Oakland Better Birth Foundation's Response to SB 1237, The *Maternal Equity and Justice Act*

For over 30 years, Nia Healing Center for Birth and Family Life and the Oakland Better Birth Foundation have stood in the gap of Black maternal mortality by providing the best births possible for Oakland's children. Our birth workers are called into this work from our local community; powerful women who educate their fellow community members on how to lead healthy lives and carry healthy pregnancies; determined women who advocate for the rights of birthing people across the intersections; birth workers who tirelessly assist birthing people and families through their transformative experiences across the reproductive spectrum. As doulas, midwives, ancestral healers, and community leaders, we stand in solidarity with certified nurse-midwives and strongly oppose SB 1237, as written.

While we do not support SB 1237 as written, we are in full support of certified nurse-midwives being able to exercise their full range of practice, with no requirements for mutually agreed upon policies, and no additional sanctions on their scope of practice when choosing to practice in out-of-hospital settings.

To understand why Nia Healing Center for Birth and Family Life, Oakland Better Birth Foundation, and Better Birth Association of Harlem, NY, cannot support this bill requires an intersectional understanding of the axes of oppression that have functioned relentlessly in this country historically and through present time.

With the advent of formalized Obstetrics and Gynecology and the bloody legacy established by J. Marion Simms through his dehumanizing experimentation on Black bodies, birth under medical supervision became birth under an oppressive, and extractive system. Prior to this, Grand Midwives held the important work of "catching babies" and passed down lineages of care to growing generations. It was not principally an occupation fixed on taking clients, but rather a lived community role with expertise and authority over how to treat the body throughout pregnancy and labor and across the lifespan. Their work was essential, held in high esteem for the attuned care they provided while serving entire communities with optimal birth outcomes It is important to remember while re-examining this history that Grand Black Midwives, in generational practices of reproductive care, were forcibly diminished and subjugated to yet another hierarchy that presumed expertise over a field in which institutionally-backed replacements were proficient at best. We must explicitly name that the eradication of these highly skilled, traditional community midwives coincided with the abolition of American Chattel Slavery, thus rendering their services obsolete in the absence of protecting the production of human capital. Thus, one strata of state sanctioned violence was replaced with another. It is also important to note that the skills and wisdom of Grand Midwives were used in training videos of certified-nurse midwives, contradicting the notion that these women were inferior providers.

Since California legalized midwifery in 1917, midwifery bills have been crafted from a centered ethos which purports midwives to be inferior practitioners to those who practice "real medicine", inheriting a patriarchal and racist foundation. Institutional measures of credibility back a 100 year smear campaign that painted midwives as

primitive, dirty, and the primary reasons babies died. 103 years later, this hierarchy still exists, and while midwives are being over-regulated as to be nearly ineffective, Black Women, Black birthing people, and Black babies are still dying, in this great state of California, at a rate 3-4x that of their white counterparts.

We assert that removing physician supervision and requirements of mutually agreed upon protocols from the text of any midwifery bill is a Reproductive Justice issue.

SisterSong defines Reproductive Justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."

The Miriam-Webster Dictionary defines **equity** as "a body of legal doctrines and rules developed to enlarge, supplement, or override a narrow rigid system of law."

Justice is defined as "the maintenance or administration of what is just especially by the impartial adjustment of conflicting claims or the assignment of merited rewards or punishments; the establishment or determination of rights according to the rules of law or equity."

The tenants of Reproductive Justice, justice, and equity are wholly missing from the language included in the *Maternal Equity and Justice Act*.

"What's missing from the care of Black women is their centered voice, validation of experience, and freedom to choose and be informed. Black women need respectful care that is free of implicit and explicit bias. It is the provider's responsibility to address those biases. To address the issue of maternal mortality we need care that originates from and is defined by Black women-led organizations, practitioners, and community members…care that centers our voices and evidence-based processes. This care has to encompass and be led by the voices of Black women as we see ourselves in relationship to our care. We have the ability to make decisions for ourselves, to process information and to question it." – Jessica Roach

While SB 1237 is heavily supported by organizations such as Black Women for Wellness Action Fund, ACNM and ACOG, certified nurse-midwives of all ethno-cultural backgrounds, and a multicultural coalition of community organizations, a brief purview of the historical record demonstrates why even the support of these groups is problematic:

No bill, regardless of the level of community consulting, that is primarily crafted by people who are not subject to the most egregious outcomes of disparity, to dictate what is fair, safe, and acceptable in a profession that is built upon a legacy of stolen, crimalized, and co-opted medicine and tradition, will ever be equitable for the non-white providers of this service, or the people they serve. Additionally, any law passed should include guidance, experiences, expertise, and best practices of Licensed Midwives, the experts on out-of-hospital birthing. As written, it is difficult to ascertain where the aforementioned have been incorporated. Noting a glaring conflict of interest, those bodies who have a vested interest in profiting off of the perpetuation of this broken system should not have a hand in crafting guidelines that ensure they're still getting their slice of the pie.

