

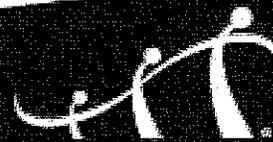
# ACNM Standards of Practice

The Extent to which ACNM Standards of Practice  
are Referenced in Statute or Regulation

A State-Level Study

Data as of May 2012

SB 481



AMERICAN COLLEGE  
of NURSE-MIDWIVES

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# ACNM Standards for the Practice of Midwifery

Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynecologic needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

Specifically,

- Midwifery care is provided by qualified practitioners.
- Midwifery care occurs in a safe environment within the context of the family, community, and a system of health care.
- Midwifery care supports independent rights and self-determination within boundaries of safety.
- Midwifery care is comprised of knowledge, skills, and judgments that foster the delivery of safe, satisfying, and culturally competent care.
- Midwifery care is based on knowledge, skills, and judgments which are reflected in written practice guidelines and are used to guide the scope of midwifery care and services provided to clients.
- Midwifery care is documented in a format that is accessible and complete.
- Midwifery care is evaluated according to an established program for quality management that includes a plan to identify and solve problems.
- Midwifery practice may be expanded beyond the ACNM Core Competencies to incorporate new procedures that improve care for women and their families.

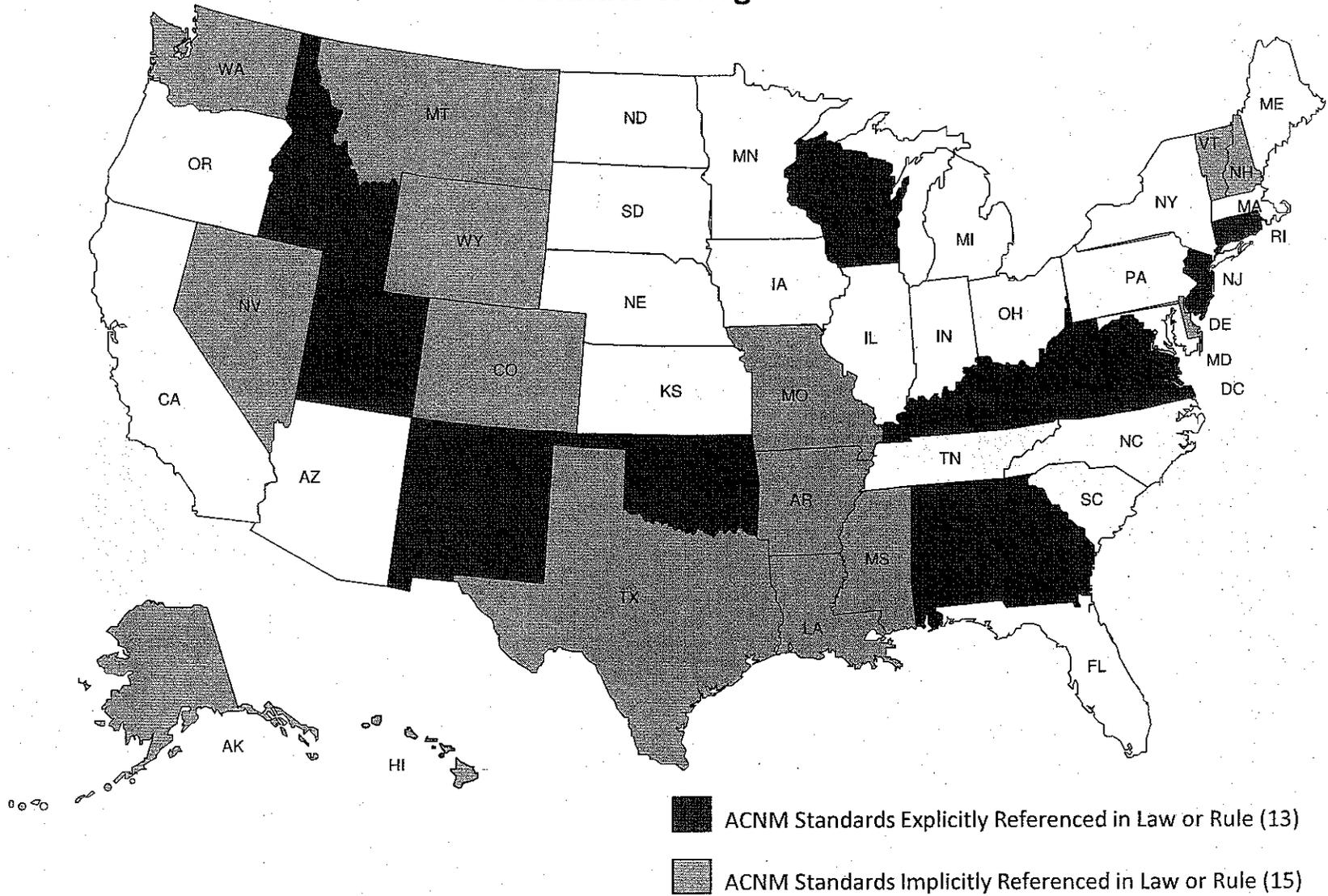


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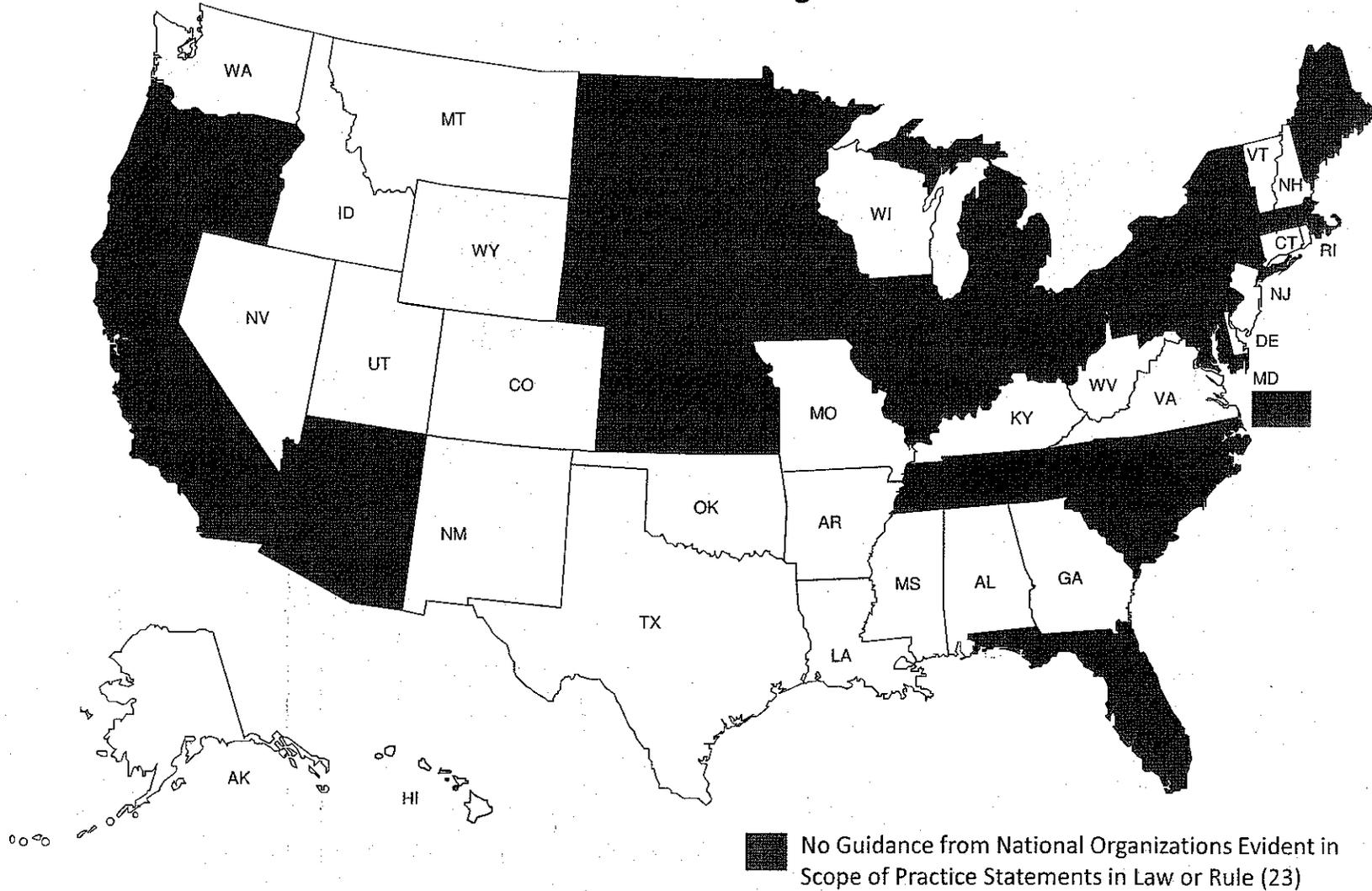
