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REVIEW COMMISSION

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As Program Director for Midwifery Education at Philadelphia University, and a past practice director, I am concerned that these regulations will severely restrict a midwife's right to practice or hold a license because of the potential cost and onerous requirements related to the collaborative agreement that fall outside the scope of Act 50, September 18, 2007. These restrictions have the potential to make it very difficult to educate midwife students as they threaten to put practicing midwives out of business. Without clinical sites we cannot educate our students and this is contrary to the purpose of Governor Rendell's Prescription for Pennsylvania which was to permit midwives, and other health care providers, to practice to the full extent of their scope.

Between 1984 and 2001 I was director of Midwifery at Hahnemann University. The midwives were employees of the Department of Ob-Gyn and the consulting physicians for the group of eight midwives included all members of the department and adjuncts who covered night call. This meant that at any one time 10-15 Obstetrician-Gynecologists and eight midwives signed the collaborative agreement between the department and midwife practice. These regulations introduce a novel and costly requirement mandating individual collaborative agreements between each midwife and each physician and attach a fee to each agreement.

Had these regulations been in effect when I was practice director it would have meant a $560 application fee for 8 licenses with prescriptive authority and an additional $520 bi-annually for renewal of the 8 licenses. On top of that, each midwife would be charged a fee to have a collaborative agreement with each physician covering night call (15 x $50 = $750) or a total of $6000 cost to the practice bi-annually. The total cost to the practice would have been $6560 for initial licensure with prescriptive authority and fees for the collaborative agreements. Bi-annual renewal fees would have totaled $6520 bi-annually. The additional $6000 for collaborative agreements is an unreasonable burden for midwives who earn, on average in Pennsylvania, $60,000-$75,000 annually and who will pay about $25,000 annually for mal-practice insurance plus M-Care if the abatement ends.

In fact, the requirement to submit midwife collaborative agreements is outside the scope of Act 50, September 18, 2007, which provides the statutory basis for prescriptive authority for nurse-midwives. Since 1985 our regulations and licensure requirements have not required submission of the collaborative agreement or payment to apply for a collaborative agreement. Every licensed midwife in the Commonwealth is required to have a collaborative agreement, and make them available for review if asked. To date, there have been no cases brought before the BOM related to failure to either have a collaborative agreement or to produce a collaborative agreement for review upon request.

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To date, there has been no demonstrated disciplinary action to indicate the need to include this requirement in the revised midwife regulations.

What follows are specific comments by section of the proposed regulations.

18.1 Definitions: The regulations should include a definition of ACME – American Commission on Midwifery Education – the accrediting body of the ACNM because it is a separate corporate entity.

18.1 Definitions - *midwife: DELETE "**in collaboration with a physician licensed by the Board to practice medicine.**"* This is outside the scope of Act 50, September 18, 2007, which provides the statutory basis for prescriptive authority for nurse-midwives and does not require a change in definition. Current regulations define the collaborating physician as a "*medical or osteopathic medical doctor who has hospital privileges in obstetrics, gynecology, or pediatrics and who has entered into a collaborative agreement with a midwife.*" The proposed definition narrows the existing definition of a collaborative physician without statutory basis. It should read: *The collaborative agreement can be with any physician licensed in the commonwealth to practice medicine so long as the physician **holds hospital privileges in the area for which they are providing consultation***. The bolded phrase is taken directly from the statute.

18.1 Definitions - *Midwife program:* This includes an error. The AMCB is NOT an accrediting body, it is an organization whose only responsibility is preparing and administering the national certification exam. The accrediting body recognized by the American College of Nurse-Midwives is the ACME – American Commission on Midwifery Education.