The very framework upon which SB 1327 is built is the very framework that has created and thrived off of the disparities this bill has been crafted to prevent. If passed, this bill puts into law notions that women and birthing people are not the experts on their bodies, and certified nurse-midwives are not capable of being trusted to practice effectively. We cannot separate the licensure of midwifery from the sexism, misogynoir, and racism embedded into it, nor can we separate the role white midwives have and still play in perpetuating systems of oppression within midwifery.

With a workforce demographic of
86% white CNMs
and
5.9% Black CNMs,
those with the most privilege, who have prospered the most,
even with present professional circumstances
are speaking the loudest.

Certified nurse-midwives largely support this bill because it is being touted, inaccurately, as freedom from physician supervision. Additionally, there have been several prior attempts to pass bills that remove physician supervision requirements, all of which have failed. Many CNMs are in favor because the bill mostly mirrors their current scope, with some exceptions (i.e. VBAC and breech birth), that they are willing to concede, should they achieve the language removal of "physician supervision". While it is true that the majority of pregnancies are low-risk and only a small percentage would theoretically fall out of SB 1237's outlined scope of practice, those that do don't deserve to be leveraged to achieve false wins and a superficial sense of equality.

With the current political climate and energy, it is the belief of the OBBF that those midwives in favor of this bill are making ill-advised concessions to achieve the goal of removing physician supervision, in name only, because they're being put in an impossible position by those who benefit most from collaborative agreements.

We cannot go back and fix this.

Although we deeply empathize with those CNMs who live in fear of having to close their birth centers or have closed their birth centers due to physicians no longer being able or willing to supervise them, we assert this is the perfect opportunity to push forth for full autonomy, not to submit to injustice for crumbs off the table.

For, those who will benefit the most, despite restrictions for mutually agreed upon protocols in place, will be the privileged white majority of certified nurse-midwives who are able to leverage their social positions to garner collaboration from physicians and surgeons. While we do not infer mal-intent, it is safe to say that those with the privilege to accept key concessions, are not the same people who suffer the unintended consequences of badly crafted policies. A brief review of the historical record (from Abolition, to Suffrage, to Abortion, through three waves of feminism, and the Black Lives Matter movement) clearly shows that the masses of nice white women

have not been so generous in leveraging their gains to uplift those whose backs have served as bridges to their victories. In the case of SB 1237, Black birthing people - the "back" of this bill - will pay with their autonomy, their ability to access care, and their lives.

Being an ally to Black birthing people means abdicating platforms of privilege, or leveraging such platforms to uplift Black birthing people and the Black birth workers who represent them.

SB 1237, as written, will negatively impact the Black, Indigenous, and Midwives of Color who are currently training, or will train in the future, to answer their calling to care for their own communities. Access to midwifery education is laden with barriers, both social and economic. The amount of education and various social supports required to be successful make midwifery education difficult to pursue. As an Advanced Practice Nursing degree, most midwifery programs total over $120,000 in cumulative educational costs. Thus, passing SB 1237, as written, translates to years of sacrifice for training to become a primary care provider, only to have one's practice authority stymied contingent upon their chosen work environment. A work environment provisioned for in their established scope of practice. The socio-cultural dynamics of race politics and bias mean that it is less likely for Black, Indigenous, and Midwives of Color to obtain cooperation from physicians and surgeons who view them as professional competition. Those in medical professions do not suffer this indignity.

In the vein of saving lives, there can be no room for divide and conquer political ploys meant to maintain maladaptive professional hierarchies. It cannot be ignored that due to trends in oppression and bureaucracy, the rights nurse-midwives abdicate will undoubtedly have unintended consequences on the care Licensed Midwives provide - consequences that will negatively impact this *slightly* more accessible route of midwifery.

Given that Black birthing people have a higher chance of dying in childbirth *in* hospital settings than outside of them, it is hypocritical to place undue restrictions on certified nurse-midwives, or any midwives, who practice outside of the hospital setting, if the same level of sanctions and oversight will not be prescribed for physicians and surgeons inside of hospital settings, who, in addition to social determinants of health, are responsible for these deaths.

Certified nurse-midwives deserve a bill that wholly affirms them as leading primary care providers and changemakers in this fight of Reproductive Justice against Black Maternal and Infant Mortality. A bill that centers the 6% of Black birthing people, 1% of Indigenous birthing people, and 0.4% of Pacific Islander birthing people who are having the worst outcomes in this state. By centering those experiencing the worst outcomes, and the midwives who are a reflection of those communities, then all birthing people, midwives, and citizens in this state will prosper. Healthy outcomes and thriving communities benefit all people. Californians deserve a midwifery bill that doesn't provide nurse-midwives freedom from physician supervision at a cost that will be paid by the people who choose to seek their care.