# Certified Nurse-Midwife (CNM®)

## States where Standards of Practice Established by ACNM are Referenced in Statute or Regulation



## Certified Nurse-Midwife (CNM®)

States where Laws or Regulations are Silent on Standards of Practice Established by  
ACNM or National Organizations



## Original Review

# Regulation of Prescriptive Authority for Certified Nurse-Midwives and Certified Midwives: A National Overview

CEU

Kathryn Osborne, CNM, PhD

**Introduction:** Certified nurse-midwives (CNMs) and certified midwives (CMs) provide primary care to women across the lifespan. Yet these primary care providers face barriers to practice that include restrictive state laws and regulations regarding prescriptive authority. The purpose of this review is to critically examine and report the regulatory requirements relative to prescriptive authority for CNMs/CMs in the United States.

**Methods:** State statutes and rules relative to midwifery practice were reviewed for all 50 United States and the District of Columbia.

**Results:** CNMs have been granted the authority to write prescriptions in all 50 United States and the District of Columbia, while CMs have been granted prescriptive authority only in the state of New York. Prescriptive authority for CNMs and CMs is regulated by individual state agencies and regulatory boards. Regulations regarding prescriptive authority for CNMs and CMs vary widely from state to state and are described, with a summary for each state presented.

**Discussion:** While CNMs are granted fully independent prescriptive authority in some states, the regulatory requirements relative to prescriptive authority for CNMs/CMs limit patients' access to necessary services in most states.

