MEDICAL BOARD OF CALIFORNIA
Licensing Program

MIDWIFERY ADVISORY COUNCIL

MEMBERS OF THE COUNCIL

Carrie Sparrevohn, L.M., Chair
James Byrne, M.D.
Karen Ehrlich, L.M.
Faith Gibson, L.M.
Monique Webster
Barbara Yaroslavsky

March 14, 2013

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

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

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

AGENDA

1:00 p.m. – 4:00 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 Council 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 the Midwifery Advisory Council Meeting Minutes
   A. August 30, 2012
   B. December 6, 2012

4. Report from the Midwifery Advisory Council Chairperson

5. Sunset Review Update
   A. Status of Proposed Adoption of CCR §1379.23-Physician Supervision Requirement
   B. Status of Proposed Adoption of CCR §1379.24-Practice of Midwifery; Drugs and Devices
   C. Recommendation to identify Certified Nurse Midwives as Licensed Healthcare Providers Sanctioned to Supervise Student Midwives
   D. Use of M.A.N.A. Reporting System

6. Program Update – Ms. Lowe
   A. Licensing Statistics
   B. Enforcement Statistics Report

7. Agenda Items for the August 8, 2013 Midwifery Advisory Council Meeting – Sacramento

8. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, 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 Susan Morrish 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
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

August 30, 2012
MINUTES

DRAFT

Agenda Item 1 Call to Order/Roll Call
The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by Chair Carrie Sparrevohn at 1:05 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Carrie Sparrevohn, L.M., Chair
James Byrne, M.D.
Karen Ehrlich, L.M.
Faith Gibson, L.M.
Monique Webster
Barbara Yaroslavsky

Staff Present:
Diane Dobbs, Department of Consumer Affairs, Legal Counsel
Kurt Heppler, Staff Counsel
Natalie Lowe, Licensing Manager
Susan Morrish, Licensing Analyst
Anthony Salgado, Licensing Manager
Kathryn Taylor, Licensing Manager
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
Jen Brown
Brooke Casey
Yvonne Choong, CMA
Laurie Gregg, M.D., ACOG
Joselyn Grole, CAM
Deanna Jesus, CAM
Tosi Marceline, LM
Diane Moher, MANA
Debra Newberry Puterbaugh, CAM
Constance Rock, LM, CAM
Shannon Smith-Crowley

Linda Walsh, CNM
(The above list identifies attendees who signed the meeting sign-in sheet.)

Agenda Item 2 Public Comment on Items not on the Agenda
No public comment was provided.

Agenda Item 3 Approval of the Minutes from the March 29, 2012 Meeting
Ms. Sparrevohn made a motion to accept the minutes from the March 29, 2012 meeting; s/Yaroslavsky; motion carried.

Agenda Item 4: Consideration of Revised Regulations; Possible Recommendation to Full Board

A. 1379.23 - Physician Supervision Requirement

Ms. Lowe provided information on the recommendations for two proposed midwifery regulations:

- 1379.23 - Physician Supervision Requirement
- 1379.24 - Practice of Midwifery; Drugs and Devices

The revised proposals were based on recommendations made by members of the public and the midwifery community during the March 29, 2012 "Interested Parties" workshop.

The Physician Supervision Requirement was the first regulation discussed. Ms. Lowe identified Business and Professions Code 2507 (f) which requires the Board to adopt regulations defining the appropriate standard of care and level of supervision required in the practice of midwifery; pointing out that since 2006, three regulatory attempts for a consensus on the supervision requirement have failed.

The proposed section 1379.23 of the California Code of Regulations sets forth a collaborative approach to the issue of physician supervision provided that the licensee establishes a collaborative relationship with a physician who has agreed to provide guidance and instruction within specific circumstances. The proposed regulation also ensures that a business relationship is not created between the physician and licensed midwife solely by consulting with or accepting a referral from the licensed midwife. Ms. Lowe requested that the following language be approved by the MAC and recommended to the Full Board to set for hearing:

1379.23 Physician Supervision Requirement.

(a) The requirement for physician supervision contained in Section 2507 of the Code is deemed to have been met if the licensed midwife has established a collaborative relationship with one or more physicians, who meet the requirements of section 1379.22, for the purpose of providing guidance and instructions regarding the care of women and/or newborns or consulting with the licensed midwife after the care of a patient has been transferred to the physician.

(b) A physician and surgeon shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with a licensed midwife solely by consulting with or accepting a referral from the licensed midwife.

NOTE: Authority cited: Sections 2018 and 2507 (f), Business and Professions Code.

Reference: Section 2507, Business and Professions Code.

Ms. Yaroslavsky asked for a motion to approve the language to present to the Full Board; s/Gibson.

Ms. Sparrevohn asked for committee input on the issue. Ms. Ehrlich had concerns that the proposed language does not provide a definition for physician collaboration when risk factors are an issue. Ms. Ehrlich asked Ms. Dobbs if the absence of a specific definition would leave midwives unable to function independently during cases of normalcy.

Ms. Dobbs answered that, in general, very minute details should be left out of regulations because such details make it difficult to accomplish the main goals.

Dr. Byrne expressed concern that the current language does not define low risk versus high risk and still leaves a requirement for a supervisory relationship. He believes the language is simply changing the relationship from supervisory to collaborative and does not provide for a truly independent practice. Ms. Dobbs disagreed stating that she does not see the proposed regulation language changing the scope of practice for midwives. Ms. Yaroslavsky also had concern that it would be better to leave the assumptions ambiguous, otherwise the regulation would have limitations in what the Council was trying to achieve. Ms. Sparrevohn agreed that the language was specific enough and that it was not going to change how licensed midwives practiced in California.

Dr. Byrne stated that from a risk management standpoint, he has seen plaintiff's attorneys try to draw a relationship where even a midwife's phone call to a doctor can bring both parties into a lawsuit regardless of status. He mentioned in statutes for certified nurse midwives (CNM), the term "supervision" is clear in what it means.

Ms. Sparrevohn stated that, because no one from the insurance industry attended the Interested Parties meeting, input from them was not provided on the proposed regulation language.

Ms. Dobbs asked Council Members to keep in mind that the regulatory language was a suggestion, and she stated interested parties could participate in the regulatory process and make recommendations for any language that is not clear. Ms. Yaroslavsky asked Ms. Dobbs if she was suggesting the Council should move forward with the recommendation and see what takes place during the Public Hearings. Ms. Dobbs responded affirmatively, stating that there would be plenty of opportunity to fine tune the language.

Ms. Sparrevohn asked if there were any additional comments from Council members. Seeing none, she asked for public comment.

Mr. Cuny identified himself as the Director of California Citizens for Health Freedom. He mentioned his organization has followed the issue of physician supervision for about 15 years, and he claims physician supervision has been a problem for the public, midwives, doctors, and the Board. He suggested the Board should sponsor legislation that might resolve the existing problems for all involved parties.

Yvonne Choong with the California Medical Association (CMA) expressed concern that the proposed regulation fails to define and establish what a collaborative relationship is. Ms. Choong believes more definition is needed by identifying what is low risk and what is high risk for physicians and insurance carriers.

Ms. Choong asked for clarification in the following areas: when care has been transferred to the physician; and, what informed consent is provided to the patient that addresses the nature of the relationship between physician and licensed midwife.

Ms. Sparrevhohn invited Dr. Gregg from the American College of Obstetricians and Gynecologists (ACOG) to speak. Dr. Gregg introduced Ms. Smith-Crowley as a lobbyist for ACOG and herself as Chairperson for District 9 in California. Dr. Gregg expressed concern that the word "collaboration" was too vague. She attended the March 29, 2012 Interested Parties meeting and mentioned that former MAC member, Dr. Haskins, provided written comments to the Board on the Physician Supervision regulation. She felt the staff tried to incorporate what was suggested in the proposed regulation, but she believes the language could be better articulated. She suggested working on the language during the current meeting and to send the proposal forward to the Board.

Dr. Gregg identified issues that she would like defined/incorporated into the regulation: informed consent; if physician supervision is removed, she recommends home births are limited to low risk pregnancies as defined by the "World Health Organization"; and, to change "Collaboration" to "midwifery directed physician consultation."

She believes the client needs to know: the training and education of the licensed midwife; the midwife is not a nurse midwife or a physician; there is no physician supervision; a Transfer Plan is in place and it outlines what the transfer plan consists of; whether or not the midwife carries liability insurance; and, additional information on the grievance process.

Dr. Gregg stated that based on home births that work well in other states, it is safer for the consumer if home births are limited to low risk births. She offered the following suggestions pertaining to transporting the mother to the hospital when necessary: the midwife engages the physician when she feels it is needed; physician consultation is done on a face-to-face basis and continues with the California standard of non-vicarious liability; the physicians are not held responsible for situations that occur at the home and outside of their presence; and, the physician assumes responsibility once the client/patient is transferred to the hospital and engages with the physician.

Dr. Gregg believes the wording of the proposed regulation does not reduce the liability concerns for doctors but could potentially make it worse. Ms. Smith-Crowley interjected by specifying that there are two separate issues, ACOG issues and liability issues.

From the standpoint of ACOG and the liability insurance carriers, Ms. Smith-Crowley recommended to stay within the standard of care by having a consultative relationship. She has not found anything that says a physician cannot supervise or consult, collaborate or have back up, and she does not believe removing physician supervision from the regulation is going to be in the best interest of the woman or baby. Based on what the statute currently states, Ms. Smith-

Crowley suggested incorporating Dr. Gregg's recommendations. She recommended putting the regulation in place for now and then work on revising the legislation later.

Ms. Yaroslavsky asked Council Members, "Does having the additional information within the specific language of the regulation resolve the issue?" Ms. Ehrlich stated that it would be redundant because midwives are required to have a Transfer Plan and are required to inform the client whether or not they carry malpractice insurance. She suggested a legislative fix should occur to strengthen the regulation.

Ms. Yaroslavsky countered by stating if the information was already in law or statute, it would not be redundant to have everything identified in one regulation. Ms. Sparrevohn suggested the language should require midwives to provide clients with informed consent documentation and a reference to the Standard of Care for California Licensed Midwives.

Dr. Gregg agreed that the additional language would better define the collaborative relationship between physician and licensed midwife. She suggested taking wording from national documentation, and she referenced a collaborative statement that is currently in place with certified nurse midwives who have standardized training. Due to the differences in how licensed midwives are trained, doctors are somewhat cautious about involving themselves. Physician protocol is to consult or seek assistance with a higher specialist when medical issues outside his/her scope. Physicians may touch base immediately with a specialist by phone but then would send the patient to have a face-to-face consult to get a better impression of what is going on. She recommended a midwife directed consultative process where the physician and the client/patient see each other face-to-face and then, if necessary, when the patient is transferred.

Dr. Byrne felt integrating the language from with the World Health Organization criteria would be very helpful. Regarding current regulations, he said there are midwives who want to practice clinically in a safe manner but are having a hard time finding physician supervisors. Physicians often are not willing to be supervisors because they do not want to be involved with clinical problems that could have been avoided with earlier contact or be drawn into litigation issues.

Dr. Byrne suggested that the regulatory changes should not be a one sided relationship where midwives are in agreement and the regulations would not change the paradigm for the doctors. Dr. Gregg agreed with this statement.

Ms. Ehrlich asked Dr. Gregg if midwifery-directed consultation would involve every client under the care of a midwife. Dr. Gregg responded no. Dr. Gregg indicated that the requirements vary from state to state. Dr. Gregg believes that if a woman chooses home birth, the hope would be that it is done with adequate education and informed consent and that the physicians are available should the midwife need them.

