Dear Allies in Birth & Reproductive Justice,

California Families for Access to Midwives is a grassroots consumer advocacy group with over 5,000 supporters throughout California. We are reaching out to you as our concerns mount about SB 1237- the Nurse-Midwife bill - after the insertion of paternalistic care restrictions & anti-maternal autonomy amendments by CMA & ACOG's powerful lobbyists which disproportionately impact BIPOC & LGBTQ+ populations. We support Nurse-Midwife autonomy, however **we oppose SB 1237 because it does not achieve true autonomy for CNMs or birthing people.**

CFAM
CALIFORNIA FAMILIES FOR ACCESS TO MIDWIVES

This bill primarily benefits the CNMs who serve *only* low risk pregnant people and denies or disrupts access to care for all those who are considered high risk or may get risked out through the course of the pregnancy.[1] Therefore, **this bill disproportionately restricts CNM access for MediCal recipients, Black, Indigenous, POC (BIPOC)[2], LGBTQIA+, low-income, & rural/underserved communities who are profiled as higher risk.** While this bill purports to be about "Equity & Justice", in actuality, **disadvantaged communities are being sacrificed for the greater good of (predominantly white) low risk pregnant people and there is ZERO resource commitment in the bill itself to Black communities & Black Nurse-Midwives.** Without concrete resourcing & with these restrictive amendments, this is a tokenizing, empty promise by an overwhelmingly white profession.[3]

SB 1237 introduces new restrictions:

- Replaces physician supervision with gatekeeping signed agreements between physicians & CNMs. The national organization **American College of Nurse-Midwives recommends against signed practice agreements** because of restrictions of scope & economic implications.[4] The CNMA Health policy committee admits that CNMs currently pay for physician supervision; this bill perpetuates unfair pay-to-play agreements;[5]
- **Restricts CNM choice for well women care** by preventing ALL gynecologic services & only allows "family planning & interconception" care for those that are between pregnancies; this potentially excludes gender transition care & care for those who cannot or will not reproduce;
- Requires CNMs to have a **gatekeeper agreement from a physician** for non-low risk birthing people to receive maternity services which disproportionately affects underserved communities named above;
- **Maternal autonomy amendment is watered down** & may leave a pregnant person without a provider in late pregnancy & their birth (see Background addendum);

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[1] According to the NIH and Merck Manual, high risk pregnancies can include:
- People under 20 or over 35.
- Socio-economic factors such as being unmarried or low income or being non-White
- Existing health conditions, ex: high blood pressure, diabetes, HIV-positive, uterine fibroids, asthma
- Being overweight & obese.
- IVF

Birthing in community birth settings has been found to improve outcomes in "high risk" pregnancies; that is, these are only considered high risk factors in a hospital setting. Perspectives on risk: Assessment of risk profiles & outcomes among women planning community birth in the United States

[2] CA Birth rate for Latinx 47%, White 27%, API 15%, Black 5%, Indigenous 0% Number of Births by Race

[3] 80% of California CNMs are white; 98% of CNMs are women 2017 Survey of NPs & Certified Nurse Midwives

[4] See Background addendum. ACNM Position Statement on Collaborative Agreements between Physician & CNM

[5] LAO Analysis of California's Physician-Supervision Requirement for Certified Nurse Midwives; FTC Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses

- **Discriminates against ALL birthing people not deemed low-risk** that don't meet non-evidence based, arbitrary legal standards[6] which disproportionately affects BIPOC & LGBTQIA+, low-income, & MediCal receiving pregnant peoples;
- Requires **gatekeeper physician agreement for out-of-hospital/community birth** despite the fact that physicians are routinely forbidden to enter into OOH agreement by insurers & hospitals; this disproportionately affects BIPOC birthing families, rural/underserved communities;[7]
- Establishes Vaginal Birth After Cesarean as a risk that requires an additional gatekeeper physician agreement[8] for birth (intrapartum care); this **VBAC amendment disproportionately affects BIPOC & LGGBTQ+ birthing families, rural/underserved communities, & aforementioned, especially those seeking community birth**;[9]
- **Criminalizes CNMs** who work with clients who are not low risk & cannot obtain gatekeeper agreements; **this disproportionately affects Black, Indigenous, People of Color Nurse-Midwives who serve their own communities** & do not have the cultural capital of physician relationships nor the substantial funding needed to purchase these agreements**;**
- **Midwives are the ONLY health care profession to have micromanaging medical restrictions in law rather than in their own governing body.**

Many women, transgender people, & pregnant/birthing people choose midwifery care because of their traumatic experiences with racism, homophobia & transphobia, health care gas-lighting, obstetric violence, and prior overmedicalized birth.[10] These traumatic experiences & socio-economic factors are directly linked to their health risk status. **This bill restricts nurse-midwifery access to the people who need it the most - BIPOC, LGBTQIA+, low income, MediCal recipients, & rural/underserved communities profiled as higher risk.**

We would welcome a dialogue with you about our concerns about this bill. We urge you to OPPOSE SB 1237; unique medical micromanagement singling out of pregnant bodies and of a profession comprised of 98% female practitioners does not belong in law. We must stop the misogynistic & misogynoiristic legislation of pregnant people's bodies & midwives.

