College Statement of Policy

As issued by the College Executive Board

This document was developed jointly by the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists.

JOINT STATEMENT OF PRACTICE RELATIONS BETWEEN OBSTETRICIAN-GYNECOLOGISTS AND CERTIFIED NURSE-MIDWIVES/CERTIFIED MIDWIVES[1]

The American College of Obstetricians and Gynecologists (the College) and the American College of Nurse-Midwives (ACNM) affirm our shared goal of safe women's health care in the United States through the promotion of evidence-based models provided by obstetrician–gynecologists (ob-gyns), certified nurse-midwives (CNMs), and certified midwives (CMs). The College and ACNM believe health care is most effective when it occurs in a system that facilitates communication across care settings and among providers. Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability.

Recognizing the high level of responsibility that ob-gyns and CNMs/CMs assume when providing care to women, the College and ACNM affirm their commitment to promote the highest standards for education, national professional certification, and recertification of their respective members and to support evidence-based practice. Accredited education and professional certification preceding licensure are essential to ensure skilled providers at all levels of care across the United States.

The College and ACNM recognize the importance of options and preferences of women in their health care. Ob-gyns and CNMs/CMs work in a variety of settings including private practice,

[1] Certified Nurse-Midwives (CNMs) are registered nurses who have graduated from a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and have passed a national certification examination administered by the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC). Certified Midwives (CMs) are graduates of a midwifery education program accredited by ACME and have successfully completed the AMCB certification examination and adhere to the same professional standards as certified nurse-midwives. Obstetrician–gynecologists (ob-gyns) pass a national certification exam administered by the American Board of Obstetrics and Gynecology or Osteopathic Board and enter ongoing Maintenance of Certification.

community health facilities, clinics, hospitals, and accredited birth centers.[2] The College and ACNM hold different positions on home birth.[3] Establishing and sustaining viable practices that can provide broad services to women requires that ob-gyns and CNM/CMs have access to affordable professional liability insurance coverage, hospital privileges, equivalent reimbursement from private payers and under government programs, and support services including, but not limited to laboratory, obstetrical imaging, and anesthesia. To provide highest quality and seamless care, ob-gyns and CNMs/CMs should have access to a system of care that fosters collaboration among licensed, independent providers.

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[2] A birthing center within a hospital complex, or a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, the Joint Commission, or the American Association of Birth Centers [From *Guidelines for Perinatal Care*, Sixth Edition. 2007. American College of Obstetricians and Gynecologists and the American Academy of Pediatrics].

[3] ACNM Home Birth Position Statement (http://www.midwife.org/siteFiles/position/homeBirth.pdf); Planned home birth. Committee Opinion No. 476. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:425–8. (http://www.acog.org/publications/committee_opinions/co476.cfm)

Approved by Executive Board of the American College of Obstetricians and Gynecologists
Approved by Board of Directors of the American College of Nurse-Midwives
February 2011

College Statement of Policy

As issued by the College Executive Board

This document was developed jointly by the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists.

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

JOINT STATEMENT OF PRACTICE RELATIONS BETWEEN OBSTETRICIAN-GYNECOLOGISTS AND CERTIFIED NURSE-MIDWIVES/CERTIFIED MIDWIVES[1]

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Approved by Executive Board of the American College of Obstetricians and Gynecologists
Approved by Board of Directors of the American College of Nurse-Midwives
February 2011

June/July 2011

Dear Rep Sanchez

The organizations and individuals below encourage you to support the following two midwifery bills that have replaced the single bill that was introduced in the last legislative session. They are:

An Act Relative to Enhancing the Practice of Nurse Midwives (House Bill 2369), which would eliminate the outdated statutory requirement for the direct supervision of Certified Nurse-Midwives (CNMs) by physicians. Only 6 states in the country still have such a requirement in place; and

An Act Relative to Certified Professional Midwives (House Bill 2368 and Senate Bill 1133; same text), which would recognize and regulate the practice of Certified Professional Midwives (CPMs).
As you may know, most Certified Nurse-Midwives (CNMs) are currently not permitted to practice in the home setting because of various practice constraints imposed by their back-up physicians or hospitals. Thus, the licensure of CPMs is key to improving the safety of home birth. Although fewer than one percent of childbearing women in Massachusetts now choose home birth, recent statistics indicate that this option is becoming more popular. **As you may know already, there is a hearing at the State House about this bill at 10AM on July 19.**

We also urge you to OPPOSE a bill that calls for yet another "study" of midwives: **An Act Establishing a Special Commission on Direct Entry Midwives and Home Birth in the Commonwealth** (House Bill 2904). There already have been sufficient studies of midwifery and home birth for public policy to be set right now.

You may also wish to review an informative 14-minute video prepared last year by a volunteer team of experts seeking to educate policy makers about the benefits of midwifery care and the option of home birth:
www.youtube.com/ourbodiesourselves#p/a/f/1/nMSCGtSSzhM.

Ironically, as midwives' role in childbirth in Massachusetts has grown more restricted, the Commonwealth's ranking on key birth outcomes has also declined. These two bills could help to reverse this disturbing trend, lower birth-related hospital costs and also likely increase rates of breastfeeding in the state. We appreciate your support of this important legislation and will follow up in the near future.

Sincerely,

Mary Garippo, Legislative Policy Committee, and Nancy Cremins, President, Women's Bar Association of Massachusetts

Judy Norsigian, Executive Director, Our Bodies Ourselves

Carol Rose, Executive Director, American Civil Liberties Union of Massachusetts

Joshua Rubenstein, Northeast Regional Director, Amnesty International USA

Ann Sweeney, Executive Director, Mass Friends of Midwives

Eva Valentine, President, League of Women Voters of Massachusetts

Bethany Withers, Policy & Programs Manager, Massachusetts NOW

Endorsing individuals:

Lucy M. Candib, MD, Family Physician, Professor, Department of Family Medicine and Community Health, University of Massachusetts Medical School and Family Health Center of Worcester

Eugene Declercq, PhD, Professor and Assistant Dean, Boston University School of Public Health

Marcie Richardson, MD, Assistant Clinical Professor, Department of OB/GYN and Reproductive Endocrinology, Harvard Medical School, FACOG

(Other endorser names available upon request.)

