New Mexico obstetricians are crying foul over an agreement forged by the state’s human services department, several managed care organizations, and the state’s midwives that will allow some Medicaid reimbursement for home births yet not require the midwives to carry liability insurance.

New Mexico has unusual parity in its numbers of midwives and obstetricians. According to the state Department of Health, there are 55 licensed midwives and 144 certified nurse-midwives in the state, a total of 199. According to the American College of Obstetricians and Gynecologists, there are 146 ACOG members (plus 51 junior fellows) in the state. In 1997, the New Mexico Medicaid program was privatized, and it’s now run by managed care organizations (MCOs). The state requires that MCOs carry medical malpractice insurance, and MCOs in turn require the same of all their providers.

Midwives performing home births typically do not carry malpractice insurance. When that insurance is available, the cost is prohibitive, but few insurance companies are willing to write policies covering home births at any cost. It’s not that there have been a large number of expensive claims, said Roberta Moore, maternal child health program manager for the New Mexico Department of Health. Insurers simply don’t see this market as profitable.

The new agreement provides for reimbursement of midwives provided that Medicaid-eligible women who choose to forgo de direct entry midwife are an independent practitioner educated in the discipline of midwifery through a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A direct-entry midwife is an independent practitioner educated in the discipline of midwifery.

A Certified Midwife (CM) is an individual educated in the discipline of midwifery who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. This term also is used in certain states as a designation of certification by the state or midwifery organization.

A Certified Professional Midwife (CPM) is a knowledgeable, skilled, and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives and is qualified to provide the midwifery model of care. The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings. CMs and CNMs typically practice in hospitals or clinics. A Certified Nurse-Midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. Unlike CMs or CPMs, CNMs are licensed in all 50 states.

The MCOS, or the midwife. The relatively small number of obstetricians in New Mexico and the state’s rural character helped proponents of the agreement argue that it offers women in underserved remote areas access to care that they ordi- narily would not have. Dr. Sharon T. Phelan, professor of ob- stetrics and gynecology at the University of New Mexico, Albuquerque, doesn’t buy this argument. In an interview, she noted that family physicians frequently perform births in rural areas of New Mexico where there are no obstetricians, so these areas are not really underserved. Those family physicians have mandatory malpractice insurance.

In addition, the agreement does not limit Medicaid reimbursement to midwives in rural areas. An Albuquerque-based midwife would receive reimbursement, even though there are many obstetricians in that city. Dr. Phelan pointed out.

Furthermore, there is a fundamental unfairness in allowing midwives to go without malpractice insurance while receiving about the same fee as an obstetri- cian does for a birth, Dr. Phelan said.

“You’re getting paid $1,200 for 9 months of care and a delivery; there are places where docs are having to deliver a hundred babies just to meet their malprac- tice insurance premiums.” Dr. Phelan said, noting that with premiums of approxi-mately $80,000 annually. New Mexico ob- stetricians are getting somewhat of a bar- gain, compared with colleagues in other parts of the country. New Mexico authori- ties basically treated the malpractice insur- ance problem “with an aspirin, which is to say [that midwives] are an exception to the rule and they don’t have to carry insurance and they could still get paid. But they did not deal with the underlying problem,” which is the malpractice insurance crisis.

And she noted that when a home birth starts going wrong, mother and baby would be transferred to a hospital. Supposing the infant or the mother dies or the child has an ongoing deficit, “who’s going to be sued?” Dr. Phelan asked. “It’s the doctor who inherited a problem that was already in development, because he or she is the one with the malpractice insur- ance. We’re the ones with the deep pockets, so we’re the ones who are going to get dragged to court and have to spend days in deposition and in court going through all that emotional stuff on our own.

The Midwives Alliance of North Amer- ica (MANA), one of the two national midwifery associations (the other is the American College of Nurse-Midwives), said that it’s true that midwives aren’t sued very often, but the reasons may be unclear. Accord- ing to Diane Holzer, MANA’s president and a licensed midwife, part of the reason may be that patients are more satisfied with their care or that midwives are able to develop more of a personal connection with their clients.

She noted that even in the nine states in which Medicaid reimbursement for home births technically is permitted, many mid- wives cannot actually receive reimburse- ment. California, for example, allows for Medi-Cal reimbursement of home births only if the licensed midwife is being su- pervised by a physician. But according to Ms. Holzer, not a single physician in Cali- fornia is willing to supervise midwives.