In community,
California Families for Access to Midwives info@cafamiliesformidwives.org

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[6] Arbitrary standards are those not between 37-42 weeks, twins+, breech, Vaginal Birth After Cesarean (VBAC), & anyone not in the low risk category in footnote 1. These are only considered high risk factors in hospital settings.
[7] 49% of Black mothers, 41% of white women, 40% of Latinx women, & 32% of API women expressed strong interest in out-of-hospital birth (with a midwife) for their next pregnancy. Listening to Mothers in California: Full Survey Report, 2018
[8] Requiring physician gatekeeping to seek alternatives to a physician-made epidemic is bad public health policy & a violation of human rights. VBAC is proven to be safer than repeat cesarean surgery. Breakdown of Risk: Comparing VBAC & Repeat Cesarean
[9] CA cesarean rates: 42% for Black women, 31% for Latinx & API, 29% for white women. High physician reliance on medically unnecessary cesareans increases poor birth outcomes/recovery, birth disparities, & sky high maternal & infant death rates. Listening to Mothers in California: Cesarean Births; A New Campaign to Reduce C-Sections Is Especially Critical for African-American Mothers & Babies
Cesarean rates are abominably high in underserved regions and/or where there are higher BIPOC patient population. When It Comes to C-Sections, All Hospitals Are Not the Same; Find your hospital's C-section rate
[10] Medical gaslighting & obstetric violence are internationally recognized forms of human rights abuse & coercion in the medical & gynecological setting that dehumanize & traumatize women & pregnant people. WHO Prevention & elimination of disrespect & abuse during childbirth; 1 in 3 birthing people in the US experiences birth trauma. Birth Trauma: Definition & Statistics

Background:

In many ways, SB 1237 mirrors the bill removing restrictions for Licensed Midwives (AB 1308) passed in 2013, a bill with medical restrictions on pregnant bodies that were also inserted by CMA & ACOG, which have since been the source of many problems & have been a barrier for bodily autonomy for pregnant people. Passing SB 1237 would further establish these problematic autonomy restrictions, that single out pregnant people among all patients in California for medical micromanagement. If SB 1237 passes, it would become virtually impossible to undo bodily autonomy restrictions in law.

Due to these restrictions in AB 1308, pregnant people have been forced to get surgery they didn't want, birth with providers they didn't choose, or risk birthing unattended. SB 1237 replicates these same problems. Consumers were & continue to be angry about these restrictions. One wrote us this week saying: "I remember when [the campaign for AB 1308] rolled over & decided to give up breech to keep vbac, forcing thousands of women to either have unwanted surgery, risk an unassisted birth, or go out of state to have their child with competent experienced care."

Licensed Midwives themselves have been left in the position of having to either abandon clients or risk criminal prosecution to care for them, particularly those in the late stages of pregnancy when it has been proven over the last 7 years that no doctor will take them .

ACNM Position Statement on Physician & CNM collaborative agreements

AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

POSITION STATEMENT

Collaborative Agreement between Certified Nurse-Midwives/Certified Midwives and Physicians or Other Health Care Providers

It is the position of American College of Nurse Midwives (ACNM) that safe, quality health care can best be provided to women and their infants when policy makers develop laws and regulations that permit certified nurse midwives (CNMs) and certified midwives (CMs) to provide independent midwifery care within their scopes of practice while fostering consultation, collaborative management, and seamless referral and transfer of care when indicated. Therefore, ACNM affirms the following:

- Requirements for signed collaborative agreements do not guarantee effective communication between midwives and physicians or other health care providers:
  - They do not assure physician availability when needed;
  - There is no evidence that they increase the safety or quality of patient care; and
  - In certain circumstances, such as the aftermath of a natural or declared disaster, such requirements have hampered the ability of CNMs/CMs to provide critically necessary emergency relief services
- Collaborative agreements signed by individual physicians incorrectly imply that CNMs/CMs need the supervision of those individuals in all situations. Based on this misconception
  - Professional liability companies have used signed agreements with their implied requirements for supervision as the rationale for raising physician premiums. These companies cite increased risk related to unnecessary supervision, and
  - CNMs/CMs may be restricted from exercising their full scopes of practice or from receiving hospital credentials, clinical privileges, or third party reimbursement for services that fall within the scope of their training and licensure.
- Requirements for signed collaborative agreements can create an unfair economic disadvantage for CNMs/CMs:
  - They have been used to limit the number of midwives who can practice collaboratively with any one physician, which effectively bars CNMs/CMs from practice in some cases;
  - They allow potential economic competitors to dictate whether or not midwives can practice in a community; and
  - They restrict access to care and choice of provider for women, which is of particular concern in underserved areas.