MEDICAL BOARD OF CALIFORNIA
Licensing Program

MIDWIFERY ADVISORY COUNCIL

MEMBERS OF THE COUNCIL

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

December 9, 2010

Medical Board of California
Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382

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

AGENDA
1:00 p.m. – 3:00 p.m.
(or until conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. **Call to Order/Roll Call**

2. **Public Comment on Items not on the Agenda**
   Note: The Board may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

3. **Approval of Minutes from the August 11, 2010 Meeting**

4. **Licensed Midwife Annual Report – Ms. Ingram and Ms. Thompson**
   A. Update on OSHPD / MBC Interagency Agreement
   B. Update on Online 2010 Annual Report Survey
   C. Addition of Neonatal and Maternal Deaths to Reporting Requirements per SB 1489
   D. Consideration of Prospective versus Retrospective Reporting of Data – Ms. Ehrlich

5. **Discussion of Changes to Midwifery Page on the Medical Board's Website – Ms. Thompson**

6. **Program Update – Ms. Thompson**

7. **Discussion of Title 16 California Code of Regulations Section 1379.30 and Effect of Sunset of Former Business and Professions Code Section 2514 – Ms. Scuri**

8. **Terms and Conditions of Probation – Ms. Whitney and Ms. Simoes**

9. **Update on Barriers to Care – Ms. Simoes**

10. **Discussion on Membership of Midwifery Advisory Council – Ms. Ehrlich**

11. **Discussion on VBAC (Title 16 California Code of Regulations Section 1379.19(b) – Ms. Scuri**

12. **Agenda Items for the April 7, 2011 meeting in Sacramento**

13. **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, and to promote access to quality medical care through the Board's licensing and regulatory functions.
NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2393 or sending a written request to that person at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.
Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the Chair may apportion available time among those who wish to speak.
For additional information call (916) 263-2393.

MEDICAL BOARD OF CALIFORNIA
Licensing Operations

Midwifery Advisory Council
Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

August 11, 2010

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 Karen Ehrlich at 11:35 a.m. A quorum was present and notice had been mailed to all interested parties.

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

Members Absent:
William Frumovitz, M.D.

Staff Present:
Ramona Carrasco, Central Complaint Unit
Diane Ingram, Manager, Information Services Branch
Letitia Robinson, Manager, Licensing Operations
Jennifer Simoes, Chief of Legislation
Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs (DCA)
Cheryl Thompson, Analyst, Licensing Operations
Linda Whitney, Executive Director

Members of the Audience:
Claudia Breglia, L.M., California Association of Midwives (CAM)
Mason Cornelius, Licensed Midwife
Frank Cuny, California Citizens for Health Freedom (CCHF)
Robyn Strong, Manager, Patient Data Section, Healthcare Information Division, OSHPD
Jeff Toney, Division of Legislation and Policy Review, Department of Consumer Affairs

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Agenda Item 2 Public Comments on Items Not on the Agenda
No public comments were offered.

Agenda Item 3 Approval of Minutes from the April 8, 2010, Meeting
It was M/S/C (Sparrevohn /Yaroslavsky) to approve the* April 8, 2010*, meeting minutes with a minor amendment.

Agenda Item 4 Licensed Midwife Annual Report

A. OSHPD / MBC Memorandum of Understanding
OSHPD and the Board have been meeting to develop a Memorandum of Understanding (MOU). The MOU has transitioned into a multi-year Inter-Agency Agreement (IAA) between the two agencies that establishes and documents the collaboration of the work being done on the Licensed Midwife Annual Report for MBC by OSHPD and provides a payment method to reimburse OSHPD for the time spent collecting data and hosting the application on their website. The agreement is currently in draft form. MBC is responsible for making changes to the online reporting application through December 2010; OSHPD will be responsible for any changes for the next two years, beginning in January 2011.

B. 2009 Report
Ms. Thompson reported that of the 217 midwives who are currently renewed and current, 27 have not yet submitted their Annual Report; 15 midwives who are currently in delinquent status have not yet submitted their reports. An administrative hold will be placed on these midwives' licenses that will block their ability to renew their license until their Annual Report has been submitted.

Ms. Gibson provided a synopsis of the 2009 Annual Report results. In 2009, 3,023 clients were served by California licensed midwives. There were 1,974 planned out-of-hospital births at the onset of labor; 1,621 of these were completed in an out-of-hospital setting. There were a total of 688 transfers of care (555 elective; 133 urgent). Nine instances of fetal demise after 20 weeks were reported. There were 4 instances of neonatal mortality (1.5 per 1,000 live births) and 1 instance of maternal mortality reported.

C. 2010 Report – Report Survey Suggestions
MBC and OSHPD have been working together on the 2010 Annual Report online survey; many of the changes are technical in nature and will make the online survey more user friendly. A "Frequently Asked Questions" section will be added to the survey, as well as clarification on some of the definitions used.

There was lengthy discussion among members on specific changes to the survey. These revisions will be incorporated into the 2010 survey by staff.

The Annual Report was developed to collect data required in law by B&P §2516. Ms. Gibson recommended changing the wording for requirement of Section 2516(a)(3)(L) to read "complications resulting in the mortality of a *neonate*" (rather than an *infant*). This technical change could be included in an omnibus bill. A corresponding change would have to be made in the Report Survey.

Dr. Haskins requested that future Annual Reports include an addendum comparing the data with that from other states or countries. Ms. Whitney indicated this could be a staff project with a report made to the Council (and possible posting on the Board's website), but that would not be included in the final report to the Legislature.

Agenda Item 5 Program Update

Ms. Thompson reported during FY 09/10, 19 new midwife licenses were issued and 74 licenses were renewed. As a comparison, in FY 08/09, 23 licenses were issued. As of August 1, 2010, there are 217 midwives in California with a renewed and current license status.

At the July 30, 2010 Medical Board meeting, Bastyr University Department of Midwifery Program, formerly known as the Seattle School of Midwifery, was formally approved by the Board with retroactivity to June 2010 when the first class graduated under Bastyr.

On Wednesday, August 18, 2010, approximately 15 midwifery candidates will sit for the NARM exam at the Medical Board's offices. This exam, which is offered twice per year, satisfies the Board's written examination requirement for licensure.

Agenda Item 6 Licensed Midwife Disciplinary Action Statistical Data

Ms. Carrasco, Complaint Unit Analyst, directed members to page 20 of their packets for information on Midwifery Program enforcement statistics. Ms. Scuri clarified that cases referred for criminal action typically deal with violations of midwifery standards or unlicensed practice, rather than issues such as DUIs.

Agenda Item 7 Update on Proposed Legislation

A. SB 1489

Ms. Simoes reported SB 1489, the omnibus bill which includes midwifery language, was amended on April 26, 2010 to include the language that clarifies the reporting requirements for midwives. The bill currently is on the Assembly third reading and has been passed through on consent. It is also on the Senate floor Consent Calendar. Amendments to the bill, such as the suggested change to B&P §2516, would be difficult to make at this point in time. Ms. Simoes suggested any additional technical changes be held for next year's omnibus bill.

Agenda Item 8 Terms and Conditions of Probation

This item was tabled until the December 2010 MAC meeting.

Agenda Item 9 Formation of Work Group to Determine Whether Regulations Are Needed to Define What Constitutes "Failure to Comply" for Purposes of B&P Section 2516

At the January 7, 2010, meeting, staff was asked to examine regulatory language that would explain what the law meant with regard to "failure to comply" in B&P Section 2516. Previous discussion centered on how complete the Annual Survey had to be in order to fulfill the requirement in law (e.g., whether a survey with sections left blank, with internal inconsistencies in reported data, and that had not been signed would be considered a "complete" survey). Ms. Sparrevohn stated that only a report that was truly complete should satisfy the requirement in law.

Ms. Whitney suggested the on-line survey could be altered so that it could not be submitted unless all sections were completed and the survey was signed; this would resolve the issue for the majority of licensees who submit their surveys on-line. Staff will implement these changes and research whether it is possible to prevent submission if there are data inconsistencies.
These changes, however, will not resolve the issue for those submitting incomplete paper versions of the survey. Staff will work with OSPHD to develop a procedure for rejecting unsigned or incomplete paper surveys and notifying Board staff so a written notification can be sent to the licensee. Ms. Ehrlich would like the incomplete survey form be returned to the licensee in order to make resubmission of the survey easier.

Agenda Item 10 Presentation on Barriers to Care and Potential Formation of Task Force
Claudia Breglia, California Association of Midwives, directed members to page 30 of their packets for a list of issues that have been identified as barriers to midwifery practice in California. Many barriers are related to the supervision requirement in the Licensed Midwife Practice Act (LMPA) and the difficulty midwives face in securing a physician willing or able to supervise them. Suppliers won't provide their products or services (such as ultrasounds, pharmaceuticals, and medical devices) without a supervising physician's signature on file. Occasionally clients are allowed to pay for services such as ultrasounds, but then the providers refuse to release results to anyone but the supervising physician. Without supervising physicians, licensed midwives are technically out of compliance with the law and are practicing illegally. This occasionally leaves midwives vulnerable to harassment. When a complaint against a midwife is investigated, only a midwife with a supervising physician is allowed to provide expert review. Since most expert reviewers work exclusively in doctors' offices and do not attend home births, this deprives midwives of a review by peers in the community who are familiar with birth in the home.

Physician supervision also creates issues with regard to prescription medication and the ability of licensed midwives to obtain emergency and other injectible medications. There is no provision for procuring or providing legend drugs and devices in law or regulation. Oxygen, syringes, suture materials, and IV equipment can also be difficult to obtain. Ms. Sparrevohn noted this is becoming an issue even for those LMs working *with* physician supervision in a clinic or office setting due to requirements for the e-prescribing of medications.

Ms. Simoes stated that the physician supervision issue would need to go to the full Board since a legislative change would be necessary in order to change the physician supervision requirement in law to physician collaboration.

The California Department of Public Health (CDPH) has jurisdiction over several areas that impact midwives. Midwives attempting to register births are not allowed to process or complete paper birth certificate forms, are not allowed to submit forms electronically, and are subject to additional requirements or restrictions by various counties that are not required by the State Office of Vitals Records. LMs are often unable to register births within the 10 days required by law due to county specific time schedules and restrictions. Ms. Simoes stated that this issue could possibly be addressed without a legislative change by meeting with CDPH to discuss birth certificate issues.

CDPH Alternative Birth Center regulations do not list licensed midwives as one of the required attendants during birth; this prohibits the hiring of LMs as out of hospital birth attendants in these settings. Additionally, CDPH's Laboratory Field Services determination that LMs must have the signature of the supervising physician on file in order to open or maintain an account makes it

difficult for LMs to open accounts with diagnostic laboratories for basic lab services such as pregnancy tests, prenatal panels, and urine tests. Both of these barriers would require a change in regulations.

The omission of licensed midwives from various lists of authorized service providers such as the Department of Health Care Services (Medi-Cal reimbursement), CDPH for the Comprehensive Perinatal Services Program (CPSP), and the Managed Risk Medical Insurance Board (Access for Infants and Mother's Program) creates payment issues for midwives and restricts birth options for low income women. Clinics are reluctant to hire LMs since they cannot be reimbursed for clinical services they provide to patients. Ms. Sparrevohn noted that any code that includes licensed nurse midwives (LNMs) could also include LMs since the scope of practice is identical for both. Addressing these issues would require regulatory changes.

