27	
123	Fetal demise diagnosed during labor or at delivery	O19		O28	

Outcomes continue on next page

124	Live born infant who subsequently died	O20		O29	
125	Unknown	O21		O30	
126	Information not obtainable	O22		O31	
127	Other	O23		O32	

SECTION P – COMPLICATIONS LEADING TO MATERNAL/INFANT MORTALITY WITHIN SIX (6) WEEKS

Line No.	Complication	Total # (A)		Out-of-Hospital (B)		After Transfer (C)	
MOTHER		Code		Code		Code	
128	Blood loss	P1		P8		P15	
129	Sepsis	P2		P9		P16	
130	Eclampsia/toxemia or HELLP syndrome	P3		P10		P17	
131	Embolism (pulmonary or amniotic fluid)	P4		P11		P18	
132	Unknown	P5		P12		P19	
133	Information not obtainable	P6		P13		P20	
134	Other	P7		P14		P21	
INFANT/FETUS							
135	Anomaly incompatible with life	P22		P30		P38	
136	Infection	P23		P31		P39	
137	Meconium aspiration, other respiratory issues	P24		P32		P40	
138	Neurological issues/seizures	P25		P33		P41	
139	Other medical issue	P26		P34		P42	
140	Unknown	P27		P35		P43	
141	Information not obtainable	P28		P36		P44	
142	Other	P29		P37		P45	

The information contain herein is accurate and complete to the best of my knowledge.

Signature:_____ Date:_____

Printed Name: _____

Let us know: Your feedback is requested (Optional)

Throughout this report there are categories for "unknown," "information not obtainable," and "other." If you use these options, we encourage you to explain the reasons on the optional page that follows the reporting form. Remember, your identity will not be linked to this information. Rather, it will be used to highlight issues that may need the attention of the Midwifery Advisory Council and/or the Medical Board of California or to assist in further improvement of the form.

Section	Line	Category -Unknown -Information not obtainable -Other	Comments/Explanation

Medical Board of California
Licensed Midwife Complaint/Disciplinary Activity
July 1, 2002 through June 30, 2007

Complaints Received
Violation Types/Total

Fraud	1
Incompetence/Negligence	24
Non-Jurisdictional	1
Unlicensed Practice	12
Unprofessional Conduct	13

Disciplinary Action Taken
Violation Type/Total

Gross Negligence	2
Unprofessional Conduct	1
Violation of Code Section 2519	1

Licensed Midwife Complaint/Disciplinary Information
July 1, 2002 through June 30, 2007

Disciplinary Decisions

Overall reason(s) for action being taken:

1 – Failed to monitor baby's heart rate during contractions. Low APGAR score; baby stopped breathing after 14 hours

1 – Failed to recognize process and risks of labor; prolonged 1st and 2nd stages of labor; failed to disclose concerns/risks with mother and make back up arrangement or consultation

1 – Allowed an unlicensed person to assist in delivery putting mother and baby as risk

1 – Negligent care of a high risk client with fetus in breech position

Complaints

Overall reasons for complaint being filed:
(These are general/summaries of the reasons why a complaint was filed with the board within the time period indicated. Further action, investigation, or disciplinary action may or may not have been taken based upon related facts/evidence.)

13 – Negligent care and treatment during labor/delivery
6 – Negligent care and treatment of client
2 – Practicing w/out supervision with high risk client
2 – Negligent prenatal care
2 – Failure to have supervising MD available
2 – Provided prescription medication to client
2 – Failure to do continuing education
1 – Operating midwifery school inappropriately
1 – Failed to register the birth of an infant
1 – Attempted VBAC on high risk client
1 – Poor supervision of student midwife
1 – Failure to abide by contract and provide service to a client
1 – Conviction of a crime/failed to disclose
1 – Allowing LM assistant to care for client while LM was out of town
1 – Providing services beyond scope of practice
1 – Failure to release records
1 – Abandoned client
1 – Unlicensed practice
1 – Fraudulent billing

Dr Richard Fantozzi, DOL
Medical Board of California
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916 / 263-2365

California College of Midwives
3889 Middlefield Road
Palo Alto, Ca 94303
650 / 328-8491

August 15, 2006

RE: Retraining program for California LMs

Dear Dr Fantozzi,

Per your request, I am developing a program for the rehab and/or retraining of California licensed midwives subject to disciplinary actions by the Board. The standard for remedial training would come directly from the Licensed Midwifery Practice Act of 1993 (LMPA) curriculum and pertinent regulations adopted by the MBC since 1993.

