Hospital Midwives Seek the Right to Certify False Labor

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WASHINGTON — Federal regulations should recognize the expertise of nurse-midwives in certifying false-labor cases in the hospital, Deanne Williams, a certified nurse-midwife, testified at a meeting of the Department of Health and Human Services technical advisory group on the Emergency Medical Treatment and Labor Act. Under EMTALA, “only a physician is recognized to certify that a woman who presents to a hospital for evaluation is actually experiencing false labor,” said Ms. Williams, executive director of the American College of Nurse-Midwives (ACNM). In the college’s view, the regulation fails to acknowledge the scope of practice under which certified nurse-midwives and certified nurse-midwives are authorized to treat patients, she said.

“Midwives have a very long history of working collaboratively with physicians to provide women’s health care, with a particular focus on women’s reproductive health cycle,” Ms. Williams said, adding that midwives attend more than 10% of the vaginal births in the United States, and 98% of the births attended by midwives occur in hospitals.

EMTALA’s requirement for physician certification “places unnecessary costs on the hospital, which is required to take physicians away from other matters to certify that the woman is in false labor, when a certified nurse-midwife or certified midwife is also licensed to make that decision,” Ms. Williams testified.

While EMTALA regulations require a signed certification that a woman is experiencing false labor and may be discharged, “there is no requirement in the regulations that a physician must personally examine the patient,” noted one advisory group member, Charlotte Yeh, M.D., an emergency physician and the CMS regional administrator for Region I in Boston.

The law’s interpretive guidelines explain further that a physician must be contacted by the qualified medical professional—i.e., nurse-midwife—to ensure that the woman with contractions has false labor. The guidelines leave it up to the individual hospitals to determine whether physicians should personally examine the patient, she said.

“The issue before the technical advisory group is whether the latitude provided by EMTALA’s interpretive guidelines is sufficient to protect patients, yet recognizes the value that nurse-midwives bring to labor and delivery,” Dr. Yeh told this newspaper. “Or, the [technical advisory] group could say that the regulations are too permissive, and that certification should be removed altogether, letting individual hospitals decide who’s qualified to determine emergency medical conditions in patients.”

It’s clear that ACNM’s request “would necessitate a change,” David Siegel, M.D., an emergency and internal medicine physician in Tampa, Fla., and the panel’s chairman, indicated. Dr. Siegel asked that the panel seek formal input from the American College of Obstetricians and Gynecologists and other appropriate medical societies and the CMS on regulations on their policies regarding this issue.

Warren Jones, M.D., Medicaid director for the state of Mississippi and a past president of the American Academy of Family Physicians, indicated that the panel should seek input from the AFP on this issue. “There needs to be a recognition that ob.gyns. are not the only physicians who deliver babies and provide maternity care. Family physicians do a lot of that. Many of them work with nurse-midwives, and many of them provide it in rural areas where it’s really needed,” he told this newspaper.

The advisory committee also will need to consider that in some states, nurse-midwives are already recognized as qualified to determine false labor, Dr. Yeh said. What the nurse-midwives want is for those qualifications to be recognized by CMS, she said.

Robert Seigal, M.D., a representative of the American College of Emergency Physicians, and a participant at the meeting, noted that the regulations might not have to be changed at all.

“If you hearken back to the actual current law, EMTALA does not appear anywhere in the definition of an emergency medical physician in EMTALA. Therefore, whether someone is in actual labor or in false labor is entirely irrelevant,” he stated.

EMTALA is meant to be a limited law, Dr. Bitterman continued. “It asks Is this pregnant woman having contractions, and if so, is it safe to go home, and if doing so would pose a hardship to the baby or the mother? The special concern is, it’s perfectly appropriate under EMTALA regulations for nurses, physicians, family physicians, or pathologists to perform the screening exam if they’re the ones designated by the hospital to make those types of decisions, he said.

“It’s a myth to think that physicians and hospitals don’t send home patients if they have active labor. We do it every day because it’s an early active labor, and because it’s safe to do so—and it meets the elements of the statute,” Dr. Bitterman said.

Dr. Yeh clarified that the word “labor” did in fact appear in the EMTALA statute under the definition of a transfer, and that a false-labor discharge qualified as a transfer.

EMTALA was enacted in 1986 to ensure public access to emergency services regardless of ability to pay. The Medicare Modernization Act of 2003 required that the department of Health and Human Services establish a technical advisory group to review EMTALA regulations. It is required by law to meet at least twice a year.

The group will advise HHS and the administrator of the Centers for Medicare and Medicaid Services on issues related to EMTALA. It is composed of representatives of hospital, physician, and patient groups, plus CMS staff and state government officials.