Ms. Ehrlich reiterated that "informed consent" was currently included in the laws and regulations, pointing out that the language identifying "moderate risk" was removed. Ms. Ehrlich stated that pregnancies are not just low risk and high risk; she argued that women in the moderate risk category have a right to determine their own care in the setting of their choice. Dr. Gregg mentioned that home births for multiples, breeches, and vaginal births after cesarean are legal in California, although ACOG continues to disagree with that.

Ms. Ehrlich stated that full informed consent is the centerpiece for midwifery. Ms. Sparrevohn added that the Standards of Care for Licensed Midwives were passed well after midwives knew they did not have physician supervision and that supervision will be defined in many different ways.

Ms. Gibson stated that at one time a document had been produced by the Board that defined all circumstances that fell under the supervision requirement. She asked Dr. Gregg to provide a definition for physician supervision and to define language used within states that do not require physician supervision.

Dr. Gregg stated that the word "supervision" was less than ideal because she thought what was being discussed was not truly supervision and did not describe the situation. She stated that a minority of states have a mandate where a client choosing home birth must consult with a doctor. She offered to provide language utilized in other states, but did not currently have the information. She added that the practice of midwifery has evolved in the last 20 years and other entities may have been involved when physician supervision was placed in the law. Dr. Byrne said that it is a challenge to compare all states because some states do not allow licensed midwifery.

Ms. Webster expressed interest in removing barriers to care and addressing liability issues. She asked if there had been feedback from the insurance companies. Ms. Sparrevohn responded that they had been invited to the Interested Parties Workshop but did not attend.

Ms. Sparrevohn invited Ms. Holtzer to speak on this topic. Ms. Holtzer introduced herself as a midwife and stated that she liked the language in the current draft, even though it wasn't perfect. In her opinion, it reflected what was actually happening with midwives who have collaborative relationships with physicians. She stated that there were physicians across California who do collaborate with midwives but are not able to supervise. She was in agreement with the suggestions Dr. Gregg recommended, but did not see how defining the word "collaborate" would work. She asked how many midwives have collaboration, based on the Office of Statewide Planning and Development, (OSHPD) statistics. Ms. Ehrlich provided the following data:

- Clients served while the licensed midwife had supervision in 2011: 6.5%
- Clients who received collaborative care: 58.2%

Ms. Holtzer pointed out the statistics reflect more than half of the midwives received collaborative care, and she stated that defining collaboration would backfire on the midwives. Ms. Holtzer was interested in knowing what the physicians collaborating with midwives thought about the regulation and asked if ACOG knew whether the physicians wanted a more defined relationship, or if they were content in collaborating with the midwives.

Dr. Byrne stated that a lot of the work he performs is directed at improving health care systems and dual care for individual women. He pointed out that the self-reported "collaboration" at 60% is great, but he questioned whether the persons identified as the "collaborators" knew they were the collaborator.

Ms. Grote identified herself as a licensed midwife in Santa Cruz County and stated that most midwives in California collaborate with a doctor who is on call, "in house" at the time of need. She claims many midwives have informal relationships with doctors they can call for non-

emergent consultation.

Ms. Grote questioned what would happen if a midwife could not find a doctor in her community to collaborate with. She questioned, "What would happen if a doctor did not want to provide consultation for the 20 midwives in his/her city?" Ms. Sparrevohn mentioned implementing the regulation would provide a more fluid process. If it didn't, the next step would be to amend the law.

Ms. Grote asked if the regulation would provide further definition in identifying the consulting doctor and what the consultation was about via the charting process. Ms. Sparrevohn explained that the regulation did not specify how a midwife should document the information but she said the consultation process may be negotiated differently between the midwife and each physician.

Ms. Grote asked if there was any value in having a regulatory stipulation for the midwife if she was unable to find a collaborating doctor. Ms. Sparrevohn acknowledged that there are places where there are no collaborating physicians, but she said it is unclear whether having a collaborative relationship would make the situation easier or harder until it was tried.

Ms. Marceline identified herself as a midwife and commented that in her practice they see approximately 60-65 women per year and their collaborative efforts are through Kaiser. Ms. Marceline includes in their OSHPD statistics related to physician supervision, clients who transfer (to her practice) because the physician chooses not to be involved if the client is planning a home birth.

Dr. Gregg stated that there are physicians who collaborate with midwives "underground" and do so at their own peril. She further stated she would be willing to collaborate with midwives if the regulation was better defined. She felt that more physicians would "step up to the plate" if they would not be put at risk and the "collaborative relationship" between physician and licensed midwife was better defined.

Ms. Ehrlich asked for Dr. Gregg's assistance in revising the drafted physician supervision language. Dr. Gregg defined collaboration as "midwife directed physician consultation." Dr. Gregg's opinion is physicians are covered under liability carriers if they have face-to-face interaction with a patient. If physicians perform an exam and provides an opinion, they are covered. Physicians do not have liability coverage when they provide advice to a midwife over the phone. If anything happened during a pregnancy, the assumption is, the client would bring suit against the physician because that is generally the person who has liability coverage.

Ms. Sparrevohn mentioned that in the physician's office where she works, a high risk client would be referred to a perinatologist for consultation. She further added that by defining the collaborative relationship as a "midwife directed doctor consultation," the physicians may be more on board. Dr. Gregg mentioned that they often see documentation in the chart referencing whether a relationship is ongoing or if it is a one-time consultation. Ms. Ehrlich stated that she would like language in the regulation to make clear that there would be no physician liability until transfer of care.

Mr. Heppler advised that when the Board and all of its Committees practice these types of

exercises for licensing or for disciplinary functions, it does so with consumer protection being paramount. In Mr. Heppler's opinion, when the Board disciplines a licensee or denies a license, it does so with the purpose to protect the public. He further stated the Board does not deal in civil litigation, as it is not the Board's duty to award monetary damages. It is not within the arena of the Board to determine or discuss civil litigation and the avoidance of civil litigation. Mr. Heppler asked the MAC to be clear in that trying to shield or promote exposure to legal liability is not the Board's role. The Board deals in administrative discipline and in public protection.

Ms. Sparrevohn asked Dr. Gregg if no change was made to the proposed physician supervision language, could the midwife and the physician define what collaboration is? She stated ACOG and the liability insurance carriers could identify what would or would not be covered. Dr. Gregg said she believed physicians would be more willing to collaborate if there were standardized procedures instead of the midwife defining the relationship. It comes down to engaging the physicians in this process.

Ms. Smith-Crowley provided information concerning physician costs associated with having to defend himself/herself in a court case. Oftentimes insurance carriers try to prove that it is a collaborative relationship so they do not have to defend the suit. She recommended adding language identifying limited responsibility to the physician would be helpful.

Ms. Sparrevohn asked for legal counsel's opinion as to whether the draft language could be changed from collaborative to midwife-directed consultation. In response, Ms. Dobbs stated that a motion was on the floor and if Ms. Sparrevohn was considering changing the regulatory language, a request should be made to send the draft back to staff and to have them continue to work on the language.

A question was asked whether the revisions could be made at the time the regulation went to a Hearing.

Mr. Heppler provided a brief overview of the regulatory process. He indicated the MAC would need to bring the recommended language to the Board for approval. The Board would then deliberate on the matter and determine whether it accepts the MAC's recommendation and if so would set the matter for a Hearing.

If the matter was set for a Hearing, there would be a 45 day comment period for the Board to accept written comments. At the Regulatory Hearing, the Board would again accept both oral and written comments. If the Board decided to proceed, all comments would be addressed by the Board. It could take an additional 45 or 50 days if further steps were required due to revisions being made.

Ms. Rock identified herself with the California Association of Midwives (CAM). She suggested midwives who are currently collaborating with physicians be surveyed to find out which of the two drafts of language was preferable from the doctor's viewpoint. Ms. Sparrevohn asked CAM if they could do this and Ms. Rock agreed.

Ms. Sparrevohn asked if there were any more comments from the Council. Mr. Heppler asked if the Council was asking for a motion. He outlined three available options: to forge ahead with the regulation as is, understanding that it may be revised; send it back for revisions; or, amend it now.

Mr. Heppler confirmed that the draft could be amended at the current time. She stated that the pitfall in amending the draft language without additional input from the medical community is that there could be additional change recommendations down the road. Ms. Sparrevohn recommended submitting the original draft proposal to the full Board in October and did not see value in changing the wording of the regulation at the time.

Ms. Yaroslavsky stated that she had made the motion and would prefer to have additional input from other people. In order to move the process forward, she was not willing to pull the motion. She recommended that in the essence of time, it would be better to work out the verbiage at the time rather than waiting. She asked legal staff if there would be any opportunity prior to October to tighten up the draft language since it appeared there wasn't complete agreement from members and ACOG.

In order to consider new language, Ms. Yaroslavsky pulled the original motion to accept the revised language and made a new motion to consider new language; Ms. Gibson who had seconded the motion agreed.

Ms. Ehrlich recommended to move forward with Dr. Gregg's suggestions as they had enough specific information.

Dr. Gregg summarized ACOG's recommendations: midwives should direct the consultation when necessary, and consultation should be face-to-face between physician and patient. In each case, consultation would not be mandated, but performed when the midwife deems it necessary.

Ms. Erhlich preferred the verbiage "medical indication" rather than "necessary" as she claims the word necessary sounds like "high risk." Mr. Heppler questioned whether it would be up to the discretion of the midwife to decide what the medical indications or conditions were to initiate the physician consultation. Council members responded yes.

Additional discussion ensued to edit and enhance the regulatory language.

Dr. Byrne clarified that if it is a consultation, the patient-physician relationship is established with face-to-face contact. By utilizing that language, in a supervisory role or in a hospital-health care system, sending a patient or wanting to send patients (even if they don't show) puts the responsibility on the physician to track them down.

Dr. Gregg recommended from the physician's perspective that section (b) should be restated. She used Utah as an example; there is no liability until there is a face-to-face consult. She was under the impression that the Council was trying to distinguish between face-to-face consultation and midwife/physician consultation, whereas the midwife continues to be the primary care provider until full transfer of care. She said they are relying on the physicians to document this information in their charts.

Ms. Sparrevohn recommended leaving section (b) as is, since the face-to-face takes place prior to the possibility of the patient being transferred. She read section (a) again, "The requirement for physician supervision contained in 2507 of the code is deemed to have been met if the licensed midwife establishes a midwife directed physician/patient consultation for medical indication."

Ms. Ehrlich interjected that the physician must meet the requirements of section 1399.72.

Ms. Sparrevohn requested public comment.

Mr. Zacherman stated that his understanding of the first part of the originally proposed regulatory language implies that the midwife would send all midwifery clients to a physician. Ms. Sparrevohn clarified that legal staff does not read the regulation in that way and they do not want to direct midwives to have a collaborative relationship with a physician for every client.

Ms. Grote questioned if there was liability protection for the doctor who provides advice over the phone to a midwife with a moderate risk client. Ms. Sparrevohn clarified that the physician is not responsible until care has been transferred from the midwife. Based on comments made by Dr. Gregg and Ms. Smith-Crowley, Ms. Sparrevohn suggested that there probably should not be a phone relationship if the physician intends to be protected. In medical settings, clarification is generally provided in writing.

Ms. Sparrevohn requested a 10 minute recess while staff typed up the edited language. The following draft regulation to Section 1379.23 in Article 3.5 in Chapter 4 of Division 13, Title 16 of the California Code of Regulations was presented. ***Council Members voted to approve the language and present to the Board at the October meeting.***

1379.23 Physician Supervision Requirement.

(a) The requirement for physician supervision contained in Section 2507 of the Code is deemed to have been met if the licensed midwife establishes a midwife-directed physician- patient consultation for medical indication. The physician must meet the requirements of Section 1379.22.

