Comments on Draft Midwifery Scope of Practice Sunrise Review

I strongly support this expanded scope of practice for midwives.

Thank you

Dr. April Bolding, PT, CCE, CD
Author, Speaker, Educator
Women's Health & Orthopedic Physical Therapist

Yes, I am in favor of allowing midwives to prescribe within their scope of practice.
Thank you,
Andrea Menin, OTR/L

Hello!

I am a licensed midwife in Washington state who works for a prominent OB in Tacoma Washington. I have worked under Dr. Phobe Ho for more than four years and believe that midwives should have the authority to prescribe basic antibiotics for common issues in pregnancy.

Specifically urinary track infections, Sexually transmitted infections and vaginitis. LM's could also prescribe anti-nausea meds that would keep pregnant patients out of the emergency room in the first trimester.

Offering contraception such as LARC , intrauterine device and/or Nexplanon are basic services that midwives interface with every day and serve the entire cycle of childbearing.

Please consider trusting licensed midwives in Washington state to offer the services. It would take a lot of pressure off of the emergency rooms and family planning centers and allow women the autonomy to make their choices in regards to providers during pregnancy and postpartum care.

Sincerely, Karin Peacock, LM

I strongly support prescription writing authorization for midwives. I was deployed as an Army general surgeon to Seoul, S. Korea for four years. Many of the OB patients were Koreans, while the dads were much larger American men. We had an incredibly high C-section rate, and I wonder if we had midwives, it would have been lower.

Dr. Suzan E. Marshall
Fmr MAJ MC US Army

Suzan E. Marshall, DO, C-MDI
Diplomat, American Board of Surgery
Certified Medicolegal Death Investigator
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As a RN, it is concerning to me that Licensed Midwives would ask for an increase in their scope without the training required for it.

Pharmacology was certainly a big component of my nursing training, and was supervised clinically over the entire program. The 5 hours suggested by the Licensed Midwives group is not enough to cover prescriptive rights, implants of BC and IUD insertions. This represents great potential harm to the public which has been expressed thoroughly by other professionals who have commented already.

What was not described in their request is the definition of "other therapies." Hopefully this can be illuminated.

Please, can this group work with their schools to enhance their education to include the services that they wish to perform UNDER SUPERVISION, to ensure that WA State women are being served by fully trained professionals?

Jana Wiley, RN

Dear DOH of Washington.

I practiced Obstetrics for many years in state of Washington For a time period we had licensed midwives at our hospital. There were many close calls in their clinical practice. The obstetrician on call had to bail them out frequently.. In this specialty two lives are involved. Half knowledge or inadequate training can be dangerous and i would respectfully urge DOH to not take any steps to extend their privilege's. As a mater of fact I think their training should be increased with proper didactics along with clinical experience under supervision. Just attending few deliveries and get license to deliver babies amazes me. Even though 85-90 % things go smoothly, normal delivery is a retrospective diagnosis and shouldn't be taken for granted.

Thanks for your consideration.

Raksha Trivedi, MD, FACOG

Dear Ms. Green,

On behalf of the Washington State Medical Association (WSMA), we appreciate the Department of Health's (Department) attention to the sunrise review concerning proposed prescriptive authority for midwives licensed under chapter 18.50 RCW. The WSMA values the role of licensed midwives who often work in esteemed partnerships with physicians to care for our state's patients and we are thankful the Department's work on this important issue.

We concur with the Department's recommendation that the applicant group work with a variety of stakeholders (including obstetricians, gynecologists, and prescribers) to fine tune elements of the proposal. As noted in our original comment letter, the proposal would benefit from additional patient safety guardrails that define to what extent and under what circumstances prescriptive authority would be permitted and that identify drugs, procedures, and treatments, and the circumstances in which they may be prescribed and treated. Additionally, stipulating the necessary additional education and training requirements is paramount to ensuring high-quality medical care.