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**Keywords:** midwives, nurse-midwife, prescribing, prescriptions, prescriptive authority, regulation

## INTRODUCTION

The ability of midwives to dispense, administer, or in any way furnish medications for their patients is central to the provision of health care to women but has long been fraught with controversy and challenges. During the Middle Ages, thousands of women healers, many of whom were midwives, were accused of practicing witchcraft and were executed. Among the crimes that often led to execution was the use of healing remedies such as ergot and belladonna, both of which were commonly used by midwives.<sup>1</sup> During the early years of the 20th Century, women in the United States began to abandon the centuries-old tradition of midwife-attended birth in exchange for birth at the hands of physicians, largely because physicians offered medications, anesthesia, and the promise of a safer, less painful childbirth experience.<sup>2</sup> Along with the introduction of nurse-midwives during the 1920s came a changing scope of practice. In addition to providing maternity care, the nurse-midwives of the Frontier Nursing Service provided primary care to women and their families and public health services to the broader community.<sup>3</sup> Although this meant that these public health nurses who were trained as midwives were treating a number of health problems, they were allowed to provide only those medications authorized by the Medical Advisory Committee of the Frontier Nursing Service.<sup>3</sup>

Since that time, the midwife's scope of practice has continued to evolve. Today, certified nurse-midwives (CNMs) and certified midwives (CMs) provide primary care to women

across the lifespan.<sup>4</sup> Certified nurse-midwives are registered nurses who have completed an accredited nurse-midwifery education program and passed the national certification examination administered by the American Midwifery Certification Board. Certified midwives have a background in a field other than nursing and complete an accredited midwifery education program. Certified midwives must meet the same core competencies and pass the same certification examination as CNMs. Despite the extensive educational background of CNMs/CMs and a requirement to pass a rigorous certifying examination, these primary care providers face barriers to practice that include restrictive state laws and regulations regarding prescriptive authority.

In March 2010, the *Patient Protection and Affordable Care Act (ACA)* was signed into law by President Barack Obama. The ACA calls for substantial changes in the US health care system that will be implemented in phases through 2014.<sup>5</sup> Among other things, the ACA will likely result in the provision of health insurance for an estimated 32 million Americans who have been previously uninsured and have therefore had minimal access to health care.<sup>5,6</sup> As primary providers of women's health care, CNMs and CMs are poised to help meet this increasing demand for health care services. As the nation faces sweeping changes with health care reform and the impending shortage of primary care providers, it will be crucial for clinicians and policymakers to remain aware of regulatory requirements for all health care providers and to move forward with modification of current laws that pose barriers to practice and limit patients' access to primary care providers. The purpose of this review is to provide a summary of statutory requirements relative to prescriptive authority for CNMs and CMs.

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Table 1. Agencies/Boards that Regulate CNMs and CMs				
Regulatory Agency/Board	States Regulated	Title(s) Used		
Board of Nursing	Alaska	Kansas	New Hampshire	ANP/APN/APNP/APON/APRN/
	Arizona	Kentucky	North Dakota	APRN/ARNP/CNM/NNMP/RNP
	Arkansas	Louisiana	Ohio	
	California <sup>a</sup>	Maine	Oklahoma	
	Colorado	Maryland	Oregon	
	Delaware	Massachusetts <sup>e</sup>	South Carolina	
	District of Columbia	Michigan	Tennessee	
	Florida	Minnesota	Texas	
	Georgia	Mississippi	Vermont	
	Hawaii <sup>b</sup>	Missouri	West Virginia <sup>d</sup>	
	Idaho	Montana	Wisconsin	
	Indiana	Nevada	Wyoming	
	Iowa			
	Illinois			APN
Department of Financial and Professional Regulation				
Department of Health and Human Services—Division of Public Health <sup>c</sup>	Nebraska		APRN-CNM	
Board of Regents—State Education Department	New York <sup>k</sup>		LM	
Board of Medical Examiners	New Jersey <sup>f</sup>		CNM/CM	
Board of Medicine	Pennsylvania		CNM	
Department of Commerce—Division of Occupational and Professional Licensing	Utah		CNM	
Nursing Care Quality Assurance Commission	Washington		ARNP	
Department of Health	New Mexico		CNM	
Department of Public Health	Rhode Island <sup>l</sup>		CNM/CM/Midwife	
Joint Regulation: Board of Nursing and Board of Medicine	Alabama		APN/Midwife/CNM	
	North Carolina <sup>s</sup>			
	South Dakota			
	Virginia			

Abbreviations: ANP, advanced nurse practitioner; APN, advanced practice nurse; APNP, advanced practice nurse prescriber; APON, advanced practitioner of nursing; APRN, advanced practice professional nurse; APRN, advanced practice registered nurse; ARNP, advanced registered nurse practitioner; CM, certified midwife; CNM, certified nurse-midwife; LM, licensed midwife; NNMP, nurse-midwife nurse practitioner; RNP, registered nurse practitioner.

<sup>a</sup>Board of Registered Nurses.

<sup>b</sup>Department of Professional and Vocational Licensing.

<sup>c</sup>Board of Registration in Nursing.

<sup>d</sup>Board of Examiners for Registered Professional Nurses.

<sup>e</sup>Board of Advanced Practice Registered Nurses is granted regulatory responsibility for CNMs.

<sup>f</sup>States that license CMs.

<sup>g</sup>Midwifery Joint Committee.

## BACKGROUND

Certified nurse-midwives constitute 1 of the 4 categories of advanced practice registered nurses (APRNs) that are legally licensed to provide health care to patients. The remaining categories of APRNs include the certified registered nurse

anesthetist, nurse practitioner, and clinical nurse specialist.<sup>7</sup> While APRN has been recognized recently as the preferred title,<sup>7</sup> a variety of titles for nurses working in advanced practice have been used over the years. As can be seen in Table 1, the varying titles that can be found in statutes and rules provide just 1 example of inconsistencies among

states in the recognition and regulation of these primary care providers.