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April 12, 2011

Hon. Susan C. Fargo, Senate Chairwoman
Chairman
Hon. Senate Members
Joint Committee on Public Health
State House Room 504
Boston, MA 02133

Hon. Jeffrey Sanchez, House

Hon. House Members
Joint Committee on Public Health
State House, Room 130
Boston, MA 02133

Testimony in Support of *House 2369: A Bill Relative to Enhancing the Practice of Nurse Midwives*

My name is Elizabeth Stevens. I currently work for the Providence Prenatal Center in Holyoke, MA and Mercy Care/Forest Park in Springfield, MA. Both practices belong to Mercy Hospital and the majority of our obstetrical patients deliver at Mercy Hospital where 55% of the vaginal deliveries are attended by nurse midwives.

In both of these practices, the nurse midwives work in collaboration with OB/GYNs in private practice who are contracted to provide supervision as required by current law. In Holyoke, the supervising physician attends the births, even though the majority of patients would prefer to be cared for during labor and birth by the midwives who care for them throughout their pregnancy. We, the nurse midwives, are not in a position to change this contract. In Springfield, labor and birth care is provided by other nurse midwives who are employed by our contracting MDs.

Providence Prenatal Center was established by Providence Hospital, Holyoke, MA, in the 1960s, and began offering bilingual nurse-midwifery services in the 1990s.

The center was set up to serve the women of Holyoke and to address the high infant mortality rate and high teen pregnancy rate in Holyoke. When Providence Hospital closed in the mid-90s, Mercy Hospital in Springfield continued the practice but eliminated care in the hospital by the practice's nurse midwives. We continue to provide gynecological care to the same women who came to us in the 1990s for obstetrical care. Now we also provide care to their daughters and granddaughters. Our patients include hard-working professional women, single mothers barely getting by with limited resources, teenagers faced with unplanned pregnancies, English speakers, bilingual women, and those who speak only Spanish. Our office is located in downtown Holyoke, easy for our patients to walk to or accessible by the use of public transportation since many have limited access to private transportation.

At a second practice site in Springfield, we serve women of a wide range of economic means and educational backgrounds. We serve immigrant women from Vietnam, numerous African countries, former Russian Republics, as well as many from Puerto Rico and other Spanish speaking countries. At both offices we offer a unique teen pregnancy program to help prepare teens to become young mothers. This involves more frequent office visits, childbirth classes, hospital tours, peer discussion groups, social service referrals and transportation when needed. Although we primarily offer obstetrical and gynecological care, our patients come to us with primary care problems because they trust us or because they do not have primary care providers. Sometimes their primary care providers are reluctant to treat women for anything during a pregnancy. Some of their problems cannot wait and we give the care that we have been trained to provide.

Nurse midwives have historically chosen to be advocates for and provide care for people whose lives are at the margin – women in poverty, women from different cultures and religions, women who don't speak English. We must be partners in decision-making about our practices and the way we provide care in order to protect the rights of these women. The requirement for physician supervision limits the decision making power to those with less investment in the practice and the care that is provided. It becomes a delegated scope of practice. Women whose lives are more complicated, whose lives are sometimes at the margins, whose needs are not met by the average private OB/GYN practice need nurse midwives who can ensure that women are equal partners in the decision-making process that affects their lives.

Eliminating statutory supervision requirements will allow needed regulatory changes and set the conditions for nurse-midwives to apply for independent hospital privileges in my community. HR 2369 will improve care for women by increasing their access to the care of their choice. Please give HR 2369 a favorable report. I thank you for your time and your consideration.

LEAGUE OF WOMEN VOTERS OF MASSACHUSETTS

133 Portland Street, Boston, Massachusetts 02114 ◆ TEL: 617-523-2999 ◆ FAX: 617-248-0881 ◆ E-MAIL: lwvma@lwvma.org

April 12, 2011

Dear Members of the Joint Committee on Public Health:

Thank you for giving me this opportunity to speak on behalf of H2369, An Act Enhancing the Practice of Nurse Midwives.

The League of Women Voters of Massachusetts is strongly in favor of H2369 because its implementation will help to promote affordable and quality health care — qualities for for which we advocate.

We urge the passage of this bill because it will bring proper recognition of autonomous practice by nurse midwives.

The American College of Obstetricians and Gynecologists (the College) and the American College of Nurse-Midwives (ACNM) affirm a shared goal of safe women's health care in the United States through the promotion of evidence-based models provided by obstetrician–gynecologists (ob-gyns), certified nurse-midwives (CNMs), and certified midwives (CMs).

Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability.

Massachusetts is one of only six states that require certified nurse midwives to be supervised by physicians.This present requirement hinders nurse midwives in doing the work for which they are trained. it's also unfair to physicians in that it leaves them open to potential liability for nurse midwives actions or omissions.

This bill will give women in MA \assachusetts greater choice in providers and birth settings.

Last July the Canadian Journal of Obstetrics and Gynecology printed the results of a study that found that for women who chose midwifery care, an average saving of $1172 per course of care was realized without adversely affecting maternal or neonatal outcomes. Cost reductions were partially realized through provision of out-of-hospital health services. Women who chose midwifery care had more prenatal visits and fewer inductions of labor; their babies had greater gestational ages and fewer inductions of labor than controls.

At a time when the Commonwealth of Massachusetts is struggling to control health care costs while providing quality health care, it would seem foolish not to allow nurse midwives to fully provide the important tasks for which they are trained.

Judy Deutsch

Reverend Judy Deutsch, Health Care Specialist
League of Women Voters of Massachusetts

Return to Web Version

Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants

See also:
Nurse Midwives, Certified
Integrated Practice Arrangements
Nurse Practitioners
Physician Assistants
Family Physicians and Physician Assistants: Team-Based Family Medicine
Non-Physician Providers, Family Physician Training With
Payment, Non-Physician Providers
Telemedicine, Licensure and Payment

Introduction

Many family physician practices include non-physician providers (NPPs) such as physician assistants, nurse practitioners and less commonly nurse midwives. Moreover, family physicians have been at the forefront of innovation in practicing with NPPs, especially in underserved communities. The Academy has supported a wide variety of efforts by policy makers to improve access to health care services in underserved communities including the innovative utilization of NPPs.

The increasing variety of situations in which NPPs practice, the emphasis on practice teams, and the growing tendency of health policy makers to identify NPPs as a means of improving the availability of health care services raises important issues regarding the appropriate relationship between NPPs and physicians. Current Academy policy on NPPs stipulates that these providers should always function under the "direction and responsible supervision" of a practicing, licensed physician though in many states nurse practitioners have independent practice authority. Academy policy on "Integrated Practice Arrangements" supports practice teams including NPPs. The Academy, however, believes that practicing physicians, NPPs and health policy makers will benefit from a more detailed set of supervision guidelines.

