1988

Nurse Midwifery; Series I; File 146

Juanita Hunter

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May 5, 1988

TO ALL CNM'S IN UPSTATE NEW YORK

The next Upstate Chapter Meeting is: May 21, 1988

9:30 to 10:00 a.m. coffee, tea etc.
10:00 to 12:00 p.m. meeting
12:00 to 1:00 p.m. TOUR (more info below)

WHERE: Suite 200
125 Lattimore Rd.
Rochester, NY 14618 (716) 461-1575

Take the NYS Thruway East or West to 390 North then follow below map.

PLEASE READ: At this meeting - Elaine Mielcarski, our Legislative Chair (see enclosed letter from Elaine detailing current pending legislation) will discuss update, situation in Downstate, and our Chapter's role.

IT IS VERY IMPORTANT THAT WE HAVE AS MANY CNM'S AS CAN COME TO TO GIVE INPUT TO WHAT COULD BE LANDMARK LEGISLATION IN THE FUTURE DEVELOPMENT OF MIDWIFERY PRACTICE IN NEW YORK STATE.

Also, CNM'S who attended convention in April will give a debriefing.

For those interested, after the meeting the Nurse-Midwives associated with Strong Memorial Hospital will offer a tour of the Birthing Center which opened 10/87.

Please come, there is no R.S.V.P. Just Come!!! Questions call (716) 461-1575 and talk with Joan, Caroline, or Allie;

Also if you want a copy of the Annual Report please share.

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1. This is an act to establish midwifery as a licensed profession in the State of New York. A Board of Midwifery will be established under the Department of Education.

2. Midwives deliver almost 5% of all the births statewide, 6.4% of all births in the metropolitan New York City area, and 25% of all births in the Health and Hospital Corporation facilities. Additionally, midwives deliver 35% of all women in the Maternal and Infant Care programs. The majority of prenatal care in Health and Hospital Corporation facilities is delivered by midwives, and they are one of the principle providers of prenatal care in the new Prenatal Care Assistance Program.

3. In response to a growing consumer demand, both service and private practices are flourishing. In 1980 there were approximately 30 private midwifery practices, in 1988 there are approximately 65 practices. This number is steadily increasing. Hospital and clinic facilities have also increased in both the number of services and the number of midwives employed by them.

4. There are currently 321 CNMs with permits to practice in New York State. There are additionally 80 vacant positions, and this number will definitely increase with the changes in residency hours as mandated by the Ad Hoc Committee on Emergency Services as of July 1989. The demand is also anticipated to increase with the increased accessibility to prenatal care.

5. The total number of CNMs graduating nationally per annum is decreasing. In 1988 this number will be 250, and in New York City, where the only two programs of midwifery education in the state are located, only 30 graduates are expected. One of the major reasons is the shrinking pool of qualified nurse applicants available to midwifery schools.

6. This bill would open a new avenue for professional licensure and draw upon new valuable resources, such as experienced and qualified foreign trained midwives, physician assistants, and other community members unable to afford the time and financial burden of dual education routed through nursing to midwifery.
7. The Midwifery Practice Act would allow the state to establish direct entry programs of midwifery as consistent with educational programs in the United Kingdom, European countries, and the State of Washington.

8. The bill creates a Board of Midwifery which will establish the requirements for and education and licensure. THE INTENTION OF THIS ACT IS NOT TO LEGALIZE THE PRACTICE OF LAY MIDWIFERY, rather it will provide a framework for the establishment of midwifery as a unique profession in the State of New York to improve the care of women and their infants.

For further information contact:

Carol K. Bronte CNM
Chairperson, Legislative Committee
Region II, Chapter I, American College of Nurse-Midwives
212/ 982-4980
Dear CNM:

I am writing to you because of an immediate need to give attention to our current midwifery practice bill. A copy of the Midwifery Practice Act is being sent to you, along with a historic review of this bill and its present activity. On March 25, this bill was reviewed again by the Downstate Chapter, with a resounding vote of support by a large group turnout. As one of the initial principal parties involved with this bill, I was asked to join their meeting and address the group. I will try to give you an overview of the discussions that preceded the renewed show of support. I am sure that some of the questions you have are similar to those expressed by Downstate members.

This is not a new bill but evolved to its present form in 1985. The initial Midwifery Practice Act was drawn up after many hours of meetings, outside help, and an overwhelming need to legalize the way we have been practicing for the last 20+ years. The practice of midwifery has been threatened in several parts of the state, including New York City and Syracuse. The potential for this remains.