As out of network providers, Ms. Breglia noted private insurance carriers pay LMs at significantly lower rates, will not pay LMs directly, or will not cover their services at all. Ms. Simoes stated the Board would typically not involve itself in private insurance payment issues. Dr. Haskins indicated LMs would need to collectively meet with individual insurance companies on this issue. Ms. Breglia reported that Florida has a law requiring insurance companies who pay maternity benefits to pay licensed midwives who attended home births. Dr. Haskins suggested that pursuing a legislative change on this issue would probably be unsuccessful at this time.

Ms. Breglia stated the time was right to address the physician supervision requirement. She thought that approaching the issue as a protection of the consultant physician and the provision of high quality care to patients would be the most successful strategy. The supervision requirement has created a barrier to quality care for consumers who choose to have their babies at home and for physicians who would like to work with midwives to provide seamless transfer into the medical system when it becomes necessary. She would prefer that an individualized, consultative relationship with a physician be required and that these physicians be released from liability for the midwife's actions prior to their assumption of the patient's care. Other states have created similar requirements in law. No states, other than California, require physician supervision of licensed midwives.

Dr. Haskins recommended that the MAC not seek a legislative solution to the physician supervision issue at this time since it is likely to be strongly opposed by the American College of Obstetricians and Gynecologists (ACOG) and the California Medical Association (CMA). She suggested addressing the various barriers by working with other government oversight agencies and approaching liability carriers and insurance actuaries with statistics on midwifery care.

Ms. Scuri stated B&P Section 2507(f) directs the Board to adopt regulations defining the appropriate level of supervision required for the practice of midwifery. She suggested the MAC may want to consider revisiting this section of law since the rulemaking process is under the Board's control, not the Legislature's, and there is "play" in how supervision is defined. She recommended that the MAC wait to approach the Board until it had consensus on how to proceed.

Ms. Whitney indicated she would direct staff to proceed with setting up meetings with the relevant oversight agencies and to report back the result of those meetings at the next MAC meeting. She will also direct staff to start researching and setting up a timeline for workshops and discussions on the regulatory process to address other identified barrier issues.

Ms. Gibson reported on a study from British Columbia, which has the same direct entry midwifery system as California, except they have a "seamless system of care" with the obstetrical/medical community. The British Columbia perinatal death rate for home births attended by midwives is 0.35 per 1,000 births; for midwives attending births in hospitals the rate is 0.57 per 1,000. The rate for physicians doing planned hospital births for the same low risk category of mothers the rate was 0.64. Midwives in California currently have a perinatal death rate of 1.9 per 1,000. It is unknown if California's rate could achieve similar results if a seamless system existed here, but the rate would most likely improve.

Ms. Sparrevohn stated the ability of LMs to procure basic lifesaving drugs, oxygen and other medications needs to be addressed; this will likely require legislative change. Currently, LMs cannot prescribe or administer or furnish drugs except under the supervision of a licensed physician.

Ms. Sparrevohn noted the listing of drugs and devices that midwives use are only included in the educational requirements in regulations; it is not included in the scope of practice. LMs have broadly interpreted this legislation to reason that since they are trained to use these drugs and devices, then it is implied that they may use them. The list includes drugs such as Pitocin and Rhogam, which, as controlled substances, can only be prescribed or administered under a supervising physician's authorization.

Ms. Breglia reported Louisiana has a law that states that a midwife licensed under these regulations may lawfully have possession of small quantities of the above named medications normally required for administration; each use shall be reported in the client's chart. Currently, there is nothing in California law that allows a LM to get a furnishing license. LMs cannot get a DEA number.

Ms. Scuri clarified that a midwife with a supervisory relationship with a physician could, under the physician's direction (which could be standardized procedures or a signed protocol), furnish medications to a patient.

Ms. Scuri noted the section of law dealing with supervision has been interpreted to essentially say, "even though you are licensed, if you don't have a supervising physician you are the same as an unlicensed person". She stated that this is not a reasonable interpretation of the law.

Ms. Ehrlich voiced her support of Ms. Whitney's plan for addressing the barriers to care by first setting up meetings with appropriate agencies. She requested that lab accounts be one of the first items addressed.

Ms. Scuri summarized by stating the midwife community is free to go in whichever direction it chooses. While it is likely they don't want to work at cross purposes with the MAC, it is their prerogative to do something that the Board is not yet ready to do.

Agenda Item 11 Proposed Meeting Dates for the Remainder of 2010 and 2011

The proposed meeting dates for the remainder of 2010 and 2011 are December 9, 2010; April 7, 2011; August 11, 2011, and December 8, 2011.

Ms. Sparrevohn made a motion to approve the proposed meeting dates; s/Yaroslavsky; motion carried.

Agenda Item 12 Agenda Items for Next MAC Meeting
Ms. Gibson asked that the new law that will add neonatal and maternal deaths to Section E of the Licensed Midwife Annual Report be added as an agenda item.

Ms. Yaroslavsky requested a review of the Medical Board's website be added as an item for the December 2010 meeting.

Agenda Item 13 Adjournment
Meeting adjourned at 4:22 p.m.

DRAFT

AGENDA ITEM 4B

The *updated*

2010 Licensed Midwife Annual Report Survey

will be distributed at the

December 9, 2010 meeting.

WELCOME TO
THE MEDICAL BOARD OF CALIFORNIA
Department of Consumer Affairs

Licensed Midwives

- Revised 2008 Licensed Midwife Annual Report Summary
  The newly revised figures are the result of changes from late reports filed after the aggregate Annual Report Sun originally released June 12, 2009, as well as corrections from original reporters who filed revised reports.

  Please note in particular changes in the figures for fetal and maternal deaths.

- Midwifery Advisory Council (MAC) Meeting Notice

- Link to OSHPD for the 2009 Licensed Midwife Annual Report

A "licensed midwife" is an individual who has been issued a license to practice midwifery by the Medical Board of Califc practice of midwifery authorizes the licensee, under the supervision of a licensed physician and surgeon, in active pract cases of normal childbirth, in a home, birthing clinic, or hospital environment. For the purposes of California licensure, t care professionals commonly are referred to as licensed midwives.

Licensed midwives, who have achieved the required educational and clinical experience in midwifery or met the challer must pass the North American Registry of Midwives' (NARM) comprehensive examination. After successful completion examination, prospective applicants are designated as a "certified professional midwife" and are eligible to submit an a California midwifery licensure.

The comprehensive licensing examination developed by NARM was adopted by the Medical Board of California, Divisic May 1996, and satisfies the written examination requirements described in Business and Professions Code section 251 NARM examination is administered twice a year, usually in February and August, at various locations throughout the U

The profession of midwifery also has another designation, that of "certified nurse-midwife" (CNM). CNMs are licensed b Board of Registered Nursing. CNMs are registered nurses who acquired additional training in the field of obstetrics and the American College of Nurse Midwives (ACNM). They commonly work in hospitals and birthing centers that also are l state and also require physician supervision. Further information or verification of licensure for a CNM may be obtained Board of Registered Nursing at (916) 322-3350, (800) 838-6828, or at www.rn.ca.gov.

There are two pathways to licensure as a midwife in California:

- **Education.** Candidates must complete a three-year postsecondary education program in an accredited midwifer approved by the board. These schools usually are accredited by the Midwifery Education and Accreditation Cour whose accreditation mirrors that of the U.S. Department of Education (DOE) requirements, and satisfies Medical California criteria. Upon completion of educational requirements, including clinical experience evaluation, the can successfully complete a comprehensive licensing examination administered by NARM.

  Additionally, an applicant for California licensure also may show current licensure as a midwife by another state standards equivalent to those of the Medical Board of California (Business and Professions Code section 2512.5

- **Challenge Mechanism.** As defined in Business and Professions Code section 2513(a)-(c), the challenge proces midwifery student and prospective applicant the opportunity to obtain credit by examination for previous midwifer clinical experience. This opportunity is provided by two approved "challenge process" programs. Maternidad La L Paso, TX, and the National Midwifery Institute, Inc., (NMI) in Bristol, VT, are the two board-approved challenge p mechanisms that are available for California licensure. Upon successful completion of the challenge process, the must successfully complete the comprehensive licensing examination. The candidate then may submit an applic licensure.

Licensure verification for licensed midwives may be obtained by contacting the Medical Board's Consumer Information 2382, or by selecting the "License Search for Licensed Midwives" link at the bottom of this page.

For more specific information related to licensed midwives, please call (916) 263-2382, e-mail Webmaster@mbc.ca.go

Medical Board of California
Attn: Midwifery Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

- License Search for Licensed Midwives
- Summary of the Licensed Midwifery Practice Act of 1993
- Standards of Care
  - California Code of Regulations Section 1379.19
  - "Standards of Care for California Licensed Midwives" (September 15, 2005 Edition)
  - ACOG Practice Bulletin: Vaginal Birth After Previous Cesarean Delivery
- Business and Professions Code, Sections 2505 - 2521
- California Code of Regulations, Sections 1379.1 - 1379.31
- Licensed Midwife Disclosure Form
- Approved Licensed Midwifery Schools
- Approved Challenge Program

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Summary of the Licensed Midwifery Practice Act of 1993

The law specifies the requirements for licensure and the scope of practice for a licensed midwife. The Licensing Program of the Medical Board of California (Board) is responsible for issuing a license to practice midwifery to all applicants who meet the requirements and pay a prescribed fee.

The law provides that:

- The holder of a midwifery license, under the supervision of a licensed physician and surgeon, is to attend cases of normal childbirth.
- The licensed midwife may provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother and immediate care for the newborn.
- The licensed midwife is to disclose to the client that a supervising physician is regularly being briefed concerning the client's pregnancy.
- The supervising physician, as described in section 2507 of the Code, is to have a current practice or training in obstetrics.
- The supervising physician is to assume care of the client should complications arise.
- A supervising physician cannot supervise more than four licensed midwives.
- No person other than a licensed midwife, may hold himself/herself out as a licensed midwife or use any other term which may indicate or imply that he/she is a licensed midwife.
- A licensed midwife cannot hold himself or herself out as a certified nurse-midwife, nurse midwife, or use the initials "CNM", unless he or she has been certified as a nurse midwife under Business and Professions Code, Article 2.5 Nurse-Midwives.
- The Board is to issue a license to practice midwifery to all applicants who meet the requirements and pay the required fee.
- An applicant for licensure must successfully complete a three-year postsecondary midwifery educational program accredited by an accrediting organization recognized by the United States Department of Education, Division of Accreditation, and successfully complete a comprehensive licensing examination adopted by the Board which is equivalent, but not identical, to the American College of Nurse Midwives exam, or;

must successfully complete an approved midwifery education program that offers the opportunity for students to obtain credit for previous midwifery education and clinical experiences and successfully complete the written licensing examination, or;

must have successfully completed an educational program approved by the Board and is currently licensed as a midwife by a state with equivalent licensing standards. (Reciprocity)

- The midwifery education program will allow the applicant to demonstrate, by practical examination, clinical competencies.
- The midwifery education program's credit by examination policy must be approved by the Board.
- Completion of clinical experiences must be verified by a licensed midwife or certified nurse-midwife and a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery.