These guidelines are intended to serve as a set of general principles with which physicians, NPPs and policy makers can assess the role of NPPs in providing patients a team-based medical home and in improving access to health care services.

It is important to note that an extremely varied set of laws and regulations defining the legal relationship between physicians and NPPs has been adopted by the federal government and all 50 states. It's also important to note that there are major differences in state scope of practice statutes among nurse practitioners, nurse midwives and physician assistants. While these guidelines will provide general direction, physicians and NPPs are urged to fully comply with all federal, state and local laws and regulations regarding health care delivery. Health insurance plans and physician practices which include non-physician providers should provide information to members/patients regarding the possibility of being seen by a non-physician provider. Such information should be stated in clear terms in plan/practice advertisements and communications, the information should be made known to the patient at the time their appointment is made, and should be clearly stated by the non-physician provider at the time the patient is seen.

Physician Responsibility

The central principle underlying physician supervision of NPPs is that the physician retains ultimate responsibility of the patient care rendered when so required by state law. In these cases, physician supervision means that the NPP only performs medical acts and procedures that have been specifically authorized by the supervising physician.

Generally speaking, it is useful to conceptualize state NPP supervision laws as providing physicians with the authority to delegate the performance of certain medical acts to NPPs who meet specified criteria and who function under certain legal requirements for supervision. Accordingly, the tasks delegated to the NPP should be within the scope of practice of the supervising physician. The physician remains responsible for assuring that all delegated activities are within the scope of the NPP's training and experience. The physician must afford supervision adequate to ensure that the NPP provides care in accordance with accepted medical standards.

Supervision

It is the responsibility of the supervising physician to direct and review the work, records, and practice of the NPP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered consistent with applicable state law. Supervision includes, but is not limited to: (1) the continuous availability of direct communication either in person or by electronic communications between the NPP and supervising physician; (2) the personal review of the NPP's practice at regular intervals including an assessment of referrals made or consultations requested by the NPP with other health professionals; (3) regular chart review; (4) the delineation of a plan for emergencies; (5) the designation of an alternate physician in the absence of the supervisor; and (6) review plan for narcotic/controlled substance prescribing and formulary compliance. The circumstance of each practice determines the exact means by which responsible supervision is accomplished.

Direction

It is the responsibility of the physician to ensure that appropriate directions are given, understood, and executed. These directions may take the form of written protocols, in person, over the phone, or by some other means of electronic communication.

Protocols developed by the supervising physician and NPP should include guidelines describing and delineating NPP functions and responsibilities. Protocols should be as specific in their guidance as the physician and NPP require for their particular practice. Many states require that the physician and NPP develop detailed written protocols, and, in some instances, these protocols must be submitted to and approved by the state medical board. As a practical matter, it is not possible to cover all clinical situations in written protocols. Nonetheless, there must be a clear understanding between the physician and NPP regarding the actions that may be undertaken by the NPP in all commonly encountered clinical situations and, especially, under what circumstances physician consultation is to be immediately obtained. The physician and NPP must regularly review protocols to ensure their currency in regard to the physician's scope of practice, the range of tasks that have been delegated by the physician and the evolving standards of medical practice. Immediate physician consultation will be indicated for specified clinical situations and in situations falling outside those specified in written and oral protocols.

Review

The supervising physician must develop and carry out a plan to ensure NPP quality of care. This plan must be in compliance with all applicable laws and regulations. The supervising physician must regularly review the quality of medical services rendered by the NPP by reviewing medical records to ensure compliance with directions and standard of care. The minimum frequency with which such review takes place is, in some instances, specified in federal and state law. In establishing the frequency and extent of record review, the physician may consider the scope of duties that have been delegated to the experience of, and the patient load of the NPP.

Off-site Supervision

In principle, supervision should recognize the diversity of practice settings in which NPPs practice. As a practical matter, the efficient utilization of a NPP will at times involve off-site physician supervision. Generally, off-site supervision of a NPP involves a physician-NPP team that has previously established a working relationship. The supervising physician or a designated alternate physician of the same specialty must be available in person or by electronic communication at all times when the NPP is caring for patients. There should be established clear transportation and backup procedures for the immediate care of patients needing emergency care and care beyond NPP's scope of practice. As with on-site supervision, the appropriate degree of off-site supervision includes an overview of NPP's activities including a regular review of patient records; and periodic discussion of conditions, protocols, procedures, and patients. (1992) (2008)

MASSACHUSETTS ACADEMY OF FAMILY PHYSICIANS

P.O. Box 1406 • Manchester, Massachusetts 01944 • Tel: 978-526-9753 • Fax: 978-526-4417

Testimony in Opposition to
H.2369, "An Act Relative to Enhancing the Practice of Nurse Midwives"
Committee on Public Health
April 12, 2011

The Massachusetts Academy of Family Physicians (MassAFP) wishes to be on record in opposition to H.2369, "An Act Relative to Relative to Enhancing the Practice of Nurse Midwives."

This bill would strike from statute the requirement that a certified nurse midwife (CNM) function as a member of a health care team which includes a qualified licensed physician who has admitting privileges to a hospital for maternity and newborn services.

The bill would also strike the current requirement that a CNM may order tests and therapeutics pursuant to guidelines mutually developed and agreed upon by the certified nurse-midwife and the supervising physician, and that any prescription for medication made by a CNM include the name of the supervising physician.

If signed into law, H.2369 would allow CNM to practice medicine independently, without the supervision of a physician. The only reference to oversight is that the bill requires the Department of Public Health to consult with the Board of Registration in Nursing and the Board of Registration in Medicine regarding schedules of controlled substances for which CNM may be registered.

As primary care physicians, family physicians oftentimes supervise and work closely with CNM's. Consistent with current law, individuals who wish to have their baby delivered by a CNM, or for whom circumstances dictate that a CNM will attend the birth of their child, can be assured that a supervising physician will be intimately involved in the care provided by that CNM.

All childbirths carry-risks, and all pregnancies require good prenatal care. CNM's provide significant access to good care in Massachusetts. The current statutory structure serves as no impediment to a respectful and professional relationship between CNM's and physicians. The public benefits from the added protections of having meaningful physician involvement, oversight by the Boards of Registration in Nursing, Medicine and Pharmacy and access to both CNM's and supervising physicians. H.2369would eliminate these important oversight requirements and yet it offers no additional patient protections to ensure continued quality care.