Certified nurse-midwives have been granted authority to write prescriptions in all 50 of the United States and the District of Columbia. Although CNMs are statutorily recognized with licensure to practice in 3 states (New York, New Jersey, and Rhode Island), only the state of New York has granted CNMs prescriptive authority. Except for requirements relative to the prescribing of controlled substances, which is regulated by the US Department of Justice Drug Enforcement Administration (DEA), there are no federal standards regarding prescriptive authority for midwives. Health care providers are regulated at the state level, with wide variation across states, particularly for CNMs, CNMs, and other APRNs.

The process of establishing or changing regulations for midwifery practice, including prescriptive authority, is conducted by 2 separate branches of state government. First, a bill must be passed by the legislative body and signed by the governor to enact a statute. All statutes provide the authority and policy direction for adoption of administrative rules by a regulatory body that has been granted rule-making authority by the legislature. In most states, the body with rule-making authority is a regulatory board, such as a board of nursing or a board of medicine, which is attached to a state agency for administrative support. For example, a board of nursing attached to a department of health receives administrative support from that state agency. In some states, rule making is conducted by a designated state agency, such as the Department of Health. Regulatory bodies (boards and/or agencies) write rules to interpret and further detail the policy set by statute. These rules generally involve a level of legislative review and approval and are made law through promulgation by the regulatory body. Rules are referred to by different titles, including administrative rules, administrative code, or rules and regulations. The authorizing statutes in combination with related rules make up the body of law that is administered and enforced by the regulatory body. This regulatory process is ongoing in every state, with changes in health policy occurring frequently, particularly since passage of the ACA.

In order to assist regulatory bodies with rule making and the regulation of midwifery practice, some state statutes authorize the creation of advisory boards. For example, in the state of New York, midwifery practice is regulated by the Board of Regents and the State Education Department. However, the Board of Regents appoints a 13-member Board of Midwifery for the purpose of providing assistance to the Board of Regents on matters pertaining to the licensure and regulation of midwives.<sup>8</sup> These boards generally do not have rule-making authority. Rather, they have been established to operate in an advisory capacity only. See Table 1 for a summary of regulatory bodies that have been granted rule-making authority for the practice of CNMs and CNMs.

## METHODS

The process of identifying regulations relative to prescriptive privileges for CNMs/CNMs began with an in-depth review of statutes and administrative rules for all 50 United States and the District of Columbia. From December 1, 2010, through May 1, 2011, data were collected on 5 specific measures of

regulation that were determined a priori and included 1) the governing bodies that license and grant prescriptive authority for CNMs/CNMs, 2) the degree of physician involvement in prescription writing, 3) the prescribing of controlled substances, 4) authority to dispense sample drugs, and 5) requirements for the use of a state formulary. As used in this review, a state formulary is a list of drugs or classes of drugs from which CNMs/CNMs are allowed to prescribe, is established by regulatory bodies, and is separate and distinct from formularies that are established for reimbursement purposes by health insurers including Medicaid and Medicare. Statutes and rules also were carefully reviewed for additional language that could impact prescribing practices for CNMs/CNMs. In order to enhance the reliability of this review, the findings for each state were sent to a member of the American College of Nurse-Midwives (ACNM), recognized as a midwifery leader, from the corresponding state for confirmation that the findings were accurate. These midwifery leaders included ACNM chapter chairs and affiliate presidents and CNMs who have been actively involved in the process of state policymaking.