I have only addressed disciplinary situations and *not* the ground-up *retraining* of LMs who have not practiced for 10 or more years. I believe that re-certification for formerly retired LMs should be done by an academically-based midwifery program. Since there are no MBC-approved midwifery training programs in California, trying to retrain retired LMs in isolation from formal academic resources would be too extensive for my personal and professional abilities.

Karen Ehrlich has also offered to work with me in designing and administering a rehab program. However, this letter is just my own personal first draft. I would appreciate your feedback and any constructive critique. Nothing is set in stone nor is it ready for public viewing.

As you know, I am familiar with the PACE program developed by Dr Norcross of UCSD to evaluate and rehabilitate at-risk physicians. I also have downloaded several informative documents describing the PAR program -- Practitioner Achievement Review -- which is a *prospective* "360-degree" evaluation program mandated by the College of Physicians and Surgeons of Alberta (Canada).

Eventually I hope to see California LMs participate voluntarily in the 360-degree prospective review process, so as to deal *preventatively* rather than *punitively* with quality of care issues. Clearly it is in the best interests of consumers and their unborn or newborn babies to have their maternity care be provided by LMs who are competent, ethical, responsible and socially adept. This would reduce the number of disciplinary cases that would require any form of rehabilitation, to the advantage of us all.

Developing the Rehab Process

After many false starts, I finally reached Elizabeth Gilmore, the current director of the New Mexico National College of Midwifery. She has agreed to work with Karen Ehrlich and I, in conjunction with the Board, to develop an effective and affordable rehab program for California midwives. Ms. Gilmore concluded that it would be possible to use current materials and evaluation processes from the National College of Midwifery as didactic testing materials. She also suggested that we adopt a clinical exam process model after the Seattle Midwifery School Challenge Mechanism. The SMS challenge process used the NARM certification criteria to define the characteristics of clinical competency as they are currently defined *by* the midwifery profession.

One of many advantages of affiliating with the National College of Midwifery is that the program can be administered completely from *within California* (i.e., respondent LM would ***not*** need to travel to New Mexico), and yet provide the services of an educational program approved by MEAC and the US Department of Education. As you know, there are no approved midwifery training programs domiciled in the state of California. The cost of the program, best as I can determine, would be approximately $1,000 to $2,000. This includes compensating the evaluator's professional time at $100 a day (standard honorarium for MBC members when attending to MBC business) and fees to use test materials originating with the NCM or NARM.

For clinical skills we would refer to the extensive and detailed lists of clinical shills developed by NARM and used by all the currently approved midwifery training programs. These were also used by Seattle Midwifery School to document appropriate clinical skills in conjunction with the Challenge process. California LM evaluators would be official preceptors for the NCM program, former evaluators for Seattle Challenge Mechanism or the NARM clinical examination. I am one of the original evaluators for the Challenge process, and have administered the SMS clinical exam to several candidates who successfully completed the licensing process.

Liability Issues & Retesting

Last but not least is policy development. The first issue is the LM candidate's right to retake a failed (or contested) part of the exam. In general, exams of this sort permit a candidate to repeat at least once any part failed (some permit two retakes), with additional fees for the cost of the evaluator's time and any proprietary exam materials. I would strongly suggest a different clinical examiner in situations that are contested by the candidate, with the possibility of video taping contested re-takes. If there is still a strong difference of opinion about whether the candidate has indeed performed satisfactory, I would suggest that a contested case be referred to the Midwifery Advisory Council to provide an informed opinion that would to be rendered to the DOL, who would make the final ruling.

The other policy issue is potential liability/litigation. I'm referring to situations that might result from an LM respondent's failure to successfully complete the program, accompanied by a claim that her failure was the result of a discriminatory, prejudiced, faulty or unfair process. Any program that I developed or administered would go the extra mile (or even two!) to be as fair as humanly possible. But we both know that these situations can engender a great deal of grief for all concerned whenever a respondent-licentiate is unable to satisfactorily demonstrate competency.

My suggestion in that regard is to configure the rehab process so that the LM's participation is voluntary, that is, the candidate would have the choice to surrender her license up-front OR voluntarily participate in the rehab process, agreeing *a priora* to abide by the final decision of the

DOL, after all retakes and reviews are concluded. I don't want a rehab program tied up in contentious litigation every time someone is unable to complete it. My experience bears out the truism that "no good deed goes unpunished". As the unpaid administrator of the College of Midwives professional liability insurance consortium, I was sued by our malpractice *carrier* in an outrageous and ultimately illegal strategy *by them* to avoid having to pay out a legitimate claim in a New Mexico case by side-lining the legal process in a California court. Eventually, the matter was appropriately concluded (they finally gave up!), but only after years of trips to the courthouse and lots of personal time and money.