Attached is the American Academy of Family Physicians Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants. These Guidelines firmly state the following:

> "Current Academy policy on non-physician providers (NPP's) stipulates that these providers should always function under the direction and responsible supervision of a practicing, licensed physician ..." (http://www.aafp.org/online/en/home/policy/policies/n/nonphysicianproviders)

In conclusion, the MassAFP believes that the public is well served by the current system regarding scope of practice for CNM in Massachusetts and encourages the Committee on Public Health to report H.2369 out "Ought Not to Pass."

MASSACHUSETTS
GENERAL HOSPITAL

Boston, Massachusetts 02114-2696
MGH Mail Address:

April 12, 2011

Hon. Susan C. Fargo, Senate Chairwoman
Hon. Senate Members
Joint Committee on Public Health
State House Room 504
Boston, MA 02133

Hon. Jeffrey Sanchez, House Chairman
Hon. House Members
Joint Committee on Public Health
State House, Room 130
Boston, MA 02133

Testimony in Support of H 2369: *A Bill Relative to Enhancing the Practice of Nurse Midwives*

My name is Angela Ferrari and I am a Certified Nurse-Midwife employed at Massachusetts General Hospital. I am here to urge you to support House 2369. I care for underserved women of the communities of Chelsea, Revere and Charlestown including recent immigrant women, undocumented women and refugee women. Additionally, I care for women with greater resources from all over greater Boston who choose midwifery care in the setting of MGH. I have 14 Nurse-Midwife colleagues and we enjoy what appears to the eye as a seamless relationship of collaboration with our 30 or more physician colleagues at MGH. While the Nurse-Midwives perform one third of the deliveries at MGH and manage the care of nearly 1,000 women throughout their pregnancies, deliveries and postpartum period, the Nurse-Midwives, because of supervisory language in Massachusetts statute, do not have legal standing within the institution we serve. We do not have admitting privileges and therefore it appears on institutional records that we do no deliveries at all at MGH. To the consumer and to the layperson, in practice it appears that MGH is a fine model for collaborative practice for midwives and physicians. In reality, the supervision requirement introduces unnecessary threats to patient safety and imposes vicarious liability on physician colleagues while at the same time threatens women's access to midwifery services at our institution.

Angela Ferrari

At MGH, because of the supervision requirement, one physician must sign the hospital privileging paperwork of 15 Nurse-Midwives in order for the Ob/Gyn service at MGH to employ Nurse-Midwives who can then work in the hospital setting. The physician's signature on the privileging paperwork makes him vicariously liable for all that the Nurse-Midwives do and on hospital and billing records this physician appears to do nearly 1,000 deliveries that are in fact down by 15 different Nurse-Midwife providers. Because his name (and names of other physicians in the outpatient settings) is on all the paperwork generated within the institution, it is not uncommon for labs and ultrasound reports to get lost for days or even infinitely as they go to incorrect providers who are not actually caring for and have never met the patient. This loss of information can be dangerous and even life threatening to patients. This cumbersome, dangerous and unnecessary process seems especially regretful as true supervision by the physician or by any of the physicians over Nurse-Midwives does not exist. Reality of practice at MGH as anywhere demands that the physician/ Nurse-Midwife relationship be practiced in a simple, collaborative manner that guarantees patient safety.

As described, Nurse-Midwives at MGH do not have independent privileges within the hospital due to the supervision requirement. Nurse-Midwives are not Medical Staff and have no power to advocate for themselves or for patient care. The hospital, therefore, can terminate the privileges of any Nurse-Midwife at any time without due process. While currently MGH enjoys the employment of Nurse-Midwives especially to serve the clients whose reimbursement rate is lowest, it would be at the discretion of the Ob/Gyn service to at any point not have a physician sign for the privileges of the Nurse-Midwives and thereby remove access to midwifery care for all women getting pregnancy services at MGH. While some patients would have the ability to transfer their care to other hospitals that have midwifery services, most of the patients currently served by Nurse-Midwives at MGH lack resources such as insurance and transportation and would therefore effectively be denied the care of Nurse-Midwives who seem uniquely suited to meet the needs of these women.

Angela Ferrari

Forty years of data support the safety of Nurse-Midwifery care in the United States and in Boston data regarding c/section rates in hospitals suggest that Nurse-Midwifery care in hospitals contributes to lower c/section rates in the facilities they practice in. Nurse-Midwives perform about 20% of vaginal deliveries in the state of Massachusetts. No data exists that suggests that supervision of midwifery practice improves patient safety and Massachusetts is only one of six states currently requiring supervision of Nurse-Midwifery practice by statute. This is important because over the last five years Massachusetts lost its only Nurse-Midwifery educational program formerly housed at Boston University School of Public Health and the Nurse-Midwifery program at the University of Rhode Island closed as well. Without Nurse-Midwives being trained in our state and with our state being restrictive to midwifery practice, there will be a shortage of Nurse-Midwife providers in Massachusetts as a large cadre of Nurse-Midwives will be retiring over the next 5-10 years. At MGH, we have trained no midwives since Boston University's Nurse-Midwifery program closed and we have had 2 of our midwives retire since that time with several more MGH Nurse-Midwives slated to retire within 10 years. It has been difficult for us to recruit midwives from outside the state as all of the New England states surrounding Massachusetts as well as New York and New Jersey have laws that are more supportive of Nurse-Midwifery practice.

The MA ACNM chapter is working closely MA ACOG chapter to identify language within legislation that accurately describes how collaboration occurs between physician and midwives in order to reflect the current reality of practice and to allow for maximum patient safety. Additionally, the national chapters of ACNM and ACOG have recently updated their joint statement on collaboration (please see addendum) that emphasizes the importance of Nurse-Midwives practicing as independent providers. We, the members of MA ACNM and MA ACOG, look forward to combining our efforts in perfecting the language within this bill that reflects the national organizations' carefully thought out statement. My Nurse-Midwife colleagues to follow will provide examples of how access and quality of care is threatened by current law requiring supervision of Nurse-Midwives. In addition, we support your primary care access bill H1502 and would like to talk with you about adding Nurse Midwives to that bill. Thank you.

Angela Ferrari

MASSACHUSETTS MEDICAL SOCIETY
860 Winter Street, Waltham, Massachusetts 02451-1411 (781) 893-4610 / 1-800-322-2303 Fax (781) 893-8009

Testimony of the Massachusetts Medical Society
In Opposition to House 2369
An Act Relative to Enhancing the Practice of Nurse Midwives
Before the Joint Committee on Public Health
April 12, 2011

The Massachusetts Medical Society wishes to be recorded in opposition to House 2369 an Act Relative to Enhancing the Practice of Nurse Midwives. This legislation repeals the existing legal structure for nurse midwifery as practiced in Massachusetts for decades. Massachusetts was number 1 among all the states in its infant mortality rate in 2010. That means that we have the lowest rate of infant mortality. Although we still lose almost 5 babies per thousand, this is a 75% better outcome over national rates a generation ago. [i] We hear a lot about Massachusetts leading the nation in many areas, but this is true quality care and medical leadership in a matter of life and death. Our outcomes cannot be divorced from the legal and regulatory structure and prevailing clinical models that created those outcomes.