(b) A physician and surgeon shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with a licensed midwife solely by consulting with or accepting a referral from the licensed midwife.

NOTE: Authority cited: Section 2018 and 2507(f), Business and Professions Code. Reference: Section 2507, Business and Professions Code.

B. 1379.24 - Practice of Midwifery

Council Members were asked to refer to page 14 of their packets concerning the Practice of Midwifery, proposed regulation 1379.24 of the California Code of Regulations. Ms. Lowe stated that current regulations outline the requirement for midwifery education programs. The education program must prepare the midwife for the management of a normal pregnancy, labor, and delivery. Midwives often face difficulty in securing supplies, such as oxygen, anesthetics, and oxytocics in order to practice safely and effectively.

Ms. Lowe provided a brief history concerning the regulation stating that at the December 2011 MAC meeting, legal counsel presented language for the proposed regulation. The MAC members approved the proposed language with minor edits. At the March 29, 2012 Interested Parties Workshop, recommendations were made to remove language pertaining to diaphragms and cervical caps and requested adding, "family planning care" instead. Ms. Lowe requested the

following language be approved by the MAC and recommended to the Full Board to set for Hearing:

1379.24. Practice of Midwifery

A licensed midwife shall have the authority, limited to the practice of midwifery as defined in section 2507 of the Code, to obtain and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests. This authority includes, but is not limited to, obtaining and administering intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, local anesthesia, oxygen, local infiltration, vitamin K, eye prophylaxis, and family-planning care.

NOTE: Authority cited: Section 2018, Business and Professions Code.
Reference: Section 2507, Business and Professions Code, and Title 16 California Code of Regulations 1379.30.

Ms. Ehrlich made a motion to recommend to the Board that the revised language be set for Hearing; s/Gibson.

Ms. Sparrevohn asked for input from the Council.

Ms. Ehrlich suggested that instead of stating postpartum oxytocics, it would be better stated as "post antihemmoragics" and to eliminate either local anesthesia and local infiltration as they mean the same thing.

Ms. Sparrevohn recommended eliminating local anesthesia from the regulation. Ms. Gibson clarified that local anesthesia is used to do infiltration.

Dr. Byrne questioned the phrase, "family planning care" stating that with so many options considered invasive, he was concerned the current language was overly broad as it could imply IUD insertions, sub dermal implants, and tubal obstruction. Ms. Sparrevohn referred to the Midwives Standard of Care that allows a midwife to add skills to her practice if she has appropriate physician backup. She indicated the midwife is able to perform an IUD insertion with a physician available, while working in a clinical setting and feels that having a physician as backup should be adequate to allow a midwife to do this. Dr. Byrne agreed, but questioned whether that should be extended to sub-dermal implants and other invasive procedures since such procedures have evolved over the last ten years.

Ms. Yaroslavsky asked if there should be more definition by outlining the scope of the appropriate level of training and the appropriate level of back up.

Ms. Dobbs recommended adding "subject to appropriate training and skill level."

Ms. Sparrevohn suggested referencing the Midwifery Standard of Care Sections (1)(J) in the family planning care.

Ms. Dobbs voiced concern over the current verbiage which seemed to suggest midwives are allowed to write prescriptions, even though it does not specifically say prescription. Ms. Ehrlich stated that midwives were authorized to obtain and administer only the specific drugs, devices and diagnostics outlined in the regulation and that midwives usually obtain supplies through supply houses or occasionally from a pharmacy, hospital, or physician. She said midwives were authorized to utilize the items identified in regulation. Ms. Dobbs suggested replacing the word "obtain" with "utilize."

Ms. Sparrevohn identified the big issue is how midwives obtain supplies. Ms. Yaroslavsky questioned whether the issue of not being able to obtain supplies caused the regulation to be written in the first place. Ms. Gibson acknowledged that it was. Ms. Yaroslavsky clarified that midwives can receive the supplies needed to do their job. She agreed that the word "obtain" should be changed.

Mr. Heppler reminded attendees the purpose of the regulation was to reconcile the educational requirements, regulatory practice requirements, and some of the statutes involving midwifery training. He conveyed issues in the pharmacy law that did not identify licensed midwives having the authority to issue prescriptions. The regulation states, "If a prescription is something that is either signed or issued by a physician, a dentist, an optometrist, a podiatrist, a veterinarian, a naturopathic doctor, a PA, nurse practitioner or a certified nurse midwife." Mr. Heppler stated that there were practical limitations per section 4040 of the Business and Professions Code, and based on the pharmacy code, midwives may not be able to acquire supplies through these means. He recommended moving ahead with the midwifery regulation. The issue comes down to whether the pharmacist could fill it or elect not to fill it. Ms. Ehrlich confirmed that midwives do have the ability to get supplies through supply houses because other states have formularies to assist practitioners.

Ms. Sparrevohn listed supplies that are prescription driven and are a problem to obtain: RhoGAM, litacaine, vitamin K, profolaxics, and oxytocics. She asked if all of these supply houses were in compliance with the law or not. She recommended looking into fixing this problem for midwives. Ms. Ehrlich acknowledged that ultimately statutory changes needed to be made; however, she recommended moving ahead with the proposed language at this time.

Ms. Yaroslavsky asked if utilizing the word "furnish" would be a better definition since the supplies are not furnished by a pharmacy. She also recommended removing the word "drug" since the term is associated with pharmacology. Ms. Sparrevohn suggested the revised language should state, "to obtain and administer," and recommended the following changes: remove the word "drug"; change oxytocics to "anti-hemorrhagics"; remove local infiltration; and, end the paragraph with "family planning care in accordance with (1)(J) of the Standard of Care for Licensed Midwives".

Ms. Sparrevohn asked for public comment on the regulation. No comments were provided.

As the maker of the motion and the second of the motion Ms. Ehrlich and Ms. Gibson accepted the revised language. ***Council Members voted to approve the language and present it to the Board at the October meeting.***

1379.24. Practice of Midwifery

A licensed midwife shall have the authority, limited to the practice of midwifery as defined in section 2507 of the Code, to obtain and administer immunizing agents, diagnostic tests and devices, and to order laboratory tests. This authority includes, but is not limited to, obtaining and administering intravenous fluids, analgesics, postpartum anti-hemorrhagics, RhoGAM, local anesthesia, oxygen, vitamin K, eye prophylaxis, and family-planning care in accordance with section (1)(J) of the Standard of Care for Licensed Midwives.

NOTE: Authority cited: Section 2018, Business and Professions Code.
Reference: Section 2507, Business and Professions Code, and Title 16 California Code of Regulations1379.30.

Agenda Item 5: Midwifery Program Update

A. Licensing Statistics

Ms. Morrish provided an update on the fourth quarter statistics for fiscal year 2011/2012 indicating that there were nine licenses issued, 37 licenses renewed, and zero applications pending.

B. 2011 Licensed Midwife Annual Report

Ms. Morrish provided an update on the 2011 Licensed Midwife Annual Report stating that as of June 30, 2012 there were 267 midwives with current/renewed status and 30 with delinquent status. Those in delinquent status did not include canceled, surrendered or revoked licenses. Of the 283 midwives that were expected to report, 241 submitted statistics to the Office of Statewide Health Planning and Development (OSHPD). There were 42 midwives who did not file a report. The Board sent out deficiency letters to remind midwives that the Licensed Midwife Annual Report (LMAR) was past due.

Ms. Morrish indicated that the Board hosted the North American Registry of Midwifes (NARM) exam on August 15, 2012 in which nine individuals sat for the exam. Ms. Morrish informed the Council that the next exam was scheduled for February 15, 2013.

C. Enforcement Statistics Report

Ms. Morrish provided an update on the enforcement statistics stating that there were a total of 26 complaints received for Fiscal Year 2011/2012. Twenty complaints were related to licensed midwives and six concerned unlicensed midwives. The Complaint Unit closed 17 complaints.

Ms. Sparrevohn inquired as to how many closed complaints involved licensed versus unlicensed midwives. She also asked how many licensed versus unlicensed midwives were referred for criminal action. Ms. Morrish did not have the specific breakdown at the time but indicated that this information could be provided in the future.

Ms. Sparrevohn recommended that in the future it would be useful for the statistics to reflect licensed versus unlicensed midwives. Ms. Yaroslavsky reiterated the importance of keeping separate statistics for licensed and unlicensed midwives.

Agenda Item 6: Update on Task Force for Midwifery Students/Midwife Assistants

Ms. Lowe provided an update on the Taskforce for Midwifery Students and Midwife Assistants. During the March 29, 2012 MAC meeting a recommendation was made to create a Task Force to determine regulations for midwife students and assistants. The meeting was scheduled for September 13, 2012 at the Board and notification was posted on the Board's website. The goal of the meeting was to discuss the apprenticeship model.

Ms. Sparrevohn asked for comment from Council Members.

Ms. Yaroslavsky recommended it would be beneficial to review the apprenticeship models used by other states to get a broader picture of the situation. Ms. Lowe stated that reference material would be provided for the Task Force meeting. Ms. Lowe confirmed Ms. Gibson was identified as a task force member.

Ms. Sparrevohn asked for public comments; none were provided.

Agenda Item 7: Consideration of Nizhoni Institute Advanced Placement and Transfer or Credit Proposal.

Mr. Worden stated that staff were not prepared to provide an update to Council Members on the Advanced Placement Proposal provided by the Nizhoni Institute at the time because the proposal was still under staff review.

Ms. Sparrevohn asked for public comments; none were provided.

Agenda Item 8: Discussion and Possible Recommendation to the Full Board on MAC Term Limits

Ms. Sparrevohn requested the Council consider adopting the following term limits: two, three year terms per Council Member.

She mentioned the term limits for Chair and Vice Chair were unclear and opened the topic up for discussion.

Ms. Yaroslavsky asked if members could serve again after their consecutive terms were up if a period of time had lapsed between appointments.

Ms. Ehrlich raised concern that with term limits there is a loss of institutional memory and knowledge on how things have come about and how decisions have been made in the past. Ms. Sparrevohn pointed out the terms do not expire at the same time and institutional memory can come from the public who attend the meetings. Her concern is that without term limits, it will be hard for new people to get the opportunity to serve and provide fresh ideas on the Council. Ms. Gibson mentioned that her term is up in March 2013, rather than June 30, 2014, as was stated in the meeting materials.

Ms. Yaroslavsky voiced her opinion that term limits are not beneficial in a democracy, and she believes the issue is not so much about term limits but rather engaging the broader community to participate beyond the day-to-day level with a governing body. She questioned why the two year terms were previously eliminated. Ms. Sparrevohn stated that the terms were adjusted to create

staggered expiration dates. Ms. Yaroslavsky noted that participants who have been involved from the beginning, like Dr. Gregg, continue to be involved. She stated that it was a good opportunity for ex-official members to participate and stay involved as audience members. She also stated that there are opportunities to chair Task Force meetings, etc., to get a variety of opinions at the table to institute change.

Mr. Heppler stated that the Council has no statutory limit on the number of members and the Council could request the Board to add additional members since there are no number restrictions. If the Council members decided that they needed new input besides conducting task force and interested parties meetings, they could expand or contract members as they see fit.