- The Board must approve specific educational programs that meet the requirements for the course of academic study, documentation of experience and skill and clinical evaluation. These programs must also be accredited by an accrediting organization approved by the Board.
- Applicants must show evidence satisfactory to the Board that he/she has met the education standards established by the Board.
- A person, who has been convicted of a misdemeanor violation of unlicenced practice (Business & Professions Code section 2052) prior to January 1, 1994, cannot be barred from licensure, solely because of that conviction.
- Licenses for licensed midwifery must be renewed every two years upon payment of the current fee and certification of 36 hours of approved continuing education.
- An expired license may be reinstated within five years from the expiration upon payment of the current fee and upon submission of proof of the applicant's qualifications.
- The current licensing fee is $300.00, renewal fee is $200.00, and the delinquency fee is $50.00.
- The Board may suspend or revoke the license of a licensed midwife for any of the following:
  - Unprofessional conduct.
  - Procuring a license by fraud or misrepresentation.
  - Conviction of a crime substantially related to the qualifications, function and duties of a licensed midwife.
  - Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.
  - Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.
  - Making or giving false statements or information in connection with the application for issuance of a license.
  - Impersonating any applicant or acting as proxy for any applicant in an examination required for licensure.
  - Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license for the purpose of providing midwifery services.
  - Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of, arranging for, a violation of any of the provisions of Article 12 of Chapter 5.
- Violators of this article are guilty of a misdemeanor.

- License Search for Licensed Midwives
- Business and Professions Code, Sections 2505 - 2521
- California Code of Regulations, Sections 1379.1 - 1379.31
- Licensed Midwife Disclosure Form

LICENSED MIDWIVES		FY 10/11			
	FY 09/10	Q1	Q2	Q3	*Q4*
Applications Received	***16***	12			
Applications Pending		4			
Licenses Issued	***19***	9			
Licenses Renewed	***74***	30			

State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNA

MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

10th Edition

2008

proceedings between the Board and respondent. Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation."

12. Community Service - Free Services

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide_____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition. Note: In quality of care cases, only non-medical community service is allowed unless respondent passes a competency exam or otherwise demonstrates competency prior to providing community service.

13. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

14. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the

for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

(Option#2: Condition Subsequent)
If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that respondent failed to complete the clinical training program.

(Option#3)
After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

19. Oral and/or Written Examination

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Probation Unit. The Board or its designee shall administer the oral and/or written examination in a subject to be designated by the Board or its designee and the oral examination shall be audio tape recorded.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

(Continue with either one of these two options:)

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

(Option 2: Condition Subsequent)
If respondent fails to pass the first examination, respondent shall be suspended from the practice of medicine. Respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that respondent has failed the examination.

Respondent shall remain suspended from the practice of medicine until respondent successfully passes a repeat examination, as evidenced by written notice to respondent from the Board or its designee.

20. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on a whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, that the Board or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions is a violation of probation.

(Option- Condition Precedent)
Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

23 Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a _____(i.e., practice, billing, or practice and billing) monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days

of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ (i.e., practice, billing, or practice and billing) shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Board or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

24. Solo Practice

Respondent is prohibited from engaging in the solo practice of medicine.

25. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____(e.g., male, female, or minor)

AGENDA ITEM 10

Discussion on Membership of Midwifery Advisory Council

The following documents are enclosed as reference material on the membership of the MAC:

- January 17, 2007 Staff Memo/Recommendations
- Minutes from the February 1, 2007 Midwifery Committee
- Relevant excerpts from the February 2, 2007 Division of Licensing Quarterly Meeting
- Composition of current Council

State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

Agenda Item 8A

To: Members, Midwifery Committee
Members, Division of Licensing

Date: January 17, 2007

From: Gary Qualset, Chief
Division of Licensing

Subject: Establishment of Midwifery Advisory Council

INTRODUCTION

Senate Bill 1638 (Figueroa, Ch. 536, Stat. 2006), added Section 2509 of the Business and Professions Code (copy attached), which authorized the Division of Licensing, hereafter "board", to create a Midwifery Advisory Council (MAC) and appoint members to the MAC. The MAC shall consist of licensees of the board that are in good standing and members of the public. At least one-half of the MAC members shall be California licensed midwives.

MAC FUNCTION AND SCOPE

The MAC is responsible for making recommendations on matters that are presented to it by the board. Additionally, per Business and Professions Code Section 2516(e) the MAC shall assist the board, in consultation with the Office of Statewide Health Planning and Development, in devising a coding system to aid in the annual reporting process related to care provided by midwives in California.

APPLICATION FOR APPOINTMENT TO THE MAC

At the November 2, 2006, Midwifery Committee meeting an overview of Senate Bill 1638 was presented. An outreach process was also described that would allow individuals to submit their application indicating interest in service on the MAC. A cover letter and Interest Form was mailed to all currently licensed midwives in California and to other parties that have an interest in home births and the practice of midwifery. A total of 24 applications were received. Applications were reviewed by staff to develop the below recommendations for appointment to the MAC. A copy of the MAC Member Interest Form and list of responses received is attached for your review.

MEETINGS

It is anticipated that the MAC will meet periodically between board meetings, primarily in Sacramento. Some of the first items to be discussed will include standard items such as: the roles and responsibilities, mission and vision, meeting protocols, Bagley-Keene

Open Meeting Act requirements, appointment of a chairperson, and ideas related to development of a coding system for annual reporting of care provided.

STAFF RECOMMENDATIONS

MAC Size

Statute does not specify what size the MAC should be. It simply specifies that the members shall be either California licensed midwives or members of the public, and indirectly that members of the board are not excluded from being appointed to the MAC. Staff recommends that the MAC consist of six (6) members. Three (3) members are to be California licensed midwives, two (2) members shall be from the public, and one (1) member shall be a member of the board.

Term of Appointment

It is also recommended that of the members initially appointed, two shall be appointed for a term of one year, two shall be appointed for a term of two years, and two shall be appointed for a term of three years. After the initial terms, the term of office of each member of the MAC is three years so that appointments are staggered over time.

Current Membership Appointment Recommendations

Following is staff's recommendation for initial appointment to serve on the MAC for the following terms:

Name	Qualification	Term
Karen Ehrlich	CA Licensed Midwife	2
Faith Gibson	CA Licensed Midwife	3
Dr. Ruth Haskins	Public Member	3
Carrie Sparrevohn	CA Licensed Midwife	1
Dr. Guillermo Valenzuela	Public Member	2
To Be Determined	Board Member	1

Attachments:

Selected Business and Professions Code Sections
MAC Member Interest Form
MAC Interest Form Response List

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1428 Howe Avenue, Suite 56
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

Midwifery Committee

Hilton Los Angeles Airport
Century C&D Room
5711 West Century Blvd.
Los Angeles, CA 90045-5672

February 1, 2007

MINUTES

Agenda Item 1 Call to Order

The Midwifery Committee (Committee) of the Medical Board of California (Board) was called to order by Chair Richard D. Fantozzi, M.D., at 2:03 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members Present:

Richard D. Fantozzi, M.D., Chair
Hedy Chang
Laurie C. Gregg, M.D.
Barbara Yaroslavsky

Staff Present:

Kathi Burns, Staff Services Manager I, Licensing Program
Kim Kirchmeyer, Deputy Director
Armando Melendez, Business Services Assistant, Business Services Office
Kelly Nelson, Legislative Analyst, Legislative/Regulatory Unit
Gary Qualset, Chief, Licensing Program
Regina Rao, Analyst, Business Services Office
Paulette Romero, Associate Analyst, Executive Office
Kevin Schunke, Regulation Coordinator, Legislative/Regulatory Unit
Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs
Pam Thomas, Analyst, Licensing Program
Linda Whitney, Chief, Legislative/Regulatory Unit
Curt Worden, Staff Services Manager I, Licensing Program

Members of the Audience:

Dorene Dominguez, Medial Board Member
Faith Gibson, L.M., California College of Midwives (CCM)
Donna Russell, California Citizens for Health Freedom

Carrie Sparrevohn, L.M., California Association of Midwives (CAM)
Tonya Brooks, L.M., Association for Childbirth and Home International (ACHI)
Diane Holzer, L.M.
Karen Ehrlich, L.M., Birth Network of Santa Cruz County
Sandra Bressler, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente

Agenda Item 2 Approval of Minutes from the November 2, 2006 Meeting

It was M/S/C (Yaroslavsky/Gregg) to approve the minutes of the November 2, 2006 Committee meeting. The motion carried unanimously.

Agenda Item 3 Establishment of Midwifery Advisory Council

Dr. Fantozzi stated three criteria of the Midwifery Advisory Council (MAC) that needed to be determined were size, term, and constituency. He explained it was his goal that midwives licensed and regulated by the Board have credibility, authenticity, and participation in the process, which is the intention of the MAC. He added the MAC is a forum where vested parties can discuss midwifery issues and make recommendations to both the Committee and the Division of Licensing (DOL).

Regarding the issue of size, it was suggested there be representatives from the key groups and stakeholders to develop and assure credibility and a successful level of quality of care. Discussion ensued regarding the MAC consisting of six members, including three licensed midwives, two public members, one from the American College of Obstetrics and Gynecology (ACOG) and one a nominee of the CMA, and one board member. Dr. Fantozzi recommended Ms. Yaroslavsky serve as the board member.

Carrie Sparrevohn, L.M., CAM, indicated in drafting the legislation, "public member" was interpreted as someone who had a stake in midwifery services as a member of the public and was not connected to a profession licensed by the board, including physicians.

Discussion continued regarding either adding a consumer public member after the MAC has been implemented, or presenting issues to the Committee as reported by consumers who attend the publicly-held MAC meetings.

Tonya Brooks, L.M., Director of the Natural Birth and Women's Center and Head of the ACHI, asked about the function of the MAC, pointed out that no members were from urban Southern California, and indicated midwifery practice in urban versus rural areas and physician supervision are two issues that need to be addressed.

Karen Ehrlich, L.M., Birth Network of Santa Cruz County, commented that there has always been a split in the midwifery community between Northern and Southern California. She recommended a Southern California licensed midwife representative serve on the MAC. She also recommended a consumer of midwifery services be considered as a full member on the MAC.

It was M/S/C (Yaroslavsky/Chang) to accept the staff recommendations as to the size, term of appointments and current membership of the MAC, with Barbara Yaroslavsky named as the board member.

Staff was directed to schedule MAC meetings approximately one month after each Midwifery Committee meeting, with the first MAC meeting anticipated to occur in early March 2007. Staff was directed to set the meeting date and work with Dr. Fantozzi to develop agenda items for the first meeting, including: appointment of a chairperson; discussion and development of meeting protocols, roles/responsibilities, and mission/visionary statement; Bagley-Keene Open Meeting Act requirements; ideas for development of a coding system for annual reporting; and re-training of licensed midwives.

