STATE AND CONSUMER SERVICES AGENCY- *Department of Consumer Affairs* EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA
Licensing Operations

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

August 30, 2012
MINUTES

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

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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:

<u>1379.23 Physician Supervision Requirement.</u>

<u>(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.</u>

<u>(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.</u>

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 nonemergent 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.***

<u>1379.23 Physician Supervision Requirement.</u>

(a) <u>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.</u>

(b) <u>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.</u>

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

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:

<u>1379.24. Practice of Midwifery</u>

<u>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.</u>

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

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.