The Midwifery Modernization Act (A8117b/S5007a) will Increase Access to Midwives and Improve Quality Maternity Care in New York State

An Overview of the Midwifery Modernization Act:

The Midwifery Modernization Act simply removes the written practice agreement requirement from the midwifery licensing law. Midwifery scope of practice, professional standards, practice protocols, and regulatory oversight by the State Education Department will remain in place. The new statute specifically mandates that midwives establish collaborative relationships with an obstetrical physician and have a written plan for emergency consultation and/or referral. Each patient will be informed of the midwife's consultation plan. Implementation of the Midwifery Modernization Act **will not** change the scope of practice for midwives, **will not** prevent midwives from obtaining professional liability insurance, and **will not** "deregulate" midwifery practice in any way.

New York State has a long tradition of safe midwifery practice.

The Maternity Center Association was established in New York City in 1918 and established the first US school for nurse-midwifery in 1931. The Association provided high quality maternity care to underserved populations, resulting in decreased rates of maternal and infant deaths in the City.[1] The tradition of safe midwifery care continued with the landmark Midwifery Practice Act in 1992, which established the licensing of independent midwives. New York has led the nation in high quality midwifery practice. Since 1992, NY has licensed over 1,300 midwives with over 1,000 currently licensed - more than any other state. Midwives attend approximately 10% of all deliveries (15% of all vaginal births) in the State.

All NY licensed midwives are qualified practitioners and are recognized as independent women's health care providers. A licensed midwife must successfully complete a graduate-level educational program registered by the New York State Education Department, complete over 1,000 hours of clinical residency, and must pass a rigorous national certifying exam approved by the American College of Nurse Midwives. In order to maintain certification, midwives are required to complete 50 hours of continuing education every five years.

Midwives manage births - without physician supervision - in hospitals, birth centers, and in homes. In every practice setting, midwives adhere to practice guidelines based on best scientific evidence and professional practice standards, initiate consultations with physicians with whom they have pre-existing clinical relationships, provide ongoing screening for higher-risk complications, and perform appropriate emergency management measures for sudden complications. Clinical relationships form the backbone of the consultation, collaboration and referral network of the entire health care system. All physicians, including primary care providers and specialists, such as obstetricians and perinatologists, routinely provide and seek consultation with other providers as their professional duty. These clinical relationships already exist **without** a formal, written agreement.

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[1] ***History: Childbirth Connection's Historic Timeline***, at http://www.childbirthconnection.org/article.asp?ck=10076

The Midwifery Modernization Act removes a significant barrier to midwifery practice.
Currently, midwives can only practice if a collaborating physician signs a written practice agreement (WPA). Midwives have increasingly found it difficult to secure a physician's signature and the requirement for a written practice agreement has become a barrier to practice. In many areas of the state, physicians are reluctant to sign their names to a WPA, despite being willing and available for consultation, collaboration and referral for the midwives' patients. The Midwifery Modernization Act simply removes the requirement for a written practice agreement, but clearly and specifically requires collaborative relationships that must be documented and maintained.

The Midwifery Modernization Act will reduce health care costs.
Midwifery care translates into significant savings in health care expenditures for Medicaid and private insurance due to lower utilization of costly interventions, a focus on primary and preventive care, and fewer costly complications. These cost savings have a direct impact on the State budget, as midwives serve a higher proportion of New York's Medicaid population in rural and lower income urban areas.

Research shows midwife-led care is safer for low-risk women and babies.
Maternal / infant research evidence and independent public health policy documents all reach the same consensus - more low-risk mothers and babies have optimal health outcomes when receiving midwife-led care.[2] Midwifery care tends to be associated with use of fewer medical interventions, lower rates of cesarean section, lower rates of low birth weight infants, lower rates of prematurity, and lower rates of newborn high-risk care, with higher rates of satisfaction and breastfeeding.

Many indicators signal concerns about the traditional maternity care system.
To improve the maternal-infant health care system, we must focus on ensuring access to maternity services for vulnerable populations. Midwives serve a higher proportion of New York's rural and lower income urban areas, where the shortages of primary care providers and health disparities are most acute.

Recently released maternal mortality statistics show an unacceptable and rising rate of women dying in childbirth in New York State.[3] While cesarean sections can be a life-saving intervention, it is now understood that the rising rate of cesarean sections includes a significant percentage that are medically unnecessary and an important contributor to the rising maternal mortality rate. Midwives have significantly lower rates of cesarean section.

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[2] ***Midwife-led Versus Other Models of Care for Childbearing Women.*** Hatem M, et al. The Cochrane Library, 2008, Issue 4, at http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004667/frame.html;

[3] ***Guide to Avoiding Unnecessary Cesarean Sections in NY*** and ***Deadly Delivery: The Maternal Health Care Crisis in the USA***

Research supports the safety of planned birth at home with a licensed midwife.
Quality scientific studies consistently show birth at home to be a safe option for the small set (fewer than 1%) of women who meet screening criteria and plan for a home birth with a licensed midwife. Unfortunately, some recently cited studies of home birth have serious methodological flaws and do not sufficiently differentiate between planned home births and unattended, emergency births outside the hospital, nor do they control for the level of education, training, and/or licensure of the birth attendant. They are not comparable to New York State regarding the level of education, licensure, and regulation of the midwife, the safety equipment available to and used by all midwives at home births and the extensive health care system in New York, including the state's Regional Perinatal Centers, that ensure timely access to medical care, including hospitalization, when needed.

Despite its misleading abstract and related press, the recently released meta-analysis of home birth[4] also provides the results of a subset analysis when poor-quality studies are removed from the data set, leaving only those studies of planned home births attended by qualified, certified midwives, comparable to the home births attended by NY licensed midwives. With this more appropriate data set, there was no significant difference in perinatal or neonatal deaths between the planned home birth group and the planned hospital birth group. Additionally, significant benefits were noted in home birth compared to low-risk hospital births, including less frequent prematurity, low birth weight, and assisted ventilation in newborns, and lower rates of infection, hemorrhage, lacerations, and operative delivery for women.

Malpractice insurance for midwives is not dependent on a WPA.
The American College of Nurse Midwives has endorsed liability insurance for midwives and their consulting physicians through Contemporary Insurance Services (301-933-3651), which does not require a WPA. This company and a number of others are poised to pick up market share if there is a change in insurance availability for midwives from MLMIC, which seems unlikely. Because removing the WPA will not change the way midwives practice, it will not change overall liability risk. This fact is supported by the availability of malpractice insurance for midwives in states that do not require a WPA. However, removing the WPA will likely lower physician risk, because they will not have signed responsibility for clients they never see.

Midwives are safe providers for mothers and babies in every practice setting.

[4] ***Maternal and Newborn Outcomes in Planned Home Birth vs Planned Hospital Births: a Metaanalysis.*** Wax JR, et. al. Am. J. Ob & Gyn, 2010, online at http://www.ajog.org/article/S0002-9378(10)00671-X/abstract