The legislation before you today "enhances" the practice of nurse midwifery by removing requirements that nurse midwives work with a physician around their prescribing and as part of "a team which includes a qualified physician licensed to practice medicine in the commonwealth which physician has admitting privileges in a hospital licensed by the department of public health for the operation of maternity and newborn services. "

This legislation is very direct in its approach and impact. It severs the connection between nurse midwives and obstetrician gynecologists. It eliminates a requirement to work with a hospital based team. You as legislators must determine whether you consider this an "enhancement" of medical care or not. Will the public will be better served without these existing statutory patient protections or not?

We have reviewed this legislation with local risk management organizations and they have significant concerns about allowing independent practice away from institutional team settings and a formal support program with triggers to get the mother to the hospital at the first sign of trouble. Mechanisms must be in place to make sure there is early identification of problem pregnancies which MUST be referred. Actuarial information indicates that supervised nurse midwives' rates for professional liability coverage would be about 1.5 to 2.0 times a primary care, non-surgical rate, while an indirectly supervised nurse midwife rate is 3.0 times the primary care, non-surgical rate. It isn't clear if insurance would be available or at what price for completely independent practice as allowed under this legislation.

The Massachusetts Medical Society believes that the existing statutory requirements contribute to our good outcomes, convey a public protection benefit and have no negative impacts whatsoever on patient choice to work with nurse midwives.

There are philosophical reasons for groups and individuals to support or oppose this legislation. There are financial reasons both to support and to oppose this legislation. If the decision were to be made for the best interest of children, the decision would be clearly not to support legislation designed to eliminate or minimize physician participation in obstetrics.

We urge you not to support House 2369.

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[i] The United States neonatal mortality rate was 20.0/1000 in 1950 and declined to 11.6/1000 in 1975. Neonatal mortality: an analysis of the recent improvement in the United States. American Journal of Public Health, Vol. 70, Issue 1 15-21, Copyright © 1980 by American Public Health Association

MOUNT AUBURN HOSPITAL

Department of Obstetrics and Gynecology
Midwives at Mount Auburn

Robyn Churchill, CNM, MSN
42 Middlesex St
Cambridge, MA 02140

April 12, 2011

Hon. Susan C. Fargo, Senate Chairwoman
Hon. Senate Members
Joint Committee on Public Health
State House Room 504
Boston, MA 02133

Hon. Jeffrey Sanchez, House Chairman
Hon. House Members
Joint Committee on Public Health
State House, Room 130
Boston, MA 02133

Testimony in Support of *House 2369: A Bill Relative to Enhancing the Practice of Nurse Midwives*

My name is Robyn Churchill. I am the Director of Midwifery at Mount Auburn Hospital in Cambridge, MA. I have worked as a Certified Nurse Midwife in Massachusetts for ten years.

On Dec 9, 1983, the first baby was delivered, or "caught", by a Certified Nurse Midwife (CNM) at Mount Auburn Hospital, Cambridge, MA. That midwifery service has been in continuous existence since then, has delivered over 8000 infants and has grown to represent 40% of the obstetric volume of Mt Auburn, employing 24 CNMs. I am the current director of that practice.

Our patient volume has steadily increased by about 10%/year for the past 5 years. CNM's attended over 800 births last year, and are on track to increase by another 10% this year. In light of the decreasing birth rate, this increase in volume speaks to the interest women have in the choice to receive care from a midwifery practice. We currently provide prenatal care at 8 clinics and attend births at Mt Auburn Hospital. Some of our patients specifically choose midwifery care and others come through community health centers where the prenatal care is provided by nurse midwives. We collaborate in collegial relationships with other medical providers, including our "supervising" OB/Gyns at all of these facilities.

When a woman chooses our midwifery practice, The CNM provides the vast majority of her care. If she develops a complication requiring more specialized management, we consult and refer to the appropriate and sufficient extra care she needs, from the provider best able to meet them. This specialist may be a perinatologist, a cardiologist, an endocrinologist, a social worker, a nutritionist, or an OB/GYN. In most cases, the primary responsibility for the woman's care remains with the CNM. Sometimes complications require collaboration with or transfer of care to an OB/GYN. All providers, including CNMs and OB/GYNs, have a professional responsibility to consult and refer to other specialists when patients need care that falls outside their own scope of

practice. Statutory supervision of my scope of practice is not required for me to meet that responsibility to my patients.

In modern practice, mandated supervision is an extra layer of "bureaucracy" that adds nothing to patient safety in a highly internally regulated health care system. It actually causes problems in delivering safe and appropriate care—problems that CNMs must spend valuable time and resources jury-rigging solutions to. For example:

- An OB/GYN has to agree to be a supervising physician, or the CNM cannot refer to him/her. A PCP or OB/GYN can refer to another provider, and the referral will be accepted. Other specialists will not accept referrals from a CNM because she is not a full medical staff member. This requires the CNM to go through the supervising OB/GYN to get the referral, creating unnecessary complexity.
- A physician can order his/her own labs, and receive those results directly. A CNM can order the tests, but because we are supervised, a CNMs test results go to her supervising physician, creating opportunities every day for errors or delay in diagnosis and treatment

It is important to understand that health care systems now have guidelines that regulate all providers--physician or midwife. Since not all providers in any category have identical skill sets, hard and fast rules about scope of practice are not practical. Additionally, providers of any kind in Mt Auburn (or in any hospital) are held responsible to professional practice guidelines, hospital and departmental guidelines, which require providers to practice within their professional set of skills, and the hospital's scope of care. To ensure that this happens, there are a number of systems already in place.

- Regular department and hospital-wide peer review
- Quality Assessment committee evaluations
- Computerized incident reporting system. Any nurse, doctor, resident, midwife, or other staff member can report an incident, or bring a case for review. This universal participation is essential to recognizing problems and improving care.
- All obstetric providers, OB/GYN, NPs, or CNMs, are held to the same practice standards within the hospital and department.
- Health care providers are further regulated by their professional organizations, licensing bodies and certifying organizations.

Physician supervision does not improve patient care. An open, collaborative environment among providers improves patient care.