IMMEDIATE CALL TO ACTION

While COVID-19 has provided ideal conditions to expedite the passing of this bill, the pandemic also exacerbates the inequities in care by allowing hospitals, in particular, to implement policies not based in science, which contradict best practices, and increase conditions for maternal-fetal mortality through the increased use of induction, cesarean section, lack of proper access to aftercare, and decreased attention due to provider stress and fatigue. On May 9th, the International Confederation of Midwives published the following Global Call to Action: https://www.internationalmidwives.org/assets/files/news-files/2020/06/calls-to-action12.pdf

Sincerely,

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A Community-Led Guided Analysis and Response to SB 1237,

The Maternal Equity and Justice Act

Given that the voices and considerations of those most impacted by this proposed Act are not readily identifiable in the text of this proposed law, we have taken the liberty of responding in line.

BLUE text is the current language of SB 1237

RED text with strikethrough is the prior language of SB 1237 or the prior law it is based upon, and reflects the edits approved by the drafters of SB 1237.

GOLD Text is the community response and analysis of community members meant to help readers navigate legal language of the State agenda.

SECTION 1. *The Legislature hereby finds and declares the following:*

(a) It is the intent of the Legislature to ensure the preservation of nurse-midwifery care in both the hospital and out-of-hospital setting by delineating the scope of practice for certified nurse-midwives. The International Confederation of Midwives and the American College of Nurse-Midwives have already clearly defined the scope of practice for certified nurse-midwives as primary care providers, including their settings of practice.

(b) There is a maternity care workforce crisis in California. At least nine counties have no obstetrician at all, and many more counties fall below the national average for obstetricians. Nurse-midwives and physicians and surgeons can work together to innovatively address this issue and fill gaps in care, before California reaches the point of a critical provider shortage. The primary way physicians and surgeons can work together to innovatively address the issue of provider shortage is by supporting certified nurse-midwives attaining full autonomy of their scope of practice, instead of enforcing more barriers to accessing care. This extension of state bureaucracy does not belong in the visioning of future equitable and sustainable healthcare models. It is of backwards thinking to undermine licensed midwifery care with the expertise of a surgeon as their scopes of practice do not always overlap, and can exist entirely separate from each other. To mediate the care crisis, proposed solutions should not cascade toward increased surgical intervention, but provide funding toward accessible midwife training, hiring, and sustaining functioning structures.

(c) California has made great strides in reducing maternal mortality. Nonetheless, there remains a large disparity for Black and indigenous birthing people, and other birthing people of color. The maternal mortality rate for Black women in California is still three to four times higher than White women. Within an integrated model of care, physicians and surgeons and nurse-midwives can work together with patients and community leaders to eradicate this disparity. This measure will set the foundation for that work. Contrary to the assertions in this statement, this measure will set back the clock on providing safe, equitable and affirming care to birthing people, their children, and the citizens of California who need reproductive care by disregarding and overwriting established midwifery protocols with state and institutionalized intervention models. While seemingly progressive, this coded language serves to mislead community members into thinking they have a choice in building care solutions, only to advance a pre-set agenda. This tactic mirrors provider-patient relationship imbalances where

care providers frequently usurp power in dialogue to coerce birthing people into acting against their own interests. If studies have shown that midwifery care improves birthing outcomes, while higher incidence of injury, trauma, and violence are enacted by physicians and surgeons, how does tethering midwives to the aforementioned, without indication or request of the birthing person, build a foundation towards eradicating disparities?

(d) Structural, systemic, and interpersonal racism, and the resulting economic and social inequities and racial disparities in health care are complex problems requiring multiple, innovative strategies in order to turn the tide. Expansion of care teams, working together in a patient-centered approach, is one of these innovative strategies. While the issues at hand are certainly nuanced through the overlap in systematic oppression, the language surrounding their "complexity" is misguiding as their affects are rather strategic, reflecting intentional pattering in the disregard of Black health and Black vitality across the board. These conditions did not arise from osmosis, yet the outward presentation of the disparities in infant and maternal health outcomes mirrors the laziness of the state in underestimating the power of the people to connect the dots for due diligence. This phrasing places the onus of responsibility on individual care providers and birthing people instead of on the system designed to profit off of Black death. It is patronizing to assume the work community members and individual care providers are already doing to show up for Black birthing people is not being thwarted by such systems.

Occam's razor dictates that simple solutions, not more complicated ones, are the best. A key Hallmark of Midwifery, as outlined ACNM's "Core Competencies for Basic Midwifery Practice" is cultural humility. It is painfully apparent that the medical establishment does not possess this value, to the detriment of all people who walk through the doors of hospitals and care centers, only to be met with substandard care, institutionalized racism, and trajectories of care rooted in an implicit and racialized bias. Strategies that center professionals and legislators, instead of patients in the formation and decision making processes, are neither innovative nor conducive to creating lasting and effective change. Strategies that center patient voices, lean convoluted processes, streamline care, and provide continuity of care for patients. It is quite obvious that patients' voices and experiences were not centered in the crafting of this law, in any of its iterations, thus erasing them from the most important parts of the political process.