The WSMA looks forward to working with the Department, the Midwives Association of Washington, and other stakeholders to best determine such parameters. Thank you again for the opportunity to provide comment on the sunrise review draft recommendations. Should you have any questions, please don't hesitate to contact WSMA's Associate Director of Legislative and Political Affairs, Alex Wehinger at alex@wsma.org.

Thanks for your consideration,

Alex Wehinger
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MIDWIVES' ASSOCIATION

OF WASHINGTON STATE

October 1, 2021

Health Systems Quality Assurance
Washington State Department of Health
Attn: Josselyn Green
Office of the Secretary

Sent via email: Josselyn.Green@doh.wa.gov

Re: Sunrise Review – Midwifery Scope of Practice

Dear Ms. Green,

The Midwives Association of Washington State (MAWS) appreciates the hard work evident in the department's draft Sunrise Review Report on Midwifery Scope of Practice and the opportunity to respond to the report's findings and recommendations. The legislative proposal (H-1639.1) would amend chapter 18.50 RCW to create a "limited prescriptive license extension" option for midwives to "prescribe, obtain, and administer medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal and nonhormonal family planning methods, as prescribed in rule."

Our association commends the department's general support for the concept and its recognition that the proposal would benefit public health by increasing access to comprehensive sexual and reproductive (SRH) services, especially in rural and underserved communities. We write now to:

A. respond to specific concerns identified in the draft report related to the education and training standards, and discuss proposed changes to H-1639.1 to incorporate the department's findings and recommendations; and

B. summarize the steps we are taking to follow up on the department's recommendation that the Midwives Association collaborate with groups representing prescribers, obstetricians and gynecologists, Certified Nurse Midwives, Bastyr University, and others to recommend parameters around the extent of prescriptive authority for hormonal oral contraceptives that should be permitted and what additional training, including preceptorship, would prepare licensed midwives for this increased scope of practice.

Response and Recommendations

A. Specific concerns identified in the draft report related to the education and training standards

1. Providing additional education and training

MAWS supports the recommendation that candidates seeking the limited prescriptive license extension obtain additional education and professional training (including preceptorships) in pharmacology, physiology, and contraindications, as prescribed by the department in rule.

2. Clarifying key terms in H-1638.1

MAWS agrees that a new definition section should be added to H-1638.1 to clarify key terms in the bill, including: "common conditions", "prenatal", "postpartum", and "hormonal and nonhormonal family planning methods," and will continue to work with stakeholders to refine these terms.

3. Specifying which drugs or classes of drugs that may be prescribed

As a general rule, the legislature does not delineate in health care profession statutes specific drugs, devices, or competencies; rather such statutes typically authorize the Department of Health to adopt appropriate rules. We believe the proposed bill, with the inclusion of the amendments suggested in A.1 and A.2 above, provides sufficient guidance to inform the Department's rule-making.

We anticipate a rigorous and collaborative rule-making process undertaken by DOH in consultation with the Midwife Advisory Committee, the Pharmacy Quality Assurance Commission, and the Washington Medical Commission that will establish specific guidelines for training, examination, continuing education, and identify appropriate legend drug & devices.

4. Amending the Legend Drug Act and Uniform Controlled Substances Act as appropriate to extend licensed midwives prescriptive authority

MAWS agrees with the Pharmacy Quality Assurance Commission that new sections should be added to H-1638.1 amending the definition sections of the Legend Drug Act (RCW 69.41.010 (17)) and the Uniform Controlled Substances Act (RCW 69.50.101(mm)) to include licensed midwives approved for the limited prescriptive license extension under chapter 18.50 RCW in the definition of "practitioner" under those statutes.

B. MAWS is collaborating with groups representing prescribers, obstetricians and gynecologists, Certified Nurse Midwives, Bastyr University, and others to recommend parameters around the extent of prescriptive authority for hormonal oral contraceptives that should be permitted and what additional training, including preceptorships, would prepare licensed midwives for this increased scope of practice.

MAWS met with The American College of Obstetricians and Gynecologists (ACOG) on Sept. 17, and AUWS of Washington State (AUWS) on Sept. 22. We hope to meet with the American College of Nurse Midwives (ACNM), Bastyr University, and others in the coming weeks.