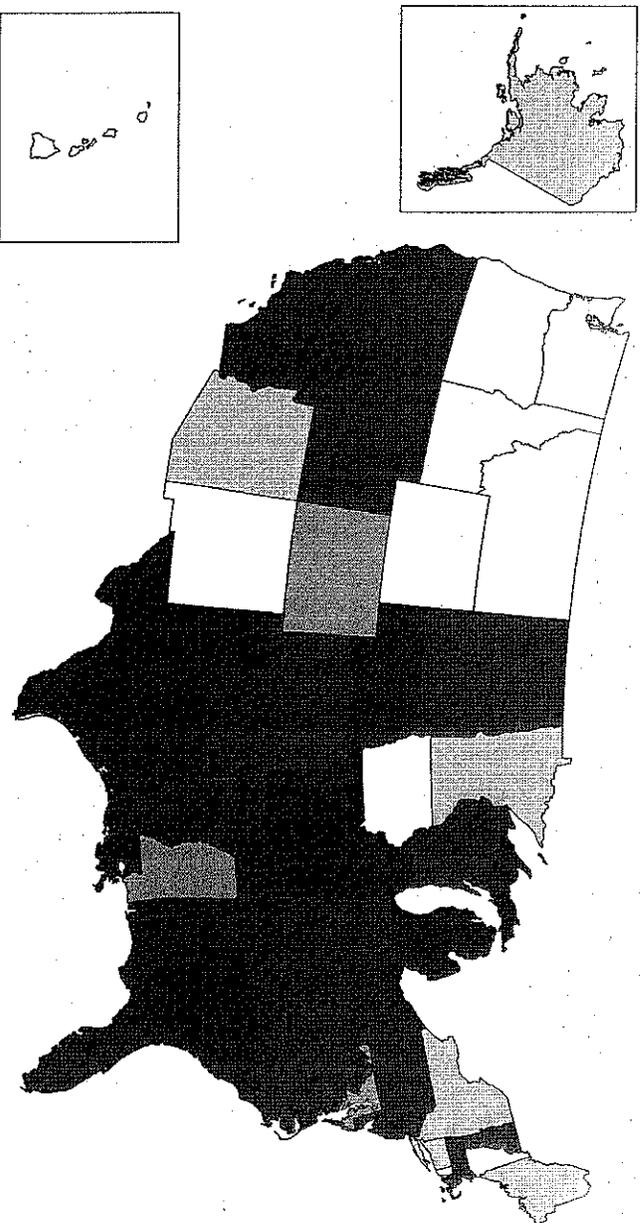
## FINDINGS

While there are similarities in the requirements that must be met in order for midwives to prescribe legend drugs (drugs that require a prescription for purchase) and controlled substances (pharmaceutical compounds that are regulated by the DEA), there is wide variation across states regarding the degree to which these requirements impose barriers to practice. At the federal level, *Title 21 Code of Federal Regulations* (21 CFR § 1300-1399) provides policy with regard to the prescription of controlled substances.<sup>9</sup> Prescribing these substances is further regulated by each individual state through the passage of laws that impose additional regulations and requirements for health care providers. For many states, the list of requirements is lengthy and beyond the scope of this review. Therefore, prescribers are encouraged to examine statutes and rules in order to identify state-specific regulations relative to prescribing controlled substances.

Presented here is a national overview of regulatory requirements as of May 1, 2011, by which CNMs and CNMs must abide with regard to prescriptive authority. These regulations are described with the assumption that the midwife seeking such authority has met the regulatory requirements for licensure to practice, specifically regulations regarding certification, educational preparation, and continuing education, the nature of which are so complex that they are beyond the scope of this review. In addition to the state-specific regulatory nuances described here, the degree to which physicians are involved in the prescribing practices of CNMs/CNMs is depicted in Figure 1. Basic regulations for CNMs with regard to the prescribing of controlled substances are depicted in Figure 2.

## Alabama

Prescriptive authority is granted to CNMs by the Joint Committee of the State Board of Medical Examiners and the Board of Nursing for Advanced Practice Nurses (Joint Committee). The Joint Committee is designated in statute as the state authority to recommend rules and regulations that must be



**Figure 1.** Degree of Physician Involvement in Prescribing Practices for Certified Nurse-Midwives/Certified Midwives. California: Signed by an administrator where practice will occur; Georgia, Illinois, Missouri, Nebraska, South Carolina, Texas: Signed collaborative practice agreement also required; Hawaii, Michigan: Signed collaborative agreement required for controlled substance prescribing only; Nebraska: Authorized medical function; Utah: First schedule II-III controlled substance prescribing and in hospital practice only.

□ No regulatory requirement for collaboration, consultation, referral, or written agreement  
 ▒ Regulatory requirement to collaborate, consult, and/or refer with physicians or other health care providers; no written agreement required  
 ▓ Regulatory requirement for a written collaboration or practice agreement; physician signature not required  
 ■ Regulatory requirement for a written collaboration or practice agreement, or practice guidelines, signed by the physician  
 ● Prescribing defined as a delegated medical act

promulgated by the Board of Nursing (BON) and the Board of Medical Examiners. Prescriptive authority for CNMs is included in state certification to practice as an advanced practice nurse (APN) and does not require separate licensure. In order to receive state certification to practice as an APN, the CNM must have a collaborative practice agreement with a physician who has engaged in the active practice of obstetrics and/or gynecology. Once certified as an APN, the CNM may prescribe legend drugs on the state formulary for APNs, which is approved by the Joint Committee.

#### Alaska

Certified nurse-midwives receive authorization to practice as an advanced nurse practitioner (ANP) from the BON. At the time of initial application for authorization to practice, the CNM must submit a consultation and referral plan that, among other things, lists at least 1 physician available for consultation and referral and the names of pharmacists for potential use. All ANPs must apply separately for authorization to prescribe and dispense legend drugs and must complete an additional application for authorization to prescribe and dispense controlled substances. Authorization to prescribe con-

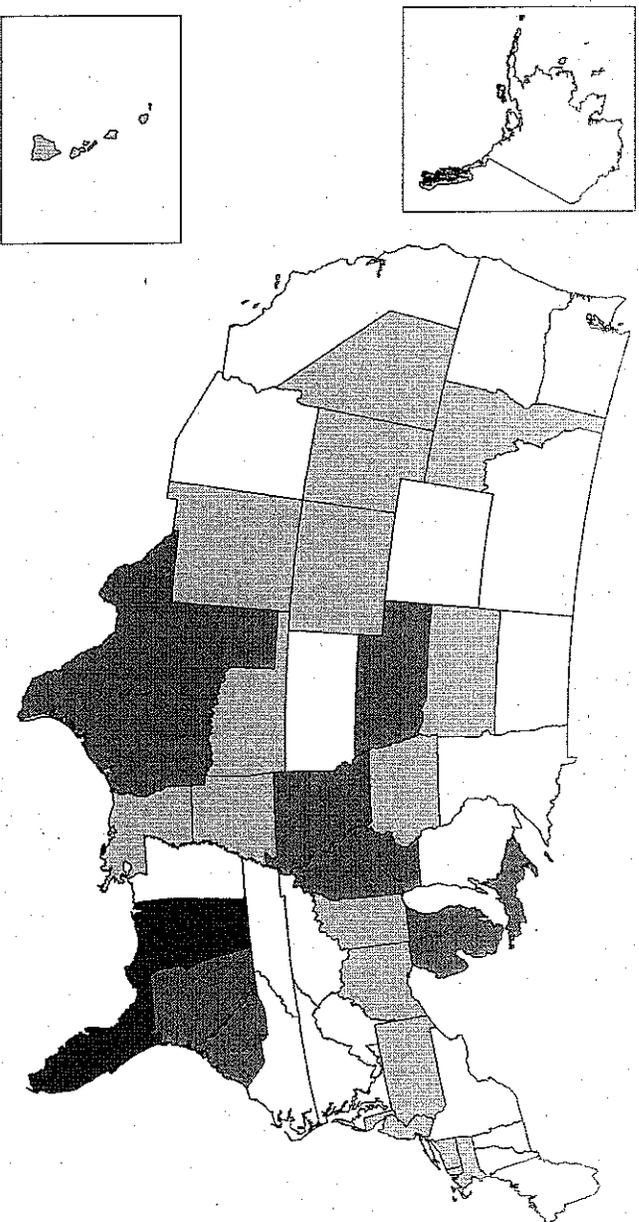
trolled substances requires at least 1 year of experience prescribing legend drugs. There are no regulatory requirements for a formal relationship with a physician.