The rehab process would include the following steps:

- A request for retraining by the LM, who would be offered the alternative of a remedial or rehab process instead of surrendering her licensed – this request document would authorize the rehab team to receive pertinent information to asses her case

- Using documents generated by the disciplinary process, an inventory would be conducted between the rehab team and MBC staff with pertinent input, so as to efficiently define the educational problem and/or identify deficiencies in clinical skills

- Development of a candidate-specific evaluation process (i.e. a "pre-test") of the respondent's knowledge base or clinical skills in the identified areas of concern

- After a review of the identified deficiencies and, using the pre-test evaluation and documents from the complaint, the rehab team would develop a corrective curriculum. The length of time allowed for this stage would depend on how extensive that curriculum was.

- When the respondent LM had concluded the study phase, a didactic exam would be administered and proctored by Karen Ehrlich, California LM, who is currently recognized as an official preceptor for NCM students.

- After successfully completing the didactic exam, a clinical exam relative to the deficiencies identified would be configured and administered by a credentialed evaluator.

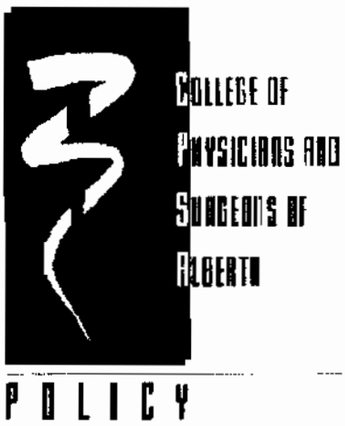
- A report of this inventory and the candidate's pass/fail status would be generated for the DOL

Again I want to emphasis that this is a first draft. I am inviting your feedback and constructive critique. I have included the address and email for the NCM, should you or other MBC staff wanted to contact her directly. I will also be sending Elizabeth Gilmore a copy of my letter. I look forward to your reply.

Faith Gibson, LM, CPM
Director, California College of Midwives / ACCM

cc: Mr Herman Hill, MBC; Licensing Operations

Elizabeth Gilmore, LM, Director, National College of Midwifery; 209 State Road 240 Taos, NM 87571. Tel 505.758.8914; fax 505.758.0302; info@midwiferycollege.org



Re-Entry into Practice

CPSA Policy

Revised June 2001

1. Registered practitioners planning to return to clinical medical practice after an absence of three years or more, or planning to change clinical disciplines within medicine, must first notify the College and complete an assessment and retraining satisfactory to the Registrar.

2. The following shall be considered by the Registrar regarding assessment and retraining:

   - Previous training and experience
   - Previous performance in practice
   - Related activity during absence from practice
   - Reasons for absence from practice
   - Intended scope of practice

3. Assessments may include but are not restricted to one or more of the following:

   - Observed performance in practice-settings
   - Structured clinical encounters
   - Structured oral interviews
   - Simulators
   - Written examinations

4. Retraining may include but is not limited to the following:

   - Directed self-study
   - Traineeships with identified preceptors
   - Formal residency training programs
   - Supervised practice

5. Physicians shall be responsible for the costs of their assessments and retraining.

6. Restrictions may be attached to a physician's registration based on the results of an assessment.

7. Only physicians who are, or were previously, registered for unsupervised medical practice in Alberta may appeal a decision of the Registrar in regard to the above to Council.

State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

To : Members, Midwifery Committee

Date: October 13, 2006

From : Herman Hill, Analyst
Licensing Operations

Subject : **Feasibility Discussion – Midwifery Assessment and Clinical Education Program Implementation**

Issue:

During discussions that occurred at the DOL Meeting on May 11-12, 2006, Dr. Richard Fantozzi, President, Division of Licensing, directed that licensing staff investigate the feasibility of implementing a Midwifery "re-entry/retraining" program. As this discussion unfolded, there was concern regarding how the Midwifery Education Accreditation Council (MEAC) and the midwifery community at-large handle this issue. Other issues that emerged as a result of this discussion included:

- Determining whether any re-entry programs are operating nationwide and within the profession of midwifery; and
- What happens to midwives who have been out of practice for a period of time (not specified) and wants to come back to the profession.

Background:

The search for information relative to this issue began with conducting an interview with Mary Ann Baul, Executive Director, Midwifery Education Accreditation Council (MEAC). This agency is one of several "directly supporting" agencies of California's Licensed Midwife Program. Other equally supportive agencies will also be discussed as it relates to information pertinent to midwifery re-entry/retraining programs.