Our conversations with ACOG and AUWS focused on recommendations for the extent of prescriptive authority and additional training requirements.

"Hormonal and nonhormonal family planning methods" include, but are not limited to: oral contraceptives, and barrier methods (such as female / male condoms, cervical caps, diaphragms, and contraceptive sponges with spermicide, vaginal pH gel, etc.).

Licensed midwives already have authorization to obtain and administer cervical caps and diaphragms. With respect to oral contraceptives, ACOG and AUWS support authorizing licensed midwives to prescribe oral contraceptives, using medically acceptable risk-screening tools to ensure that they are prescribing and managing for low-risk patients within their appropriate scope of care. In addition, initial and continuing education should include training on the absolute and relative contraindications of hormonal and nonhormonal family planning methods.

Long-acting reversible contraceptives (**LARC**) provide effective contraception for an extended period without requiring user action. Such methods include, but are not limited to: injections, intrauterine devices (IUDs), and subdermal contraceptive implants.

We agree with ACOG and AUWS' recommendation that licensed midwives be required to take any LARC trainings that are also required of other providers at the federal or state level.

Parameters for continuing education to ensure competency:

ACOG and AUWS made several recommendations about initial and continuing education that would be prescribed in rule.

- The education / training should meet a minimum hour or credit threshold. It should be didactic and include simulations, as well as a specific number of observed insertions in patients. The applicant report identifies recommended skills and education for hormonal and nonhormonal family planning methods and LARC for consideration during the DOH rulemaking process.
- ACOG and AUWS agreed with MAWS that there should be a competency examination for the "limited prescriptive license extension." Such competency examinations provide another threshold for evaluating practitioner readiness and competency, and are used by many other medical professions.

"Common prenatal and postpartum conditions"

The proposed bill would authorize licensed midwives to "prescribe, obtain, and administer medications and therapies" (including, but not limited to, antibiotics, antifungals, and antivirals) for the prevention and treatment of "common prenatal and postpartum conditions," which should be defined to include:

- Nausea and vomiting,
- Anemia,
- Urogenital infections including urinary tract infections (UTIs), bacterial vaginosis (BV), and vulvovaginal candidiasis (VCC);
- STIs including chlamydia, gonorrhea, syphilis, trichomoniasis and herpes simplex virus (HSV); and
- Breast infections.

We recommend the following conditions to be indications for consultation:

- Syphilis,
- HIV,
- Hepatitis C,
- Hepatitis B,
- Severe anemia unresponsive to treatment,
- Significant vomiting unresponsive to treatment,
- Persistent or resistant infections (of the urinary tract, breast, etc.), and
- Primary or non-primary first episode genital HSV infections during the third trimester.

"Consultation" refers to a situation in which the midwife, using their professional knowledge of the client or by client request, seeks the opinion of a physician competent to give advice in the relevant field.

Enhancing educational requirements:

MAWS will work with MEAC-approved midwifery schools to integrate the competencies and training standards into pre-service midwifery education; we anticipate this to be a concurrent step with developing the trainings and competency assessments for licensed midwives.

ACOG, AUWS and MAWS all agree that additional continuing education hours on pharmacology, physiology, antibiotics, antifungals, antivirals, hormonal and nonhormonal family planning methods, LARC, and contraindications be required by rule for each renewal cycle (every three years) consistent with similar education requirements for other practitioners.

Disciplinary Actions:

The state of Washington has a vigorous regulatory and disciplinary framework for health practitioners, including licensed midwives. The same regulatory framework utilized to

investigate other practitioners acting outside the standard of care will be used for licensed midwives incorrectly or inappropriately managing this expanded scope.

In closing, we have appreciated working with Health Systems Quality Assurance on the Sunrise Review process. We will continue to review the report findings and recommendations and work with other provider groups to address concerns raised and refine the legislative proposal for consideration in the 2022 session.