Ms. Yaroslavsky stated that an increase in the size of the Council was a good idea and ex-official members should be involved or appointed to subcommittees. She recommended having volunteers in place to help support staff to research and culminate national and international information and she suggested the MAC Chairperson meet with Board staff and legal counsel to set that up. Ms. Sparrevohn stated that she is looking for participation from the public and other midwives so as not to lose the history of the Council.

Ms. Sparrevohn indicated that the MAC did not want to enact term limits for the members.

Ms. Sparrevohn asked how long the term limits have been for the Chairperson. Members stated that the time frames have varied but recommended term limits should be two years. Ms. Yaroslavsky recommended the Chairperson give thought to this issue and discuss with staff before providing a recommendation to the MAC.

Ms. Sparrevohn made a motion to set two year term limits for officers; s/Ehrlich.

Ms. Yaroslavsky asked Ms. Sparrevohn to outline her perspective. Ms. Sparrevohn clarified by stating the issue of term limits has been discussed and she would set the term in office at two years without term limits. Mr. Heppler asked Ms. Sparrevohn if she was making no limit to the terms served as a MAC member, clarifying that she was making a term limit for an officer. Ms. Sparrevohn stated she was attempting to identify the length of term since it had not been previously identified.

Council Members voted to approve two year term limits for officers.

Agenda Item 9: Agenda Items for the December 6, 2012 Midwifery Advisory Council Meeting

Ms. Gibson voiced concern with data discrepancies on the OSHPD Licensed Midwife Annual Report. Ms. Sparrevohn asked Mr. Worden to look into the issue. Mr. Worden stated that staff would meet with OSHPD once the change recommendations were identified. He further clarified that the Board's Information Systems staff were working to incorporate a new computer system at the Board and currently do not have the time to work on changing the LMAR. Staff are also involved in preparing the Annual and Sunset Review Reports, but should be able to focus on addressing these issues in the next month or two.

Some MAC members voiced concern that they had hoped the recommended changes would be in

the works. Mr. Worden mentioned, due to deadlines, staff have had to prioritize workload.

Ms. Sparrevohn asked if there were additional items to place on the agenda for the next meeting.

Dr. Byrne asked for an overview of the goals and objectives related to the data reporting processes.

The following agenda items were identified by Ms. Sparrevohn for the December 6, 2012 MAC meeting:

- Midwifery Program Statistics
- Student Assistants Task Force Update
- MANA Task Force Update
- OSHPD LMAR Update
- An Overview of the Goals and Objectives related to Data Reporting

Agenda Item 10 Adjournment
Ms. Sparrevohn made a motion to adjourn the meeting. Motion carried, adjourned at 3:49 p.m.

MEDICAL BOARD OF CALIFORNIA
Licensing Operations

Midwifery Advisory Council
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

December 6, 2012
MINUTES

DRAFT

Agenda Item 1 Call to Order/Roll Call
The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by Chairperson Carrie Sparrevohn at 1:06 p.m. A quorum was present and notice was sent to interested parties.

Members Present:
Carrie Sparrevohn, L.M., Chair
Karen Ehrlich, L.M.
Faith Gibson, L.M.
Monique Webster
Barbara Yaroslavsky

Staff Present:
Diane Dobbs, Department of Consumer Affairs, Legal Counsel
David Galbraith, Assistant
Kurt Heppler, Staff Counsel
Natalie Lowe, Licensing Manager
Susan Morrish, Licensing Analyst
Anthony Salgado, Licensing Manager
Kathryn Taylor, Licensing Manager
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
Bruce Ackerman, M.A.N.A.
Jennifer Brown, L.M.
Brooke Casey, L.M.
Rachel Fox-Tierney, L.M.
Diane Holzen, L.M.
Lesley Nelson
Laura Perez, Sacred Birth Place
Constance Rock, L.M., C.A.M.
Geri Ryan, Nizhoni Institute
Shannon Smith-Crowley, A.C.O.G.
Linda Walsh, C.N.M.A.

(The above list identifies attendees who signed the meeting sign-in sheet.)

Agenda Item 2 Public Comments on Items Not on the Agenda
No public comment was provided.

Agenda Item 3 Responsibilities of Council Members Under the Open Meeting Act
Ms. Dobbs provided information on the Bagley-Keene Open Meeting Act (Open Meeting Act). She defined a meeting as any congregation in which the majority of the members of a State body assemble to discuss, hear, or deliberate on any matter within the subject matter jurisdiction of the body.

The basic purpose of the Open Meeting Act is for all State business to be conducted in the open so that the public has an opportunity to participate in the process and all decision making of the body is done in a transparent manner. Some of the responsibilities under the Open Meeting Act are at the Board staff level: to provide public notice of the meeting and to identify the agenda items so that the public has an opportunity to prepare for and effectively participate in the meeting.

Ms. Dobbs stated that the MAC is made up of six members with a majority of four members required to hold a meeting. She referred to the following examples in what would be considered violations of the Open Meeting Act:

- If the Board asks the MAC to provide regulatory recommendations pertaining to physician supervision of midwives, and four members of the MAC decide to engage to discuss this either in person, over the telephone, or by e-mail without notifying the public or the meeting being formally noticed, it would be in violation of the Open Meeting Act.

- It would be a clear violation if two members decide to discuss a particular matter and each calls another member of the MAC on the same topic in an effort to come up with a consensus on the issue without the public notice requirements. It is prohibited to have two council members in discussion with additional people in an effort to reach a majority consensus, outside of the jurisdiction of the MAC.

She further stated, in addition to avoiding actual discussions and actual violations, as the examples demonstrate, efforts should be made to avoid the perception that issues are being discussed outside of the public's ear, or that "back door deals" are being made by members of the MAC.

Ms. Dobbs advised that while MAC members are free to give their personal opinion on a matter that is within the jurisdiction of the committee, outside of the meeting setting, she cautioned that care should be taken in doing so and that the member should make it clear that they are speaking as an individual and not as a member of the MAC. She provided another example:

- If MAC members are "blogging" on a subject that is within the jurisdiction of the MAC, although they may be stating their opinion, public members could easily perceive that this is the opinion of the MAC. Care must be taken to ensure that when MAC members give an opinion that the public understands that this is their personal opinion and not the opinion of the MAC.

Ms. Dobbs advised that the same kind of care should be taken when discussing matters within the jurisdiction of the MAC, with members of the public. Ideally, if a MAC member is approached from a member of the public asking for a comment on any matter that is within the jurisdiction of the MAC, or a matter that involves discipline which is not within the jurisdiction of the MAC, the Board recommends refraining from comment. If the matter concerns a disciplinary matter, the Board recommends ending the conversation immediately and providing the information to Board staff so the information can be passed on to one of the disciplinary committees for full disclosure to all the parties in the case. Though MAC members are not involved in disciplinary decisions, taking this approach would help dispel any perception of inappropriate behavior regarding disciplinary matters.

For other matters that may come up with the public that is within the jurisdiction of the MAC, the Board recommends that information is passed on to the MAC Chairperson, or to Board staff. If appropriate, those matters could be added as an agenda item so that a public discussion of the matter could take place.

Ms. Dobbs outlined the importance of communication being done appropriately by MAC members to dispel the perception that improprieties have occurred.

Agenda Item 4: Approval of the Minutes from the August 30, 2012 Meeting
Ms. Yaroslavsky made a motion to accept the minutes from the August 30, 2012 meeting; s/Webster.

Ms. Sparrevohn asked for comments from the MAC. Ms. Ehrlich was in disagreement with information identified in the August 30, 2012 minutes. She offered to review the audio recording of the meeting to verify the accuracy of information stated in the minutes.

Following discussion, Ms. Yaroslavsky withdrew her previous motion. The Agenda Item was then tabled. Members were asked to provide Board staff with any input regarding the minutes.

Agenda Item 5 Discussion of Possible Statute Revisions
Ms. Lowe led a discussion on the issue of expanding the supervision requirements for midwifery students, which had been discussed at prior Board meetings; specifically, to add Certified Nurse Midwives (CNMs) to Business and Professions Code section 2514 which would allow a licensed midwife (LM), a physician and surgeon, or a CNM to supervise students.

Issues that needed to be considered prior to moving forward with legislation would be that adding a licensee that is not within the Board's jurisdiction would require outside input from the CNMs licensing authority. Also, CNMs may not have the authority to supervise a license type outside of their authorities jurisdiction. Adding CNMs would also place the authority for action outside of the Board's control which may cause difficulty for the Board to take action against the student who would be within the Board's control, and this may not serve the Board's mission of providing consumer protection.

Based on this preliminary information, Ms. Lowe requested direction from the MAC to determine if further research was warranted in this matter.

Ms. Sparrevohn recommended holding an interested parties meeting to gain a broader perspective on the topic. She believes CNMs can supervise student midwives and suggested getting BRN input, citing there are CNMs teaching in schools who are willing to precept students. Preceptors are difficult for student midwives to find. If a CNM is acting outside the law, she suggested the Board can contact and pursue a complaint with the BRN.

Ms. Ehrlich mentioned CNMs already have authority to sign off (precept) student midwives and suggested adding them to the regulation would define what they may do when working with midwives.

Ms. Yaroslavsky asked what the barriers were in moving forward with recommending draft language. She suggested holding an interested parties meeting to get feedback from the community and asked MAC members if the intent was to tighten up rather than loosen regulations.

Ms. Whitney clarified the processes involved. If interested in moving forward, the MAC would make a motion to the Board; the Board would then invite the associations for the CNMs and other appropriate parties to the meeting for their comments and recommendations. The Board would consider including the meeting comments into Sunset Legislation since this would be the appropriate place to discuss in the coming year.

Ms. Ehrlich made a motion to recommend to the Board that CNMs be added to existing statute to allow CNMs to supervise midwifery students; s/Gibson; motion carried.

No public comment was provided.

Ms. Sparrevohn asked Ms. Lowe to provide a brief update on regulations that have not moved forward.

Ms. Lowe identified two proposed regulations that were discussed at the prior MAC meeting:

- 1379.23-Physician Supervision Requirement
- 1379.24-Practice of Midwifery; Drugs and Devices.

During the August 2012 MAC meeting, the MAC agreed to recommend to the Board the regulatory language for the two proposed regulations. Prior to the Board's Quarterly meeting in February 2013, it was determined that the regulatory change recommendations would be included in the Sunset Review report and would not be brought before the Board.

Agenda Item 6 Program Update

A. Licensing Statistics

Ms. Lowe provided a program update. During the first quarter of fiscal year 2012-2013 the Board received eight new LM applications, and five new licenses were issued. At the end of the quarter 272 licenses were in Renewed/Current status with 29 in Delinquent status. At the last MAC meeting staff reported 42 licensees were delinquent in completing their annual reports to the Office of Statewide Planning and Development (OSHPD). At the end of the first quarter OSHPD reported that 41 licensees were still delinquent.

When asked how long an LM license can stay in delinquency status Ms. Lowe clarified that the license can remain delinquent for up to five years from the expiration date. To renew, the LM must pay previous renewal fees and any accrued delinquent fees. If the license is not renewed within five years from the expiration date, the LM is required to re-apply for a license.

B. Enforcement Statistics

During the first quarter of the fiscal year the Board received four complaints. One complaint involved an unlicensed midwife. Two LM investigations were opened during the first quarter. One case was referred to the Attorney General's Office and another LM case was referred for criminal action.

C. Licensed Midwife Annual Report Data Clarification

After the March 30th due date, Board staff sent delinquency letters to licensed midwives who had not submitted their 2011 Licensed Midwife Annual Report (LMAR). The LM is unable to renew their midwife license until they complete and submit any delinquent LMAR(s) to OSHPD.