(e) State studies show that successful physician-midwifery integration enhances well-being and maternal and neonatal outcomes. In a historical and political climate of hierarchy and power-differential between physicians, surgeons, and nurse-midwives, what does a "successful" integration between physicians and midwives look like in practice and who determines these measures of success? While surveys of health are polled from client outcomes, they are equally a barrier to a midwife's provision of care as it is a barrier to any client's access of care. If birthing people are not at the forefront of these conversations, metrics provided in studies and surveys are essentially null, if not provided in proper context of birthing peoples' experiences in these models of care. Patients' experiences cannot be reduced to dichotomies of success/failure or to cost/benefit analyses as a lens of efficacy in outcomes. It should also be noted that those most often surveyed for studies are white people of higher socio-economic means, who are educated, able to advocate for themselves, and who most-often receive the highest standards of care and consideration compared to their non-white counterparts. Additionally, given the demographics of practicing physicians in California being 66% male and 32% white, and practicing nurse-midwives being 82% white, with Black and Pacific Islander women having significantly higher mortality rates, once again, the question is asked: Who's well-being and who's success are truly being considered?

(f) Nurse-midwives attend 50,000 births a year in California and are currently underutilized. Passing this bill, as written, would further underutilize nurse-midwives and reach to criminalize their work if they do not, or cannot, adhere to a narrowly defined scope of practice.

(g) Supporting vaginal birth could improve health outcomes and save millions in annual health care costs in California. This is true. Additionally, supporting citizens in accessing equitable care across their lifespan (from menarche through post-menopausal years, and providing sexual health care to male-identified people, as defined in the certified nurse-midwives scope of practice) could not only improve the chances of full-term pregnancies and vaginal births, but a better baseline of health overall, resulting in improved health outcomes and saving millions in annual health care costs in California.

(h) California is the only western state that still requires nurse-midwives to be supervised by a physician and surgeon and one of only four states in the nation that still requires this. Forty-six other states have removed the requirement for physician and surgeon supervision. Further still, 27 states (plus the District of Columbia) provide for full autonomous practice of certified nurse-midwives, in comparison to the 12 states that require collaboration with a physician and/or a surgeon. Alaska, Arizona, Idaho, New Mexico, and Colorado all have legislations in place that model fully autonomous practice models for CNMs. Additionally, both the American College of Gynecologists and the American College of Nurse-Midwives have issued independent and joint statements indicating that certified nurse-midwives are trained primary care providers; requiring collaborative agreements produces no more optimal outcomes than autonomous practice, and in fact, hamper midwives' ability to perform lifesaving care. As the requirement is written, we fail to see how requiring the signature of a physician and a surgeon for mutually agreed upon protocols and procedures will function differently in real time, than the requirement for collaborative care agreements. Great leaders know when to follow the examples of others. And, while California leads the way in many progressive issues, this is a wonderful opportunity to follow the example of our neighbors.

(i) Bodily autonomy including the choice of health care provider and the personalized, shared involvement in health care decisions is fundamental to reproductive rights. If this statement is truly valued by those who authored this legislation, why is it written in such a way that explicitly contradicts this notion? For the birthing person, if out-of-hospital birth plans were to follow these narrowly defined state requirements, a person's probability of "risking out" exponentially increases. In reality, normal pregnancies, labors, and births come across a broad spectrum. The power of the legislature to shorten this spectrum of what can be "normal" gestation is arbitrary, and actually targets birthing people whose pregnancies are not at risk. It has nothing to do with how supportive care can be provided to ensure safer birth for diverse experiences. It does not ultimately center client consent as it creates vulnerability in the delivery room, with potentially deeper gaps in childbirth education. Even in cases where a client may be willing to accept the risk via informed consent SB 1237 sets a precedent for birthing people to expect and accept limited care options as standard practice if their embodied pregnancy, labor, or delivery exists outside the parameters defined by the state. On the side of the practitioner midwives will be criminalized if they choose to honor their patient's wishes outside of state approved care. The parameters outlined in this bill undermine and effectively strip both patients and providers of their fundamental rights to a mutually agreed upon relationship based upon shared decision making.

(j) Every person is entitled to access dignified, person-centered childbirth and health care, regardless of race, gender, age, class, sexual orientation, gender identity, ability, language proficiency, nationality, immigration status, gender expression, religion, insurance status, or geographic location. Again, this assertion is not supported by the body of this bill. By reducing midwifery care to antepartum, intrapartum, and postpartum

periods, family planning, and interconception care, those who choose not to or cannot reproduce, are effectively excluded from seeking primary care from a certified nurse-midwife. As it is written, many common experiences along the reproductive spectrum will not be honored equally to state-preferred birth experiences. Those who are deemed "geriatric" (over the age of 40) during pregnancy, using gender affirming hormones prior to becoming pregnant, having different disabilities (physical, medical, or otherwise), undocumented or uninsured, or living in a county that has no physician for a nurse-midwife to craft mutually agreed upon protocols with, are at risk of being excluded from partnering with a nurse-midwife for their primary or reproductive care all together.

(k) The core philosophy of nurse-midwifery is to provide patient-centered, culturally sensitive, holistic care in collaboration with physicians and surgeons and other health care providers, all of which are key to reducing disparities in maternal health care. This assertion of the philosophy of nurse-midwifery is fundamentally incorrect. According to the American College of Nurse-Midwives, midwives are primary care providers who "assume responsibility for the provision of and referral to appropriate health care services, including prescribing, administering and dispensing of pharmacologic agents." Collaboration with and referrals to other health care professionals is implemented, as needed, per the judgement of the midwife, not through statute or legislation.