#### Arizona

Certified nurse-midwifery practice is considered a specialty area of the registered nurse practitioner (RNP), and CNMs are regulated as APRNs by the BON following issuance of a certificate to practice as an RNP. The BON grants full authority to prescribe and dispense legend drugs and controlled substances to RNPs who apply separately for such authority and meet the required qualifications. There are no regulatory requirements for a formal relationship with a physician.

#### Arkansas

Prescriptive authority is provided to CNMs, who must be licensed as APNs, through the granting of a certificate of prescriptive authority that is separate from the license to practice. Nurse-midwives seeking a certificate of prescriptive authority must have a collaborative agreement with a physician, and new prescribers must undergo 300 hours of preceptorial experience prior to the granting of prescriptive authority.



**Figure 2. Regulations Regarding the Prescribing of Controlled Substances**  
 Illinois, Missouri, South Carolina, Texas: State issued prescriber number also required. Massachusetts: for Schedule VI prescribing only. Ohio, Pennsylvania: issued with prescriptive authority by the board of nursing.

Oversight of prescriptive authority for APNs is provided to the Arkansas BON by the Prescriptive Authority Advisory Committee, which is comprised of 1 physician and 2 APNs.

### California

Prescriptive authority is granted to CNMs who have been issued a certificate to practice nurse-midwifery by the Board of Registered Nurses upon the separate issuance of a "furnishing certificate." Section 2746.51 of the *Nurse Practice Act, Business and Professional Code*, defines furnishing as "the act of making a pharmaceutical agent or agents available to patients in strict accordance with a standardized procedure." The furnishing of legend drugs and controlled substances must be conducted under the supervision of a physician with training in obstetrics, in accordance with standardized procedures or protocols that have been developed collaboratively and agreed upon by the CNM, supervising physician, and an administrator at the institution where practice will occur. Nurse-midwives must undergo 6 months of physician-supervised experience in the furnishing or ordering of drugs prior to the issuance of the furnishing certificate. Nurse-midwives are authorized to prescribe medications to treat the partners of their patients who have been diagnosed with a sexually transmitted infection.

### Colorado

Authority to practice is granted by the BON to CNMs who qualify for inclusion on the advanced practice registry as advanced practice nurses. All CNMs engaged in practice must be covered by liability insurance in the amount of at least \$500,000 per claim/\$1,500,000 annual aggregate. Prescriptive authority is granted separately from authority to practice by the BON using a 2-tiered process. First, the CNM must apply for provisional prescriptive authority (RXN-P), which can be granted only if the CNM has completed a postgraduate preceptorship (with a physician or a physician and an APN with full prescriptive authority) of not less than 1800 hours. During the preceptorship, all prescriptions must be signed and/or authorized by the preceptor or another practitioner with full prescriptive privileges. A physician preceptor must sign an attestation that the CNM completed the 1800 hour preceptorship. In order to obtain full prescriptive authority, the CNM with provisional prescriptive authority must complete a mentorship (with a physician or a physician and an APN with full prescriptive authority) of not less than 1800 additional hours within 5 years of being granted provisional prescriptive authority. In order to obtain full prescriptive authority, the RXN-P and all mentors must provide signed documentation of the completed mentorship to the BON, after which time the CNM is granted full prescriptive authority with no further need for

physician involvement. All CNMs with prescriptive authority must keep an Articulated Plan on file. The Articulated Plan must include a 1-time signature of all mentors and strategies for safe prescribing, mechanisms for ongoing collaboration, and a quality assurance plan.

#### **Connecticut**

Certified nurse-midwives are granted full prescriptive authority upon licensure as a "licensed nurse-midwife" by the Connecticut Department of Public Health. Licensed nurse-midwives are regulated by the Connecticut Department of Public Health with the advice and assistance of an advisory panel made up of 3 licensed nurse-midwives who do not hold an office in the Connecticut Chapter of ACNM. Nurse-midwives must have a clinical practice relationship with an obstetrician-gynecologist; however, there is no requirement to document this relationship in writing.

#### **Delaware**

Prescriptive authority for CNMs is granted in 1 of 2 ways. Prescription-writing privileges may be granted by the BON to CNMs at the time of initial licensure as an APN. This authority is pursuant to a signed collaborative agreement with a physician that includes a plan for consultation, referral, and protocols that has been approved by the collaborating physician. Nurse-midwives who hold a current APN license may apply separately for independent practice and/or independent prescriptive authority. Such authority requires the CNM to submit a previously established collaborative agreement but does not include a requirement for established guidelines or protocols. Rules and regulations related to independent practice and independent prescriptive authority are developed by the Joint Practice Committee (JPC), which is comprised of 1 public member, 1 pharmacist, 2 physicians, and 5 APNs (1 of whom must be a CNM). Approval to practice independently, without written guidelines or protocols, is granted by the JPC with the approval of the Board of Medical Licensure and Discipline.