Midwifery Education Accreditation Council (MEAC)

The purpose of MEAC is to establish standards for the education of competent midwives and to provide a process for self-evaluation and peer evaluation for diverse education programs. The U.S. Secretary of Education has listed MEAC as a nationally recognized accrediting agency for post secondary midwifery education programs. MEAC's responsibilities are directly related to midwifery education programs (schools) and not to developing, maintaining, or evaluating possible reentry or similar programs, if they currently exist. For this reason, MEAC should not be expected to and has fundamentally declined to provide a framework for any retraining, re-entry, or rehabilitative programs that may be a result of this administrative inquiry. During previous assessments of midwifery education programs, none were found to have implemented re-entry or retraining programs for midwives.

North American Registry of Midwives (NARM)

The subject of existing reentry programs for midwives was posed to NARM (Ida Darraugh, Director of Testing). The director's response indicated that there was no specifically designed 're-entry" programs monitored or administered by NARM. However, the director indicated that NARM had received a recent request from the state of Florida to allow one candidate to retake the NARM Certification examination because she had not been in practice for a few years but meets the requirements for licensing in Florida. The NARM examination has not been redesigned to address this particular situation.

The director further discussed that each state has different regulations regarding re-entry. Licensing staff's review of Utah, Virginia, and Texas midwifery practice statutes indicates no such information as it relates to a definable re-entry program. The director also indicated that some states only require retaking the NARM examination as being part or all of the remediation for keeping or being reissued their license or certification.

NARM's published information contained in their Candidate Information Bulletin (CIB) provides information concerning "Suspension or Revocation of Application", "Revocation of Certification", and "Recertification". None of these processes could leave one to assume that a re-entry program that embraces a certain level of scrutiny beyond a written examination is offered to the midwife. Further, the director indicated that NARM has revoked only three certifications, all of whom were not licensed midwives practicing in California. None of the revoked certifications have been from a state with licensing statutes, nor have the former CPMs whose certifications/licenses had been previously revoked have reapplied for certifications or re-licensure. NARM publishes revocation notices in the CPM news, which is available on NARM's website. The director felt that it would not be of any direct benefit to inform the MBC of these revocation notices.

In order for eligible midwives to acquire the nationally recognized "certified professional midwives" (CPM) designation, they must be administered and successfully pass NARM's comprehensive certification examination. The national certification does not qualify the midwife for California licensure. However, the comprehensive examination is the Medical Board of California's licensing examination for midwives licensed in California, as required by statute.

Finally, the director validated that NARM's existing policies concerning certification does not meet the probable standard of a re-entry program and that it is not NARM's responsibility to monitor CPMs for compliance with state regulations. It is for this reason that NARM would not be involved unless a complaint was received by NARM. The effect of that notification would imperil the midwife to de-certification actions as a CPM.

UCSD Physician Assessment and Clinical Education (PACE) Program

Dr. Carole Sussman, Associate Director and COO, responded to a licensing staff e-mail and telephone inquiry concerning whether the existing PACE program for physicians could be tailored to the probable needs of licensed midwives. Dr. Sussman mentioned that the current PACE Program was designed expressly for healthcare professionals, with emphasis on physicians and surgeons. The PACE Program consists of a two-phased approach. Phase I of the program is a two-day clinical competency assessment that uses a variety of evaluative methods to provide an overall picture of the physician's skills, knowledge, and physical health. Phase II further evaluates the participant's skills and knowledge in a "clinical setting" by way of discussion with the faculty,

examination, and physician participation. The length of this portion of the evaluation is at least one week. Dr. Sussman further stated that it would be highly unlikely that the program could serve midwives in its current form and that a comparable program would have to be created for midwives. No further information or guidance relative to re-entry programs was provided. It was agreed that a PACE-like model could be used for midwives.

American College of Nurse-Midwives (ACNM)

Contact was made with several ACNM program directors regarding re-entry programs. It was disclosed that ACNM has created a "pilot program" titled "ACNM Reentry to Midwifery Practice Program". The purpose of the program appears to be designed "for midwives who are not currently engaged in the practice of midwifery and must update their skills and knowledge of current clinical practice after an extended absence to meet prevailing standards." The program consists of two components that include: 1) Continuing Education, and 2) Clinical Refresher.