***SEC. 3.** Section 2746.2 of the Business and Professions Code is amended to read:*

(b) (1) The board shall appoint a committee of qualified physicians and surgeons and nurses called the Nurse-Midwifery Advisory Committee. Here is a list of Advisory Committees sanctioned under California's Department of Public Health. Licensed Midwives, physicians, and surgeons all report to the Medical Board of California. Certified nurse-midwives are already presided over by the Board of Registered Nursing, should a patient have a grievance. Mandating an additional Advisory Committee is a punitive tax for certified nurse-midwives, who are both Advanced Practice Registered Nurses and Primary Care Providers, asserting their right to autonomy. Mandating an advisory committee, in response to removing "physician supervision" (in language only) reinforces the notion that midwives are not trusted to manage their affairs through established professional channels, or that they need additional layers of oversight, if they're going to be practicing outside of the hospital.

(2) The committee shall make recommendations to the board on all matters related to midwifery practice, education, appropriate standard of care, and other matters as specified by the board. The committee shall provide recommendations or guidance on care when the board is considering disciplinary action against a certified nurse-midwife. Certified nurse-midwives have several overseeing bodies, including the American College of Nurse-Midwives, American Midwifery Certification Board, International Confederation of Midwives, Board of Registered Nursing, and the Accreditation Commission for Midwifery Education. All of these bodies operate on the highest standards of professionalism and, as the experts in midwifery, are wholly qualified to address any all considerations inferred in section (2).

(3) The committee shall consist of four qualified nurse-midwives, two qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member. In short, this committee is a waste of valuable resources that can be directed to patients, or doing the work to dismantle policies and cultures that are harmful to providers and patients alike. If the medical establishment currently doesn't recognize the authority of nurse-midwives, or pay adequate respect and attention to the needs of birthing people, creating an additional layer of bureaucracy will not be beneficial. It should be noted that there is a glaring lack of consideration for Licensed Midwives to be present on this committee, despite them being the experts on out-of-hospital birth and community midwifery, and are subjugated, culturally and professionally, by the medical

establishment, including nurse-midwives. Lastly, who "qualifies" the physicians and nurse-midwives to sit on this committee, that may be allowed to function and make recommendations in their absence?

(4) If the board is unable, despite good faith efforts, to solicit and appoint committee members pursuant to the specifications in paragraph (3), the committee may continue to make recommendations pursuant to paragraph (2). "Taxation without Representation" is a fitting allegory to the implications of how this provision can be enacted in real time. For which, birthing people and those seeking health care from certified nurse-midwives will suffer. This provision is an obvious addition to placate those whose interests are also served in the establishment of this committee.

SEC. 4. *Section 2746.5 of the Business and Professions Code is amended to read:*

2746.5. *(a) The certificate to practice nurse-midwifery authorizes the ~~holder, under the supervision of a licensed physician and surgeon,~~ holder to attend cases of ~~normal~~ low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including ~~family-planning care, for the mother,~~ interconception care, family planning care, and immediate care for the ~~newborn.~~ newborn, consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. The shift in language from "normal" to "low risk" should be noted, as the use of "risk" as parameter is differently defined within and external to hospital settings, thus impacting whom certified nurse-midwives would be able to serve. This analysis of risk should be determined between birthing people and their providers, not by hospitals, legislatures, or external practitioners.*

Since the publishing of the bill on 5/19/2020, the inclusion of "gynecologic and family planning services" has been stricken from the bill. This fundamentally disenfranchises those people who choose to receive their well person care from a midwife, instead of an OBGYN. Not only does this harm those who choose to not receive care from an OBGYN, for whatever reason they choose not to or cannot do so, it also drastically reduces the Certified Nurse-Midwife scope of practice and services that can be offered to the community.

"Interconception/Interpregnancy Care" and "family planning care" are not adequate linguistic substitutions for the removal of "gynecologic" care, as per definition, both categories of care are predicated on reproduction, not on well person care. If these models are used to expand the scope of certified nurse-midwives, they should be able to do so without eliminating previously approved aspects.

According to ACNM's Essential Facts About Midwives, "While midwives are well-known for attending births, 53.3% of CNMs/CMs identify reproductive care and 33.1% identify primary care as main responsibilities in their full-time positions. Examples include annual exams, writing prescriptions, basic nutrition counseling, parenting education, patient education, and reproductive health visits."

Additionally, if 9 counties in California have no OB-GYN, and certified nurse-midwives are not legally allowed to provide well-person, gynecologic care, how are people in those counties supposed to access preventative, maintenance, and lifesaving care?

For purposes of this subdivision, "low-risk pregnancy" means a pregnancy in which all of the following conditions are met:

(1) There is a single fetus.

(2) There is a cephalic presentation at onset of labor.

(3) The gestational age of the fetus is greater than or equal to 37 weeks and zero days and less than or equal to 42 weeks and zero days at the time of delivery.