During the August 30, 2012 MAC meeting, Board staff was asked to provide an overview of the goals and objectives of the data reporting processes. Ms. Lowe explained Senate Bill 1638 was passed in 2007, resulting in Business and Professions Code 2516, with the intent to provide accurate home-birth data to professionals and consumers. The measure was put in place to assist California LMs to improve midwifery standards of care and develop appropriate policy changes in midwifery education. The regulation states that each LM who assists, or supervises a student midwife assisting in childbirth in an out-of-hospital setting shall annually report to OSHPD. From the inception of the regulation, concerns have been raised regarding some of the information that is collected.

D. Student Illegal Practice Letter

Ms. Lowe provided an update regarding the Student Illegal Practice letter stating that during the Task Force for Midwifery Students and Midwife Assistants held on September 20, 2012, discussion ensued regarding the practice of unlicensed midwifery students soliciting for clients and employing LMs to assist them in out of hospital births. A letter was sent to all LMs in California at the end of November, outlining that these practices were illegal and that LMs involved in aiding and abetting a student in this practice may be subject to Board action, including but not limited to suspension or revocation of his or her license. And likewise, any student found to be in violation of this provision would risk possible denial of licensure as well as criminal action. Ms. Lowe indicated that staff had received feedback regarding the letter, including questions on different practices that are currently being performed in the community. Ms. Lowe reminded the committee as well as LMs in California that Board staff is unable to interpret laws and recommended anyone with questions regarding what constitutes legal practice to refer to their legal counsel.

When asked if there were questions, Ms. Ehrlich provided the following example: a student midwife studying with Ms. Ehrlich had a friend who wanted this student to be her midwife. The two women came to Ms. Ehrlich's practice and she herself became the friend's midwife, and supervised her student while she performed the midwife services during the birth. Ms. Ehrlich asked whether this scenario would be legal or not, given what the letter says. She requested that Board staff provide written expectations for supervising midwives that outline what they may or may not do when supervising student midwives.

Ms. Yaroslavsky stated that the letter is very clear, that an unlicensed individual soliciting clients to be employed as a midwife and employing others, is not following the law. She asked if the example Ms. Ehrlich provided was within the guidelines of soliciting for business. Ms. Ehrlich said it was not.

Ms. Yaroslavsky reiterated that if someone was unclear and had questions pertaining to what is appropriate, they should ask their own legal counsel for clarification.

E. Implementation of Continuing Education Audit

Ms. Lowe provided background information on the Continuing Education (CE) requirements for LMs. Business and Professions Code Section 2518(a), specifies that 36 hours of CEs are required every (2) years to renew a midwife license. The LM is required to sign a statement certifying that they have met the CE requirements on the renewal form. Unless audited, proof of the CE is not required to be submitted to the Board.

Due to staffing limitations, LMs have not been audited recently. With recent changes, the audit processes are now automated and the computer system can randomly select a percentage of licensee's based on specific criteria. Board staff anticipates conducting the first LM audit in December 2012. If audited, the LM is asked to provide proof of CE credits within the renewal cycle which Board staff will review to determine compliance with the law.

7. Update on Task Force for Midwifery Students/Midwife Assistants

Ms. Lowe provided an update on the task force for midwifery students and midwife assistants stating that on September 20, 2012, the Midwifery Student and Midwifery Assistant Task Force meeting was held at the Board's headquarters. The purpose of the meeting was to address the role of midwifery students and midwifery assistants in the practice of midwifery. The meeting was attended by MAC members Ms. Sparrevohn and Ms. Ehrlich, two LMs, one CNM and one California student midwife. Board staff and Legal Counsel were also present.

Meeting attendee's suggested regulations needed to be defined or clarified in the following areas:

- The role of the student midwife.
- The role of the midwife assistant.
- Define the midwifery student/preceptor relationship.
- Outline supervision requirements for student midwife/assistants.
- Identify what students can or cannot do in out-of-hospital birth patient care.
- Determine what actions can be taken by a student midwife prior to the supervising midwife's arrival at the out-of-hospital birth location.
- Determine whether the supervising midwife must be at the out-of-hospital birth location prior to the student midwife or assistant's arrival.
- To meet licensing requirements, clarify student enrollment in a Board approved midwifery education program.

Ms. Lowe concluded the update by noting Board staff and Legal Counsel were still collecting and reviewing information obtained during the task force meeting and MAC members would be provided copies of the task force meeting information in the near future.

Ms. Sparrevohn asked how many of the problems identified at the task force meeting could be resolved with regulation. She requested Board staff provide an update at the next MAC meeting. Ms. Sparrevohn asked for comment from the MAC.

Ms. Ehrlich expressed concern that written expectations were needed for midwives supervising students, and student expectations should be outlined as well, due to midwives being prosecuted by agencies.

Ms. Sparrevohn and Ms. Yaroslavsky expressed concern that too much regulation could interfere with the midwife's ability to practice. Ms. Yaroslavsky asked Ms. Ehrlich to be specific on what community issues should be addressed by more regulation. Ms. Erhlich clarified that she wasn't necessarily looking for changes in regulations, but for the Board to provide statements. She referred to the Medical Board Newsletter and asked that the Board provide specific guidelines. Ms. Yaroslavsky commented that the current discussion did not pertain to barriers to care and explained that specific issues should be identified so that Board staff can make a determination on whether to move forward on an issue.

Ms. Ehrlich commented that a student midwife issue was brought to her attention from the midwife community, specific to doctors and nurses not yet licensed, who are allowed to work under the supervision of a licensed (medical) person.

Ms. Whitney provided regulatory information to the MAC stating that physicians in post graduate training, not yet licensed, have a specific period of time they cannot exceed to work under the supervision of another physician. If the physician exceeds the time frames they are taken out of practice in their residency. As was discussed during the Midwife Student/Assistant Task Force, midwifery students have a period of time between finishing the requirements to become licensed and obtaining a midwifery license. The law does not address this. Until a midwife license is issued, the student cannot practice, even if they have met the requirements for licensure. This was one of the issues identified in the Sunset Review report. Another issue not identified in regulation concerns who can assist, and how students can assist in out-of-hospital births. This was also identified in the Sunset Review report and will be part of a discussion on whether the legislature wants to move forward by adding additional language to current regulations.

Ms. Whitney mentioned that since the Sunset Review hearing had not yet occurred, it was unclear how the Legislature would react to the issues presented at the Legislative hearing. She outlined the importance for the midwife community to participate in the hearing. As identified during the Student/Assistant Task Force meeting, Board staff cannot provide guidance or legal advice related to regulatory "gray areas." She suggested MAC members review the executive summary, as well as the midwife section of the Sunset Review report, which would be available soon on the Board's Internet Web site. Questions concerning the report should be directed to Ms. Lowe or Ms. Whitney.

Ms. Sparrevohn asked for additional questions.

Ms. Gibson requested Ms. Perez, a student midwife, to speak on behalf of the midwife community. Ms. Perez identified herself as a student midwife who would soon take the licensing exam. She reviewed the "solicitation" letter Board staff had sent and explained that as a student

not yet licensed, she is under the supervision of an LM. Ms. Perez does not believe over-regulation is the answer because it may cause unnecessary trepidation among students.

Discussion ensued to clarify the intent of the "solicitation" letter LMs received. Ms. Yaroslavsky paraphrased a section of the letter, "It has come to the attention of the Board that some students in the state are soliciting clients and employing LMs to assist them in out-of-hospital births." She stated that the letter was addressed to LMs with the intent to provide awareness that this is an illegal practice should they be approached by a student in this way. Ms. Whitney added that as a LM, if a student midwife or a person not involved in midwifery asks you to assist in a home birth, and you agree, you will be aiding and abetting in an unlawful practice. To be involved in the birth, the client must be your client, not someone else's.

Ms. Sparrevohn asked for public comment on the agenda item.

Ms. Ryan with the Nizhoni Institute introduced herself to the MAC and provided input from an educator's standpoint. The Nizhoni Institute is an accredited school under two sets of regulations: the California Bureau of Post-Secondary Education and the Midwifery Education Alliance in California (MEAC). Students are provided expectation guidelines and the role of "student" does not change until they are licensed. When attending births, students are always under LM supervision and are not to arrive at the home before the LM. Students are on an individual learning contract by month until they receive their midwife license. Education may be extended from 3 to 5 years, depending on student readiness to take the exam. She suggested discussions should begin with California midwives and the Midwife Associations to identify and talk about the issues. Ms. Ryan stated that she believes there is more confusion among the LMs than with the student midwives.

Ms. Ehrlich asked if other schools were retaining student enrollment until the student was ready to apply for their midwife license. Ms. Ryan clarified that MEAC regulations require the school to have an independent learning contract with the student. The Department of Education requires this. The student has not graduated from a MEAC accredited program until they have a license.

8. Update on Midwives Alliance of North America Task Force

Ms. Sparrevohn provided an update on the Midwives Alliance of North America (MANA) Task Force meeting. She referred to the MANA Statistics Project Report, identified in the meeting packet as Agenda Item 8. During the MAC meeting in March 2012, MAC members approved the creation of a task force to look at the feasibility of moving the California statistical reporting process to the MANA reporting system.

At Ms. Sparrevohn's request, the proposal was drafted by Mr. Ackerman and Ms. Brown in lieu of the task force. The proposal was forwarded to Board staff for review. Change recommendations were discussed during a meeting with Board staff and Ms. Sparrevohn. The current proposal reflects the edits that were made by Ms. Sparrevohn, Mr. Ackerman, and Ms. Brown.

Ms. Sparrevohn indicated that there is dissatisfaction among midwives with the current midwifery data collection process in California. She considers the MANA reporting system to be a well-informed data collection system that is used nationally and believes many midwives throughout the State currently provide data to MANA. Ms. Sparrevohn outlined the following reasons that

changing the current data collection process to MANA would be beneficial:

- MANA is a national database that provides data comparison with other states. Some states have mandated the use of MANA for data collection.
- Using MANA allows "best practices" to be identified and implemented in California statutes and regulations.
- Data is collected when a woman enters care rather than reporting retrospectively after outcomes have occurred. This lowers the possibility of incomplete data and inquiries by the medical community.
- The MANA review team "flag" potential errors. For data clarification purposes, MANA staff provide follow up with LMs.
- The data submittal deadlines must be adhered to and cannot be submitted later, i.e., during license renewal.

Ms. Sparrevohn added that the MANA reporting system was designed by an interdisciplinary team that provides maternal health research and an information maintenance and design system which she believes OSHPD does not have. She suggested seeking a statutory change in how midwifery data is collected in California to accommodate changes in the requirements without having to revise regulation through the Legislature. She suggested changing the reporting period from calendar year to fiscal year to accommodate MANA timeframes.

Ms. Sparrevohn identified some of the financial obstacles to implement the MANA reporting system:

- Start-up costs to enroll all of the midwives would be approximately $25,000.
- Program utilization training for midwives would be necessary.

She recommended that LMs use MANA for reporting purposes, and the data MANA collects could then be provided to OSHPD to comprise the LMAR statistics.

MANA would incorporate California out-of-hospital birth data into a National database. LM data would reside with the MANA research services, which will be the basis for research and improve midwifery practices and birth outcomes in California.

Ms. Ehrlich agreed with this recommendation and believed that it was in the best interest of LMs and the healthcare community to use MANA as it would provide a better understanding of what midwives do. Ms. Gibson confirmed reporting data should be prospective. Ms. Yaroslavsky was supportive to move forward and thanked the team for outlining the project goals and objectives.