Sincerely,

Jennifer Segadelli

Jen Segadelli, JD, MSM
President
Midwives' Association of Washington State

Katherine Camacho Carr, PhD, ARNP, CNM, FACNM, FAAN
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September 25, 2021
Washington State Department of Health
Transmitted by email to optom-sunrise@doh.wa.gov

Dear Colleagues:

I am writing in support of the sunrise review of the Midwifery statute (chapter 18.50 RCW) to create a "limited prescriptive license extension" for Licensed Midwives (LMs) in Washington State, who's formal, standardized and accredited educational preparation should prepare LMs to prescribe, obtain and administer medications appropriate to the scope of practice for midwives. There continue to be marked political and regulatory barriers that restrict midwifery practice in our state, as well as nationwide. I have been involved in midwifery practice and education for more than 4 decades, including direct entry midwifery and nurse-midwifery, and have spent much of my career reviewing the evidence supporting the necessity of a uniformly educated and regulated midwifery profession that meets the International Confederation of Midwives (ICM) standards for education, as part of state and national efforts to improve the access to and the outcomes of maternal, infant and reproductive health care in the United States (Camacho Carr et al., 2015).

According to the World Health Organization (WHO), when properly educated, regulated, and integrated, midwives are positioned as essential providers around the globe to improve maternity care in many countries (World Health Organization, 2020). "When midwives are educated to international standards, and midwifery includes the provision of family planning, it could avert more than 80% of all maternal deaths, stillbirths and neonatal deaths. Achieving this impact also requires that midwives be licensed, regulated, fully integrated into health systems and working in interprofessional teams" (World Health Organization, 2020). The International Confederation of Midwives provides a common global, professional *Definition of a Midwife* and the *Essential Competencies for Midwifery*

Practice, which also stress the importance of appropriate formal education, licensure and regulation of midwives. These documents describe a scope of midwifery practice that includes the necessary competencies, including the ability to prescribe appropriate medications and devices, in order to deliver comprehensive reproductive health care, including family planning, as well as some aspects of primary care and may provide guidance when developing the parameters around prescriptive authority (International Confederation of Midwives, 2020, 2019).

Another regulatory issue that restricts midwifery practice relates to the recognition of the varying formalized accredited educational routes to midwifery. Few state statutes recognize the three distinct educational pathways (CNM, CM and CPM) to becoming a licensed midwife in the United States as described in Table 1 (American College of Nurse-Midwives, 2019; North American Registry of Midwives, 2020; and North American Registry of Midwives, 2016). For example, Washington State does not recognize the Certified Midwife (CM), who complete a U.S. Department of Education accredited education program consistent with the Certified Nurse-Midwife but without a nursing prerequisite. This lack of regulatory uniformity contributes to conflict and confusion among stakeholders and the public when discussing and understanding regulatory oversight. However, wide variances in midwifery educational preparation, competencies and scope of practice also exist. The pathway to becoming a state licensed 'midwife' is currently regulated through more than 50 unique licensure models. State-by-state laws, including more than one law in some states, such as Washington, prevent a common understanding and definition of title, educational requirements, as well as scope of practice. The American College of Nurse-Midwives (ACNM) provides a helpful CNM/CM/CPM Comparison Chart of the types of US midwives, educational pathways, and certification requirements and is summarized in Table 1 (American College of Nurse-Midwives, 2019).

Reforming state-promulgated midwifery laws and regulation will assist in scaling up additional qualified and licensed providers to address the critical maternity care and women's

health care workforce shortage and help to eliminate the confusion. Due to the challenges with governmental integration of the various types of midwives and in the interest of safety and quality of care, ICM developed a group of essential documents that describe the "three pillars" of midwifery. The pillars include education, regulation and association and were built upon the foundation of the ICM *Essential Competencies for Basic Midwifery* and the ICM *Definition of a Midwife* (International Confederation of Midwives, 2020; International Confederation of Midwives, 2019). Table 2 contains the ICM *Definition of a Midwife* (International Confederation of Midwives, 2020). (Please note that the international definition of a midwife contained in the Sunset Review, Report to the Legislature is **inconsistent** with the current ICM Definition.) Together these documents comprise the global standards for midwifery education, practice and regulation and are a complete package of information for midwives, policy makers, regulators, other health care providers and governments (International Confederation of Midwives, 2020; International Confederation of Midwives, 2019; International Confederation of Midwives, 2013; and International Confederation of Midwives, 2011).