Your favorable report for HR 2369 will help us streamline that care, and eliminate the waste of time, duplication and complexity, while ensuring Massachusetts women will continue to have increased choice and access to high-quality maternity care.

Robyn T Churchill, CNM,MSN
Director of Midwifery
Midwives at Mt Auburn
330 Mt Auburn St, Parsons 1
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The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

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Chair
Tourism, Arts & Cultural Development

April 12, 2011

Jeffrey Sanchez, House Chair
Susan C. Fargo, Senate Chair
Joint Committee on Public Health
State House
Room 130
Boston, MA 02133

RE: Committee Hearing, April 12, 2011

Dear Chairman Sanchez & Chairwoman Fargo,

I am writing to you regarding four bills that I have co-sponsored that are being heard by the committee today and that I would like to voice my support of:

H2348: An Act Relative to the Modernization of Optometric Patient Care & H2357: An Act Relative to Optometrists
These bills give optometrists the ability to treat and diagnose certain ocular diseases, particularly glaucoma.

H2369: An Act Relative to Enhancing the Practice of Nurse Midwives
This bill expands the ability of nurse midwives to treat patients by allowing them to order certain medications and tests.

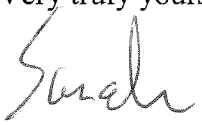
H2367: An Act Establishing a Board of Registration in Naturopathy
This bill establishes educational and testing standards for naturopathic doctors and provides oversight by a state board of registration.

As the health care needs of individuals continue to grow, it is important that we give trained professionals the opportunity to treat patients to the fullest extent of their abilities. People often are very comfortable with a medical professional they have been seeing for some time and frustrated by having to see someone else for a procedure their current physician has the educational experience but not approval to do. These bills will correct

that and give the citizens of the Commonwealth the care they need from trained professionals while keeping health care costs down by taking away the unnecessary visits to multiple doctors.

Should you have any further questions or comments, please do not hesitate to contact my office.

Very truly yours,



Sarah K. Peake

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

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Chair

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April 12, 2011

Senator Susan C. Fargo, Senate Chair
Representative Jeffrey Sanchez, House Chair
Honorable Members of the Joint Committee on Public Health

RE: ***House Bill 2348, An Act relative to the modernization of optometric patient care;***
House Bill 2357, An Act relative to optometrists;
House Bill 2369, An Act relative to enhancing the practice of nurse midwives.

Dear Chairwoman Fargo, Chairman Sanchez and Distinguished Committee Members:

I write today in support of ***House Bills 2348, 2357*** and ***2369***. I respectfully request that the committee review these bills and report them favorably.

Massachusetts is alone among the States when it comes to prohibiting Optometrists from providing treatment for glaucoma. While Massachusetts allows Optometrists to diagnose and co-manage the treatment of a patient's glaucoma, Optometrists are prevented from actually providing the treatment. ***House 2348*** and ***House 2357*** both recognize that Optometrists receive the necessary education and clinical training to treat glaucoma. Passage of these two bills would bring Massachusetts in line with our fellow states in allowing patients to utilize the skills of Optometrists when it comes to treatment of this eye disorder. Furthermore, these pieces of legislation have built in safeguards by allowing Optometrists to prescribe relevant medication, while prohibiting them from prescribing Schedule II drugs.

House 2369 will allow nurse midwives greater flexibility in providing optimal care to women and their children.

If I can be of any further assistance please do not hesitate to contact my office.

Yours truly,

Anne M. Gobi
State Representative

AMG/pad

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
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CHAIR:
JOINT COMMITTEE ON CHILDREN, FAMILIES
AND PERSONS WITH DISABILITIES

State Representative Kay Khan
April 12, 2011
Joint Committee on Public Health
Testimony in Support of H. 2369, An Act Relative to Enhancing the Practice of Nurse Midwives

Chairwoman Fargo, Chairman Sanchez, and Members of the Committee I would like to thank you for the opportunity to submit testimony before the Committee. I am writing in support of H. 2369, An Act Relative to Enhancing the Practice of Nurse Midwives. H. 2369 would remove certain barriers to the practice of nurse-midwifery with the goal of improving access to quality nurse-midwifery care to Massachusetts women while lowering overall health care costs.

Over 450 Certified Nurse-Midwives (CNMs) licensed in the state of Massachusetts provide care to women in 2/3 of hospitals, two outpatient birth centers and in physician offices. They attended over 10,000 births in Massachusetts in 2004, which constituted 13 percent of all births, and 19 percent of all vaginal births. CNMs provide women's health care including maternity care to women of all ages throughout their lifespan. This means that midwives perform physical exams, prescribe medications, order laboratory tests, as needed, diagnose and treat minor illness conditions, provide prenatal care, gynecological care, labor and birth care, as well as, health education and counseling to women of all ages.

Many studies have documented the high quality care provided by nurse-midwives with excellent patient satisfaction and birth outcomes. A study of obstetricians, family practice physicians, and nurse-midwives, showed that nurse-midwives were most likely to provide all of the prenatal services recommended by the American College of Obstetricians and Gynecologists (ACOG). A large study using national birth certificate data showed that, among women at risk, babies delivered by nurse-midwives had a 30 percent lower risk of neonatal death or low birth weight.

In addition to their proven safety record, nurse midwives have an excellent record of providing low cost maternity care. This fact is especially important because childbirth is the leading cause of hospitalization in the United States and is one of the most costly areas for Medicaid. Any efforts to reduce the cost of health care must address the high cost of maternity care, especially the high cost of cesarean sections. Studies from 2005 indicate that the cost for a cesarean section delivery is, on average, 50 percent more than the cost for a vaginal delivery. Nurse-midwives are a possible answer to the rapidly rising cesarean rate in this country. The rate of cesarean section delivery in Massachusetts is 33 percent and rising. When you examine a group of low-risk women cared by nurse-midwives and physicians, women cared for by nurse-midwives are almost 20 percent more likely to deliver vaginally and have cesarean rates on average 5 percent lower than those cared for by physicians. This results in lower health care costs due to lower consumption of medical dollars and lower hospital length of stays.

Under the current laws and regulations, nurse-midwives practice under the supervision of a physician. Chapter 94C requires physician supervision of prescribing practice. Board of Nursing regulations, promulgated as required by law with the Board of Medicine, broaden this supervision requirement to include the entire scope of nurse-midwifery practice. Multiple

attempts by the Board of Nursing to work with the Board of Medicine to redraft regulations to limit supervision only to prescribing—the minimum required by statute—have failed over the 35 years.