If you, upon starting practice, wrote for a copy of the New York State Public Health Law and Sanitary Code, you found words which discuss conduct, definitions, and the ability to assist birth. You did not find words giving you permission to use any of the modern obstetric methods necessary to practice. In fact, there are laws that say you cannot write on an order sheet or give verbal orders. In 1984, a Syracuse anesthesiologist, also President of the Board of Medical Mutual Liability Insurance Company, supported by other physicians at St. Joseph's Hospital, challenged my ability to do just that. He effectively brought my practice of several years to a halt. In essence, this could stop private physicians altogether from practicing with CNM's. Those CNM's who are in private practice cease to be cost effective. If you cannot take call without waking up your backup, who must then, in turn, call in the admission and any subsequent orders, you are no longer useful to the practice. If you are a hospital staff midwife, you lose control over the management of your patient because residents will write all the orders and challenge all the decisions. In New York City, a local nursing organization challenged the CNM's ability to perform episiotomies and repairs, based on the same lack of legal capability. In some cities, all narcotic orders have to be written by an M.D. prior to admission, and in other areas, all hospital standing orders are now being ruled illegal and the practice stopped. We as CNM's have quieted our uneasiness about this vulnerability by saying that the

Continued
precedent was established years ago of midwives practicing under the standing orders of the M.D., and therefore, this continued practice gives us "squatter's rights." The fact is, we are practicing illegally, the squatters were pushed off the land, and the Indians are confined to reservations. Incidentally, when Mr. Abbott, President of St. Joseph's Hospital, wrote to Albany for clarification, Albany responded with a letter stating that we had no legal right to write on an order sheet. After several letters of correspondence, Mr. Abbott solely, through his good graces, made a unilateral decision that I would continue giving and writing standing orders. Two years later, Community-General Hospital, which has several nurse practitioners, was told by the state that the nurse practitioners must stop writing orders. The hospital's Department of Nursing then challenged the midwife's privileges, and a memorandum was sent to the floors instructing nurses to stop taking orders from the midwives practicing there. Both of these incidents took months and considerable legal fees before tenuous remedies were found. With standing orders in general now being challenged, what next for CNM's?

Other problem areas include some hospitals unilaterally moving the CNN's from the Department of OB to the Department of Nursing. This has led to a lack of understanding of OB management responsibilities and risks inherent in the role of the CNN. It has changed the number and scope of CNN's practicing in some cases and lowered the salary scale of the staff CNN's. One CNN director of a large midwifery service was recently told in New York City that there will be no further raises for the CNN's as long as they are coupled with the nursing pay scale.

So why can't we achieve what we need without separate licensure? Because nursing is looked upon with immense animosity by the legislators in Albany. We have been warned on several occasions by lobbyists as far back as 1982 that any association with NYSNA will spell certain defeat of our efforts. Shortly prior to one of our meetings with our lobbyist in 1983, nursing representatives of the Nurse Practice Act were physically fighting in the corridors in Albany. CNN's, on the other hand, have not generated a negative image but rather are looked on favorably by legislators exposed to them. Nursing constitutes an immense body of people. The bestowing of prescription writing and laboratory ordering privileges to such a vast, diverse number is considered too risky by many legislators.

So the need for the Midwifery Practice Act was initially recognized to legalize the practice of midwifery, and now, there is increasing need to secure greater access to midwifery. There is very real concern over the shortage of midwives in New York State. This shortage will worsen in the future due to 1) the severe shortage of nurses whom we recruit from, 2) the declining enrollment in nursing schools, and 3) the high burnout rate of the
nurses currently practicing. We must ask ourselves, is it ethical for us to further drain the nursing profession by expecting it to supply all of our vacancies. It is shocking to know that there are over 100 midwifery vacancies currently in New York State, in addition to an increase in new demand from several directions. The need to look for new avenues to increase midwifery is particularly timely because of the Bell Committee's prior recommendations to limit resident hours to 60 per week. This will become law in July of 1989. Hospitals and the Health Department, in filling the manpower shortage that this will create, are looking to midwifery. If we are not there, those positions will still be filled, quite probably by physician's assistants, etc. This would be unfortunate, since we have many experienced, foreign-trained midwives who could be brought into the mainstream by a refresher course. Many of these, however, are not nurse midwives. The International Confederation of Midwives, whom we are a product of, has an educational route for both nurses and post-high school educated non-nurses who then go through an extended midwifery training program. The international definition of midwifery, as you know, embraces both routes. We could set up a similar route whereby college educated applied health people, such as respiratory therapists and physical therapists, etc., could take a midwifery program, sit an ACNM exam, and become certified, as an example. CNM's would be setting the standards, and the standards will be high.

