BIRTH RIGHTS BAR ASSOCIATION

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ANALYSIS of California Senate Bill 1237 (2019-2020): State Midwifery Laws and Changes in Nurse-Midwife Scope of Practice

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California recognizes two types of licensed midwives, each set forth separately in statute in the Business and Professions Code under the Healing Arts Division. *Licensed Midwives* (LMs) are regulated by the Board of Medicine, while *Certified Nurse Midwives* (CNMs) are regulated by the Board of Nursing. Despite these distinct sets of legal authorization, both licensed professions influence the ecology of midwifery in California. Similarly, changes to either profession's statutes affects midwifery as a whole, both in the governance of midwives and in patient access to midwifery care.

Overview of SB 1237

Introduced in February 2020, SB 1237 is the result of a multi-year effort to eliminate physician supervision from CNM scope of practice requirements. The legislation addresses the following nine points:

1. Legislative declaration
2. Lab referrals and conflict of interest
3. Composition of the committee
4. Scope of practice
5. Drugs and devices
6. Repair of lacerations of the perineum
7. Disclosure requirements
8. Birth certificate reporting
9. Alignment with the California Constitution

Much of the bill is consistent with LM statutory provisions. The disclosure requirements, for example, are almost identical. Where there are differences, many reflect well-established variances between CNMs and LMs, such as the distinct scopes for drugs and devices.

Two key provisions warrant further discussion: the legislative declaration (Point 1, above), and Cal. Bus. & Prof. Code § 2746.5 (Point 4), in which "low-risk pregnancy" is defined and the physician and surgeon supervision requirement is removed.

Legislative Declaration

A legislative declaration by itself carries minimal legal effect; however, by providing insight into legislators' intentions in creating the law, it can play an informative role should other parts of the law later come into dispute. For this reason, it is important that the declaration accurately reflect those intentions rather than obfuscate them.

An example of obfuscation is the legislative declaration's broad statements about perinatal health, paired with its exclusion of LMs from its list of providers: "Within an integrated model of care, physicians and surgeons and nurse-midwives can work together with patients and community leaders …" While this bill governs only CNM practice, the maternity care landscape includes CNMs, MDs, and LMs. The declaration's omission of LMs might later be interpreted as a deliberate statement of policy. The overall integration of midwifery is best served by recognition of *all* perinatal care providers. Alternately, a more general statement might be equally effective in affirming the entire maternity care landscape: "Within an integrated model of care, providers can work with patients and community leaders …"

In addition, the omission of LMs deepens the declaration's failure to acknowledge scientific determinations that it is midwifery care itself, rather than a mere expansion of the maternity care team, that contributes to better outcomes for birthing people and newborns.

> *Regardless of birth setting, midwife-led care has been linked to significantly improved perinatal outcomes, and maternal experience, in both healthy and at-risk populations.*[1]

The significance of accurate language in the legislative declaration, however, is eclipsed by that of language concerning scope of practice, as analyzed below.

Section 2746.5: Scope Restrictions

Section 2746.5 carries the direct legal authority to eliminate physician and surgeon supervision of CNMs. Given the history of the medicalization of birth and physician pursuit of hegemony over other providers primarily through scope of practice restrictions, it is hardly surprising that this text is the end-result of many amendments.

The three provisions of § 2745.6 under discussion 1) establish that a CNM is authorized to practice independently, *i.e.* without physician and surgeon supervision, 2) clarify how and when a CNM works with physicians and surgeons, and 3) define what care is considered outside the CNM scope of practice. The implications of these provisions are discussed below.

- *Restrictions on* out-of-hospital *CNM care vs. restrictions on* all *CNM care*

One key difference from the originally introduced bill is the current version's attachment of certain conditions[2] to *all CNM practice*. The original bill attached these conditions *only* to CNM *out-of-hospital practice*. To enumerate these conditions in statute is to limit CNM practice.

[1] Saraswathi Vedam et al., "Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes," PLOS ONE 13, no. 2 (February 21, 2018): e0192523, https://doi.org/10.1371/journal.pone.0192523, *citing* Yang YT, Attanasio LB, Kozhimannil KB. State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes. Women's Heal Issues [Internet]. 2016 May [cited 2017 Apr 2]; 26(3):262–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26965196; Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other mod- els of care for childbearing women. In: Sandall J, editor. Cochrane Database of Systematic Reviews [Internet]. Chichester, UK: John Wiley & Sons, Ltd; 2013 [cited 2017 Apr 2]. Available from: http://doi. wiley.com/10.1002/14651858.CD004667.pub3; and McRae DN, Muhajarine N, Stoll K, Mayhew M, Vedam S, Mpofu D, et al. Is model of care associated with infant birth outcomes among vulnerable women? A scoping review of midwifery-led versus physician-led care. SSM—Popul Heal. 2016; 2:182–93.