Continued on following page

Licensing Requirements in New Mexico

To be licensed as a direct-entry midwife in New Mexico, an applicant must complete 12 months of theoretical and clinical education at an accredited midwifery school, pass a licensing exam, and show evidence of the following clinical experience:

- Observing and managing 40 labors.
- Delivering 25 newborns and pla- centas.
- Completing 25 postpartum assessments.
- Making 100 prenatal visits with at least 15 different women.
- Starting one successful intravenous line.
- Performing 30 newborn examina- tions.
- Administering 15 uses of prophylac- tic eye medications.
- Making 30 postpartum visits with mothers and babies within 36 hours of deliveries.

Source: New Mexico Department of Health

Regulation of Direct-Entry Midwives in the United States

<table>
<thead>
<tr>
<th>State</th>
<th>Regulation</th>
<th>Legal by statute, but licensure unavailable</th>
<th>Legal by judicial interpretation or statutory inference</th>
<th>Not legally regulated, but not prohibited</th>
<th>Prohibited</th>
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Sources: Midwives Alliance of North America, American College of Nurse-Midwives

* These states have Medicaid reimbursement for midwives.

Note: A direct-entry midwife is an independent practitioner educated in the discipline of midwifery distinct from the discipline of nursing.

Source: April 2006 data, Midwives Alliance of North America
Continued from previous page

Why is that? “It’s the question of the ages,” Ms. Holzer said in an interview. “That’s what all say it is a philosophical question. They don’t believe [home birth] is safe. But there are lots of studies out there that show that it is safe. I don’t think that safety is in question if you take a look at the data out there. A lot of physicians have told us that their insurance companies have actually come out and said that if they are part of hospital practitioners, they will be dropped.”

Physicians tend to be more accepting of nurse-midwives than of those without nursing degrees, Dr. Phelan said, adding that she has worked alongside nurse-midwives for 30 years, has helped train them, and is highly supportive of the use of nurse-midwives in birthing centers and hospitals. Some physicians may have the impression that someone can call herself a midwife after attending a 2-day workshop and participating in a number of births. In reality, the requirements are more stringent. (See box, previous page.)

Despite the malpractice crisis that is causing many physicians to move away from obstetrics, the number of home births nationwide appears to be holding steady. Ms. Holzer said: “Birth is a natural process, and doesn’t need to be interfered with to the extent that it has become in this country,” she added.

“I understand the reason why some women want home births,” Dr. Phelan said. “There is the perception of the rigidity of hospital settings, the unwillingness to have family in attendance, [the concern that] we’re going to cut episiotomies, the higher rate of C-section, all of those kinds of things. But I think much of that has changed. I think more and more hospitals are trying to have a more homelike birth experience with the ability to still provide the current technology and safety.”

Research Rule

On Informed Consent Eyed

By Elizabeth Mechanic

Rockville, MD. — The Food and Drug Administration is reviewing a decade-old regulation that allows clinical studies of emergency treatments to be conducted without obtaining informed consent in people with certain life-threating conditions.

The FDA’s reappraisal and proposed revision of the rule were prompted by concern that current safeguards do not provide enough protection of human subjects, and by comments that the safeguards are too onerous and impede important research.

At present, a narrow exception to the informed consent requirement exists in the case of patients who cannot provide consent because of their conditions and who have no family members available to give consent.

To be exempts from informed consent, an investigation must meet certain criteria, including the following:

The patient is in a life-threatening situation.

The available treatments are unproven or not satisfactory.

Evidence supports the prospect of direct benefit to the individual.

Since the regulation went into effect in October 1996, the FDA has received 56 requests to conduct emergency research under this rule. A total of 21 studies have been conducted, are being conducted, or are about to start enrollment, according to the FDA.

The FDA has issued draft guidance geared toward institutional review boards, clinical investigators, and sponsors developing and conducting emergency research. The agency also sponsored a public hearing in October on emergency research.

At that hearing, presenters offered examples of emergency research that could not otherwise have been done without the exception.

Although the current rules could be simplified, the exemption to informed consent is critical, said Dr. Paul Pepe, professor of surgery, medicine, and public health, and Higgins Family Chair in emergency medicine at the University of Texas Southwestern Medical Center at Dallas.

“Studies of the automated external defibrillator are an example of the tremendous lifesaving potential of emergency treatments,” he said. Such studies also show that treatments that have been widely accepted and appear to be logical may in fact be harmful in some populations. It is added. For example, intravenous fluid resuscitation was found to be harmful in certain trauma populations. If these studies had not been done, Dr. Pepe explained, many people would have died.

The FDA will be seeking comments on the guidance, as well as comments made at the hearing, to determine whether the rule should be modified.