The language of the current Midwifery Practice Act has gone through a metamorphosis, beginning in 1982 and ending in 1985. Assemblyman Gottfried and his aide helped us put the bill into a legally correct format during the last rewriting. Each rewriting has been circulated to the members of Upstate chapters through the years. The wording is now compatible with all the other professional licensure bills that passed. The original bill did use the terms nurse-midwife and ACNM. This turned out to be illegal. We were told that we cannot use the name of another licensed profession when seeking separate licensure. We did learn two weeks ago that we can make reference to the ACNM if addressing qualifying exams.

Getting the bill passed by Albany is going to be difficult. The State Education Department has not licensed a new profession in many years. Because of this, we were advised that we would need a lobbyist. In 1982, the Downstate Chapter voted to request a voluntary assessment of $100 per each member. In addition to this, many of the larger services donated varying sums of money. The newly-formed Upstate chapter also voted to give support. We have remaining $28,000 in a fund for this purpose. Our attention and energy have been diverted from this bill to the liability insurance problem. Now it is time to review our efforts. A committee was formed to investigate lobbyists. The final firm chosen (McNamee, Lochner, Titus, and Williams, P.C.) is very well respected by both the Senate and Assembly and were willing
to prorate for this year. It is expected to take the rest of this and next year to achieve our goals. The total cost is expected to be between 45 and 50 thousand dollars. All CNM's registered with the state will be receiving a letter with a voluntary assessment of $100 for this year. This will be repeated next year. There was a strong show of support by midwives downstate. We need to shoulder our share of the responsibility upstate.

In the coming weeks, our lobbyist, Kerry Marsh, will have information on how to begin the grass roots effort to gain support for the bill. We need Senate sponsors. The senators most involved with health care are all upstate. I will pass on all information that I get to you.

I also will be at the May 21 meeting to answer any questions that you have.

Sincerely,

Elaine Hielcarski, C.N.M.

EH/dd
abc/14
June 8, 1988

New York State Assembly
Albany, NY 12248

Dear Member of the Assembly

Oppose All447

As a nurse-midwife, I am obviously in favor of the services of nurse practitioners being more available to the citizens of New York. However, I write to you now in opposition to All447, known as the nurse-practitioner bill. My concern relates to the lack of a collegial relationship between nurse-practitioners and "collaborating" physicians. The supervising rather than consultative and referral relationship the bill promulgates unduly constrains the practice of nurses who have been certified as a result of successfully completing a recognized educational program and satisfying any other criteria set up by the certifying body. Such consultative and referral relationships rather than supervision are essential to meeting the needs of underserved rural and urban populations; service delivery problems could not be alleviated by the means suggested.

The idea that one physician can supervise unlimited numbers of nurse-practitioners, including four off-site (with no distance defined) attributes "supernatural" powers to physicians and puts them in a precarious position vis a vis professional liability risk.

In addition, the bill sets a precedent which is not to be found in situations of family physician/specialist medical practice and thus is discriminatory to the practice of nursing. For example, family practitioners in general do not have privileges to perform cesarean section. Yet they are not required to submit or post the name/s of the general surgeon/s or obstetrician/s who would provide surgical back-up, nor must women at risk of cesarean be managed under an obstetrician's supervision. The recognition of limits of skill and knowledge on the part of both family practitioners and nurse-practitioners is handled through use of a double standard and at the expense of nursing.
I further believe that Maternity Center Association's (MCA) New Family Program, description enclosed, could not function with the success and economy that it demonstrates if the nurse-practitioner were required to have supervision by her pediatric colleague. Both practitioners on the team are employees of MCA; their collegial relationship is one of mutual respect and has worked well for over three years. The program is currently being evaluated by a researcher from the Cornell Department of Public Health for the efficiency of operation. There has been no need to legislate their mutual concerns for families through mandating chart review. Each is a professional in his/her own right. In short, I see this proposed legislation as damaging to the high quality, satisfying and cost-effective form of care being provided to new families at MCA.

Thank you for this opportunity to acquaint you with MCA's experience on this issue.