Massachusetts is 1 of only 6 states that still require statutory supervision by a physician. CNMs are legal in all states but the need for physician supervision, including requiring signed practice agreements, means most CNMs are vulnerable to the decision of doctors to terminate or refuse to participate in practice agreements with midwives. Without a supportive physician, a CNM may not apply for practice privileges at a hospital. In several high-need Massachusetts communities, women want but do not have access to CNM services, for this reason. Finding a physician willing to provide this oversight can be a futile task because many physicians do not want the added liability and the added competition. This leads to less midwifery care where it is sometimes needed the most. There has been a considerable amount of concern voiced by physicians that allowing nurse-midwives to practice independently would somehow lower the standard of maternity care provided to women in the Commonwealth, however this concern has little basis in fact. Although midwives attend less than 10 percent of births in the United States, they attend 70 percent of births in Europe. Most of the developed world, including Europe, has lower rates of maternal and infant mortality than the United States does.

Nurse-midwives care for vulnerable, underserved populations, and have a record of excellent outcomes for mothers and babies with a dramatically lower C-section rate and fewer birth complications. By removing the supervisory requirement for CNMs by physicians, there is a resultant increase in utilization for these underserved areas and populations. Due to the current legislation requirement that physicians supervise CNMs, CNM's must locate physicians willing to supervise them.

Given the track record of nurse-midwives in Massachusetts of providing our citizens with safe, cost-effective maternity care, and given our critical shortage of obstetricians and gynecologists, we should be doing everything possible to encourage safe nurse-midwifery practice and to promote a strong midwifery model of care in Massachusetts. By removing the supervision language in this bill we will be making an enormous first step in that positive direction.

Thank you for your consideration on this important matter. I respectfully request that the Committee adopt a favorable report for H. 2369 as swiftly as possible.

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
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Chair
Committee on Elder Affairs

April 12, 2011

Joint Committee on Public Health
State House Room 130
Boston, MA 02133

Dear Chairman Sanchez, Chairwoman Fargo, and Honorable Members of the Committee:

I write in support of House Bill 2369, *An Act Relative to Enhancing the Practice of Nurse Midwives*. I am a sponsor and supporter of this bill.

Midwifery services are an important aspect of health care services offered to pregnant women and can provide a cost-effective and holistic approach to women's health needs. Currently, the state of Massachusetts only regulates one type of midwife, Certified Nurse Midwives (CNMs). Certified Midwives (CMs) and Certified Professional Midwives (CPMs) are not subject to any state oversight. There are over 400 CNMs licensed in Massachusetts, and they may practice in any setting, receive mandated third party reimbursement, except through HMOs, and have prescriptive authority. There are no CMs in Massachusetts, but they have the skills as CNMs and are trained in the same way. There are over 30 CPMs in Massachusetts, and while their scope is narrower than for CNMs and CMs, they are qualified to provide the midwifery services.

H. 2369 would create a Board of Registration in Midwifery to regulate the practices of CNMs, CMs, and CPMs. It would also authorize the Department of Public Health, in consultation with this new Board, to regulate prescriptive practice for CNMs and CMs, and it would establish a collaborative relationship between midwives and physicians. H. 2369 is necessary to improve access to midwife services and to ensure that midwifery care is practiced safely.

I urge the Committee to report this bill favorably. Thank you for your consideration.

Sincerely,

Alice K. Wolf
State Representative

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
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Committees:
Public Service
Bonding, Capital Expenditures and State Assets
Global Warming and Climate Change

TO: Committee on Public Health

FROM: Representative William N. Brownsberger W.N.B.

RE: H2369

DATE: April 12, 2011

I am writing in support of H2369, An Act relative to certified professional midwives and enhancing the practice of nurse midwives.

Women's health care and maternity care provided by midwives in the state of Massachusetts continues to grow. Midwives care for vulnerable, underserved populations, and have a record of excellent outcomes for mothers and babies.

The changes proposed in H2369 to enhance the practice of nurse midwives are important to health care access and I hope the Committee will report this bill favorably.

WAREHAM NURSE MIDWIVES, P.C.
Louise Racine Bastarache CNM, NP, MS
332 Main Street
Wareham, MA 02571
(508) 295-3088
Fax (508) 295-2079

April 12, 2011

Hon. Susan C. Fargo, Senate Chairwoman
Chairman
Hon. Senate Members
Joint Committee on Public Health
State House Room 504
Boston, MA 02133

Hon. Jeffrey Sanchez, House

Hon. House Members
Joint Committee on Public Health
State House, Room 130
Boston, MA 02133

Testimony in Support of *House 2369: A Bill Relative to Enhancing the Practice of Nurse Midwives*

My name is Louise Racine Bastarache. I have been practicing as a certified nurse midwife for 20 years. I am the owner and president of Wareham Nurse Midwives PC, a nurse midwifery practice located in Wareham established in 1998. I have Allied Health privileges at Tobey Hospital in Wareham where I deliver 25% of the babies. I provide these women with prenatal care and postpartum care in my office. I also offer annual physicals, gynecological care and limited primary care according to my scope of practice. My patients are self-selecting, that is they choose to come to the midwifery practice for their care. They vary from working women, mothers at home with their children, students, menopausal women and teenagers. Some travel a distance from Cape Cod, others are local residents. All are seeking the midwifery model of care.

Midwifery started at Tobey Hospital in 1988 because 2 midwives were advocating for women's right to choose to have a natural childbirth in a hospital setting

with a midwife. However, they were only given the opportunity to practice because a physician was agreeable to supervise them, and the hospital administrator was convinced this would help bring births to this small community hospital. The CNMs were hired as employees of the physician practice and allowed to deliver babies and provide well women gynecology within the guidelines dictated by the supervising physicians. I joined these 2 pioneering midwives in 1992 as an employee of the physician OB/GYN group because the numbers of patients seeking midwifery care grew showing the need in our community. Clinical performance was always respected; many of the nurses, some physicians and physician's wives and other hospital employees chose to have their babies and their gynecological care with the midwives.

Over time business issues became challenging. CNM practice exists at the "mercy" of the current law requiring physician supervision and even broader regulations requiring supervision of all practice and detailed written guidelines. This translates into control of our employment and therefore of access to midwifery care for women by physicians and hospitals. The liability for the clinical practice of the midwives they supervise burdens physicians and makes us as a professional group unappealing to work with even though we are licensed, credentialed and carry our own malpractice insurance. I took the opportunity to start my own practice when the physicians decided they no longer wanted the midwives in their practice. But I could only do so because these physicians were willing for a monetary fee, in addition to all the revenues they receive for the consultations and referrals that are generated from the clients I send to them, to provide the clinical "supervision". Otherwise, after all these years of serving the medical needs of our patients, midwifery services would no longer have existed in Wareham. Our

clients would no longer have had healthcare providers. We can no longer ignore that this "supervisory" burden has limited access to care for the women of the Commonwealth!