When asked if a motion could be entered during the meeting, Ms. Dobbs clarified that the Agenda Item was written as an "update" on the MANA Task Force and didn't provide information on decisions being made. Ms. Sparrevohn said that the task force was established to offer an opinion to send to the Board. She asked if this could be accomplished given the wording of the Agenda.

Ms. Whitney suggested that on behalf of the MAC, Ms. Sparrevohn could recommend to the Board, development of legislative language to request transferring the LM data collection to

MANA and that the data be provided to OSHPD. This recommendation could be presented during the February 1, 2013 Quarterly Board meeting.

Ms. Ehrlich made a motion to recommend to the Medical Board developing legislative language pertaining to data statistics; s/Yaroslavsky; motion carried.

Agenda Item 9 Proposed Midwifery Advisory Council Meeting Dates for 2013

Due to the number of "interested party" meetings and task force meetings in the upcoming year, Ms. Sparrevohn questioned whether three MAC meetings would be appropriate or four MAC meetings a year. She suggested eliminating one or more interested parties/task force meetings in the coming year to accommodate a fourth MAC meeting.

Mr. Worden explained that there is more work involved in the preparation of a MAC meeting than an interested parties meeting, and based on available staff time, Board staff can only accommodate holding three meetings a year. Board staff are also currently working on several assignments simultaneously at this time such as Sunset Review, incorporating a new licensing computer system, along with high workloads. He stated that scheduling additional interested parties meetings would have to occur around timeframes that are feasible for staff.

Ms. Sparrevohn stated that she would like to see midwife regulatory change recommendations given adequate review time before the August 2013 MAC meeting.

Ms. Whitney outlined the Sunset Review process. The Board will present the Sunset Review report during the first Legislative hearing in early March 2013. In late April 2013, a more substantive Legislative hearing will occur to address issues identified in the Sunset Review report. Ms. Whitney stated that the second hearing would be of more importance to attend. The Board, along with Legislative staff will assist in crafting regulatory language before it goes before the Legislative Council and review by the attorneys for the Legislature. The attorneys for the Legislature will prepare the actual draft language of the Bill.

The Board and MAC will have an opportunity to comment and make change recommendations to the draft language if it does not address imperative areas. The Legislative attorneys prepare the written language of the Bill according to the "letter of the law" but may change the language based on discussions at the hearing. Based on member's testimony, the Legislature may vote to amend the language of a Bill.

The Board will have a sense of where the legislation is going in July 2013 and the MAC will be updated during the August 2013 MAC meeting before the Legislature is back in session. The Board will work with the Legislature at that time. Ms. Whitney stated that it is the Legislature's Bill and emphasized the importance for the midwifery community to be party to the process and attend the hearings. Ms. Whitney added, the exact regulatory language is not presented to the MAC because the Board is developing the regulatory concepts the MAC is in agreement with. The issue can move forward in the legislative process as long as the MAC is in agreement with the regulatory concepts. The wording can be written after the concepts have been identified.

Ms. Yaroslavsky recommended that the LMs review the midwife section of the Sunset Review report and provide input now, rather than waiting until the Legislature comes back from summer

break in September. She suggested comments and suggestions pertaining to the report should be directed to Ms. Lowe or Ms. Whitney.

Ms. Whitney mentioned that many people in the midwifery community have signed up for "mail alerts" and are notified when items of interest are posted on the Board's Internet Web site. She confirmed that the Legislative hearing dates will also be posted on the Board's Internet Web site for those who are interested. She confirmed that often the Board leaves it up to the licensee organizations themselves to provide updates to their constituents. Ms. Yaroslavsky agreed that moving forward, the organizations themselves should be sharing relevant Board information with their members. Ms. Whitney validated that most of the midwifery organizations are following what the MAC does and will be following what occurs with the Legislative discussions that occur.

MAC members reviewed suggested MAC meeting dates for 2013, outlined in Agenda Item 9. MAC members agreed on the following meeting dates:

- March 14, 2013
- August 8, 2013
- December 5, 2013

All meetings will be held at the Board's headquarters in Sacramento.

Ms. Sparrevohn asked for date and location information for the upcoming Quarterly Board meetings. Ms. Lowe provided the following information:

- January 31-February 1, 2013 Burlingame
- April 25-26, 2013 Los Angeles
- July 18-19, 2013 Sacramento
- October 24-25, 2013 Ontario

Agenda Item 10 Agenda Items for the First 2013 Midwifery Advisory Council Meeting – Sacramento

The following agenda items were identified for the March 14, 2013 MAC meeting:

- Report from the MAC Chairperson
- Update on Midwifery Students/Assistants-Defining Regulations
- MANA Statistics Project/OSHPD Update
- Sunset Review Update

Ms. Yaroslavsky suggested Ms. Sparrevohn may want to consider adding items of interest from the midwife community as MAC agenda items, such as inviting guest speakers to provide short presentations on educational opportunities or other relevant information for constituents.

Agenda Item 11 Adjournment

Ms. Sparrevohn motioned to adjourn the meeting. Motion carried, adjourned at 2:50 p.m.

Appendix I

Midwifery Program

- Background and Description of Midwifery Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments

Section 1 – Background and Description of Midwifery Program

History and Functions of the Midwifery Program

A licensed midwife is an individual who has been issued a license to practice midwifery by the Medical Board of California (Board). The Midwifery Practice Act was chaptered in 1993 and implemented in 1994 with the first direct entry midwives licensed in September 1995. The practice of midwifery authorizes the licensee, under the supervision of a licensed physician, in active practice, to attend cases of normal childbirth, in a home, birthing clinic, or hospital environment.

Pathways to licensure for midwives include completion of a three-year postsecondary education program in an accredited school approved by the Board or through a Challenge Mechanism. Business and Professions (B&P) Code section 2513(a)-(c) allows a midwifery student and prospective applicant the opportunity to obtain credit by examination for previous midwifery education and clinical experience. Prior to licensure, all midwives must take and pass the North American Registry of Midwives (NARM) examination, adopted by the Board in 1996, which satisfies the written examination requirements set forth in law.

In order to provide the guidance necessary to the Board on midwifery issues, effective January 1, 2007, the Board was mandated to have a Midwifery Advisory Council. This Council is made up of licensed midwives (pursuant to B&P Code section 2509 at least half of the Council shall be licensed midwives), a Board Member, a physician, and a member of the public (currently an individual who has used a licensed midwife). The Board specifies issues for the Council to discuss/resolve and the Council also identifies issues and requests approval from the Board to develop solutions to the various matters. Some items that have been discussed include physician supervision, challenge mechanisms, required reporting, and student midwives. The Midwifery Advisory Council Chair attends the Board meetings and provides an update on the issues and outcomes of the Council.

Major Legislation/Regulations Since the Last Sunset Review

Legislation

- *SB 1638 (Figueroa, Chapter 536, Statutes of 2006) Midwifery Advisory Council and Midwife Annual Report*

This bill required the Board to create and appoint a Midwifery Advisory Council. It required licensed midwives to make annual reports to OSHPD on specified information regarding birth outcomes, with the first report due in March 2008. This bill also required each licensed midwife who assists or supervises childbirth occurring in an out-of-hospital setting to annually report to OSHPD specified information regarding his or her practice for the previous year. This bill required the data to be consolidated by OSHPD and reported back to the Board for inclusion in the Board's annual report.

- *SB 1575 (B&P Comm., Chapter 799, Statutes of 2012) Omnibus*

This bill established a retired license status for licensed midwives.

Regulations

➢ *Amend CCR section 1379.20*

This regulatory change in 2005 required a midwife, who does not carry liability insurance, to disclose this fact to the client in either written or oral form and note this disclosure in the patient's file.

➢ *Adopt CCR section 1379.19*

This new section added in 2006 defined the appropriate standard of care for licensed midwives and the level of supervision required for the practice of midwifery. The adoption of midwifery standards of care was necessary because midwifery is a distinct profession.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2012 Medical Board Sunset Report

Section 3 – Fiscal and Staff Issues

The fees collected for the Midwifery Program go into the Licensed Midwifery Fund. When this Program began in 1994, it received a $70,000 loan from the General Fund. In order to ensure solvency, this loan was paid off over the course of the next ten years, and paid in full in 2004.

This fund currently does not have any approved budget appropriation. Now that the fund is solvent, the Board will be seeking an augmentation to establish an appropriation in FY 2013/2014 to fund the personnel needed to administer the Midwifery Program. Each year, the Board would request repayment from the Midwifery Program for the staff resources to perform the licensing and enforcement functions of the Program. The Board will be analyzing the impact of this appropriation to determine if a future fee increase is necessary to ensure the solvency of this fund. There have been no General Fund loans from the Licensed Midwifery Fund.

The Licensed Midwives submit an application and initial license fee of $300 and have a biennial renewal fee of $200. The renewal fee comprises about 70% of the fees received in the Licensed Midwifery Fund.

Table 2. Fund Condition Midwifery					Proposed	Proposed
(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Beginning Balance	78	101	121	154	186	217
Revenues and Transfers*	24	27	33	34	33	33
Total Revenue	102	128	154	188	219	250
Budget Authority	--	--	--	--	--	--
Expenditures	1	7		2	2	2
Loans to General Fund	--	--	--	--	--	--
Accrued Interest, Loans to General Fund	--	--	--	--	--	--
Loans Repaid From General Fund	--	--	--	--	--	--
Fund Balance	101	121	154	186	217	252

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
LICENSED MIDWIFERY FUND							
Licensed Midwife Application and Initial License Fee (B&P 2520) (Title 16, CCR 1379.5)	300.00	300.00	5,700	5,400	12,300	9,900	29.60%
Licensed Midwife Biennial Renewal Fee (B&P 2520) (Title 16, CCR 1379.5)	200.00	200.00	16,400	21,200	19,400	23,400	69.95%
Licensed Midwife Delinquency Fee (B&P 2520) (Title 16, CCR 1379.5)	50.00	50.00	300	250	100	150	0.45%

For staffing issues, refer to Full 2012 Medical Board Sunset Report.

Section 4 – Licensing Program

Application Review

CCR section 1379.11 requires the Board to 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. The midwifery program's goals have been to review all applications received within 30 days. The program has met these goals for the past four fiscal years and is currently reviewing applications for licensure as a midwife within 30 days. The Board is currently in compliance with the mandated timeframes and is also reaching the internal goals that have been set by the program.

Due to the small number of new applications received, processing times have neither decreased nor increased significantly in the last few years. The Board has seen a slight increase in applications each year and anticipates that these numbers will continue to grow. Pending applications for the Midwifery program are very small and those in a pending status are outside of the Board's control. The Board is continuously striving to review and approve applications within the set timeframes to ensure compliance with the law is met and has ensured that this occurs by reviewing policies and procedures within the program for best practices.
The tables below show the Midwifery Program licensee population, licenses issues and licenses renewed.

Table 6. Licensee Population

		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Licensed Midwife	Active	199	219	252	270
	Out-of-State	21	22	21	20
	Out-of-Country	0	0	0	0
	Delinquent	21	18	19	28

Table 7a. Licensing Data by Type

Licensed Midwife		Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	16	20	0	20	2	2	0	-	-	29
	(Renewal)	99	n/a	n/a	99	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	41	40	0	40	2	2	0	-	-	25
	(Renewal)	98	n/a	n/a	98	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	33	31	1	31	4	4	0	-	-	23
	(Renewal)	125	n/a	n/a	125	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data			
	FY 2009/10	FY 2010/11	FY 2011/12
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	16	41	33
Initial License/Initial Exam Applications Approved	20	40	31
Initial License/Initial Exam Applications Closed	0	0	1
License Issued	20	40	31
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	2	2	4
Pending Applications (outside of board control)*	2	2	4
Pending Applications (within the board control)*	0	0	0
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)	29	25	23
Average Days to Application Approval (incomplete applications)*	-	-	-
Average Days to Application Approval (complete applications)*	-	-	-
License Renewal Data:			
License Renewed	99	98	125
* Optional. List if tracked by the board.			