Agenda Item 4 Program Update

Mr. Qualset introduced the new Licensing Operations Manager, Kathi Burns. He reported there will be a meeting with the Office of Statewide Health Planning and Development (OSHPD) on February 15, 2007, regarding development of a system for midwife annual report coding. He indicated the *ACOG Practice Bulletin, Number 54, July 2004*, containing "Vaginal Birth After Previous Cesarian Delivery" standards of care was now a link on the Board's website, as required by patient disclosure regulations.

Staff was directed to notify all licensed midwives regarding the annual reporting requirements after the February 15, 2007, meeting with OSHPD.

Agenda Item 5 Public Comment on Items Not on the Agenda

Carrie Sparrevohn, L.M., CAM, suggested employing the same type of mechanism for licensed midwives that is used to address issues for physicians under investigation, i.e., implementation of a competency exam specific to a particular deficiency that is drafted by expert reviewers.

Faith Gibson, L.M., CCM, stated licensed midwives had spent the past dozen years attempting to assemble a midwifery council and the expectation of the midwifery community was the MAC would be an opportunity for licensed midwives to bring issues of concern to the Board and not vice versa. She indicated she had received several e-mails regarding issues midwives would like addressed by the MAC and would prefer that midwives draft their own agenda.

Donna Russell, California Citizens for Health Freedom, expressed her organization's disappointment with the current membership of the MAC. She asked the Committee to take a closer look at the function of the MAC and the membership component and consider working in collaboration with the licensed midwives to use the MAC as a forum for discussing midwifery issues.

Agenda Item 6 Adjournment

The meeting was adjourned at 3:05 p.m.

Agenda Item 7 Establishment of Special Faculty Permit Review Committee

Mr. Qualset reported this would begin the process to establish the Special Faculty Permit Review Committee, to be comprised of two board members and one representative from each California medical school. The board members already appointed are Ms. Chang as the public member and Dr. Fantozzi as the physician member. Staff is recommending the DOL accept the nominations received from Stanford, Loma Linda, University of California, San Diego, University of California, San Francisco, and University of California, Los Angeles medical schools. He added the remaining three medical schools (University of California, Davis, University of California, Irvine, and University of Southern California) have indicated they will submit nominations for consideration at the April 27, 2007, meeting.

It was M/S/C to accept the nominations for the Special Faculty Permit Review Committee, as follows: Lawrence M. Shuer, M.D., Stanford University School of Medicine, Daniel Giang, M.D., Loma Linda University School of Medicine, Andrew L. Ries, M.D., University of California, San Diego, Neal H. Cohen, M.D., University of California, San Francisco, and Neal Parker, M.D., University of California, Los Angeles. The motion carried unanimously.

Agenda Item 8 Midwifery Committee Report

Dr. Fantozzi reported the Midwifery Committee (Committee) met on February 1, 2007, and recommended adoption of the staff recommendations regarding the size, term, and membership for the Midwifery Advisory Council (MAC). He indicated the first meeting is anticipated to occur in March 2007. He stated the Committee is requesting the DOL accept the staff recommendations for the MAC. Dr. Fantozzi informed the Division there will be a meeting with the Office of Statewide Health Planning and Development on February 15, 2007, regarding midwife annual report coding.

Diane Holzer, L.M., Midwives Alliance of North America, voiced concern for the interpretation of the definition of public members that included MDs who have gone on record stating their opposition to midwifery and homebirth in particular and excluded non-professional consumers who have a vested interest in midwifery issues. She added the midwifery model of care includes woman centered practice and that true public members, i.e., women they serve, should be involved in making decisions regarding this profession.

Dr. Fantozzi clarified the MAC has six members, but there is no intent to exclude consumers and other interested parties from attending the publicly held meetings and voicing their concerns.

The Division then went back into Closed Session, reconvening in Open Session reconvening at 11:00 a.m.

Karen Ehrlich, L.M., representing Birth Network of Santa Cruz County, expressed her gratitude in being nominated as a member of the MAC and will work in the spirit of cooperation; however,

she wanted to go on record as having mixed feelings regarding the configuration of the MAC. She indicated midwives believe they are being regulated without representation, there was no midwifery input into the composition of the MAC, and the public members should be consumers of midwifery services and not MDs.

Faith Gibson, L.M., California College of Midwives, expressed the same reservations as previous speakers regarding the lack of consumer members as public members and hoped the MAC itself can rectify this problem if it becomes an ongoing issue. She submitted letters into the record from other licensed midwives regarding MAC appointments and issues for discussion.

Donna Russell, California Citizens for Health Freedom, went on the record as holding the same concerns as the previous two speakers.

Dr. Gregg recommended going back to the drawing board with the MAC to obtain more pre-meeting consensus building. She indicated she had wanted to serve on the MAC as it is now structured but stepped down so a public board member could be appointed.

It was M/S/C to accept the Committee's recommendations as to size, term, and membership for the MAC. The motion carried with five in favor, one abstain (Gregg).

Agenda Item 9 Update on International Medical School Re-evaluations

Mr. Qualset stated that, per member request, copies of the Self-Assessment Report were provided to DOL members after minor edits had been made by staff. He indicated the report will be mailed out this month to international medical schools scheduled for re-evaluations in the coming years, with the schools given an estimated eighteen month response period to complete and return the report. He added the reports will then be reviewed by staff and expert consultants to determine if site visits are needed.

Staff was directed to confer with Division medical consultants to establish reasonable response periods regarding international medical school re-evaluations.

Agenda Item 10 Division Chief's Report

Mr. Qualset highlighted the application processing times for US/Canadian and International medical school graduates, the number of licenses received and issued, and the volume of calls handled by the Consumer Information Unit from his quarterly statistics report, applauding staff efforts. He reported there was now a link on the Medical Board's website to the *ACOG Practice Bulletin Number 54, July 2004* article regarding "Vaginal Birth After Previous Cesarean Delivery," required to be provided to patients per Section 1379.19(b)(1) of the CCR.

Midwifery Advisory Council
Reappointment Schedule

Name	Initial Term*	Current Term
Barbara Yaroslavsky	1 Year	2008-2011
Carrie Sparrevohn, L.M.	1 Year	2008-2011
Karen Ehrlich, L.M.	2 Years	2009-2012
Dr. William Frumovitz		2009-2012
Faith Gibson, L.M.	3 Years	2010-2013
Dr. Ruth Haskins	3 Years	2010 -2013
Dr. Guillermo Valenzuela	2 Years	2007-2009/Expired

*All terms after the initial term are for a period of (3) three years.

ACOG
PRACTICE
BULLETIN

CLINICAL MANAGEMENT GUIDELINES FOR
OBSTETRICIAN–GYNECOLOGISTS

NUMBER 54, JULY 2004

(Replaces Practice Bulletin Number 5, July 1999)

This Practice Bulletin was developed by the ACOG Committee on Practice Bulletins—Obstetrics with the assistance of T. Flint Porter, MD and Carolyn M. Zelop, MD. The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Vaginal Birth After Previous Cesarean Delivery

A trial of labor after previous cesarean delivery has been accepted as a way to reduce the overall cesarean delivery rate (1). Although vaginal birth after cesarean delivery (VBAC) is appropriate for most women with a history of a low-transverse cesarean delivery, several factors increase the likelihood of a failed trial of labor, which in turn leads to increased maternal and perinatal morbidity. The purpose of this document is to review the current risks and benefits of VBAC in various situations and provide practical management guidelines.

Background

Between 1970 and 1988, the cesarean delivery rate in the United States increased dramatically from 5% to nearly 25% (1–3). The rapid growth was likely a result of increased pressure that discouraged physicians from performing vaginal breech deliveries and midpelvic forceps deliveries. At the same time, increasing reliance on continuous electronic monitoring of fetal heart rate and uterine contraction patterns led to an increase in the number of cesarean deliveries performed for presumed fetal compromise and dystocia, respectively. With few exceptions, major improvements in newborn outcomes as a result of the increased cesarean delivery rate are yet to be proved (4).

Changing Concepts

The dictum "once a cesarean, always a cesarean," which dominated obstetric practice in the United States for nearly 70 years (5), began changing gradually approximately 30 years ago as improvements in obstetric care made a trial of labor after a previous cesarean delivery safer for both the woman and the fetus. Based on the findings of several large series that documented the relative safety of a trial of labor after a previous cesarean delivery (6–9), organizations such as the National Institutes of Health and the American College of Obstetricians and

Gynecologists enthusiastically embraced VBAC as a way to decrease the cesarean delivery rate in the United States.

The national enthusiasm for VBAC led to a decrease in the cesarean delivery rate, which reached 20.7% in 1996 (10). During the same period (1989–1996), the VBAC rate increased from less than 18.9% to 28.3%. Some third-party payers and managed care organizations even mandated that all women who had previous cesarean deliveries undergo trials of labor (11, 12). Many physicians were pressured into offering VBAC to unsuitable candidates or to women who wanted to have a repeat cesarean delivery. As the VBAC rate increased, so did the number of well-publicized reports of uterine rupture and other complications during trials of labor after previous cesarean deliveries (11, 13, 14). As a result, many physicians and hospitals have discontinued the practice altogether. This abrupt change in practice has contributed to the cesarean delivery rate in the United States increasing again, reaching an all-time high of 26.1% in 2002, while the VBAC rate has decreased by 55% to 12.6% (15).

Supportive Evidence

Despite thousands of citations in the world's literature, there are currently no randomized trials comparing maternal or neonatal outcomes for both repeat cesarean delivery and VBAC. Instead, VBAC recommendations have been based on data from large clinical series suggesting that the benefits of VBAC outweigh the risks in most women with a previous low-transverse cesarean delivery (6–9, 16–18). Most have been conducted in university or tertiary-level centers with full-time in-house obstetric and anesthesia coverage (19). Only a few studies have documented the relative safety of VBAC in smaller community hospitals or facilities where resources may be more limited (17, 20–22). Furthermore, the early series of women attempting a trial of labor after a previous cesarean delivery focused on successful VBAC and maternal mortality. It has become apparent that women who fail a trial of labor are at risk for several maternal complications, including uterine rupture, hysterectomy, the need for transfusion, and endometritis (16, 19, 23), as well as perinatal morbidity and mortality (24, 25).

Clinical Considerations and Recommendations

▶ *Who are candidates for a trial of labor?*

The preponderance of evidence suggests that most patients who have had a low-transverse uterine incision from a previous cesarean delivery and who have no contraindications for vaginal birth are candidates for a trial of labor. Following are selection criteria useful in identifying candidates for VBAC:

- One previous low-transverse cesarean delivery
- Clinically adequate pelvis
- No other uterine scars or previous rupture
- Physician immediately available throughout active labor capable of monitoring labor and performing an emergency cesarean delivery
- Availability of anesthesia and personnel for emergency cesarean delivery

Based on the findings from several retrospective studies, it may be reasonable to offer a trial of labor to women in the following other specific obstetric circumstances.