Sincerely,

Ruth Watson Lubin, CNM, MA, EdD, FAAN
General Director

MATURENITY CENTER INSTALLS "NEW FAMILY" PROGRAM

Gyn/Pediatric Services Will Promote Wellness

By CAROLYN J. CARLSON

Maternity Center Association is launching a service providing perinatal support, including well woman gynecological and well child pediatric care, for Childbearing Center mothers and infants for up to two years after birth. christened the "New Family Program," it is the latest in a long series of demonstration projects assisted by MCA. The first comprehensive program of its kind in a freestanding birth center, the NFP was developed in response to requests for such services with the CSC's family-centered and economical approach to health care.

"Childbearing Center families have been asking for this kind of service all along, and we felt that it was the right time to undertake this project," said Alexandra Peters, a two-time CSC mother and chairman of the MCA Board subcommittee which developed and designed the program. The idea for the New Family Program was incorporated in the initial plan for the CSC in 1973, but the decision was made to establish the CSC prenatal, birth and postpartum services on a strong footing before expanding the program to include post-maternity services.

A survey of CSC families conducted last January showed that of the 154 adult respondents, 87 percent were interested in such a program. The respondents indicated that those least likely to participate would be those living within an easy commuting distance of the Center who had not already established a relationship with a physician.

As a result, the New Family Program will be limited at first to CSC parents who are residents of Manhattan and expecting their first child on or after March 15, 1985. If successful, however, the program may expand to include those from other boroughs. "Because it will be run as a demonstration project," said Ms. Peters, "we will be examining and restructuring the program to meet families' needs."

The New Family Program will allow the same quality attention that has been the standard at the CSC. Care will be provided by a nurse-physician team which promotes wellness by means of a strong emphasis on education and disease prevention. As in the CSC, appropriate referrals will be made in the case of illness.

Parents interested in the program will sign up by the 34th week of pregnancy for the year following the baby's birth, when they will have the option to renew for another year. It is estimated that the annual fee will be about 10 percent cheaper than the cost of receiving similar care from community offerings. Preventive care such as this is not currently covered by health insurance companies, but MCA hopes that successful demonstrations of this kind will encourage insurers to reimbursate preventive care in the future. Although the cost of visits to the same physicians for the treatment of an illness would not be included in the NFP fee, such fees frequently are covered by family insurance policies.

Continued on page 7
May 20, 1988

RE: OPPOSITION TO NURSE PRACTITIONER BILL, A11847

Dear Member of the Assembly,

As president of the Northeastern New York Chapter of the Association of Rehabilitation Nurses, I am writing to voice our opposition to the amendment of the Nurse Practice Act as proposed in Bill A11847, the Nurse Practitioner Bill.

Although the intent of this legislation is to expand the nurse's role in diagnosing and treating illnesses and prescribing medications, it would in fact restrict independent nursing practice. Written practice agreements and collaborative practice with physicians is limiting to the Nurse Practice Act as it is currently stated. Also, Article 28 facilities are excluded from this legislation and therefore, these Nurse Practitioners would be unable to use the title Nurse Practitioner. I understand the intent in supporting the bill is to support the profession of nursing, however, this may not be the outcome of this legislation.

The goal of nursing is to recruit and retain bright, intelligent men and women into the profession. This legislation may encourage some nurses, specifically those employed by Article 28 facilities, to actually leave the state of New York in order to retain the title of Nurse Practitioner that they have worked so hard to achieve. As stated in the bill only those nurses who have completed the educational requirements and testing can be titled Nurse Practitioner.

Nurses in the field of Rehabilitation are some of the most innovative in terms of career decisions and expansion of the nursing role. This legislation would serve to further fragment nursing and confuse society, who has been very accepting of the Nurse Practitioner role. The limitations of physician sponser would also prove to be an added burden since most Rehabilitation practitioners function off-site. The end result would be what we have been so desperately trying to avoid, a further nursing shortage, and further societal confusion.
June 2, 1988

New York State Assembly
Legislative Office Building
Albany, New York 12248

Dear Member of the Assembly

The American Nurses' Association (ANA), which represents 188,000 nurses from 53 constituent state members, is strongly opposed to A.11447/S.8477 which is an Act intended to amend the New York State education law in relation to nurse practitioners.

ANA's function, as the professional society for nursing, is to foster high standards of nursing practice. For over three decades, the American Nurses' Association has enunciated certain principles for legislation that would provide the best possible protection of the public health and welfare. ANA has particular concern about the arrangements that are implemented by various states to regulate the practice of nursing. ANA has a long-standing policy that advanced nursing practice is regulated by the profession.

