Hospital Midwives Seek Right to Certify False Labor

EMTALA's guidelines leave it up to the hospital to determine whether doctors should examine the patient.

BY JENNIFER SILVERMAN
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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 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 care during the maternity 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., who is 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.

'There is no requirement ... that a physician must personally examine the patient' before she is certified as having false labor and discharged.

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 prescriptive, 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 specialty organizations 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, emphasized that the panel should seek input from the AAFP 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," Dr. Jones said in an interview with 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 Bitterman, 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 statute, the word 'labor' 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."

Therefore, it's perfectly appropriate under EMTALA 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 comprised of representatives of hospital, physician, and patient groups, plus CMS staff and state government officials. ■

Industry Expert: Health Savings Accounts Engage Consumers in Care

BY MARY ELLEN SCHNEIDER
Senior Writer

Health savings accounts and other consumer-directed insurance products can help lower health care utilization and encourage better health behaviors, according to an industry expert.

Consumers "begin to recognize that the behaviors that they have can lead to a health outcome that can actually cost them money in the long run," said Doug Kronenberg, who is chief strategy officer for Lumenos, an Alexandria, Va.–based company that sells health savings accounts.

"And therefore they begin to think about changes in their behavior that can impact that health care," he commented.

When an employer or insurer combines that with a program that also shows consumers the financial benefits of changing their behavior and offers support tools, consumers really become engaged in their health care, Mr. Kronenberg commented during a teleconference that was sponsored by the Kaiser Family Foundation.

For example, employers can create financial incentives for consumers to complete a health risk assessment.

Health savings accounts (HSAs) were authorized under the Medicare Modernization Act of 2003 and are portable accounts that consumers can use to pay for certain qualified medical expenses.

The accounts are generally offered in conjunction with a high-deductible insurance plan, and both consumers and employers can contribute to these accounts.

HSAs and similar accounts, such as health reimbursement accounts, can also create big savings for employers, Mr. Kronenberg said.

With these types of plans, consumers tend to see the money as their own, and utilization of health care services typically drops.

"That's not a bad thing, when you take a look at the environment we're in today, as long as you're getting the right kind of utilization reduction," Mr. Kronenberg said.

However, Mila Kofman, J.D., who is an assistant research professor at the Health Policy Institute at Georgetown University, Washington, commented that HSAs coupled with high-deductible plans are just shifting the cost burden for health care from the insurer and the employer to the consumer.

And one of the possible pitfalls of the plans is that consumers who are facing deductibles of $1,000 or more each year will simply forego needed medical care because they can't afford to pay for it. This could actually raise the cost of health care in general if consumers skip or delay screenings and other preventive care that can identify problems early, Ms. Kofman said. ■

DATA WATCH

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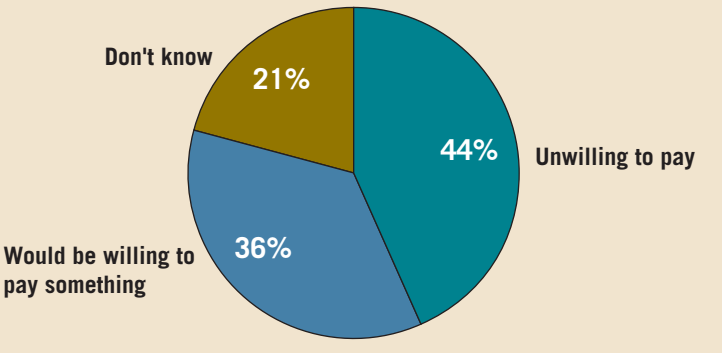

Note: Based on a nationwide survey of 2,387 adults conducted Feb. 4-8, 2005. Percentages do not add to 100% because of rounding.
Sources: Harris Interactive, Wall Street Journal Online

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