More Than One Previous Cesarean Delivery

Women who have had 2 previous low-transverse cesarean deliveries have traditionally been considered candidates for a trial of labor. However, the few studies that address this issue report a risk of uterine rupture ranging between 1% and 3.7% (9, 26, 27). In the only study that controlled for other potential confounding variables, the risk of uterine rupture during labor was nearly 5 times greater for women with 2 previous cesarean deliveries when compared with women who had 1 previous cesarean delivery (27). Women with a previous vaginal delivery followed by a cesarean delivery were only approximately one fourth as likely to sustain uterine rupture during a trial of labor (27). Therefore, for women with 2 prior cesarean deliveries, only those with a prior vaginal delivery should be considered candidates for a spontaneous trial of labor.

Macrosomia

Although macrosomia (usually birth weight greater than 4,000 g or 4,500 g, regardless of gestational age) is associated with a lower likelihood of successful VBAC (28–31), 60–90% of women attempting a trial of labor who give birth to infants with macrosomia are successful (30, 31). The rate of uterine rupture appears to be increased only in those women without a previous vaginal delivery (31).

Gestation Beyond 40 Weeks

Awaiting spontaneous labor beyond 40 weeks of gestation decreases the likelihood of successful VBAC, but the risk of uterine rupture does not increase (32, 33). In one study of more than 1,200 women attempting a trial of labor after 40 weeks of gestation, only labor induction was associated with an increased risk of uterine rupture (33).

Previous Low-Vertical Incision

In 1 case series and 4 retrospective studies, women with a previous low-vertical uterine incision were just as likely to have successful VBAC as women with a previous low-transverse uterine incision (34–37). In addition, there was no increase in maternal or perinatal morbidity.

Unknown Uterine Scar Type

The type of uterine incision performed at the time of a prior cesarean delivery cannot be confirmed in some patients. Many authorities question the safety of offering VBAC under these circumstances; others suggest that the uterine scar type usually can be inferred based on the indication for the prior cesarean delivery. Two case series, both carried out at large tertiary care facilities, reported rates of VBAC success and uterine rupture similar to those from other contemporaneous studies of women with documented previous low-transverse uterine incisions (38, 39). In one small, randomized controlled trial (n = 197) comparing labor augmentation with no intervention in women with a previous cesarean delivery and unknown scar, 5 uterine scar disruptions occurred in the group that received labor augmentation while no scar disruptions occurred in the group without augmentation (40).

Twin Gestation

The safety of VBAC in women with twin gestations has been examined in small case series and 2 small, retrospective studies (41–44). In the 2 trials, which included a total of only 45 women with twin gestations, the rates of successful VBAC and uterine rupture did not differ significantly between study subjects and women with singleton gestations who also were attempting VBAC.

▶ *What is the success rate for trials of labor?*

Most published series of women attempting a trial of labor after a previous cesarean delivery indicate that 60–80% have successful vaginal births (17, 23, 45–48). The earliest studies usually included only those subjects who met strict inclusion criteria, excluding those who were not felt to be appropriate VBAC candidates. However, in a population-based study of nearly 40,000 women from hospitals throughout California, 61.4% of women who attempted VBAC were successful (17).

There is no completely reliable way to predict whether a trial of labor will be successful in an individual patient (49–52). Generally, success rates for women whose first cesarean delivery was performed for a nonrecurring indication are similar to those of patients who have not undergone a previous cesarean delivery (46, 53, 54). Most women who have undergone a cesarean delivery because of dystocia also can have a successful VBAC, but the percentage may be lower (50–80%) than for those with nonrecurring indications (75–86%) (46, 55–58). If the prior cesarean delivery for dystocia was performed before complete cervical dilation (5–9 cm), 67–73% of VBAC attempts are successful compared with only 13% if the prior cesarean delivery was performed after complete cervical dilation (56). Other aspects of obstetric history also influence the likelihood of a successful VBAC. Women who have given birth vaginally at least once are 9–28 times more likely to have a successful trial of labor than women who have not undergone vaginal delivery (14, 59). If the most recent delivery was a successful VBAC, the likelihood of failure is reduced by 30–90% (52, 60). Factors that negatively influence the likelihood of successful VBAC include labor augmentation and induction (52, 61, 62), maternal obesity (63, 64), gestational age beyond 40 weeks (33), birth weight greater than 4,000 g (30), and interdelivery interval of less than 19 months (65).

▶ *What are the risks and benefits associated with VBAC?*

Neither elective repeat cesarean delivery nor VBAC is without risk. Generally, successful VBAC is associated with shorter maternal hospitalizations, less blood loss and fewer transfusions, fewer infections, and fewer thromboembolic events than cesarean delivery (8, 16, 23, 25). However, a failed trial of labor may be associated with major maternal complications, such as uterine rupture, hysterectomy, and operative injury (16, 18, 23, 25, 48), as well as increased maternal infection and the need for transfusion (23). Neonatal morbidity also is increased with a failed trial of labor, as evidenced by the increased incidence of arterial umbilical cord blood gas pH levels below 7, 5-minute Apgar scores below 7, and infection (25, 47, 66). However, multiple cesarean deliveries also carry maternal risks, including an increased risk of placenta previa and accreta (67, 68). Based on these risks, one decision model analysis found it is reasonable to consider a trial of labor if the chance of success is 50% or greater, and the desire for future pregnancy after cesarean delivery is at least 10–20% (67).

The incidence of maternal death with VBAC is extremely low. In a recent meta-analysis, only 3 maternal deaths were reported among the more than 27,000 women who attempted a trial of labor after a prior cesarean delivery (25). Although the incidence of perinatal death is low (generally less than 1%), it is more likely to occur during a trial of labor than an elective

repeat cesarean delivery (18, 25, 47, 69). Uterine rupture has been associated with fetal death, as well as severe neonatal neurologic injury (24, 70–72).

Uterine rupture during a trial of labor after a previous cesarean delivery is a life-threatening complication that has been directly attributed to attempted VBAC. In most cases, the cause of uterine rupture is unknown, but poor obstetric outcomes can result even in women who are appropriate candidates for VBAC. The exact incidence of uterine rupture is difficult to determine because reports in the literature have sometimes grouped true, catastrophic uterine ruptures together with asymptomatic scar dehiscences. Additionally, early case series included ruptures in the absence of labor as well as ruptures during labor in women with previous classical incisions (24). The rate of uterine rupture is largely dependent on the type and location of the previous incision. Uterine rupture rates in women with previous classical incisions and T-shaped incisions range between 4% and 9% (73). Although uterine rupture occurs more often in women undergoing a trial of labor than women who elect repeat cesarean delivery, rupture rates during attempted VBAC generally are less than 1% (17, 18, 25).

The risk of uterine rupture also is influenced by obstetric history. A previous vaginal birth significantly reduces the risk of uterine rupture (74). The risk of uterine rupture appears to be inversely related to the length of time between deliveries, ie, the longer the interval between deliveries, the lower the risk of rupture (75–77). Women who attempt VBAC who have interdelivery intervals of less than 24 months have a 2–3-fold increased risk of uterine rupture when compared with women who attempt VBAC more than 24 months after their last delivery (76). Finally, the findings of one nonrandomized trial suggest that compared with a double layer closure, a single layer closure of the hysterotomy incision in the primary cesarean delivery may increase the risk of uterine rupture 4-fold during a subsequent trial of labor (78).

Common signs of uterine rupture are a nonreassuring fetal heart rate pattern with decelerations or bradycardia (18). Other findings are more variable and include uterine or abdominal pain, loss of station of the presenting part, vaginal bleeding, and hypovolemia.

▶ *What factors should be taken into consideration when evaluating the cost-effectiveness of a trial of labor after a previous cesarean delivery and an elective repeat cesarean delivery?*

A true analysis of the cost-effectiveness of VBAC should include hospital and physician costs, the method of reimbursement, potential professional liability expenses, and the probability that a woman will continue with childbearing after her first attempt at VBAC (79). Higher costs may be incurred by a hospital if a woman has a prolonged labor or has significant complications or if the newborn is admitted to a neonatal intensive care unit. Additionally, evidence suggests that cost savings are not achieved unless at least 70% of women who attempt a trial of labor are successful (80–82).

▶ *Should women with a previous cesarean delivery undergo induction or augmentation of labor?*

Spontaneous labor is more likely to result in a successful VBAC rather than labor induction or augmentation (52, 61, 62). A meta-analysis of studies published before 1989 found no relationship between the use of oxytocin and rupture of the uterine scar (83). In contrast, several more recent large studies have shown an increased risk (37, 61, 62, 84). In one large retrospective study of more than 20,000 women, uterine rupture was nearly 5 times more common among women undergoing labor induction with oxytocin compared with those who had an elective repeat cesarean delivery (37). However, uterine rupture occurred in less than 1% of women in both groups. Furthermore, among the women attempting VBAC, the rate of uterine rupture was not different between those who received oxytocin and those who labored spontaneously.

There is considerable evidence that cervical ripening with prostaglandin preparations increases the likelihood of uterine rupture (37, 61, 85–87). In a review of Washington State birth records, the rate of uterine rupture during labor induced with prostaglandin was 24.5 in 1,000, which was 15-fold higher than that of women electing to have a repeat cesarean delivery (37). Likewise, misoprostol has been associated with an unacceptably high rate of uterine rupture in women with a previous cesarean delivery (88–91). Therefore, the use of prostaglandins for induction of labor in most women with a previous cesarean delivery should be discouraged.

▶ *How should midtrimester delivery be accomplished in women with a previous cesarean delivery?*

Some women with a history of a cesarean delivery will require delivery during the midtrimester in a subsequent pregnancy, usually because of fetal demise or the presence of anomalies. The published data on midtrimester VBAC are limited to single cases and small case series that report both successful and failed VBAC, as well as uterine rupture during a trial of labor (92–94). The induction agents in these reports are typically prostaglandin preparations, including misoprostol. A second-trimester

hysterotomy is associated with its own risks, and the decision to attempt a trial of labor in the midtrimester should probably be based on individual circumstances, including but not limited to the number of previous cesarean deliveries, gestational age, placentation, and the woman's desire to preserve reproductive function.

▶ *What are contraindications for VBAC?*

A trial of labor is not recommended in patients at high risk for uterine rupture. Circumstances under which a trial of labor should not be attempted are as follows:

- Previous classical or T-shaped incision or extensive transfundal uterine surgery
- Previous uterine rupture
- Medical or obstetric complication that precludes vaginal delivery
- Inability to perform emergency cesarean delivery because of unavailable surgeon, anesthesia, sufficient staff, or facility
- Two prior uterine scars and no vaginal deliveries

In addition, a combination of factors that would not ordinarily constitute a compelling case to proceed with a primary cesarean delivery might be considered sufficient to choose repeat cesarean delivery instead of VBAC in some situations.

▶ *How should patients be counseled?*

The enthusiasm for VBAC varies greatly among patients and physicians. It is reasonable for women to undergo a trial of labor in a safe setting, but the potential complications should be discussed thoroughly and documented. If the type of previous incision is in doubt, attempts should be made to obtain the patient's medical records. After thorough counseling that weighs the individual benefits and risks of VBAC, the ultimate decision to attempt this procedure or undergo a repeat cesarean delivery should be made by the patient and her physician. Global mandates for a trial of labor after a previous cesarean delivery are inappropriate because individual risk factors are not considered. It should be recognized that there are repeat elective cesarean deliveries that are clinically indicated (95). The informed consent process and the plan of management should be documented in the medical record.