The American College of Nurse-Midwives (ACNM) and the American College of Obstetrician Gynecologists (ACOG), the two largest professional societies whose members care for women, have issued published opinions on the need for midwives in the United States to meet ICM minimum standards for the practice of midwifery (American College of Obstetricians and Gynecologists, 2017; American College of Nurse-Midwives, 2014). Expanding the scope of practice for Licensed Midwives LMs) in Washington would help meet this need. The CNM and CM educational pathways and certification title meet minimum requirements endorsed by both ACNM and ACOG. **However, awarding of the CPM certificate alone is not always consistent with meeting the minimum ICM educational preparation standards**. Some states have chosen to administer their own midwifery licensure examination, which also may not be consistent with international standards. Even more concerning are states that have no regulations. In addition, accredited direct entry education programs would need to identify possible gaps in the education program that would need to be addressed in order to expand prescriptive authority for the graduates. **For**

these reasons it is imperative that the state educational standards for midwifery be evaluated, along with defining the prerequisite knowledge and competency to obtain, prescribe and administer drugs and devices. This will ensure that the ICM standards and the Definition of Midwifery are met, including an expansion of the midwifery scope of practice in order to provide safe, quality sexual and reproductive health care to Washington State families.

Given my considerable experience with deliberations regarding these issues within midwifery groups, both internationally and within the United States, I would be happy to provide clarification or answer questions if I can be of further assistance.

Sincerely,

Katherine Camacho Carr, PhD, ARNP, CNM, FACNM, FAAN
Professor Emerita, Seattle University
Past President, American College of Nurse-Midwives
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References

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Table 1 Highlights from the CNM/CM/CPM Comparison Chart

Certified Nurse-Midwife/Certified Midwife	Certified Professional Midwife
• Must complete a graduate degree	• Does not require an academic degree but does require high school diploma or equivalent
• Must successfully complete an accredited midwifery education program	• Must successfully demonstrate 1 of 4 pathways of education; one pathway allows for an apprenticeship model
• CNMs are licensed in all 50 states and are also nurses; CMs are licensed in 5 states and are not required to be nurses	• Licensed in 31 states
• Education accreditation: Accreditation Commission for Midwifery Education (ACME)	• Education accreditation: Midwifery Education Accreditation Council
• Certification: American Midwifery Certification Board (AMCB)	• Certification: North American Registry of Midwives (NARM)
• AMCB certificants: ~ 12,500	• NARM certificants: 2,069

Sources: American College of Nurse-Midwives, 2019; North American Registry of Midwives, 2020, 2016.

Table 2 – ICM Definition of a Midwife

> A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

Source: International Confederation of Midwives, 2020

Washington State Department of Health
Tumwater, WA 98501

Submitted via electronic mail to mwsunrise@doh.wa.gov

RE: Midwifery scope of practice sunrise review

September 30th, 2021

To Whom It May Concern:

Planned Parenthood Alliance Advocates – Washington (PPAA) is pleased to submit the following comments in strong support of the Midwives Association of Washington's proposal to expand the midwifery scope of practice to include prescriptive authority for contraception and certain other pregnancy-related medications and therapies. While we recognize that the current proposal may require minor revisions to provide additional clarity, overall this proposal will promote increased access, quality of care, and patient safety. As such we urge DOH to issue a recommendation in support of this policy.

PPAA is committed to ensuring that all people in Washington can access quality, affordable sexual and reproductive health care services that help them plan their families and achieve their personal pregnancy goals. This includes supporting access to high-quality contraceptive and other sexual and reproductive health (SRH) care from qualified providers who are well positioned to meet patients' unique health care, cultural, and other needs, such as licensed midwives. We strongly support this proposal because it will promote access to high quality, patient-centered contraceptive, pregnancy, and postpartum care, and in turn will promote equitable access to health care, reduce health disparities, and improve outcomes across the state.