ANA's policies on legal regulation of nursing practice are guided by two premises. The first is that protecting the health and welfare of the public is the foundation of any legislation regulating the practice of nursing. The second premise is that the public's health and welfare should be protected with a minimum amount of governmental regulation and professional regulation of the practice of nursing should be recognized. Legislation for licensing nurses should contain only provisions that bear a direct and substantial relationship to the protection of the public health and safety.

The law therefore should not provide for recognition or regulation of advanced nursing practice. More appropriately, the professional society should regulate advanced nursing practice through professional certification of practitioners, peer review and other means which demonstrate that the advanced practitioner is competent to practice in such a role according to professional standards. Certification of specialists in nursing practice is a judgment made by the profession, upon review of an array of evidence examined by a selected panel of nurses who are themselves specialists and who represent the area of specialization.
To regulate advanced nursing practice through the law and specify the scope of advanced practice of nursing could serve to restrict nursing practice of those regulated as well as all others not regulated. As is true in all professions, nursing is dynamic rather than static. As new needs and demands are placed upon nursing, and as a consequence of nursing research, the scope of nursing practice may change and expand.

ANA is opposed to amending section 6902 of the education law by adding the new proposed subdivision three addressing advanced nursing practice. It is not necessary for the law to be amended to authorize advanced practice for nurses in a specialty area. The functions performed by nurse specialists are covered within their scope of practice as defined by the nurse practice act. Because specialists in nursing practice hold licenses in the state in which they practice, they are subject to the legal constraints and external (outside the profession) regulations that apply under the nursing practice act. Additionally, ANA recognizes that the public needs clear evidence that a nurse who claims to be a specialist does indeed have expertise of a particular kind. The profession of nursing has a social obligation to the public to satisfy that need, which it does by means of certification of specialists and by accreditation of the graduate programs that educate specialists in nursing practice.

I especially want to share with you that in other states where legislation has been put in place to address the practice of nurse practitioners, nurses have found these statutes to be more harmful than helpful to the overall welfare of nurses and the public they serve. As a matter of fact, ANA has been asked to assist many of these other states to rescind or amend the legislation which they have ultimately found to be restrictive and unworkable. The legislation which sought to support the practice of nurse practitioners actually has been found to restrict their practice and, in addition, restrict the practice of other nurses as well. All nurses, in addition to nurse practitioners, are currently formulating nursing diagnoses and treating patients within the scope of their education. No nurse in New York State has been prosecuted for practicing as a nurse practitioner. A.11447/S.8477 implies that diagnosing, treating and performing therapeutic measures are not encompassed in the current scope of nursing practice. By implication, and despite the disclaimer clause, ascribing specific activities only to nurse practitioners narrows the scope of practice of other nurses. The restrictions placed on the practice of the nurse practitioner through this bill imply that nurses are not professionally equipped to function without rigid physician oversight. The bill implies that the nurse practitioner is not credible enough to recognize his or her individual practice limitations or to refer patients to physicians when necessary. The section of this bill which authorizes prescriptive privilege is overly restrictive, cumbersome and limited to very few nurse practitioners in New York State.

It is also important to consider the impact A.11447/S.8477 will have on liability insurance coverage especially during this time when there is much change occurring in the insurance industry and rates are ever increasing for obtaining insurance coverage. The linking of nurse practitioners to
physicians in strict collaborative practice with written practice agreements and written protocols will increase the liability of each practitioner and the insurance cost of both.

Nurse practitioners currently serve as cost effective providers of primary care services to otherwise underserved populations. By requiring a formal relationship between the nurse practitioner and physician, this bill will cede to physicians' control over access to the services of these nurse practitioners. Placing the physician in the position of gatekeeper to nurse practitioners will increase the overall cost of health care.

As president of the American Nurses' Association, I strongly urge you to vote in opposition of A.11447/S.8477, as it is the responsibility of the professional society to regulate specialty nursing practice. Great efforts are being directed at this time toward recruitment and retention of nurses in order to reverse the critical nursing shortage which exists. The impact of legislation such as A.11447/S.8477 which severely diminishes independent practice will only serve to decrease the attractiveness of the nursing profession.

Again, I urge you to vote in opposition of A.11447/S.8477. Thank you.

Sincerely,
Margaretta M. Styles
President

Local 237, Teamsters opposes S.8477, A.11447 regarding amendments to the education law for nurse practitioners. The nurse practitioner would be required to collaborate with a physician in accordance with practice agreements and written protocols, which would be filed with the State Education Department.

Currently registered professional nurses provide quality cost effective health care services. Nurses provide health care services in occupational health, public health and school settings when a physician is not present as well as in hospitals and other health care agencies. The State of New York should be encouraging nurses to practice rather than discouraging practice through burdensome and unnecessary laws and regulations.