▶ *How does management of labor differ for patients undergoing VBAC?*

Despite extensive data on VBAC, there is relatively little information on how labor should be conducted. Management of labor varies in different situations.

External Cephalic Version

There are limited data about external cephalic version for breech presentation and VBAC. The data suggest that it may be as successful in VBAC candidates as in women who have not undergone a previous cesarean delivery (96).

Analgesia

Vaginal birth after cesarean delivery is not a contraindication to epidural anesthesia, and adequate pain relief may encourage more women to choose a trial of labor (97, 98). Success rates for VBAC are similar in women who do and do not receive epidural analgesia, as well as in those women who receive other types of pain relief (99, 100). Epidural analgesia rarely masks the signs and symptoms of uterine rupture.

Intrapartum Management

Once labor has begun, a patient attempting VBAC should be evaluated promptly. Most authorities recommend continuous electronic monitoring. However, no data suggest monitoring with intrauterine pressure catheters is superior to external monitoring. Personnel who are familiar with the potential complications of VBAC should be present to watch for nonreassuring fetal heart rate patterns and inadequate progress in labor.

Augmentation

The safety of oxytocin for augmentation of contractions during a trial of labor after a previous low-transverse cesarean delivery has been examined in several studies. Reported uterine rupture rates vary widely in the early studies (0.4–8%), which may reflect the inadvertent inclusion of asymptomatic scar dehiscence among cases of catastrophic uterine rupture (83, 101, 102). Nevertheless, in a recent study of 1,072 patients receiving oxytocin augmentation, the rate of symptomatic uterine rupture was 1% compared with 0.4% in those who labored spontaneously (84). In a nested case–control study, there was no association between uterine rupture and oxytocin dosing intervals, total oxytocin received, and mean duration of oxytocin administration (103).

Delivery

There is nothing unique about the delivery of the fetus during a trial of labor. The need to explore the uterus after a successful vaginal delivery is controversial. Most asymptomatic scar dehiscences heal well, and there are no data to suggest that future pregnancy outcome is better if the dehiscence is surgically repaired. Excessive vaginal bleeding or signs of hypovolemia at delivery

require prompt and complete assessment of the previous scar and the entire genital tract.

- ***How should future pregnancies be managed after uterine rupture?***

If the site of the ruptured scar is confined to the lower segment of the uterus, the rate of repeat rupture or dehiscence in labor is 6% (104). If the scar includes the upper segment of the uterus, the repeat rupture rate is 32% (104, 105). Therefore, women who have had a previous uterine rupture should give birth by repeat cesarean delivery before the onset of labor.

Summary of Recommendations

The following recommendations are based on good and consistent scientific evidence (Level A):

- Most women with one previous cesarean delivery with a low-transverse incision are candidates for VBAC and should be counseled about VBAC and offered a trial of labor.
- Epidural anesthesia may be used for VBAC.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Women with a vertical incision within the lower uterine segment that does not extend into the fundus are candidates for VBAC.
- The use of prostaglandins for cervical ripening or induction of labor in most women with a previous cesarean delivery should be discouraged.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Because uterine rupture may be catastrophic, VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care.
- After thorough counseling that weighs the individual benefits and risks of VBAC, the ultimate decision to attempt this procedure or undergo a repeat cesarean delivery should be made by the patient and her physician. This discussion should be documented in the medical record.
- Vaginal birth after a previous cesarean delivery is contraindicated in women with a previous classical uterine incision or extensive transfundal uterine surgery.

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The MEDLINE database, the Cochrane Library, and ACOG's own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and March 2004. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

- I Evidence obtained from at least 1 properly designed randomized controlled trial.
- II-1 Evidence obtained from well-designed controlled trials without randomization.
- II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than 1 center or research group.
- II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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Vaginal birth after previous cesarean delivery. ACOG Practice Bulletin No. 54. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:203–12.

CALIFORNIA CODES
BUSINESS AND **PROFESSIONS CODE**
SECTION **2505**-2521

2505. This article shall be known and may be cited as the Licensed Midwifery Practice Act of 1993.

2506. As used in this article the following definitions shall apply:
(a) "Board" means the Medical Board of California.
(b) "Licensed midwife" means an individual to whom a license to practice midwifery has been issued pursuant to this article.
(c) "Certified nurse-midwife" means a person to whom a certificate has been issued pursuant to Article 2.5 (commencing with Section 2746) of Chapter 6.
(d) "Accrediting organization" means an organization approved by the board.

2507. (a) The license to practice midwifery authorizes the holder, 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.
(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, 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. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.
(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician and surgeon.
(d) The ratio of licensed midwives to supervising physicians and surgeons shall not be greater than four individual licensed midwives to one individual supervising physician and surgeon.
(e) A midwife is not authorized to practice medicine and surgery by this article.
(f) The board shall, not later than July 1, 2003, adopt in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government **Code**), regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery.

2508. (a) A licensed midwife shall disclose in oral and written form to a prospective client all of the following:
(1) All of the provisions of Section 2507.
(2) If the licensed midwife does not have liability coverage for

the practice of midwifery, he or she shall disclose that fact.
(3) 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.
(4) The procedure for reporting complaints to the Medical Board of California.
(b) The disclosure shall be signed by both the licensed midwife and the client and a copy of the disclosure shall be placed in the client's medical record.
(c) The Medical Board of California may prescribe the form for the written disclosure statement required to be used by a licensed midwife under this section.

2509. The board shall create and appoint a Midwifery Advisory Council consisting of licensees of the board in good standing, who need not be members of the board, and members of the public who have an interest in midwifery practice, including, but not limited to, home births. At least one-half of the council members shall be California licensed midwives. The council shall make recommendations on matters specified by the board.

2511. (a) No person, other than one who has been licensed to practice midwifery by the board, shall hold himself or herself out as a licensed midwife, or use any other term indicating or implying that he or she is a licensed midwife.
(b) Nothing in this article shall be construed to limit in any manner the practice of an individual to whom a certificate has been issued pursuant to Article 2.5 (commencing with Section 2746) of Chapter 6, or to prevent an individual to whom a certificate has been issued pursuant to Article 2.5 (commencing with Section 2746) of Chapter 6 from holding himself or herself out as a certified nurse-midwife, nurse midwife, midwife, or from using the initials "CNM."

2512. The board shall issue a license to practice midwifery to all applicants who meet the requirements of this article and who pay the fee required by Section 2520.

2512.5. A person is qualified for a license to practice midwifery when he or she satisfies one of the following requirements:
(a) (1) Successful completion of a three-year postsecondary midwifery education program accredited by an accrediting organization approved by the board. Upon successful completion of the education requirements of this article, the applicant shall successfully complete a comprehensive licensing examination adopted by the board which is equivalent, but not identical, to the examination given by the American College of Nurse Midwives. The examination for licensure as a midwife may be conducted by the Division of Licensing under a uniform examination system, and the division may contract with organizations to administer the examination in order to carry out this purpose. The Division of Licensing may, in its discretion, designate additional written examinations for midwifery licensure

that the division determines are equivalent to the examination given by the American College of Nurse Midwives.

(2) The midwifery education program curriculum shall consist of not less than 84 semester units or 126 quarter units. The course of instruction shall be presented in semester or quarter units under the following formula:

(A) One hour of instruction in the theory each week throughout a semester or quarter equals one unit.

(B) Three hours of clinical practice each week throughout a semester or quarter equals one unit.

(3) The midwifery education program shall provide both academic and clinical preparation equivalent, but not identical to that provided in programs accredited by the American College of Nurse Midwives, which shall include, but not be limited to, preparation in all of the following areas:

(A) The art and science of midwifery, one-half of which shall be in theory and one-half of which shall be in clinical practice. Theory and clinical practice shall be concurrent in the areas of maternal and child health, including, but not limited to, labor and delivery, neonatal well care, and postpartum care.

(B) Communications skills that include the principles of oral, written, and group communications.

(C) Anatomy and physiology, genetics, obstetrics and gynecology, embryology and fetal development, neonatology, applied microbiology, chemistry, child growth and development, pharmacology, nutrition, laboratory diagnostic tests and procedures, and physical assessment.

(D) Concepts in psychosocial, emotional, and cultural aspects of maternal and child care, human sexuality, counseling and teaching, maternal and infant and family bonding process, breast feeding, family planning, principles of preventive health, and community health.

(E) Aspects of the normal pregnancy, labor and delivery, postpartum period, newborn care, family planning or routine gynecological care in alternative birth centers, homes, and hospitals.

(F) The following shall be integrated throughout the entire curriculum:

(i) Midwifery process.

(ii) Basic intervention skills in preventive, remedial, and supportive midwifery.

(iii) The knowledge and skills required to develop collegial relationships with health care providers from other disciplines.

(iv) Related behavioral and social sciences with emphasis on societal and cultural patterns, human development, and behavior related to maternal and child health, illness, and wellness.

(G) Instruction shall also be given in personal hygiene, client abuse, cultural diversity, and the legal, social, and ethical aspects of midwifery.

(H) The program shall include the midwifery management process, which shall include all of the following:

(i) Obtaining or updating a defined and relevant data base for assessment of the health status of the client.

(ii) Identifying problems based upon correct interpretation of the data base.

(iii) Preparing a defined needs or problem list, or both, with corroboration from the client.

(iv) Consulting, collaborating with, and referring to, appropriate members of the health care team.

(v) Providing information to enable clients to make appropriate decisions and to assume appropriate responsibility for their own

health.
(vi) Assuming direct responsibility for the development of comprehensive, supportive care for the client and with the client.
(vii) Assuming direct responsibility for implementing the plan of care.
(viii) Initiating appropriate measures for obstetrical and neonatal emergencies.
(ix) Evaluating, with corroboration from the client, the achievement of health care goals and modifying the plan of care appropriately.
(b) Successful completion of an educational program that the board has determined satisfies the criteria of subdivision (a) and current licensure as a midwife by a state with licensing standards that have been found by the board to be equivalent to those adopted by the board pursuant to this article.

2513. (a) An approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience. The applicant shall demonstrate, by practical examination, the clinical competencies described in Section 2514 or established by regulation pursuant to Section 2514.5. The midwifery education program's credit by examination policy shall be approved by the board, and shall be available to applicants upon request. The proficiency and practical examinations shall be approved by the board.
(b) Completion of clinical experiences shall be verified by a licensed midwife or certified nurse-midwife, and a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery. Physicians and surgeons, licensed midwives, and certified nurse-midwives who participate in the verification and evaluation of an applicant's clinical experiences shall show evidence of current practice. The method used to verify clinical experiences shall be approved by the board.
(c) Upon successful completion of the requirements of paragraphs (1) and (2), the applicant shall also complete the licensing examination described in paragraph (1) of subdivision (a) of Section 2512.5.

2514. Nothing in this chapter shall be construed to prevent a bona fide student who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training from engaging in the practice of midwifery in this state, as part of his or her course of study, if both of the following conditions are met:
(a) The student is under the supervision of a licensed midwife, who holds a clear and unrestricted license in this state, who is present on the premises at all times client services are provided, and who is practicing pursuant to Section 2507, or a physician and surgeon.
(b) The client is informed of the student's status.