(4) Labor is spontaneous or induced.

(5) 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 consistent with this section. As previously stated, the conditions as stated in Sections 1-5 create a very narrow selection of criteria for what "risk" is and how it can be managed in out of hospital settings.

This narrow categorization of low risk is also vague, which creates opportunities for care providers to improperly apply or manipulate this law, while removing agency from patients, who should have the primary say in their healthcare. Pre-existing conditions can include being over 35 years of age (deemed "geriatric"), conceiving via IVF, or being obese - none of which are inherent health risks- and could disqualify a large number of people from being able to access midwifery care.

Abuse of these criteria, or a difference in professional opinion as to what constitutes qualification to manage conditions, places birthing people at the mercy of their care providers, leading to disparities in care, the issue this bill is intended to begin to address.

(b) (1) The certificate to practice nurse-midwifery authorizes the holder to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon to do either of the following:

(A) Provide a patient with care that falls outside the scope of services specified in subdivision (a).

(B) Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium. This section is self-serving, the ethos is not rooted in science, and is a platform to perpetuate violence on the bodies of birthing people. With a C-Section rate of 23.9% currently, down from 26% in 2013, and a national average of approximately 30%, 20-30% of birthing people within their child bearing years will be ineligible (i.e. "risked out") for midwifery care, despite the data stating that VBAC is the safest method of giving birth and the incidence of one primary concern of hemorrhage - a situation midwives are trained to take care of - happens in approximately 0.3-0.7%. of VBAC cases. Black women and Pacific Islander women are overrepresented in cesarean births at 35.4% and 33%, respectively.

Studies have shown that one risk of experiencing a cesarean section is based largely on where a person births their child, not on the medical necessity of receiving one. It is important to note, not all physicians and surgeons allow TOLAC. Therefore, automatically requiring transfer to a physician or a surgeon, based upon circumstances out of their control, removes the right of birthing people to choose their care and increases the likelihood of being coerced into an unnecessary repeat surgery.

Additionally, Licensed Midwives are able to facilitate VBAC births, transferring if and when appropriate. As such, this bill creates two standards of care that directly contradict each other; Either midwives are equipped to facilitate VBAC (we assert they are), or they are not.

To improve birth outcomes, Black Mama's Matter Alliance recommends to "empower women to engage with their providers and make active decisions about care." In their analysis of Vaginal Birth after Cesarean, ACOG asserts that birthing people have the right to be fully informed of the benefits and risks of their choices and to collaborate with their care providers to plan accordingly. Neither of these recommendations reflects that birthing people who've experienced a prior cesarean section should be automatically under the care of a physician or surgeon, nor do they reflect that certified nurse-midwives must consult with a physician or surgeon prior to providing primary care to a birthing person.

Lastly, the requirement for physicians to automatically provide care to patients who've had a prior cesarean section is akin to the sacrifices Licensed Midwives made in AB 1308, in which, for exchange of removal of physician supervision, the midwives lost their legal ability to facilitate breech births, in order to retain their legal right to facilitate VBAC. Removing a midwife's ability to facilitate breech birth and VBAC is akin to erasing the ability to have the lifesaving skills and knowledge to facilitate these types of common birthing experiences; This is particularly concerning for those birthing people living in rural areas, who do not have access to nearby hospitals (or who choose not to use them) and are thus barred from accessing lifesaving care. With the added pressure of the pandemic, midwives who possess these skills should legally be able to use them. These concessions have been made, for no other reason, than professional bullying and oppression. Lifesaving skills should never be leveraged to pass bills due to ego-laden professional boundary marking, primarily to retain power differentials and profit margins.

(2) If a physician and surgeon assumes care of the patient, the certified nurse-midwife may continue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, as indicated by the mutually agreed-upon policies and protocols signed by both the certified nurse-midwife and a physician and surgeon.

(3) After a certified nurse-midwife refers a patient to a physician and surgeon, the certified nurse-midwife may continue care of the patient during a reasonable interval between the referral and the initial appointment with the physician and surgeon. Who determines what a "reasonable interval" is? How is this information communicated to the nurse-midwife?

(c) (1) If a nurse-midwife does not have in place mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon pursuant to paragraph (1) of subdivision (b), the patient shall be transferred to the care of a physician and surgeon to do either or both of the following: This requirement is overly restrictive and antithetical to creating equity in care-provider professional relationships. If a physician and surgeon don't have to physically be present, this requirement places undue burden on midwives to source physicians and surgeons before being able to care for their patients. And, if a midwife is unable to find a physician or surgeon amenable to crafting mutually agreed-upon policies, for any reason, then the birthing person loses autonomy in their choice of care provider. In no way does this requirement establish a system of equity for birthing people or nurse-midwives.

(A) Provide a patient with care that falls outside the scope of services specified in subdivision (a).

(B) Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.