Consistent access to birth control gives people the ability to decide when and if they have children, giving them more career and education opportunities, encouraging healthier pregnancies, and fostering healthy children and families. Increasing access to high-quality, client-centered contraceptive care is an important tool to help Washingtonians achieve their pregnancy goals and promote positive maternal and child health outcomes.[i]

Leading medical authorities, including the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association, and the American Academy of Family Physicians, agree on the benefits of comprehensive birth control access and recommend that patients have access to the full range of FDA-approved contraceptives. Washington voters and policymakers have also long recognized access to contraception as a critical part of individuals' basic health care needs, and in recent years Washington has taken a number of important steps to improve access to contraception and the full range of SRH services.

Despite the many measures our state has passed to protect the right to affordable contraception and other SRH services, not all Washingtonians are able to access these rights. Department of Health (DOH) data shows that despite the progress our state has made in improving access to the tools Washingtonians need to plan their families and achieve their pregnancy goals, over one third of pregnancies in Washington are unintended. This rate is even higher for Medicaid patients, Washingtonians with low incomes, Black and Hispanic Washingtonians, and others who have long faced disproportionate barriers to health care and other resources.[ii] Washington State has also seen an alarming increase in sexually transmitted infections in recent years, aligning with nationwide trends of increased rates of chlamydia, gonorrhea, and syphilis. Due to centuries of systemic racism that

exacerbates other barriers to care, this trend also disproportionately impacts Black and Hispanic Washingtonians.[iii]

Ensuring that Washingtonians in need of SRH services can access a qualified provider to meet these needs is a critical component of our state's ability to address these health trends and promote health equity for all Washingtonians. DOH's "Health of Washington Report – Sexual Health" identifies a shortage of qualified providers as a barrier to SRH services, noting that "many primary healthcare providers are not trained to address health concerns related to sexual issues, and culturally appropriate prevention services are often unavailable."[iv] Washington's most recent physician supply estimate underscores this concern: the report notes that the supply of physicians specializing in obstetrics and gynecology decreased slightly between 2019 and 2020.[v]

Licensed midwives are well-positioned to address these shortages and ensure that all Washingtonians have access to qualified, culturally competent providers to meet their sexual and reproductive health care needs. Midwives already provide a wide range of pregnancy-related care, including contraceptive counseling, testing for sexually transmitted infections, and more. Allowing qualified midwives to build on these services by prescribing a broader range of contraception, treatment for the common sexually transmitted infections and urinary tract infections they diagnose, and other pregnancy-related medications will increase Washingtonians' ability to access the care they need at their preferred health care provider.

Allowing midwives to prescribe contraception is particularly critical to ensuring that all people in Washington can access culturally competent, client-centered contraceptive care from a trusted and qualified provider. Many patients – particularly those in rural and medically underserved areas – may have no source of care other than their midwife. And because midwives can already provide contraceptive counseling and STI testing, allowing licensed midwives to address the needs identified during patient visits will increase continuity of care for patients who have already developed a relationship with a trusted midwife. This will empower patients to receive care from a provider who is familiar with their individual SRH needs and goals without forcing patients to receive unnecessary referrals to another provider they may not know or trust. For patients who lack reliable transportation, have competing work and family obligations, or cannot afford to pay for an extra medical appointment, allowing qualified midwives to offer this care may be the difference between their patients being able to access needed SRH care and going without.

Thank you for the opportunity to comment. We urge you to build on the work our state has already done to increase access to SRH services by giving qualified midwives the prescriptive authority they need to provide critical, client-centered SRH care to their patients and improve health equity and outcomes for Washington patients.