The requirement of S.8477, A.11447 that nurses join in a mutual practice agreement with a physician has resulted in a restraint of trade in other areas of the country. Decreased competition in the health industry will increase costs by increasing health insurance rates. It is likely that in areas of the state where there are physician shortages, health care which could be provided by a nurse will be unavailable because there is no physician with whom a practice agreement can be made.

Further, the requirements for mutual practice agreements will likely create difficulties with liability claims and the cost of liability insurance. The increased cost of liability insurance for both the nurse practitioner and the physician will be passed along to employees and employers through higher health insurance rates.

To encourage cost-effective, accessible health care, Local 237, Teamsters urges defeat of A.11447, S.8477.
Martha Orr
Executive Director
New York State Nurses Association
2113 Western Avenue
Guilderland, New York 12084

Dear Martha,

Recently, I was delighted to learn that I will be returning to theANA House of Delegates as a California delegate. I am still vitally interested in the membership issue and would like to work with NYSNA in any way that I can to help reverse the unfortunate decision to allow non-RNs membership inANA. Enclosed is a copy of the letter that I mailed to 62 journals and specialty organizations, calling for support and help at the next House. I am unsure how many journals actually printed my letter besides Nursing Outlook and the Oncology Nursing Society's bulletin, but I did hear from several Editors. The Editors who wrote me stated that a large proportion of their constituency was made up of associate degree nurses and they did not want to print my letter because they believed it would alienate their own members. The idea that "associate nurse" and "associate degree RN" are being thought of as the same thing is frightening. Obviously, many nurses do not even really understand what is going on here and there is much education that still needs to be done!

If NYSNA is planning any pertinent strategies and needs speakers to support your ideas, I would be happy to speak to the issue or to do anything that needs doing. Please just let me know how I can help. I am SO pleased that NYSNA will be in Louisville this summer and I am looking forward to talking with you then.

Stay well —

Sincerely yours,

Theresa Stephany
June 8, 1988

Dr. Elizabeth Bear
College of Nursing
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425

Dear Dr. Bear:

I very much appreciated the opportunity to speak with you concerning the pending Midwifery Practice Act in New York. As I indicated to you, The New York State Nurses Association opposes this legislation which would remove any requirement that persons licensed as midwives be registered nurses.

I am enclosing for your information a copy of the memorandum of support distributed by the New York State Chapters of the American College of Nurse-Midwives. This memorandum is of particular concern to NYSNA in that we are not clear that the support is representative of all nurse midwives in New York or even of all the New York chapters of the American College of Nurse Midwives.

I understand that the American College of Nurse-Midwives has no official position of record with respect to the licensure and practice of midwifery by others than registered nurses. Frankly, in this era of strong external attacks on the practice of registered nurses, including numerous proposals to replace nurses with less qualified personnel, this neutrality on the part of your organization is baffling to me.

Recently, a report of a major task force on health personnel in New York intentionally struck all references to "nurse" in the context of comments on midwifery. In conference with officials of the Health Department it was made clear to me that the substitution of lay midwives for nurse midwives was envisioned as a means of reducing the costs of obstetrical care. The proposed legislation in New York would be the instrument of implementing that intent.

I am also enclosing the position statement of the Nurses Association of the American College of Obstetricians and Gynecologists. A similar position of The American College of

Sincerely,

Martha L. Orr
Executive Director

cc: Janet Mance
Director, Legislative Program
Juanita Hunter Ed.D., RN
President, NYSNA

Elizabeth Bear
June 9, 1988
Page Two

Nurse-Midwives would be of enormous help in combating the replacement of nurse midwives by less qualified persons.

Thank you for your consideration of this matter. If you would like further information, please contact me or Janet Mance, the Director of NYSNA's legislative program.

Sincerely,

Martha L. Orr
Executive Director

cc: Janet Mance
Director, Legislative Program
Juanita Hunter Ed.D., RN
President, NYSNA
Dear Colleague,

Many of you may know already that I am a minority voice among New Yorkers in regard to the proposed New York State Midwifery Practice Act A-4737/S-4917; I testified in opposition to it in the spring of 1987 and my position has not changed.

After much soul-searching, I have decided to communicate my concerns to you directly. I hope you will be able to take a few minutes now to read this open letter thoughtfully. It is not an easy task for me to write it because I have concerns not only about the bill (attached), but also about the process with which its submission moved through the New York chapter (Region II, Chapter 1) in both this and prior years.