#### **District of Columbia**

Certified nurse-midwives are granted prescriptive authority by the BON upon receipt of a certificate, which is issued by the Board, to practice as a CNM. Statutorily, it is recognized that CNMs work in collaboration with physicians and other health care providers; however, there is no requirement for a collaborative agreement between CNMs and any other provider in order to prescribe legend drugs or controlled substances.

#### **Florida**

Certified nurse-midwives are granted prescriptive authority by the BON upon certification as an advanced registered nurse practitioner (ARNP). All acts of the CNM-ARNP, including the prescribing of medications, must be conducted under the supervision of a medical doctor or doctor of osteopathic medicine, pursuant to written protocols that have been filed with the BON. Unless granted an exemption by

the Board, all CNMs must carry malpractice insurance in the amount of \$100,000 per claim/\$300,000 annual aggregate.

#### **Georgia**

Certified nurse-midwives are granted prescriptive authority as a delegated medical act by the BON. Certified nurse-midwives (recognized in statute and rule as APRNs) who wish to prescribe medications must file a protocol with the Board of Medicine that has been signed by the CNM and the delegating physician, indicating that the CNM's practice will include the writing of prescriptions as a delegated medical act. The prescribing of controlled substances and the receipt and distribution of drug samples are also conducted as delegated medical acts.

#### **Hawaii**

Authorization to practice as an APRN is granted by the BON to registered nurses (RNs) who meet the qualifications necessary to practice in an expanded role; CNM is 1 of 4 APRN specialties. Authorization to write prescriptions for legend drugs is granted by the BON to qualifying CNMs separate from the authorization to practice. Nurse-midwives who wish to prescribe controlled substances must apply separately for controlled substance authorization. A collaborative agreement with a physician is required only for the prescribing of controlled substances. All prescribing is done pursuant to an exclusionary formula that is established by the BON upon the recommendations of the Joint Formulary Advisory Committee, which is comprised of 2 licensed APRNs, 2 licensed physicians, 3 licensed pharmacists, 1 representative of the University of Hawaii John A. Burns School of Medicine, and 1 representative of a school of nursing with an APRN program. A newly passed provision will expand the authority of APRNs to prescribe controlled substances without a physician's signature.

#### **Idaho**

The BON grants full prescriptive authority to CNMs who apply for such authority upon initial licensure as an advanced practice professional nurse (APPN). Applicants for a license as an APPN may choose to apply for licensure without prescriptive authority and may apply for prescriptive authority at a later date. There are no regulatory requirements for a formal relationship with a physician.

#### **Illinois**

Certified nurse-midwives are licensed and regulated by the Department of Financial and Professional Regulation as an APN. Nurse-midwives are required to practice pursuant to a jointly developed written collaborative agreement. As part of the collaborative agreement, the collaborating physician may, but is not required to, delegate prescription writing authority to the CNM. In order for CNMs to prescribe controlled substances, the collaborating physician must delegate authority to do so, and the CNM must obtain a "mid-level practitioner controlled substance license." Article 65 of the *Nurse*

*Practice Act* (statute relative to APN practice) is scheduled to be repealed (at sunset) on January 1, 2018, at which time legislation relative to the practice of APNs must be introduced, passed by the legislature, and signed by the governor.

#### **Indiana**

Limited licensure as a CNM is granted by the BON and does not include prescriptive authority. In order for CNMs to prescribe legend drugs and controlled substances, CNMs must apply for separate authorization to do so from the BON. Nurse-midwives who desire to obtain prescriptive authority must enter into a written practice agreement with a physician, which must be submitted to the BON before such authority will be granted.

#### **Iowa**

Certified nurse-midwives are licensed as a registered nurse (RN) and registered with the BON as an ARNP. This registration allows the autonomous practice of nurse-midwifery with full prescriptive authority. There are no regulatory requirements for any relationship with a physician.

#### **Kansas**

Certified nurse-midwives are granted a "certificate of qualification" by the BON to practice as a category of ARNP. Starting January 1, 2012, CNMs will be licensed (rather than certified) as APRNs. A collaborative practice agreement with a responsible physician, which includes the classes of drugs the CNM is allowed to prescribe, must be maintained at the CNM's clinical practice site. If the authority is included in the collaborative practice agreement, CNMs may be authorized to prescribe medications to treat the partners of their patients who have been diagnosed with a sexually transmitted infection.

#### **Kentucky**

Certified nurse-midwives are granted prescriptive authority by the BON with licensure to practice as an APRN. All APRNs who engage in the prescribing of scheduled and unscheduled legend drugs must have a written collaborative agreement with a physician. This written agreement must be available for review by the BON. All APRNs who engage in the prescribing of schedule II-V controlled substances must have, on file at the practice location, a written Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances (CAPA-CS) that has been signed by the collaborating physician and the APRN. Advanced practice registered nurses with a CAPA-CS must notify the BON of the existence of the collaborative agreement and the name of the collaborating physician.