18.1 Definitions - *Midwife colleague:* Why do these proposed regulations include a definition of a midwife colleague? The term is self-explanatory and the term and its definition in the proposed regulations are inaccurate. Further, when compared to regulations for the practice of physicians, physician assistants, and Nurse Practitioners, this requirement is novel. There is no such designee in the Medical Practice Act, Physician Assistant Regulations or Nurse-Practitioner regulations, related to a physician, physician assistant, or nurse-practitioner colleague either in practice with, or covering call for, a the designated practitioner. If it must be included the term should be changed to *"midwife practice partner/midwife colleague"* and the definition amended to read: *"A midwife duly licensed to practice midwifery in the Commonwealth by the State Board of Medicine who is in practice with, or covering call for, another duly licensed midwife."* Further the limitation, by definition of this individual, to one responsible for the care of "a pregnant woman" is novel and inaccurate and restricts the scope of the midwife further than the definition included in current and proposed regulations. The midwife's scope of practice as defined in the current and proposed regulations covers the antepartum, intrapartum, postpartum, and non- surgically related gynecological care of women as well as care of the neonate (first 28 days). Act 50, September 18, 2007, which provides the statutory basis for prescriptive authority for nurse-midwives, does not limit the prescriptive authority to pregnancy. This restriction is outside the scope of the statute.

18.2 (i) and (ii) are inaccurate. Before 1971 the title certified nurse-midwife was awarded to a midwife upon graduation from an ACNM recognized midwifery education program. In 1971 the certification exam was established and shortly thereafter the accreditation process for education programs. In 1971, ACNM grand-mothered in all known graduates of recognized education programs and they were awarded the title of Certified Nurse-Midwife and the right to uses the initials CNM without sitting the certification exam. ACNM continued to administer the certification exam until 1991 when the ACNM Certification Council (ACC) was separately incorporated and assumed the responsibility for the national certification examination and the issuance of certificates. Today ACC, known since 2005 as the **American Midwifery Certification Board (AMCB)**, is the only organization that confers and verifies the CNM and CM credential.

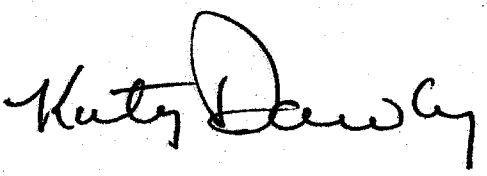
18.5 (g) The statute, Act 50, September 18, 2007, does not require submission of collaborative agreement to the BOM for review. This requirement is novel, associated with potentially restrictive costs, and goes beyond the law and our current regulations. It should be deleted.

18.6 (5) amend this to read: "...and certification by the *ACNM, the ACC,* the AMCB or its successor..." for accuracy.

18.6 (6) second line: why *"may be eligible?"* The statute, Act 50, September 18, 2007, does not say a nurse-midwife with a Master's degree *"may be eligible to prescribe...."* It says "A nurse-midwife may, consistent with the midwife's academic educational preparation who possesses a Master's degree, or its substantial equivalent, and national certification **may** prescribe..." meaning has permission to. As currently written the proposed regulations appear to give the BOM the right to say a midwife is not eligible and reject the application for a certificate to prescribe even though s/he may have a "master's degree or its substantial equivalent, and National certification...." "*May be eligible"* introduces ambiguity into the regulations and goes beyond the scope of the legislation and should be deleted.

18.9 (a) and (b) The requirement that a midwife or collaborating physician notify the BOM of termination of a collaborative agreement within 30 days of a change is novel, a potential restriction of ability to practice, and beyond the scope of the legislation. There is no current regulatory requirement, and the statute, Act 50, September 18, 2007, does not require the midwife, to notify the BOM of the existence or dissolution of a collaborative agreement with a physician. Statute only requires that the collaborative agreement exist. Since 1985, midwife regulations have only required the midwife to have a collaborative agreement and there have been no disciplinary actions relating to the failure to abide by this requirement. This languages stems from Physician Assistant regulations and the physician assistant license to practice is tied to the license of the supervising physician. This is not the case with the midwife license as midwives, by regulatory definition, are independent practitioners.

Thank-you for providing me an opportunity to comment on these regulations. If you have any questions I can be reached at 215-951-2528 (o) or 215-779-8733 (c).



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