2514.5. (a) Within 60 days following January 1, 1998, the board shall adopt regulations setting forth educational requirements. To develop these regulations, the board shall update the educational

requirements set forth in Sections 2512.5, 2513, and 2514. These updated sections shall reflect national standards for the practice of midwifery and shall be subject to public hearings prior to adoption. The board shall review and update the regulations every two years.

(b) The board shall adopt the written examination required by this article by July 1, 1994.

2515. The board shall approve specific educational programs intended to meet the requirements of subdivision (a) of Section 2512.5 and Section 2514 for the course of academic study, documentation of experience and skill, and clinical evaluation. These programs shall also be accredited by an accrediting organization approved by the board.

2515.5. Each applicant shall show by evidence satisfactory to the board that he or she has met the educational standards established by the board pursuant to this article or the equivalent thereof.

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 in March, with the first report due in March 2008, 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 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 total number of clients served with collaborative care available through, or given by, a licensed physician and surgeon.

(C) The total number of clients served under the supervision of a licensed physician and surgeon.

(D) The number by county of live births attended as primary caregiver.

(E) The number, by county, of cases of fetal demise attended as primary caregiver at the discovery of the demise.

(F) The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.

(G) The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.

(H) The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.

(I) The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.

(J) 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.

(K) 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.
(L) A brief description of any complications resulting in the mortality of a mother or an infant.
(M) 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, 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 of each year. The board shall include this information in its annual report to the Legislature.
(g) Notwithstanding any other provision of law, a violation of this section shall not be a crime.

2517. A person who has been convicted of a misdemeanor violation of Section 2052, prior to the effective date of this article, shall not be barred from licensure under this article solely because of that conviction.

2518. (a) Licenses issued pursuant to this article shall be renewable every two years upon payment of the fee prescribed by Section 2520 and submission of documentation that the licenseholder has completed 36 hours of continuing education in areas that fall within the scope of the practice of midwifery, as specified by the board.
(b) Each license not renewed shall expire, but may be reinstated within five years from the expiration upon payment of the prescribed fee and upon submission of proof of the applicant's qualifications as the board may require.

2519. The board may suspend or revoke the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising which is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety **Code** or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and **Professions Code**.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety **Code**, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and **Professions Code**, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance

of or arranging for a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

2520. (a) (1) The fee to be paid upon the filing of a license application shall be fixed by the board at not less than seventy-five dollars ($75) nor more than three hundred dollars ($300).

(2) The fee for renewal of the midwife license shall be fixed by the board at not less than fifty dollars ($50) nor more than two hundred dollars ($200).

(3) The delinquency fee for renewal of the midwife license shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25) nor more than fifty dollars ($50).

(4) The fee for the examination shall be the cost of administering the examination to the applicant, as determined by the organization that has entered into a contract with the Division of Licensing for the purposes set forth in subdivision (a) of Section 2512.5. Notwithstanding subdivision (b), that fee may be collected and retained by that organization.

(b) The fees prescribed by this article shall be deposited in the Licensed Midwifery Fund, which is hereby established, and shall be available, upon appropriation, to the board for the purposes of this article.

2521. Any person who violates this article is guilty of a misdemeanor.

Barclays Official

CALIFORNIA CODE OF REGULATIONS

Title 16. Professional and Vocational Regulations

Division 13. Medical Board of California

Vol. 21

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tion 94310 of the Education Code or an educational institution located outside the state which has accreditation by a national or applicable regional accrediting agency recognized by the United States Department of Education;

(d) Require each research psychoanalyst student prior to admission to have shown achievement in teaching, training or research with demonstrated aptitude in his or her primary filed of scholarly or scientific endeavor;

(e) Require each student to participate in at least 560 hours of classroom training over at least three (3) years on all phases of psychoanalysis;

(f) Require each student to participate in continuous case conferences conducted by graduate psychoanalysts;

(g) Require each student to undergo a minimum of 300 hours personal psychoanalysis conducted by a graduate psychoanalyst who has a minimum of five years of postgraduate clinical experience in psychoanalysis following the completion of his or her psychoanalytic education;

(h) Require each student to conduct at least three (3) psychoanalyses under the supervision of three different graduate psychoanalysts, at least one of which is taken to termination except in those rare instances where a delay may post an extreme hardship to the student and the institute has made provision for continuing supervision of the student after graduation until at least one case is taken to termination;

(i) Require each student to either pass a comprehensive examination or write an approved thesis.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2529, Business and Professions Code.

HISTORY:

1. Editorial correction of printing error restoring subsection (g) designation (Register 90, No. 51).
2. Amendment of subsection (h) filed 11–9–90; operative 12–9–90 (Register 90, No. 51).

§ 1375. Applicants from Equivalent Institutions.

(a) Any applicant from a psychoanalytic institution which is claimed to be equivalent to an institute specified in Section 2529 shall have presented to the division evidence that such institution complies with the criteria set forth in Section 1374.

(b) In its discretion the division may register an applicant who graduated from an equivalent institution before the time of its approval by the division, if the program undertaken by the applicant as a student otherwise complies with the provisions of Section 1374.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2529, Business and Professions Code.

§ 1376. Unprofessional Conduct.

The division may deny, suspend, revoke or impose probationary conditions upon a registrant for unprofessional conduct as specified in Section 2529 of the code which includes, but is not limited to, the following:

(a) Any violation of the research psychoanalysts law.

(b) Any violation of the Research Psychoanalysts Regulations.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2529, Business and Professions Code.

§ 1376.1. Disciplinary Actions.

Any action taken by the division to deny, suspend, revoke or impose probationary conditions upon a registrant shall be pursuant to the Administrative Procedure Act (Section 11500 et seq. of the Government Code).

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2529, Business and Professions Code.

§ 1377. Fees.

(a) The registration fee is $100 for research psychoanalysts and students, except that if the registration will expire less than one (1) year after its issuance, then the registration fee is $75.

(b) The biennial renewal fee is $50.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2529.5, Business and Professions Code.

§ 1377.5. Verification of Student Status.

Students renewing their registration shall present to the division verification of their continuing student status from the registrar or similar official of the psychoanalytic institute attended.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2529.5, Business and Professions Code.

§ 1378. Expiration of Registration.

All registrations expire and become invalid at midnight on the last day of February of each even–numbered year if not renewed. To renew an unexpired registration, the registrant shall, on or before the date on which it would otherwise expire, apply for renewal on a form provided by the division, accompanied by a required verification and the prescribed renewal fee.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 152.6 and 2529.5, Business and Professions Code.

Article 4. Standardized Procedure Guidelines

§ 1379. Standardized Procedures for Registered Nurses.

A physician and surgeon or a podiatrist who collaborates in the development of standardized procedures for registered nurses shall comply with Title 16 California Administrative Code Sections 1470 through 1474 governing development and use of standardized procedures.

NOTE: Authority cited: Sections 2018 and 2725, Business and Professions Code. Reference: Section 2725, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former Article 4 (Sections 1376–1377.1) to Article 2 (Sections 1366 and 1366.1), and new Article 4 (Section 1379) filed 8–3–83; effective thirtieth day thereafter (Register 83, No. 32). For prior history, see Registers 81, No. 32; and 78, No. 17.

Article 5. Research Psychoanalysts

NOTE: Authority cited: Sections 2529 and 3510, Business and Professions Code. Reference: Section 3510 and Chapter 5.1 (commencing with Section 2529), Division 2, Business and Professions Code.

HISTORY

1. Renumbering of Article 15 (Sections 1379–1379.86) to Article 5 (Sections 1379–1379.86) of Subchapter 3 filed 5–20–77; effective thirtieth day thereafter (Register 77, No. 21). For latest prior history, see Register 76, No. 52.
2. Repealer of Article 5 (Sections 1379–1379.86) and redesignation as Chapter 13.7 (Sections 1399.50, et seq.) filed 11–22–77; effective thirtieth day thereafter (Register 77, No. 48). For prior history, see Register 72, Nos. 39 and 49, Register 73, Nos. 18, 21, 35 and 38, Register 74, No. 45, Register 76, Nos. 30, 33 and 52; and Register 77, No. 25.
3. Editorial correction of History note No. 2 (Register 78, No. 33).
4. New Article 5 (Sections 1378–1378.32, not consecutive) filed 10–12–78; effective thirtieth day thereafter (Register 78, No. 41).
5. Renumbering and amendment of Article 5 (Sections 1378–1378.32, not consecutive) to Article 3 (Sections 1367–1378, not consecutive) filed 8–3–83; effective thirtieth day thereafter (Register 83, No. 32). For prior history, see Registers 81, No. 32; and 79, No. 29.

Chapter 4. Licensed Midwives

Article 1. General Provisions

§ 1379.1. Location of Office.

The Midwifery Licensing Program is located at 1426 Howe Avenue, Sacramento, CA 95825.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2505 through 2521, Business and Professions Code.

HISTORY

1. New chapter 4, article 1 and section filed 4–26–95; operative 5–26–95 (Register 95, No. 17).

§ 1379.2. Definitions.

For the purposes of the regulations contained in this chapter and for purposes of Article 24 of Chapter 5 of Division 2 (commencing with section 2505) of the code:

(a) "Accrediting organization approved by the board," as used in section 2515 of the code, means either an accrediting organization that is recognized by the United States Department of Education, Division of Accreditation, or an accrediting organization that is equivalent thereto.

(b) "Board" means the Division of Licensing of the Medical Board of California.

(c) "Code" means the Business and Professions Code.

(d) "Midwifery education program" includes but is not limited to nurse midwifery education programs.

NOTE: Authority cited: Section 2514.5, Business and Professions Code. Reference: Sections 2505 through 2521, Business and Professions Code.

HISTORY

1. New section filed 4–26–95; operative 5–26–95 (Register 95, No. 17).
2. Amendment of first paragraph, new subsection (a), subsection relettering, and amendment of NOTE filed 7–23–98; operative 8–22–98 (Register 98, No. 30).

§ 1379.3. Delegation of Functions.

Except for those powers reserved exclusively to the "agency itself" under the Administrative Procedure Act (Section 11500 et seq. of the Government Code), the board delegates and confers upon the executive director of the board, or his/her designee, all functions necessary to the dispatch of business of the board in connection with investigative and administrative proceedings under the jurisdiction of the board.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2505 through 2521, Business and Professions Code.

HISTORY

1. New section filed 4–26–95; operative 5–26–95 (Register 95, No. 17).

Article 2. Fees

§ 1379.5. Midwifery Fees.

The licensed midwifery fees are fixed as follows:

(a) The license application fee shall be $300.00.

(b) The biennial renewal fee shall be $200.00.

(c) The delinquency fee shall be $50.00.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2520 through 2521, Business and Professions Code.

HISTORY

1. New article 2 and section filed 4–25–95; operative 5–25–95 (Register 95, No. 17).
2. Change without regulatory effect amending section number filed 9–14–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 37).

Article 3. Application

§ 1379.10. Application for Licensure as a Midwife.

An application for licensure as a midwife shall be filed with the board at its principal office on the prescribed application form (Application for Midwife License – 62A–1(Revised 5–2000) which is incorporated by reference. The application shall be accompanied by such evidence, statements or documents as therein required and filed with the fee required by section 1379.5.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2512, 2517 and 2520, Business and Professions Code.