The program guidelines identified certain information that concludes that re-entry or "refresher" programs were previously recognized during the late 1960s through the mid-1980s. During this period, foreign-prepared nurse-midwives were required to complete one of these refresher programs before being certified (not licensed) as a nurse-midwife in the United States. These refresher programs no longer exist, although the term "refresher" is used to describe the program designed for "reentering midwives" by one of the ACNM accredited education programs, which includes the following:

- OHSU Nurse-Midwifery Program, Portland, OR;
- San Diego State University, San Diego, CA;
- Baystate Medical Center. Springfield, MA;
- University of Medicine and Dentistry of New Jersey, Newark, NJ;
- University of Minnesota, School of Nursing, Minneapolis, MN; and the
- University of Puerto Rico, San Juan PR

The above listed ACNM accredited midwifery education programs have not been formally approved by the Medical Board of California. It could not be determined during this exchange whether the "pilot reentry programs" had been implemented at these locations. ACNM would not release information that disclosed the number of sites, if any, where the pilot program is being tested. Further, no additional program provisions considered or included conditions where the midwife had been referred to the program due to the imposition of disciplinary action that warrants competency assessments before re-licensing or re-certification.

Licensed Midwife Submission – Retraining Program for California Licensed Midwives:

During the conduct of this staff inquiry, contact was made with Faith Gibson, who presented a draft recommendation for a retraining program for midwives. This draft recommendation is the result of collaborations between Karen Ehrlich, and Elizabeth Gilmore, Director of the National College of Midwifery, Taos, New Mexico. Ms. Gibson, Ehrlich, and Gilmore are California licensed midwives. The latter is a Board-approved post secondary midwifery education program (school) currently in good standing with the Medical Board of California, Division of Licensing.

In summary, Ms. Gibson offers a process where midwives who have not practiced for extended periods of time would participate, on a voluntary basis, in the "360-degree prospective review process", similar in scope to that of the UCSD PACE model. Ms. Gibson's draft recommendation has been presented to Dr. Fantozzi in an earlier forum. Staff reviewed the three-paged document and found that the elements of the retraining process or design presented potential opportunities for a California retraining program for midwives. However, in its current form, revisions and structure may be required.

Discussion:

The information obtained during this inquiry did not validate the practicality or feasibility of implementing a re-entry or retraining program for midwives in California. At the core of this issue is the challenge of how the framework in which minimum standard competencies of the midwife will be assessed. Further, other issues facing the implementation of this type program that must be resolved include:

- **The design of the practical components of the program, e.g., competency assessment, peer review, retraining, and assessment outcomes, and other areas of concern;**
- **Whether or not the program would be voluntary upon request of the midwife, or mandatory, as a result of the imposition of disciplinary recommendations from the Division of Licensing;**
- **Probable revision of existing statutes and regulations to support program implementation, under the "force of law", which currently does not exist; and**
- **Program costs to the potential midwife involved and to the Medical Board of California to sustain this program over time. This issue may present circumstances that could be adverse to the forward movement of program implementation. The reason being that if high to nominal cost factors are not mitigated, midwives who may benefit from this program approach may not participate, due to the probability of high costs.**

Conclusions:

The examination of existing re-entry programs for midwives could not disclose any material or concrete information regarding any programs currently operating that could be considered a reentry program or model for midwives. NARM's existing programs or processes do not compare to what one would expect of a reentry program for an allied healthcare professional. The ACNM "Pilot Reentry Program" may be operating at several locations, but actual locations were not disclosed so that a preliminary assessment could be made of its feasibility. ACNM has not published any anticipated outcomes, performance measures, or expected results for the program. The existing PACE Program for healthcare professionals (physicians & surgeons) may not be suitable for midwives in its current configuration. However, using the framework of a PACE-like model may show some promise. The draft recommendation presented by Faith Gibson, with support from Karen Ehrlich and Elizabeth Gilmore, uses the UCSD PACE model, to a certain extent, but might require further revisions and improvements to be recognized as a potential example of a re-entry/retraining program for midwives.

Recommendations:

Due to the absence of any credible or concrete information concerning existing re-entry programs for midwives, this issue of concern could be exploited more fully and effectively by the soon-to-be-created Midwifery Advisory Council for the Division of Licensing. Once the members are impaneled, this subject could be thoroughly pursued by its members, using the resources of the existing midwifery community, in liaison and collaboration with other healthcare professionals. Partnerships could also be re-established with representatives of the California Medical Association (CMA), the American College of Obstetrics and Gynecologists (ACOG), represented midwifery advocacy groups and associations, in furtherance of any progress made to implement a program of this level of significance. Further, The Medical Board of California may be able to more effectively use the Expert Reviewer Program (Licensed Midwives) as an investigative and reporting arm of the Midwifery Advisory Council that would pursue probable alternatives of creating a Midwifery Assessment and Clinical Education Program, with supporting statutory authorities.

I look forward to answering any questions you might have at the meeting. If you have any questions or comments concerning this program proposal for midwives prior to the meeting, please contact me at (916) 263-2393 or by e-mail at hhill@mbc.ca.gov .