Verification of Application Information

Applicants are required by law to disclose truthfully all questions asked on the application for licensure. Out-of-state and out-of-country applicants must meet the same requirements as California applicants.

The application forms and Letters of Good Standing are valid for one year. After one year, they must be updated to ensure that correct and current information accurately reflects any change in an applicant's credentials. The Board requires primary source verification for certification of midwifery education, examination scores, Letters of Good Standing, diplomas, certificates, and challenge documentation.

Two questions on the application refer to discipline by any other licensing jurisdiction for the practice of midwifery or any other healing arts license type. If an affirmative response to either of these questions is provided, the applicant must provide a detailed narrative of the events and circumstances leading to the action(s). The involved institution or agency must also provide a detailed summary of the events and circumstances leading to any action. Certified copies of all orders of discipline must be provided directly by the appropriate agency. Copies of pertinent investigatory and disciplinary documents must be provided to the Board directly by the appropriate authority.

One question on the application refers to convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution. If an affirmative response to this

question is provided, the applicant must submit a detailed narrative describing the events and circumstances leading to the arrest and/or conviction. Certified copies of the police report, arrest report and all court documents must be provided directly by the issuing agency to the Board. If the records are no longer available, the court must provide a letter to that effect.

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case by case basis to determine if a license should be issued or whether the applicant is eligible for licensure.

Individuals applying for a midwifery license must submit either fingerprint cards or a copy of a completed Live Scan form in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction. Criminal record history reports are obtained from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to issuing a license.

All Licensed Midwives with a current license have been fingerprinted. As fingerprinting is a requirement for license, a midwife's license will not be issued prior to completion of this requirement. The Board receives supplemental reports from the DOJ and FBI following the initial submittal of fingerprints should future criminal convictions occur post licensure. Supplemental reports will be reviewed by the Enforcement program to determine if any action should be taken against the licensee.

A midwifery applicant must disclose all current and/or previous licenses held and provide a Letter of Good Standing (LGS) from each state or province to be sent directly to the Board verifying the applicant's licensure information and whether any action has been taken against the license. If the LGS indicates action has been taken, certified documents from the state or province must be provided detailing the circumstances related to the action and the outcome.

Pursuant to B&P Code section 2512.5(a)(1), upon successful completion of the education requirements, 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 organizations to administer the examination in order to carry out this purpose.

The comprehensive licensing examination developed by the North American Registry of Midwives' (NARM) was adopted by the Board in May 1996, and satisfies the written examination requirements as outlined in law.

School Approvals

The Board approves midwifery schools by independently conducting a thorough and comprehensive assessment to evaluate the school's educational program curriculum and the program's academic and clinical preparation equivalent. Schools wishing to obtain approval by the Board must submit supporting documentation to verify that they meet the requirements of B&P Code section 2512.5 (2). Currently BPPE does not provide any role in approval of midwifery schools.

Currently there are 11 approved midwifery schools. The three year program at each approved school has been accepted as meeting the educational requirements for a license as a midwife in California. Approval was granted based on the program meeting the qualifications listed in B&P Code section 2512.5 (2) and CCR. The re-assessment of approved schools is not currently mandated by law or regulation as it pertains to the midwifery program; however, the Board has begun looking into ways in which the re-assessment process could be completed to ensure approved schools are maintaining compliance with B&P Code section 2512.5 (2).

If an international midwifery school were to apply for approval by the Board it would be required to submit the same documentation and requirements as a U.S. school. As of this date, the Board has yet to receive an application for approval of an international midwifery school.

Continuing Education/Competency Requirements

Under Article 24 of the Medical Practice Act commencing with section 2518 of the B&P Code, the Board has adopted and administers standards for the continuing education (CE) of midwives. The Board requires each licensed midwife to document that the license holder has completed 36 hours of CE in areas that fall within the scope of the practice of midwifery as specified by the Board.

Each midwife is required to certify under penalty of perjury, upon renewal, that she has met the CE requirements. CCR section 1379.28 requires the Board to audit a random sample of midwives who have reported compliance with the continuing education requirements. The Board requires that each midwife retain records for a minimum of four years of all continuing education programs attended which may be needed in the event of an audit by the Board.

Due to limited staffing resources, the Board does not currently conduct CE audits on midwives. CCR section 1379.28 does require the Board to audit once every two years, a random sample of midwives who have reported compliance with the CE requirement. The Board is currently reviewing ways in which this process can be implemented.

If a midwife fails the audit by either not responding or failing to meet the requirements as set forth by section 1379.28 of CCR, the midwife will be allowed to renew her license one time following the audit to permit her to make up any deficient CE hours. However, the Board will not renew the license a second time until all of the required hours have been documented to the Board. It is considered unprofessional conduct for any midwife to misrepresent her compliance with the provisions of CCR, section 1379.28.

Approved CE consists of courses or programs offered by: the American College of Nurse Midwives, the Midwives Alliance of North America, a midwifery school approved by the Board, a state college or university or by a private postsecondary institution accredited by the Western Association of Schools and Colleges, a midwifery school accredited by the Midwives Education Accreditation Council, programs which qualify for Category 1 credit from the California Medical Association or the American Medical Association, the Public Health Service, the California Association of Midwives, the American College of Obstetricians and Gynecologists, and those approved by the California Board of Registered Nursing or the board of registered nursing of another state in the United States.

The Board approves the CE programs that offer the CE courses. CCR section 1379.27 defines the criteria for approval of courses. The Board has not received any recent applications for CE providers or courses. The Board has previously approved several programs as noted above.

CCR section 1379.27 (b) requires the Board to 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 Board documentation concerning each of the items described in section 1379.27 (a) of the CCR.

The Board is currently reviewing ways in which the CE policy is carried out and the procedures related to the certification and auditing of approved programs and courses of CE hours is being performed. The Board anticipates that the auditing function of the Board will be carried out in the current fiscal year to insure that all licensed midwives are in compliance with the current requirements.

Section 5 – Enforcement Program

The licensee population in the Midwifery Program is small and the number of disciplinary actions filed against licensees is also proportionally small with a total of 5 disciplinary actions being filed over the past three fiscal years. Of the four disciplinary actions that have been adjudicated, all have been resolved with either a revocation or a license surrender. With this volume of activity it is difficult to identify trends or patterns.

The majority of the complaints received regarding licensed midwives relate to the care provided during labor and delivery which resulted in an injury to the infant or mother. These complaints are considered to be the highest priority. The Board also receives complaints regarding the unlicensed practice of midwifery which are also considered "urgent" complaints. The Program's complaint prioritization policy is consistent with DCA's guidelines.

There are currently no mandatory reporting requirements for licensed midwives with the exception of statistical information that is collected by the Office of Statewide Health Planning.

The Midwifery Program does not have a statute of limitations established in statute but recognizes public protection as its highest priority and strives to investigate each complaint as quickly as possible.

The licensee population in this category is fairly small, however, there have been some complaints related to unlicensed practice. The Board utilizes its investigative resources to pursue and prosecute, if appropriate, individuals providing midwifery services without the proper credentials.

The Midwifery Program utilizes the Medical Board's disciplinary guidelines as a model for disciplinary actions imposed on midwives.

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	7	9	22
Closed	0	0	0
Referred to INV	8	9	22
Average Time to Close	9	10	12
Pending (close of FY)	0	0	0
Source of Complaint (Use CAS Report 091)			
Public	4	5	16
Licensee/Professional Groups	2	3	4
Governmental Agencies	1	2	6
Other	0	0	0
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	0	1	4
CONV Closed	0	1	4
Average Time to Close	0	3	9
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied	0	0	0
SOIs Filed	0	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI (from case referred to AG's Office to one of outcomes above--withdrawn, dismissed, declined)	0	0	0
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	0	2	3
Accusation Filed--Average Days from Case Referred to AG's Office to Accusation Filed	0	66	164
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations (from case referred to AG's Office to one of the outcomes above--withdrawn, dismissed, declined)	0	0	0
Pending-Accusation Filed (close of FY)	0	1	0
Pending-No Accusation Filed (close of FY)	1	1	3

Table 9b. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	0	1	1
Stipulations	0	0	0
Average Days to Complete	0	874	878
AG Cases Initiated	1	2	2
AG Cases Pending (close of FY)	1	2	3
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	0	1	1
Surrender	0	0	0
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	0
Probationary License Issued	0	0	0
Other	0	0	0
PROBATION			
New Probationers	0	0	0
Probations Successfully Completed	0	0	1
Probationers (close of FY)	1	1	0
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	0	0	0
Probations Extended	0	0	0
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	0

Table 9c. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	8	10	26
Closed	8	11	25
Average days to close	212	269	210
Pending (close of FY)	7	6	7
Desk Investigations (Use CAS Report EM 10)			
Closed	5	7	19
Average days to close	48	116	78
Pending (close of FY)	1	0	3
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	n/a	n/a	n/a
Average days to close	n/a	n/a	n/a
Pending (close of FY)	n/a	n/a	n/a
Sworn Investigation			
Closed (Use CAS Report EM 10)	0	4	0
Average days to close	0	537	0
Pending (close of FY)	0	6	0
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	0	0	0
PC 23 Orders Requested	0	0	1
Other Suspension Orders	0	0	1
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	0	0	0
Referred for Diversion	0	0	0
Compel Examination	0	0	0
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued	0	0	0
Average Days to Complete	0	0	0
Amount of Fines Assessed	$0	$0	$0
Reduced, Withdrawn, Dismissed	$0	$0	$0
Amount Collected	$0	$0	$0
CRIMINAL ACTION			
Referred for Criminal Prosecution	1	0	1

Table 10. Enforcement Aging						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	0	0	0	0%
2 Years	0	0	0	0	0	0%
3 Years	0	0	1	1	2	100%
4 Years	0	0	0	0	0	0%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	0	0	1	0	2	100%
Investigations (Average %)						
Closed Within:						
90 Days	8	4	3	11	26	47%
180 Days	2	1	4	6	13	24%
1 Year	0	0	1	2	3	6%
2 Years	1	3	1	4	9	16%
3 Years	0	0	2	2	4	7%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	11	8	11	25	55	100%

Cite and Fine

The Midwifery Program has not utilized its citation and fine authority primarily because there are no technical violations which would be appropriate to resolve through this administrative remedy.

Cost Recovery and Restitution

Two disciplinary actions were taken against licensees over the past 3 fiscal years which resulted in cost recovery. In both cases, the penalty imposed as a result of the disciplinary action was license revocation. The former licensees are continuing to make payments to the Board for the ordered costs.

The Board also has the ability to seek cost recovery for investigations referred for criminal prosecution. The following chart identifies the costs ordered and received for criminal investigations.

Fiscal Year	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Criminal Cost Recovery Ordered	$0	$0	$0	$18,356
Criminal Cost Recovery Received	$0	$0	$0	$1,620

The Board does not seek restitution from the licensee for individual consumers. However, cases involving unlicensed practice can be referred by the Board to the local district attorney for prosecution. Restitution has been ordered by a judge as a part of the criminal case prosecuted by the district attorney. The restitution identified in Table 12 was ordered due to these unlicensed cases.