Sincerely,

Leslie Edwards
Public Policy Analyst
Planned Parenthood Alliance Advocates - Washington

[i] Guttmacher Institute, "Testimony of the Guttmacher Institute Submitted to the Committee on Preventive Service for Women." January 12th, 2011. Accessed at https://www.guttmacher.org/sites/default/files/pdfs/pubs/CPSW-testimony.pdf

[ii] Washington State Department of Health, "Unintended Pregnancy." October 19th, 2016. Accessed at https://www.doh.wa.gov/Portals/1/Documents/1500/MCH-UP2016-DU.pdf

[iii] Washington State Department of Health, "STD Fast Facts: Washington State 2017." Accessed at https://www.doh.wa.gov/Portals/1/Documents/Pubs/347-350-FastFacts2017.pdf

[iv] Washington State Department of Health, "Sexual Health." August 23rd, 2013. Accessed at https://www.doh.wa.gov/Portals/1/Documents/1500/RPF-Sex2013.pdf

[v] Washington State Office of Financial Management Health Care Research Center, "2019-20 Physician Supply Estimates for Washington State." November 2020. Accessed at https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2019-20.pdf

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
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Olympia, WA 98504-7864

Sunrise Reviews in Progress
Nursing Care Quality Assurance Commission (NCQAC) Comments
Approved September 9, 2021

Midwifery Scope of Practice

We are providing the following Nursing Commission comments on whether the proposal meets the criteria in chapter 18.120 RCW.

Meets Criteria:

A thorough case is made that providing limited prescriptive authority to midwives would increase access to care in rural and underserved areas. A plan for curriculum changes in schools and education needed for midwives in practice is outlined with a focus on safety and quality.

Paula R. Meyer MSN, RN, FRE
Paula R. Meyer MSN, RN, FRE
Executive Director
NCQAC

Laurie Soine ARNP, PhD
Laurie Soine PhD, ARNP
Chair
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ARNPs United of Washington State (AUWS) represents the more than 9000 licensed advanced registered nurses (ARNPS) in the state. ARNPs include nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists.

AUWS continues support of the expansion of the scope of practice (SOP) of licensed midwives to "prescribe, obtain, and administer medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal and nonhormonal family planning methods, as prescribed in rule."

As recommended in the Department of Health draft report regarding licensed midwife SOP, the licensed midwives association consulted with AUWS regarding education and training for the expanded SOP. AUWS reviewed the curriculum offered by Bastyr University for midwifery, pharmacology requirements for ARNPs, training for placement of long-acting reversible forms of contraceptives, and information regarding the potential for oral contraceptive pills to become over-the-counter. It is important to note that there have been many professional associations that endorse oral contraceptives being made available over-the-counter, as is emergency contraception.

Midwifery student education recommendations
The Bastyr University curriculum requires a 1.5 quarter credit Pharmacology and Treatments course. This is equivalent to 15 hours of class time. The program also includes several courses on botanicals and complementary and alternative medicine. AUWS recommends the curriculum be changed to have a 3 quarter-credit course (30 hours) making it equivalent to what the requirement for ARNP initial prescriptive authority, with a clinical application of the didactic content. The additional 15 hours in the curriculum would focus on contraceptives and antibiotics. In addition, training for placement of Nexplanon requires a 2 hour workshop while IUD placement training is 3 hours. These 5 hours of training would be in addition to the 15 hours of additional pharmacology.

Currently licensed midwives who endorse in the future
A licensed midwife who has had a pharmacology course comparable to the one offered at Bastyr would have an additional 15 hours of pharmacology focused on antibiotics and contraceptives. A midwife without pharmacology would be required to complete 30 hours of education. The 5 hours of Nexplanon and IUD placement training would also be required. Midwives should also have a requirement to apply the educational content in a clinical setting with an appropriately licensed prescribing clinician for 60 hours. There should also be clinical supervision for placement of long-acting contraceptives.

Timely access to contraceptives prescribed by licensed midwives can prevent unintended pregnancies. Timely access to antibiotics can prevent complications from infections including sexually transmitted infections that can also be transmitted to sexual partners. It is in the best interest of public health to find a path forward for the expansion of the SOP of licensed midwives.