[2] The conditions require a singleton pregnancy, cephalic presentation, birth at 37-42 weeks of gestation, spontaneous or induced labor, and no preexisting maternal disease. § 2746.5 (a)(1)-(5).

Furthermore, the replacement of a broad standard for "normal" pregnancies (ACNM Core Competencies) with a narrow list of five conditions that define "low-risk" additionally narrows CNM practice. While reference to the ACNM standard renders CNM scope more dynamic in the face of changing science, the use of a list makes it more rigid, since any developments with effects on any of the listed items would require new legislation.

The current bill essentially offers CNMs a tradeoff similar to one in LM law: CNMs stand to gain independent practice at the cost of increased restrictions in scope. Many CNMs currently practice within these constraints.

- *Alignment of bill text with LM statutory language*

The change from a designation of "normal" to "low-risk" features another drawback: the LM statute uses the term "normal" rather than "low-risk." While either term can be both value-laden and vague, it would be most reasonable to use the *same* language for both CNMs and LMs.

- *CNM care for* non-*low-risk pregnancies*

Some conditions categorized as outside of "low-risk" are ones for which many CNMs wish to provide care, such as twins, breech presentation, and gestation beyond 42 weeks; likewise, many pregnant people with these conditions wish to receive midwifery care. This bill accommodates these needs by allowing CNMs to provide care in these instances if the CNM has a plan in place for consultation, collaboration, and referral. Note that physician *supervision* is not required, only a plan already agreed to by the CNM, physician, and surgeon.

One condition *not* specifically categorized by § 2746.5(a)(1)-(5) as outside the scope of "low-risk" is a patient with a prior cesarean surgery, *i.e.* a patient seeking a Vaginal Birth After Cesarean (VBAC). This is another condition for which people desire midwifery care, often because physicians, surgeons, and hospitals refuse to provide it.[3]

SB 1237 places VBAC outside the scope of "low risk" by means of an aggressive, yet rather meandering, one-two punch. First, § 2746.5(a)(5) requires that:

> *The patient has no preexisting disease or condition, whether arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the certified nurse-midwife is not qualified to independently address pursuant to this section.*

Then, § 2746.5(b) adds the following condition to the ones that require a mutually-agreed-upon plan: "Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium."

This is an extraordinary method of ruling a condition high-risk, and suggests that the drafters were not entirely certain of the rationale for doing so: the text essentially declares that VBAC should be treated as high-risk, even though it is not defined as such.

[3] Lisa Pratt, "Access to Vaginal Birth after Cesarean: Restrictive Policies and the Chilling of Women's Medical Rights during Childbirth," William & Mary Journal of Women and the Law 20 (2014 2013): 105.

The objections to this restriction, by contrast, are straightforward:

- VBAC is *not* particularly high-risk. Ample data show that physicians and surgeons who automatically consign VBAC seekers to repeat surgery do so without medical basis. They, however, are not required to consult with midwives on the known risks of repeat surgery.
- CNMs *are* qualified to independently address VBAC care. The American College of Nurse-Midwives, which defines standards of care for CNMs, states, "Certified nurse-midwives and certified midwives are qualified to provide antepartum and intrapartum care for women who are candidates for VBAC."[4] Furthermore, like other professionals, CNMs are able to determine which cases are not suitable for their care. For example, one CNM might decide that a candidate for a vaginal birth after 3 previous cesarean sections would be better served by an obstetrician. Another CNM might be willing to provide care to a VBA3C, but only if the patient is under age 40. Patients and pregnancies are unique, and each CNM is skilled in deciding which potential complication is beyond their professional comfort zone.
- VBAC is a topic on which medical opinion has traditionally swung back and forth. Sometimes standard medical practice is driven by medical science, of varying quality; sometimes by fears of medical malpractice suits or increases in premiums;[5] and sometimes by a clear disregard of recommended best practices by its own professional organization.[6]

This VBAC restriction does not directly serve the interests of pregnant people, but instead acts as a control mechanism over CNM practice. That very control permits physicians and surgeons to further restrict access to VBAC. As a result, people seeking VBAC are left with few provider options and consequently, a low VBAC rate.[7] California's 2018 VBAC rate was lower than all but ten others states, even though its overall Cesarean surgery rate is *better* than average.[8]

The curtailment of VBAC access not only runs contrary to state and national public policy calling for a reduction in the Cesarean rate, but also affects the right of birthing people to make decisions about their care, thereby undercutting the legislative declaration, which recognizes bodily autonomy as fundamental to reproductive rights.