The Board is unable to identify how much is collected for the victim/patient because the court receives the funds and provides it to the victim/patient and the Board is not notified.

Table 11. Cost Recovery

	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13**
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	1	1	0
Amount of Cost Recovery Ordered	$0	$11,565	$12,530	$0
Amount Collected	$0	$150	$5,880	$10,165

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.
**As of 9/30/12

Table 12. Restitution

	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Amount Ordered	$0	$0	$0	$1,500
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2012 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2012 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2012 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2012 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2012 Medical Board Sunset Report

Section 11 – New Issues

Physician Supervision

Section 2057 of the B&P Code authorizes a licensed midwife, *under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics*, 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&P Code section 2507(f) requires the Board *by July 1, 2003* to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (CCR section 1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

Although required by law, physician supervision is essentially unavailable to licensed midwives performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of licensed midwives who perform home births. According to these companies if they supervise, or participate, in a home birth they will lose their insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the licensed midwife needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a licensed midwife as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of licensed midwives. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician. For example, in New York, licensed midwives are required to establish and maintain a collaborative relationship with a physician. The midwife is required to maintain documentation of such collaborative relationships and make information about such collaborative relationships available to his or her patients. However, documentation of the collaborative relationship does not have to be submitted to the licensing authority.

In New Jersey, the licensed midwife is required to establish written clinical guidelines with the affiliated physician which outlines the licensee's scope of practice, circumstances under which consultation, collaborative management, referral and transfer of care of women between the licensee and the affiliated physician are to take place. Theses clinical guidelines must include provisions for periodic conferences with the affiliated physician for review of patient records and for quality improvements. The licensed midwife is required to provide this information to the licensing authority upon request. It is considered professional misconduct to practice without established clinical guidelines.

States such as Arkansas and South Carolina provide a very detailed list of situations where physician intervention or referral is required. Other states, such as Virginia and New Mexico, have laws requiring collaboration between a physician and a midwife, but limit physician liability, stating that any consultative relationship with a physician does not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife. New Mexico law requires that each woman

accepted for care must be referred at least once to a duly licensed physician within four (4) weeks of her initial midwifery visit. The referral must be documented in the chart.

The Board, through the Midwifery Advisory Council has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care. It appears the physician supervision requirement needs to be addressed through the legislative process.

Lab Orders and Obtaining Medical Supplies

Licensed midwifes have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, licensed midwives are not able to obtain the medical supplies they have been trained and are expected to use: oxygen, necessary medications, and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the licensed midwife's patient and child.

The Board, through the Midwifery Advisory Council held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

Midwife Students, Apprentices and Assistants

Section 2514 of the B&P Code authorizes 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 to engage in the practice of midwifery as part of her course of study if: 1) the student is under the supervision of a physician or a licensed midwife who holds a clear and unrestricted California Midwife License and that midwife is present on the premises at all times client services are provided; and 2) the client is informed of the student's status. There has been disagreement between the Board and some members of the midwifery community regarding what constitutes a "bona fide student". However, the current statute is very clear regarding a student midwife.

Some members of the midwifery community hold that an individual who has executed a formal agreement to be supervised by a licensed midwife but is not formally enrolled in any approved midwifery education program qualifies the individual as a student in apprenticeship training. Many midwives consider that an individual may follow an "apprenticeship pathway" to licensure. The original legislation of the Midwifery Practice Act, included the option to gain midwifery experience that will then allow them to pursue licensure via the "Challenge Mechanism" detailed in B&P Code section 2513(a) which allows an approved midwifery education program to offer the opportunity for students

to achieve credit by examination for previous clinical experience. This was included to allow for those who had been practicing to meet the requirements for licensure. The statute clearly states a midwife student must be formally enrolled in a midwifery educational institution in order to participate in a program of supervised midwifery clinical training. This may have been included with the assumption that midwifery education programs would be created statewide for individuals seeking this career path. There is currently one approved education program in California. A written agreement between a licensed midwife and a "student" does *not* qualify as a "program of supervised clinical training". Accordingly, these types of arrangements are not consistent with the provisions of B&P Code section 2514. A Task Force consisting of members of the Midwifery Advisory Council has recently been formed to examine this issue. However, the issue of students/apprenticeships may need to be addressed through the legislative process.

A similar concern revolves around the use of "assistants" by a licensed midwife and the duties the assistant may legally perform. It has been brought to the attention of the Board that licensed midwives use midwife assistants. Currently, there is no definition for a midwife assistant, the specific training requirements or the duties that a midwife assistant may perform. Some licensed midwives only use another licensed midwife as an assistant. Other licensed midwives use a midwife student who is enrolled in a recognized midwifery school and who has an official agreement with the student and midwifery school to provide clinical training to the student midwife. Other licensed midwives use someone who may or may not have formal midwifery training and/or someone that the licensed midwife has trained. The duties that a midwife assistant performs vary from midwife to midwife. Some midwife assistants only setup the birthing area prior to the baby being born and then cleanup the birthing area after the baby has been born. Some midwife assistants also hand supplies to the midwife during the delivery of the baby. Other midwife assistants (unlicensed individuals and not an official midwife student) actually assist the midwife with the birth of the baby. Current statute and regulations do not address the use of a midwife assistant, the need for formal training or not, or the specific duties of an assistant. Current statute does not provide a licensed midwife with the authority to train or supervise a midwife assistant who is actually assisting with the delivery of an infant. The issue of a midwife assistant is not an issue that can be addressed with regulation with the current statutes that regulate the practice of midwifery. The issue of the midwife assistants should be addressed with legislation.

Section 12 – Attachments

Refer to Full 2012 Medical Board Sunset Report

programming. RCCI also provides advice on issues involving human resources and health system reform.

Based upon the information available, it appears RCCI may move into the accreditation of postgraduate training residency programs in other countries. The initial programs likely will be in the UK and Australia since the postgraduate training programs in those countries are similar to Canada's. To date, RCCI has not accredited any international postgraduate training programs.

RCCI has already taken the first step of consulting and setting up new international postgraduate training programs to be equivalent to RCPSC accredited postgraduate training programs. It is safe to assume that RCCI accreditation to these new postgraduate training programs will be following in the near future.

These two new programs were presented to the Licensing Committee at its meeting on January 31, 2013. The Board will continue to review and assess these new programs to determine how to address them when considering postgraduate training for purposes of California licensure.

Allopathic and Osteopathic Postgraduate Training Programs (New)

Currently the Board recognizes Accreditation Council Graduate for Medical Education (ACGME) accredited postgraduate training for the purposes of allopathic medical school students' clinical clerkship training and for the required postgraduate training for licensure as a physician and surgeon. ACGME accredited postgraduate training programs are at institutions that are accredited by the Joint Commission. Recently ACGME has accredited postgraduate training programs in hospitals that are accredited by the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP). B&P Code section 2089.5 specifically references the "Joint Commission on Accreditation of Hospitals" as the hospital accreditation agency for ACGME postgraduate training programs.

American Osteopathic Association (AOA) accredits postgraduate training for licensure purposes for osteopathic medical school graduates. AOA accredited postgraduate training programs are usually obtained in hospitals that are accredited by the AOA-HFAP.

ACGME and AOA have reached an agreement for ACGME to approve all postgraduate training programs for both Allopathic medical schools (M.D. degrees awarded) and Osteopathic medical school (D.O. degrees awarded) graduates. This change will require an amendment to B&P Code section 2089.5 to include the AOA-HFAP as an approved accreditation agency for hospitals offering ACGME accredited postgraduate training programs.

The need to amend B&P Code section 2089.5 was presented to and approved by the Licensing Committee and the Full Board at the Board's January 31, 2013meeting.

Midwifery Program (New)

In addition to the new issues listed in Appendix 1 – Midwifery Program of the Sunset Review Report, the Midwifery Advisory Committee (MAC) identified two additional issues at its December 6, 2012 meeting. The MAC determined that Business and Professions Code (B&P) section 2514 does not include certified nurse midwives (CNM) as being able to supervise midwifery students. The MAC supported amending B&P section 2514 to include CNMs, who are licensed by the Board of

Registered Nursing (BRN), as individuals who can supervise midwifery students. The Board will need to seek the BRN's input on this issue too.

Currently both physicians and CNMs are identified as being able to sign off on clinical experience for license midwife students pursuant to B&P section 2513, but supervision of training is not specifically identified in law.

Another issue discussed at the MAC's December 6, 2012 meeting was a proposal to change the current retrospective method of collecting data for the required annual reporting of licensed midwife statistics. These statistics are currently being reported to the Office of Statewide Health Planning and Development (OSHPD). The reporting system that the MAC evaluated is from Midwives Alliance of North America (MANA). MANA is a private organization and the MANA data reporting system is a prospective data collection system. The Board will continue to look at the feasibility and desirability of this change and determine if it should move forward to request a statutory change to Business and Professions Code Section 2516 in order to change the methodology used for collection of data and the mechanism for reporting this to the Legislature.

AGENDA ITEM 6A

MIDWIFERY PROGRAM LICENSING STATISTICS

Licensed Midwives	FY 12/13	Q1	Q2	Q3	Q4
Applications Received	20	8	12		
Applications Pending	5	5	6		
Licenses Issued	17	5	12		
Licenses Renewed	31	31	32		
Licenses Cancelled					

Licensed Midwives	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	31	9	5	8	9
Applications Pending	0	6	3	3	0
Licenses Issued	31	4	8	10	9
Licenses Renewed	123	24	31	31	37
Licenses Cancelled	1	0	0	1	0

Licensed Midwives	FY 10/11	Q1	Q2	Q3	Q4
Applications Received	41	12	11	6	12
Applications Pending	2	4	1	2	2
Licenses Issued	40	9	13	5	13
Licenses Renewed	98	30	17	20	31
Licenses Cancelled	3	0	2	0	1

Licensed Midwives	FY 09/10	Q1	Q2	Q3	Q4
Applications Received	16	2	0	10	4
Applications Pending	N/A	N/A	1	0	2
Licenses Issued	19	2	2	10	5
Licenses Renewed	74	18	4	29	23
Licenses Cancelled	3	0	0	2	1

MBC Licensing Statistics	
Renewed / Current Status	286
Delinquent Status	24

MIDWIFERY PROGRAM ENFORCEMENT STATISTICS	FY 09/10	FY 10/11	FY 11/12	FY 12/13 Qtr 1	FY 12/13 Qtr 2
COMPLAINTS					
Total number of complaints received	**7**	**10**	**26**	**3**	**2**
Licensed midwives	6	8	20	1	2
Unlicensed midwives	1	2	6	2	0
Total number of closed complaints	**5**	**8**	**17**	**3**	**2**
Licensed midwives	5	6	11	2	3
Unlicensed midwives	0	2	6	1	2
INVESTIGATIONS					
Total number of open investigations	**5**	**2**	**3**	**1**	**0**
Licensed midwives	3	2	3	1	0
Unlicensed midwives	2	0	0	0	0
Total number of closed investigations	**3**	**0**	**1**	**1**	**3**
Licensed midwives	2	0	1	0	1
Unlicensed midwives	1	0	0	1	2
Total number of cases referred to the Attorney General (AG)	**1**	**1**	**2**	**0**	**1**
Licensed midwives	1	1	2	0	1
Unlicensed midwives	0	0	0	0	0
Total number of cases referred for criminal action	**1**	**1**	**1**	**0**	**3**
Licensed midwives	0	0	0	0	1
Unlicensed midwives	1	1	1	0	2
The number of probation violation reports referred to the AG	**0**	**0**	**0**	**0**	**0**