Why is it important to remove the word “supervision” from nurse-midwife statute?
Midwifery prioritizes and is grounded in patient safety. The midwifery model of care, and the paradigm within which it functions, differs in critical ways from the medical model. While ostensibly mandated to optimize patient safety, supervision — an undefined, and functionally indefinable, concept — prevents the blossoming of an authentic midwifery model of care, subverts the midwife’s ability to practice to the full extent of his or her education and licensure, inhibits autonomous practice and small business ownership potential. Not only midwives, but also the women and families that we serve, pay the price.

The concept of supervision creates a sense of hierarchy that is antithetical to effective team-based care. The current requirement for midwives to practice as providers tethered to physicians leaves them unable to promote the midwifery model of care without getting permission from someone else first; it also fosters interprofessional tension because of the idea that the physician “supervisor” is legally responsible for the CNM’s actions.

Merriam-Webster defines supervision as “the action or process of watching and directing what someone does or how something is done.” The dictionary meaning of supervision implies responsibility, management, and control. However, in practice, certified nurse-midwives (CNMs) and obstetricians are colleagues and team members, “experts in their respective fields of practice and … educated, trained, and licensed independent providers who may collaborate with each other based on the needs of their patients” (ACOG and ACNM Joint Statement of Practice Relations Between Obstetrician Gynecologists and Certified Nurse-Midwives/Certified Midwives, 2011). CNMs rely on their physician colleagues for consultation, referrals, and transfer of care when the complexity of the patient is not within his or her scope of practice.

How does California define “supervision” of nurse-midwives?
In the state of California, Business and Professions Code 2746.5 reads:

“The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.”

“As used in this article, ‘supervision’ shall not be construed to require the physical presence of the supervising physician.”

In the California Code of Regulations 1462, the nurse-midwifery management process includes that the CNM “… assumes direct responsibility for the development of comprehensive, supportive care for the client and with the client; assumes direct responsibility for implementing the plan of care; initiates appropriate measures for obstetrical and neonatal emergencies.”

And California Code of Regulations 1463 states that the scope of CNM practice includes “… conducting deliveries on his or her own responsibility and caring for the newborn and the infant. This care includes preventive supports physiologic birth for better perinatal outcomes. results in fewer cesarean births.

NURSE-MIDWIFERY CARE
reduces the use of unnecessary procedures, reduces health care costs, and increases access to care.
measures and the detection of abnormal conditions in mother and child.”

If a CNM has direct responsibility to develop and implement a plan of care for a patient and if a CNM conducts deliveries on his or her own responsibility, what does supervision mean in this context?

Is the physician required by law to inspect and review CNM charts or approve care given by a CNM? No.

Is the physician required by law to co-sign CNM prescriptions? No.

Is the physician required by law to see a CNM patient at any point in her pregnancy or well-woman care? No.

Is the physician required by law to direct care of the CNM patient and/or be physically present during the clinic visits or hospitalization? No.

California law requires that in order for a CNM to lawfully “furnish” (prescribe) medication, a physician needs to be telephonically available. It is left to the educated discretion of the CNM when to consult, refer, or transfer care to a physician. That is the extent of the supervision required by statute and regulation; however, insurance companies, hospitals, and vendors see the word supervision, and interpret it to mean “physician management and control,” imposing barriers that unnecessarily restrict CNM practice and limit women’s access to quality health care.

Prior to 1985, the California Board of Registered Nursing had two requirements for compliance with the supervision requirement: a written agreement with a supervising physician to identify the respective responsibilities of the physician and CNM and a communication arrangement for hospital referrals. This regulatory language (16 CCR 1464) was repealed in 1985 and not replaced.

The Medical Board of California attempted to write regulations to define supervision for licensed midwives, and after ten years of failed efforts concluded in their 2012 Sunset Review Report that the task was not possible.

CNMs already work without supervision in the dictionary sense and they have outstanding safety record in maternity care outcomes:
- lower cesarean rates
- lower epidural rates
- lower episiotomy rates
- higher rates of breastfeeding
- healthy births for mom and baby

Removing state-mandated supervision would place the nurse-midwife in charge of the economics of his or her practice, allowing him/her to practice as a business partner with a physician, not merely an employee of the physician. CNMs want to remain in partnership with physicians while autonomously practicing the midwifery model of care. When economically tied to a physician, a CNM cannot expand practice and provide care where there are no or insufficient physicians. State-mandated supervision stifles innovation in health care and inflates costs by minimizing competition.

Removing the word supervision would directly and positively affect the California health care system by providing for:
- improved access to health services
- lower health care costs
- improved quality of care
- greater innovation in health care delivery

Adapted from Midwifery: Evidence-Based Practice, American College of Nurse-Midwives, Silver Spring MD, Revised April 2012.