(2) After the certified nurse-midwife initiates the process of transfer pursuant to paragraph (1), for a patient who otherwise meets the definition of a low-risk pregnancy but no longer meets the criteria specified in paragraph (3) of subdivision (a) because the gestational age of the fetus is greater than 42 weeks and zero days, if there is inadequate time to effect safe transfer to a hospital prior to delivery or transfer may pose a threat to the health and safety of the patient or the unborn child, the certified nurse-midwife may continue care of the patient consistent with the transfer plan described in subdivision (a) of Section 2746.54.

(3) A patient who has been transferred from the care of a certified nurse-midwife to that of a physician and surgeon may return to the care of the certified nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer from the care of the nurse-midwife pursuant to paragraph (1) is resolved. Birthing people are not objects to be passed back and forth between care providers at whim. Given the long established power differentials between nurse-midwives and physicians, the notion that the physician or surgeon "may return to the care" upon discretion of the physician or surgeon is highly subjective, does not demonstrate the quality of collaboration, shows zero good faith to the respect of the professional qualifications of certified nurse-midwives, and most importantly, deprives birthing people their agency in this entire process.

A more equitable and logical solution would be that if co-managed care is required for a more complicated pregnancy, the physician or surgeon should address the condition itself and co-manage with the midwife remaining as the primary care provider, unless the condition presented is such that the midwife would not be present at their labor or birth, or be able to address their well-person or gynecological needs. Particularly for Black, Indigenous, and patients of Color, continuity of care is one of the greatest needs and factors for positive health outcomes.

(d) The certificate to practice nurse-midwifery authorizes the holder to attend pregnancy and childbirth in an out-of-hospital setting if consistent with subdivisions (a), (b), and (c). The certificate to practice nurse-midwifery is much more expansive than the subdivisions of (a), (b), and (c) and is unduly restricted by the parameters of said subdivisions. A certified nurse-midwife's scope of practice authorizes the midwife to practice in all settings, with no scope difference contingent upon where the midwife chooses to practice.

(e) This section shall not be interpreted to deny a patient's right to self-determination or informed decisionmaking with regard to choice of provider or birth setting. This section is akin to throwing a rock and hiding the proverbial hand. While this section "shall not be interpreted to deny a patient's right to self-determination or informed decisionmaking with regard to choice of provider or birth setting" the crafting of this bill creates ironclad conditions to do just that. Birthing people are dealing with, and dying from, self-perpetuating systems of oppression, which also include the people within them. This language is flowery, has no teeth, and does absolutely nothing to protect a birthing person's right to autonomy or to protect them from the myriad axes of oppression, which will be compounded by the statutes of this bill. This inclusion of language is gaslighting in its highest form and is insulting to the intelligence and dignity of birthing people and certified nurse-midwives alike.

~~*(b)*~~ *(f)* ~~*As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The practice of*~~ *The certificate to practice nurse-midwifery does not* ~~*include*~~ *authorize the* ~~*assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any*~~ *holder of the certificate to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version. Several studies have shown that midwives are prime candidates to*

perform external cephalic versions, with success rates comparable to those of obstetricians. The American College of Nurse Midwives also offers skills building courses for nurse-midwives to ensure continuing education and maintenance of skill competency. Additionally, the previously referenced studies have shown that ECV is an underutilized technique that is safe to be administered in low-risk pregnancies. By disallowing nurse-midwives to perform external cephalic versions, a profit pipeline is being ensured via unnecessary recommendations to physicians and surgeons - who may or may not suggest or implement the procedure - which increases the risk of a birthing person receiving a cesarean section, whether it's truly warranted or not.

(g) A certified nurse-midwife shall document all consultations, referrals, and transfers in the patient record.

(h) (1) A certified nurse-midwife shall refer all emergencies to a physician and surgeon immediately.

(2) A certified nurse-midwife may provide emergency care until the assistance of a physician and surgeon is obtained.

(i) This chapter does not authorize a nurse-midwife to practice medicine or surgery. ~~(c)~~ Per the language of Section 2052, this phrasing is contradictory. Given that certified nurse-midwives are primary care providers who would be expected to treat sick people (within their scope of practice) who would present with "ailment [sic], blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition"; in providing care, certified nurse-midwives would be well within their rights to assess, make diagnoses, and use their prescriptive authority - granted in this bill - to address said sickness or ailments they would encounter with patients. Oftentimes, it is a care provider, such as a CNM, who will assess a parent's mental state, primarily watching for postpartum depression, which affects 10%-20% of birthing people, with Black birthing people at higher risk for experiencing the disorder, yet less likely to receive treatment for it. Additionally performing and repairing episiotomies, which are defined as surgeries, are well within a certified nurse-midwife's scope of practice. This language is prohibitive, nonsensical, and an obvious attempt by medical doctors to retain authority over processes and practices they truly have no say in or jurisdiction over. If the goal is to "do no harm" and to relieve a system that is strained by granting certified nurse-midwives their practice authority, including this section is counter productive to that aim.

