As organizations working in separate capacities to support and advance midwifery in California CFAM, CAM and CALM collaborated on the following statement to point to overriding concerns with SB 1237 Dodd - Nurse Midwife Bill 2020.

SB 1237 is problematic in a variety of ways. Here are the four primary concerns:

1. SB 1237 claims to remove physician supervision from nurse-midwives enabling them to practice autonomously. However, the bill does not do that. While it may technically remove the phrase “physician supervision” from statute, it simply replaces it with a practice agreement with a physician. This practice agreement is required for California nurse-midwives, but physicians are not required to enter into such an agreement, which keeps the ability of nurse-midwives to practice dependent upon a physician. For all practical purposes such agreements function as physician supervision, which is why other states are currently working to remove these requirements from their statutes. In short, SB 1237 does not fix the fundamental problem of physician supervision, it just calls it something different. By allowing physicians to remain the gatekeepers to nurse-midwifery care, this repackaging of physician supervision will not result in expanded access to maternity care.
2. SB 1237 creates a nurse-midwifery advisory board with radically increased regulatory power over nurse-midwife practice, but without any protections to prevent a physician majority forming to write the rules for nurse-midwives. This provision would only add to, not take from, physician ability to limit and control the profession of nurse-midwifery. The BP&E Committee Consultant, who provides neutral analysis of bills before the committee, noted that this provision may be problematic given that the physician members on the nurse-midwife advisory committee are not required to specialize in obstetrics or maternity care. Further, the proposed composition of the advisory committee gives physicians regulatory power over a profession in which they are direct competition. Taken together, these provisions increase the barriers between birthing people and nurse-midwifery care.
3. SB 1237 simultaneously undermines the clinical judgment of midwives and patient autonomy in one fell swoop by giving legislators the power to put scope of practice guidelines into statute that limit access to nurse-midwifery care in ways that have no basis in evidence. Additionally, this bill has no provisions for patients to exercise their right to self-determination in the context of informed decision making. In sum, SB 1237 places intimate and personal medical decisions in the hands of legislators, not with birthing people and their families.
4. Other states look to California as a model for health care policy and legislation. Instead of following states with bad laws, we should aspire to be visionaries when it comes to crafting the very best laws regarding nurse-midwifery practice and maternity care in the United States. California deserves better than SB 1237.

Accompanying this statement is legal analysis from Susan Jenkins legal counsel to The Big Push for Midwives Campaign

Senate Bill 1237: Concerns

I have reviewed the most recent (May 19, 2020) version of this bill on the California Legislature website at https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201920200SB1237&showamends=false. At the request of CALM, CAM, and CFAM, I provide these notes to set for my concerns about this bill and its potential negative effects.

As an attorney who has worked with all types of midwives, including serving as general counsel for ACNM, legal counsel for AABC, legal counsel for the Big Push for Midwives Campaign, and legislative consultant for CALM, I am greatly concerned about the potential harmful impact of this bill on limiting access to community birth options and on the right to informed consent and refusal of pregnant and birthing clients in all birth settings. Specifically, I am greatly concerned about the following aspects of this bill, should it become law:

1. It creates an inappropriate and harmful precedent, both statewide and nationally, by setting a different standard for community (*i.e.,* out-of-hospital) birth than for hospital birth, and compounds that harm by granting the Board of Registered Nursing (BRN) authority to set standards and practice guidelines for community birth practice. I am aware of no other state that does so (except Nebraska which prohibits CNMs from providing home birth services). Nothing good can come from giving the CA BRN, which has notoriously been hostile to community birth and to CNMs who provide home or birth center services, this kind of statutory authority to set standards and guidelines over community birth services. We have no reason to assume that the BRN's negative attitude has been or will be changed. [*See* SECTION 3 of the bill, adding new subsection (b) to Section 2746.2 of the statute, and SECTION 4 of the bill, adding new subsection (e) to Section 2746.5 of the statute]

2. Members of the BRN who will have authority to set standards and practice guidelines for CNMs under this bill, specifically with respect to community birth, are unlikely to have had any experience or clinical education specific to community birth. The same must be said for at least 90% of CNMs in California, and most if not all physicians -- yet these are the pool to be drawn from when the board appoints the Nurse-Midwifery Advisory Committee. Notably absent from this Advisory Committee are Licensed Midwives (LMs), the only state-licensed health professionals who are specifically educated in community birthing and have expertise in community birth.

3. Standards and clinical practice guidelines that might be developed by the BRN, potentially with input from CNMs and physicians with minimal or no community birth experience, could potentially come to be regarded as a general standard of care for all providers of community birthing services, thus negatively affecting LMs and their clients, despite the lack of input by LMs or LM clients, and despite the probable lack of community birth expertise on the part of the BRN or its advisory committee. Where are the voices of birthing persons and families in this process?

4. The ostensible chief purpose of this bill is to repeal the current requirement for physician supervision of CNM practice [SECTION 4, amending and repealing in part subsection(b) of Section 2746.5 of the statute]. Good. However, the bill adds a multi-leveled set of standards, some of which are mandatory, some of which call for BRN rulemaking, that will inevitably require physician involvement in a CNM's practice, without regard to the preferences or rights of consent and refusal held by the CNM's client.

5. Moreover, the practical effect of the physician-involvement standards will likely require CNMs or their clients to identify and seek the cooperation of a specific individual obstetrician or family practitioner who will adopt "mutually agreeable" guidelines and plans of care.

This is similar in effect to statutes and regulations that require CNMs to enter into written agreements with physicians or develop written practice guidelines acceptable to a physician. ACNM urges its state affiliates to repeal laws that require written practice agreements or guidelines with physicians, the impact of which is not dissimilar to mandated supervision. This bill, therefore, provides no real improvement over the supervision language it repeals.

6. For the great majority of California CNMs, the repeal of supervision language and other provisions of this bill will have no practical impact because their ability to hold clinical privileges in hospitals or admit clients to hospitals for birth will continue to be constrained by restrictive hospital and medical staff bylaws, which will almost certainly continue to prevent autonomous practice for the hospital-based CNM. AS CNMs have learned in other states, hospitals are not bound by "no supervision" practice laws but may legally continue to set so-called "higher" standards of physician control. CNMA would do better if their bill did away with supervision, as in subsection (b) of Section 2746.5, and adopting provisions similar to the clinical privileges law in the District of Columbia which requires hospitals to grant independent clinical privileges and full voting medical staff membership, with full admitting and discharge privileges, to CNMs, nurse practitioners, and clinical psychologists [*see* DC Code sections 44-507, 44-509 https://code.dccouncil.us/dc/council/code/sections/44-507.html].

The Analysis provided for Senate Bill 1237 doesn't recognize the real and potential problems associated with the bill, and makes it sound much better than it is. I consider this bill highly problematic. Furthermore, most of it is unnecessary, having been added as a compromise to compensate for the repeal of the supervision language. All that is really needed is repeal of supervision; all the other new provisions are either unnecessary, harmful, or pose a potential problem. For these reasons, I recommend opposition to California Senate Bill 1237.

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