There are more problems for advanced practice nurses who want to practice independently in their own business because the law and supporting regulations require supervision. Here are 2 examples:

* Convincing insurance companies to accept direct billing from a nurse-midwife was difficult and tedious because of this subordinate relationship. It seems they were more comfortable paying the "employed" midwife by paying the physician. Managed care companies credential independent providers, not dependent ones. There are still many hurdles; for example, there is a Commonwealth Care product called Essential that will not pay a nurse-midwife to perform an annual physical. Another example is a major insurance company that will not pay me the First Assist Fee for a Cesarean Section even though I am credentialed to do the surgery with the physician and need to perform that role in a community hospital. I provide this service without compensation--the insurance company keeps the money. When the CNM is paid directly, most insurance companies pay us at 65% of the physician rate for the same ICD-9 code, because we are "supervised." Therefore, income is limited and the growth of the practice is restricted.

* Paying a fee to a physician to "supervise" my work is a financial burden. The physicians do not work in my office; they do not supervise my work in actual practice. Yet they believe they have entitlement to compensation as my "supervisors," and I have little choice but to pay it. For me, this became 10% of my gross earnings, then they increased their fee when they needed more income! Few CNM's will work in these

clinical situations and this limits midwifery accessibility in the smaller communities in the state.

Envision a team approach that provides for the primary care of women in a model that is optimal, satisfying for the patient, and economical for the healthcare system. Midwifery care creates that environment. Nurse midwives in their practices teach nutrition and preventative health, provide immediate medical attention by appropriate consultation and referral for a problem or situation, and safeguard the health and wellbeing of pregnant women and their babies. Teamwork, not competition; financially appropriate, not burdensome or outrageous. That is midwifery care! Licensed independent nurse-midwives --**without mandated physician supervision**--can provide excellent and affordable care for women of the Commonwealth! Please give a favorable report to this bill so we can begin the next steps through regulation revision, to independent hospital privileges and fair, independent credentialing and payment by insurers. This will ensure the access to midwifery care that women want and deserve in Massachusetts.

Women's Bar Association
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July 26, 2011

Senator Susan Fargo
Senate Chair
Joint Committee for Public Health
Room 504
State House
Boston, MA 02133

Representative Jeffrey Sanchez
House Chair
Joint Committee for Public Health
Room 130
State House
Boston, MA 02133

Re: Senate 1133 and House 2368, An Act Relative to Certified Professional Midwives and House 2369, An Act Relative to enhancing the Practice of Nurse Midwives

Dear Senator Fargo, Representative Sanchez and Members, Joint Committee for Public Health:

The Women's Bar Association of Massachusetts (WBA) supports the bill establishing a Committee on Midwifery under the Board of Registration in Medicine and strongly urges the Committee for Public Health to act favorably on Senate 1133 and House 2368.

The WBA also supports the bill that removes the supervisory requirement for Certified Nurse-Midwives by physicians, which would allow Certified Nurse-Midwives to practice in the home setting and strongly urges the Committee for Public Health to act favorably on House 2369.

Women choosing to utilize a midwife should be ensured that care is being practiced safely in all settings with clear standards set by the Committee on Midwifery under the Board of Registration in Medicine. The establishment of such a Committee would be an invaluable information source for those seeking this care and would help to maintain high standards in the profession of midwifery.

Childbearing women should be afforded as many options as possible when deciding on their choice of health care providers for pre-natal care and childbirth. Many women in

Massachusetts are choosing midwives to provide them with this care in settings such as hospitals and birth centers as well as when birthing at home. Midwifery is the dominant model of pre-natal care in countries such as Holland, Sweden and Japan. These countries boast of a better maternal-fetal health outcome than the United States and a significantly lower rate of caesarean sections. According the American College of Nurse-Midwives, women utilizing the services of a midwife during childbirth experience fewer medical interventions such as episiotomy, instrumental deliveries and caesarean sections.

Massachusetts has Boards of Registration for other health professionals and for veterinarians, television technicians, real estate brokers, barbers, cosmetologists, etc. A Committee on Midwifery under the Board of Registration in Medicine is long overdue.

The Women's Bar Association of Massachusetts is a professional association of women attorneys and judges, with over 1,500 members across the Commonwealth. Founded in 1978, the WBA is one of the largest women's bar associations in the nation. We are committed to the full and equal participation of women in the legal profession and in a just society. We voice our position on issues affecting women and children.

The WBA asks the Committee to act favorably on Senate 1133 and House 2368 as well as House 2369. Furthermore, we question the need for House 2904, An Act Establishing a Special Commission on Direct Entry Midwives and Home Birth in the Commonwealth because there are sufficient studies of midwifery and home birth for public policy to be set now. Please contact us if you need more information.

Sincerely,

Nancy M. Cremins, President

Kristin W. Shirahama, Board Member and Co-Chair, Legislative Policy Committee

The Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON, MA 02133-1054

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JOINT COMMITTEE ON CHILDREN, FAMILIES
AND PERSONS WITH DISABILITIES

March 14, 2012

The Honorable Jeffrey Sánchez
Massachusetts House of Representatives
State House, Rm. 130
Boston, MA 02133

Dear Representative Sánchez:

I would like to take this opportunity to thank you for co-sponsoring *An Act Relative to Enhancing the Practice of Nurse-Midwives* (H. 2369) which was signed into law on February 2, 2012.

I sincerely appreciate that you were able to join me along with the Governor for the special bill signing ceremony. It was a wonderful day and the Massachusetts Chapter of the American College of Nurse Midwives and I are extremely grateful for your support over the many years that the bill has traveled through the legislature.

This legislation updates the language regarding nurse-midwifery practice in Massachusetts by more accurately reflecting today's practice arrangements with obstetricians-gynecologists. "Nurse –midwives shall practice within a health care system and have clinical relationships with obstetricians-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient." This is a big step forward for advanced practice nurses and will also improve cost containment efforts.

Again thank you for your interest and your support.

Sincerely,

Kay

Kay Khan

Thank you so much for all your help over the last several years in getting this bill done. I am so appreciative of all the work that you and your staff did and the many hours dedicated to legislation relative to Nurse-midwives — you are the best!

Kay