(j) ~~As used in this article, "supervision"~~ This section shall not be construed to require ~~the physical presence of the supervising physician.~~ a physician and surgeon to sign protocols and procedures for a nurse-midwife or to permit any action that violates Section 2052 or 2400. If physicians and surgeons are not required to sign protocols and procedures, what happens to birthing people if they opt out? As certified nurse-midwives are primary care providers in their own right, it is not for a physician or surgeon to "permit" them to do anything. If a nurse-midwife acts outside of their scope of practice, it is for their overseeing board, not a physician or a surgeon, to investigate and reprimand them. The professional and profit drivin dynamics that currently exist between physicians and midwives, and physicians and patients, are not so simple that they can be legislated away. This clause allows for those physicians and surgeons who are not onboard with progressive legislation to simply opt out. This places birthing people in increasingly precarious conditions, instead of ensuring safety and collaboration in their care experience.

~~(d) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.~~

~~(e)~~ (k) ~~Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board.~~ This section shall not be construed to require a nurse-midwife to have mutually agreed-upon, signed policies and protocols for the provision of services described

in subdivision (a). Given that subdivision (a) is a legal redefinition of a nurse-midwife's scope of practice, the inclusion of this subdivision is patronizing, at best. Essentially, it is a clause that insists the authority to define the scope of practice for nurse-midwives is in the hands of the lawmakers, not the established channels of authority, and that midwives don't need permission to adhere to it.

In Summary:

Certified nurse-midwives train their entire careers to be experts in reproductive care across the lifespan, including but not limited to assisting birthing people in their journeys to parenthood. They have existed millenia prior to the advent of either the physician or the surgeon - midwives attended the births of both of these professions. This bill represents a powerful opportunity to do right by the Grand Midwives who birthed a nation, yet were deemed inferior by the very men who owed their lives to them. This bill represents a powerful opportunity to do right by Black women and Black birthing people, in particular who are dying at the hands of a system with too much blood on its sleeves. This bill represents an opportunity to participate in simple, yet radical, justice to begin the work of repairing what has been done by putting a stop to what will be done. However, as written, The Maternal Equity and Justice Act rings as hollow on the ears of Black, Indigenous, and [non]birthing people of Color as "the Land of the Free."

Every primary care provider has to use their judgement on where or not they are comfortable, capable, or willing to work with a patient or to refer them out. Not every care provider practices the same way and statistics are not wholly representative of an individual patient, their history, and their human potential. Conversely, patients, as fully autonomous sentient beings, have the right to enter into contracts of care, free from coercion by either care provider, policy, or statute. This is not something that can, or should, be attempted to be solved by law.

As it is written, SB 1237 is a continuation of a deeply racist and misogynistic history. As it is written, SB 1237 is an active participant in the genocide of Black people, through reinforcing systems of obstetric violence.

As it is written, SB 1237 is the certified nurse-midwife's white moderate, more concerned with the keeping of the "order" than truly liberating midwives from the crushing weight of the same systems that are detrimental to the tenants of Reproductive Justice.

As it is written, SB 1237 plays sleight of hand and prioritizes profits over people.

As written, instead of following the example of 27 other states in our Union, SB 1237 is a missed opportunity to provide a powerfully simple solution to a complex problem, ultimately improving health and birth outcomes.

Black people are dying at the hands of the State, the Medical Industrial Complex, and by countless other ways this country enacts violence upon our bodies. As guardians of our community and our legacy as Black birthworkers, Nia Healing Center for Birth and Family Life and the Oakland Better Birth Foundation will not stand for our loved ones being sold down the river, to appease the egos of anyone complicit in this toxic system. We staunchly reject the notion that those who choose to practice or seek care external to state sanctioned institutions will be penalized for it. We vehemently reject the notion that if one is Black, of Color, Queer, Womxn, Non-Binary, Trans, Low-Income, Houseless, fat, or any other unacceptable body, that we are not entitled to care based in parity. We assert the lack of parity rooted in structural racism, interpersonal racism, and implicit bias is literally costing lives.

The *Maternal Equity and Justice Act,* as written, is well-named and well-meaning, thus conveniently oblivious of the violence it perpetuates. However, creating lasting change means dismantling the systems that allow violence to happen in the first place, not merely opting for the minor disruption and discomfort of reform. Accolades are not advancement. Politicking is playing chess with the lives of real people. To truly be an ally and accomplice in the pursuit of human dignity requires providing the platform for the people to prosper on their terms.

Nia Healing Center for Birth and Family Life and the Oakland Better Birth Foundation call for this bill to not pass, as written, unless amended to reflect Certified Nurse-Midwives receiving their full dues. We also endorse the letter written by CFAM, CAM, CALM, and Susan Jenkins regarding their concerns with SB 1237.

In Solidarity with Black Birthing People, Nurse-Midwives, Licensed Midwives, and our Fellow Californians:

Samsarah Morgan, Founder, Doula, Executive Director, Nia Healing Center for Birth and Family Life, Oakland Better Birth Foundation
Jewel Buchanan-Boone, M.S., Full Spectrum Doula, Roots of Labor Birth Collective, Lead Researcher and Principal Author
Jessalyn Ballerano, BA, CD, CCCE, OBBF Communications Coordinator
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Heather Moore-Farley, Community Board Member OBBF, Parent
Laura Cox, CLEC, Community Board Member OBBF
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