VBAC Recommendations

BRBA offers three suggestions, with the most highly preferred option listed first:

1. Governance of VBAC care should *not* take place in statute, but rather in rules. For such an intricate, frequently changing issue, regulation offers a place of governance that is both more adaptable to change *and* driven by midwifery expert opinion.

[4]ACNM Board of Directors, "Position Statement: Vaginal Birth After Cesarean," September 2017, https://www.midwife.org/acnm/files/ACNMLibraryData/UPLOADFILENAME/000000000090/VBAC-PS-FINAL-10-10-17.pdf.

[5]Sonya Charles and Allison B. Wolf, "Whose Values? Whose Risk? Exploring Decision Making About Trial of Labor After Cesarean," Journal of Medical Humanities, October 20, 2016, 1–14, https://doi.org/10.1007/s10912-016-9410-8.

[6]"ACOG Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery," Obstetrics & Gynecology 133, no. 2 (February 2019): e110, https://doi.org/10.1097/AOG.0000000000003078.

[7]Michelle J K Osteran, "Recent Trends in Vaginal Birth After Cesarean Delivery: United States, 2016–2018," no. 359 (2020): 8.

[8]Gaby Galvin, "CDC Data Finds Increasing Rate of Vaginal Birth After C-Section," US News & World Report, March 5, 2020, https://www.usnews.com/news/healthiest-communities/articles/2020-03-05/the-rate-of-vaginal-birth-after-c-section-is-increasing-in-the-us-the-cdc-finds.

2. If a transfer to regulatory authority is not possible, then § 2746.5(b)(1)(B) should be removed, so that VBAC is not automatically considered outside of "low-risk."
3. If neither of the above options are possible, the tradeoff between greater all-over practice autonomy for a restriction on VBAC care is still an improvement over the status quo.

Conclusions

The complexity of the interaction of earlier law governing CNMs, SB 1237, and the current law governing LMs, suggests that a visual comparison would provide the clearest demonstration of the tradeoffs being proposed.

	Status Quo	SB 1237
LMs	LMs practice independently within the statutory definition of "normal" birth that includes 5 key conditions.	LMs practice independently within the statutory definition of "normal" birth that includes 5 key conditions.
CNMs	CNMs practice under physician supervision within a statutorily undefined definition of "normal."	CNMs practice independently within the statutory definition of "low-risk" that includes 5 key conditions.
Pregnant and laboring people	Pregnant and laboring people struggle to access the full range of options for birth, especially if they are seeking a VBAC, or vaginal delivery of multiples or breech.	Pregnant and laboring people struggle to access the full range of birth option, especially if they are seeking a VBAC, or vaginal delivery of multiples or breech.

It is evident that neither the status quo nor SB 1237's proposed revisions represent best practices in CNM governance; the bill as introduced came closer to that goal. The California Medical Association and the obstetricians and gynecologists they represent have consistently acted as the key barrier to better legislation. The amendments to SB 1237 were made in response to the gatekeeping demands of the California Medical Association.

With the caveat that continued negotiation over VBAC might still bear fruit, BRBA nonetheless believes that SB 1237 represents a step in the direction of more independent CNM practice that is reasonably well aligned with the Licensed Midwives law. For this reason, we encourage California midwives to unite behind SB 1237 as well as form an alliance for the future legislative work necessary to improve midwife governance and by doing so, improve maternity care as a whole.

In the ideal maternity care landscape, physicians and surgeons will cease to act as gatekeepers to care or independent practice, but will instead work in an integrated and collaborative manner with all midwives, regardless of credential. Protocols for consultation, collaboration, referral, and transfer will be based on best practices and be required of physicians as well as midwives. Scope of practice laws will be written in accordance with national standards, clinical details will be reserved for regulations, and oversight will be provided by peers with community input. CNMs and LMs will be able to practice to the full extent of their education and training, and pregnant people will be able to fully access a range of care and make choices for their own bodies.