At a special meeting of the chapter on March 25th, it was obvious that emotions ran high in support for the bill among those present and I must defer to the majority voice, but I do have the sense that the implications of the bill have not been thought through and that some of the arguments in favor of the bill are not factual. Here are my thoughts:

1. Most important, as the bill currently reads, New York State nurse-midwives will be surrendering the autonomy provided them by the ACNM’s certification; philosophy; definition; standards for practice; quality assurance; peer review and accreditation of educational programs to an as yet unknown group of persons to be appointed by the New York State Board of Regents. We do not know what criteria and standards that board might adopt nor to whose or what professional group control of our practice might be subjected.

2. Also important is the fact that as written, the bill requires no educational program prerequisite to sitting a licensure examination. This is in direct opposition to both the New York State Medical and Nurse Practice Acts which explicitly address educational requirements. Apparently the examination and licensure will be available to any interested party.

3. Support for the bill as written means deviation from the stated intent of the membership of the American College of Nurse-Midwives. The college membership voted in favor of separate licensure for nurse-midwifery, not for direct entry midwifery which is espoused by A-3747/S-4917. Therefore, the
college should have been consulted, but was not, about the use of official stationery for a fact sheet in support of the bill which had been put into circulation well before the March 25th meeting at which a membership vote to move forward was finally taken. A mailing from the legislative committee dated February 1, 1988 states that the bill will be reintroduced, when in fact the bill had already been reintroduced on January 6th. At the meeting an explanation that bills are automatically reintroduced was given. I submit that sponsors do not reintroduce bills unless requested to do so. It is ludicrous to think that every bill ever introduced goes forward on its own momentum. The legislature would still be considering bills relating to hor --drawn trolleys!

4. As written, the bill ignores the critical role of nurses in the delivery of maternity care in the state. Nursing is not included on the board which is peopled by physicians, midwives, a pharmacist and one consumer.

5. I believe that nurse-midwives can best serve the childbearing families of this state and nation. I also believe that the acknowledged shortage of nurse-midwives can best be alleviated by expanding current programs rather than by turning to other groups or individuals. Lest it seem that my preference for the nursing prerequisite for midwifery education is merely professional turf-guarding, I would like to further acquaint you with my rationale:

a. The Needs of Childbearing Families

The preparation of maternity care personnel should be based on the public health and individual needs of the families to be served. Matters of population distribution and geography can be crucial, especially in rural areas. To be able to provide nursing and midwifery as separate entities may be logistically and economically impossible. Mary Breckinridge learned that lesson many years ago in Kentucky and many rural areas in New York State have similar problems of low population density.

As well, infants deserve not only to be born healthy, but to be born into healthy families. The ability to evaluate the health of all family members, particularly those who may be charged with the care of the infant, is critical, especially in the underserved areas upstate and the inner-city neighborhoods of New York City.

b. The Myth of Non-Nurse Midwifery Superiority

The Netherlands, with its system of direct entry midwifery, which surely works for them, is often held up as a model to be emulated because its rate of perinatal survival surpasses our own. The corollary to this position would be that the poorer position of the United States is the result of
our system of nurse-midwifery, and we know that nurse-midwifery
programs unfailingly improve outcomes. Japan, which has a nursing
prerequisite to midwifery, has the best rate of perinatal survival
in the world (5.5 /1,000 in 1986) while Holland is only 8th among
developing countries, lagging behind Finland, Sweden, Iceland,
Switzerland, Denmark, and Norway. In addition to Japan, Sweden,
Finland, and Norway have a prerequisite of nursing for midwifery
practice. Note that at least Finland, Sweden, and Norway have
geographic and population configurations similar to our own.

Holland also is touted because of its substantial number of
planned home births. Those countries surpassing Holland's record
have all or virtually all confinements taking place in-hospital, and
in the Scandinavian countries the management of low risk births is
routinely the province of nurse-
midwives. While these facts are merely associated and not
necessarily causal, it does appear that the midwifery management,
rather than the site of birth, is the critical factor in outcomes.
I mention this because proponents of direct entry midwifery are
often also proponents of home birth. In sum, preparation of
personnel should be based on the needs and epidemiology of the
families concerned, rather than on the adoption of systems of other
nations where conditions may or may not be similar.