HISTORY

1. New article 3 and section filed 6–30–95; operative 7–30–95 (Register 95, No. 26).
2. Amendment filed 11–6–2000; operative 12–6–2000 (Register 2000, No. 45).

§ 1379.11. Review of Applications; Processing Time.

(1) The board shall inform an applicant for licensure as a midwife in writing within 30 days of receipt of an application as to whether the application is complete and accepted for filing or is deficient and what specific information is required.

(2) The board shall inform an applicant for licensure as a midwife in writing within 30 days after notification that an application has been accepted for filing as to whether the applicant meets the requirements for licensure.

NOTE: Authority cited: Section 2018, Business and Professions Code; and Section 15376, Government Code. Reference: Section 2512, Business and Professions Code; and Section 15376 et seq., Government Code.

HISTORY

1. New section filed 10–5–95; operative 11–4–95 (Register 95, No. 40).

§ 1379.15. Verification of Minimum Clinical Experiences Required.

(a) A person may obtain educational credit by examination for previous midwifery education and clinical experience. An applicant for licensure on or before December 31, 1997, who would rely upon such education and experience as his/her sole qualifications for taking the comprehensive licensing exam pursuant to sections 2512.5 and 2513 of the code shall have obtained all of the experiences described in subsection (c) within ten years immediately preceding the date of application.

(b) A person who applies for licensure as a midwife on or after January 1, 1998, who would rely upon credit by examination for previous education and experience as his/her sole qualifications for taking the comprehensive licensing exam pursuant to sections 2512.5 and 2513 of the code shall have obtained at least 50 percent of the experiences described in subsection (c) within five years immediately preceding the date of application.

(c) For purposes of satisfying section 2513(b) of the code, an approved midwifery education program shall verify the following minimum number of clinical experiences:

(1) 20 new antepartum visits clinical experiences

(2) 75 return antepartum visits

(3) 20 labor management experiences

(4) 20 deliveries

(5) 40 postpartum visits, within the first five days after birth

(6) 20 newborn assessments

(7) 40 postpartum/family planning/gynecology visits

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2513, Business and Professions Code.

HISTORY

1. New section filed 5–22–96; operative 6–21–96 (Register 96, No. 21).

Article 3.5. Midwifery Practice

§ 1379.19. Standards of Care for Midwives.

(a) For purposes of Section 2507(f) of the code, the appropriate standard of care for licensed midwives is that contained in the "Standard of Care for California Licensed Midwives" (September 15, 2005 edition) ("SCCLM"), which is hereby incorporated by reference.

(b) With respect to the care of a client who has previously had a caesarean section ("C–section") but who meets the criteria set forth in the SCCLM, the licensed midwife shall provide the client with written informed consent (and document that written consent in the client's midwifery record) that includes but is not limited to all of the following:

(1) The current statement by the American College of Obstetricians and Gynecologists regarding its recommendations for vaginal birth after caesarean section ("VBAC").

(2) A description of the licensed midwife's level of clinical experience and history with VBACs and any advanced training or education in the clinical management of VBACs.

(3) A list of educational materials provided to the client.

(4) The client's agreement to: provide a copy of the dictated operative report regarding the prior C–section; permit increased monitoring; and, upon request of the midwife, transfer to a hospital at any time or if labor does not unfold in a normal manner.

(5) A detailed description of the material risks and benefits of VBAC and elective repeat C–section.

NOTE: Authority cited: Sections 2018 and 2507, Business and Professions Code. Reference: Section 2507, Business and Professions Code.

HISTORY

1. New article 3.5 heading and new section filed 2–7–2006; operative 3–9–2006 (Register 2006, No. 6).

§ 1379.20. Liability Insurance Disclosure.

A midwife who does not have liability insurance coverage for the practice of midwifery shall disclose that fact to the client on the first visit or examination, whichever comes first.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2508, Business and Professions Code.

HISTORY

1. New section filed 5–17–96; operative 6–16–96 (Register 96, No. 20).
2. Change without regulatory effect amending section filed 1–24–2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 4).

§ 1379.22. Physician Requirements.

A physician described in Section 2508 of the code shall have hospital privileges in obstetrics and shall be located in reasonable geographic and/or temporal proximity to the patient whose care the physician will assume should complications arise.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2508, Business and Professions Code.

HISTORY

1. New section filed 11–28–95; operative 12–28–95 (Register 95, No. 48).

Article 4. Continuing Education

§ 1379.25. Definitions.

For purposes of this article:

(a) "Continuing education" means the variety of forms of learning experience undertaken by licensed midwives for relicensure, which are meant to directly enhance the licentiate's knowledge, skill or competence in the provision of midwifery services.

(b) "Continuing education hour" means at least fifty (50) minutes of participation in an organized learning experience. One academic quarter unit is equal to ten (10) continuing education hours. One academic semester unit is equal to fifteen (15) continuing education hours.

(c) "Course" means a systematic learning experience, at least one hour in length, which deals with and is designed for the acquisition of knowledge, skills, and information related to the practice of midwifery.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2518, Business and Professions Code.

HISTORY

1. New article 4 (sections 1379.25–1379.28) and section filed 7–8–97; operative 8–7–97 (Register 97, No. 28).

§ 1379.26. Approved Continuing Education Programs.

(a) The following programs are approved by the division for continuing education credit:

(1) Programs offered by the American College of Nurse Midwives;

(2) Programs offered by the Midwives Alliance of North America;

(3) Programs offered by a midwifery school approved by the division;

(4) Programs offered by a state college or university or by a private postsecondary institution accredited by the Western Association of Schools and Colleges;

(5) Programs offered by a midwifery school accredited by the Midwives Education Accreditation Council;

(6) Programs which qualify for Category I credit from the California Medical Association or the American Medical Association;

(7) Programs offered by the Public Health Service;

(8) Programs offered by the California Association of Midwives;

(9) Programs offered by the American College of Obstetricians and Gynecologists; and

(10) Courses offered by a provider approved by the California Board of Registered Nursing or the board of registered nursing of another state in the United States.

(b) Only those courses and other education activities that meet the requirements of Section 1379.27 which are offered by these organizations shall be acceptable for credit under this section.

(c) A maximum of one third of the required hours of continuing education may be satisfied by teaching or otherwise presenting a course or program approved under this section.

(d) Tape–recorded courses and correspondence courses offered by an approved provider shall be accepted for no more than half of the total required hours.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2518, Business and Professions Code.

HISTORY

1. New section filed 7–8–97; operative 8–7–97 (Register 97, No. 28).
2. Amendment of subsection (a)(9) and new subsection (a)(10) filed 10–25–2004; operative 11–24–2004 (Register 2004, No. 44).

§ 1379.27. Criteria for Acceptability of Courses.

(a) Those courses and programs referred to in section 1379.26 above shall meet the following criteria in order to be acceptable to the division:

(1) Faculty—the course or program instructor shall: (A) be currently licensed or certified in his/her area of expertise, if appropriate, and (B) show evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area. The curriculum vitae of all faculty members shall be kept on file.

(2) Rationale—The need for the course and how the need was determined shall be clearly stated and maintained on file.

(3) Course content—The content of the course or program shall be directly related to midwifery, patient care, community health or public health, preventive medicine, professional ethics, the Medical Practice Act, the Licensed Midwifery Practice Act, or improvement of the midwife–client relationship.

(4) Educational objectives—Each course or program shall clearly state educational objectives that can be realistically accomplished within the framework of the course.

(5) Method of instruction—Teaching methods for each course or program shall be described, e.g. lecture, seminar, audio–visual, simulation.

(6) Evaluation—Each course or program shall include an evaluation method which documents that the educational objectives have been met—for example, written examination or written evaluation by each participant.

(7) Attendance—A course provider shall maintain a record of attendance of each participant.

(b) The division will not give prior approval to individual courses or programs; however, the division will randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received. If an audit is made, course providers will be asked to submit to the division documentation concerning each of the items described in subsection (a) above.

(c) Credit toward the required hours of continuing education will not be accepted for any course deemed unacceptable by the division after an audit has been made pursuant to this section.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2518, Business and Professions Code.

HISTORY

1. New section filed 7–8–97; operative 8–7–97 (Register 97, No. 28).

§ 1379.28. Audit and Sanctions for Noncompliance.

(a) The division shall audit once every two years a random sample of midwives who have reported compliance with the continuing education requirement. No midwife shall be subject to random audit more than once every four (4) years. Those midwives selected for audit shall be required to document their compliance with the continuing education requirements of Section 2518 of the code and this article.

(b) Any midwife who is found not to have completed the required number of hours of approved continuing education will be required to make up any deficiency during the next biennial renewal period. Such midwife shall document to the division the completion of any deficient hours identified by audit. Any midwife who fails to make up the deficient hours during the following renewal period shall be ineligible for renewal of his/her license to practice midwifery until such time as the deficient hours of continuing education are documented to the division.

(c) It shall constitute unprofessional conduct for any midwife to misrepresent his/her compliance with the provisions of this article.

(d) The division requires that each midwife retain for a minimum of four years records of all continuing education programs attended, including the title of the course or program attended, the length of the course or program, the number of continuing education hours, the sponsoring organization and the accrediting organization, if any, which may be needed in the event of an audit by the division.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2518 and 2519, Business and Professions Code.

HISTORY

1. New section filed 7–8–97; operative 8–7–97 (Register 97, No. 28).

Article 5. Educational Requirements

§ 1379.30. Midwifery Education Program.

The midwifery education program shall prepare the midwife to practice as follows:

(a) Management of the normal pregnancy.

(b) Management of normal labor and delivery in all birth settings, including the following, when indicated:

(1) Administration of intravenous fluids, analgesics, postpartum oxytocics, and RhoGAM.

(2) Amniotomy during labor.

(3) Application of external or internal monitoring devices.

(4) Administration of local anesthesia, paracervical blocks, pudendal blocks, and local infiltration.

(5) Episiotomy.

(6) Repair of episiotomies and lacerations.

(7) Resuscitation of the newborn.

(c) Management of the normal postpartum period.

(d) Management of the normal newborn care, including administration of vitamin K and eye prophylaxis.

(e) Management of family planning and routine gynecological care including barrier methods of contraception such as diaphragms and cervical caps.

NOTE: Authority cited: Section 2514.5, Business and Professions Code. Reference: Sections 2512.5 and 2514.5, Business and Professions Code.

HISTORY

1. New article 5 (sections 1379.30–1379.31) and section filed 7–23–98; operative 8–22–98 (Register 98, No. 30).

§ 1379.31. Evidence of Completion of Educational Requirements.

For purposes of Section 2515.5 of the code, either of the following shall be deemed satisfactory evidence that an applicant has met the educational standards required for licensure as a midwife:

(a) A diploma issued by a midwifery program approved by the division; or

(b) A notice of successful completion of the challenge program (credit by examination) issued by a program approved by the division.

NOTE: Authority cited: Section 2514.5, Business and Professions Code. Reference: Section 2515.5, Business and Professions Code.

HISTORY

1. New section filed 7–23–98; operative 8–22–98 (Register 98, No. 30).

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