c. Nurse-Midwifery Care Equals Quality and Cost
Effectiveness

In order to provide the most economical and yet highest quality
care possible, at MCA's Childbearing Center we employ nurse-midwives
who give all required nursing and midwifery care supported by
nurse-midwife assistants who provide round-the-clock coverage at the
center. Direct-entry midwives would need nursing assistance and
another helper to do laundry, sterilize equipment, and clean birth
rooms. The nurse-midwife assistants are high school graduates who
are given in-service training. As MCA develops birth centers for
disadvantaged families, assistants will be selected from among
neighborhood resident applicants, thus providing cultural sensit-
ity as well as entry-level jobs in the health care field. Our
system has worked well for 12 and 1/2 years; several assistants have
gone on to become nurses or nurse-midwives because of their exposure
to the profession.

d. The Myth of Reducing the Shortage through Direct Entry
Programs

Persons interested in nurse-midwifery can currently become
certified in as short a time as three years. Most European
direct-entry programs are university-based and require four years to
complete. The energy, cost and time required to establish a new
program specifically geared to non-nurses would, in my opinion, be
better spent in expanding our current schools of nurse-midwifery.
An important reason is that clinical experience, always critical, is
and would be difficult to secure for any kind of program. In
an attempt to solve this problem and also to provide students the opportunity to learn normal childbirth management away from high tech settings, accredited freestanding birth centers will be the initial experience sites for students enrolled in the new cooperative community-based program being implemented in June '88 by a consortium of MCA, the Frontier School of Midwifery and Family Nursing, the Frances Payne Bolton School of Nursing, Case Western Reserve University, and the National Association of Childbearing Centers. Expectations are high that this program, along with the refresher course already begun by Frontier (50 applicants on file for each program) will expand the nurse-midwifery pool substantially in the short run. At full operation, if the birth center concept continues to grow, the community-based program should produce as many as 600 new graduates each year. This represents three times the number of graduates in university-based programs where the medical school controls clinical experience and often limits it to medical students who may or may not be interested in obstetrics.

Maternity nurses all over the state, but especially in rural and other areas without sufficient house staff coverage, are and have long been practicing de facto nurse-midwifery, managing labor and "catching babies" without the benefit of further education. These nurses deserve the opportunity to add midwifery to their skills and should be the recipients of a vigorous outreach program. Most, I believe, would return to their hospital of origin after their 1-2 year program because of family ties and commitments. A simple survey should verify this assumption. We can only strengthen the entire health care delivery system when we strengthen nursing and nurses. In addition, I am assured by New York State Health Department officials that student nurse-midwives will be included in the State Health Service Corps Program.

All this is not to say that the current system is without problems. The lack of prescriptive privileges for nurse-midwives is a particularly sore point. However, as far as I can tell, no attempt has been made to accept the offer made in the Health Department's testimony at 1987 hearings on the bill to work toward alleviating such problem areas. If any New Yorkers would be willing to work on this direction, please call or write to let me know.

In sum, I hope you will agree with me that we nurse-midwives have accomplished a great deal in improving the care of mothers, infants and families. We have been innovative and courageous over the almost 65 years of our practice in this nation. Our record has been built on our preparation and I for one do not see that dropping the nursing prerequisite will help us to achieve our major goal of expanding and improving the care we provide.

Sincerely,

Ruth Watson Lubic RN, CNM, EdD, FAAN
General Director
INTRODUCED BY R. OF A. GOTTFRIED, DANIELS -- Multi-Sponsored by -- R. OF
A. BENNETT, BUTLER, CONNORS, BILL TROY, DIAZ, ECV, FARRELL, GRABER,
HARENGER, KOPPEL, LIPSCUTZ, MARLEA, SANDERS, SRHNERIO, SILVER,
TORRES, WEINSTEIN, YOUNG -- read once and referred to the Committee on
Higher Education.

AN ACT to amend the education law, in relation to the profession of mid-

The People of the State of New York, represented in Senate and Assem-

Section 1. The education law is amended by adding a new article one
hundred forty to read as follows:

ARTICLE 150

MIDWIFERY

Section 6900. Introduction.
6 § 6901. Definitions.
7 § 6902. Practice of midwifery and use of the title "midwife".
8 § 6903. Licensure.
9 § 6904. Limited licensure.
10 § 6905. State board of midwifery.
11 § 6906. Duties of the board.
12 § 6907. Practice under licensure.
14 § 6909. Restrictions of license.
15 § 6910. Introduction. This article applies to the profession of
16 midwifery. The general provisions for all professions contained in art-
17 cle one hundred thirty of this title, as added by chapter nine hundred
18 eighty-seven of the laws of nineteen hundred seventy-one, apply to this
19 article.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets
[ ] is old law to be omitted. LB000657-01-7

(over)