#### **Louisiana**

Certified nurse-midwives who have been licensed by the BON as an APRN may apply separately to the BON for prescriptive authority. Prior to the granting of prescriptive authority, CNMs must have a written collaborative agreement with a

physician in active clinical practice that is signed by the collaborating physician and the CNM. The clinical practice agreement must include the types and categories of drugs that will be prescribed by the CNM and must be reviewed and signed at least annually by the CNM and collaborating physician. All APRNs who apply for prescriptive authority must demonstrate evidence of working at least 500 hours in clinical practice with a collaborating physician during the year preceding application.

#### **Maine**

Certified nurse-midwives are granted prescriptive authority upon licensure by the BON to practice advanced practice registered nursing. Prescriptive authority granted to CNMs includes authorization to prescribe drugs or devices listed on the state authorized formulary and to treat the partners of their patients who have been diagnosed with a sexually transmitted infection. The state authorized formulary includes all nonscheduled drugs that are Food and Drug Administration (FDA) approved and drugs listed in Schedules II, III, IIIIN, IV, and V. There are no regulatory requirements for a formal relationship with a physician.

#### **Maryland**

Certified nurse-midwives, who are licensed as RNs, must be certified by the BON to practice nurse-midwifery; prescriptive authority is granted through this certification by the BON. All CNMs must have a collaborative plan in place, which must include the name of a collaborating physician and medications that the midwife plans to prescribe and dispense. Collaborative plans must be submitted to the BON and reviewed by the Certified Registered Nurse-Midwife Review Committee, which is comprised of an equal number of obstetricians and CNMs. This committee then recommends the plan to the BON for approval.

#### **Massachusetts**

Certified nurse-midwives who have been authorized to practice as nurses in an expanded role (nurse-midwife) by the Board of Registration in Nursing are granted prescriptive authority with that authorization. All CNMs must work as a member of a health care team that includes a licensed physician with hospital admitting privileges. Nurse-midwives must practice according to mutually agreed upon practice guidelines, including guidelines for prescribing, that have been signed by the supervising physician and have received institutional approval or approval by the Board of Registration in Nursing.

#### **Michigan**

Registered nurses who meet the education and certification requirements for the practice of nurse-midwifery must apply for a "specialty certification" to practice and are regulated by the BON pursuant to the *Public Health Code*. Certified nurse-midwives who hold a specialty certification to practice midwifery may prescribe legend drugs and controlled

substances only as a delegated medical act. Nurse-midwives with specialty certification who wish to prescribe controlled substances must enter into a written authorization agreement with a delegating physician, which is signed by the physician. Written authorization agreements must be maintained at the practice site of the delegating physician.

#### **Minnesota**

Registered nurses who are also CNMs must be certified by the American Midwifery Certification Board and submit a copy of their certification to the BON. No additional licensure is required for full prescriptive authority, which is regulated by the BON. There are no regulatory requirements for CNMs to have a formal relationship with a physician.

#### **Mississippi**

Certified nurse-midwives who are licensed as an RN may apply for certification by the BON to practice as an APRN. Prescriptive authority for legend drugs is granted by the BON with this certification. Prior to beginning practice, all CNMs must have a collaboration agreement that is documented in a protocol that has been mutually agreed upon by the CNM and collaborating physician and approved by the BON. Prescriptive authority for controlled substances requires additional certification and payment of additional fees.

#### **Missouri**

Certified nurse-midwives must apply to the BON for recognition as an APRN, at which time those who meet the requirements will be issued a "Document of Recognition." Nurse-midwives must have a mutually agreed upon collaborative practice agreement with a physician who practices no more than 30 miles from the practice site of the CNM, unless the CNM is practicing in a health professional shortage area, in which case, the physician's practice must be within 50 miles of the CNM's practice. The authority to prescribe is extended to CNMs only if the collaborative practice agreement delegates such authority and only for those drugs that have been delegated in the agreement. Nurse-midwives who wish to prescribe controlled substances must apply to the BON for a certificate of controlled substance prescriptive authority and must demonstrate completion of 300 hours of preceptorial experience before such authority will be granted. Authority to prescribe controlled substances is granted only if such authority is delegated in the collaborative practice agreement.

#### **Montana**

Full prescriptive authority is granted by the BON to CNMs who are licensed as APRNs and who apply separately for prescriptive authority. All CNMs with prescriptive authority must submit a quality assurance plan to the BON, which identifies a mechanism for quarterly peer review that is to be conducted by a CNM who also has prescriptive authority. There are no regulatory requirements for a formal relationship with a physician.

#### **Nebraska**

Certified nurse-midwives are granted a license to practice nurse-midwifery as an APRN-CNM by the Department of Health and Human Services Division of Public Health, predicated on a recommendation from the Advanced Practice Nursing Board. Prior to practicing, the CNM must submit to the APN Board a written practice agreement with a collaborating physician that has been signed by the physician and approved by the Board. Such an agreement must include mutually agreed upon protocols for all delegated medical functions; the prescribing of legend drugs and controlled substances is considered a delegated medical function. Certified nurse-midwives must also carry malpractice insurance coverage in the amount of \$200,000 per claim/\$600,000 annual aggregate.

#### **Nevada**

Certified nurse-midwives who have been issued a certificate of recognition as an advanced practitioner of nursing by the BON must apply separately for prescriptive authority. All CNMs must submit, with their initial application for a certificate of recognition as an advanced practitioner of nursing, and maintain at their practice sites a mutually agreed upon protocol that outlines the current practice and ongoing collaborative relationship between the CNM and each collaborating physician. Applicants for prescriptive authority must submit a signed statement from the collaborating physician indicating that the CNM is competent to prescribe the drugs that are listed in the protocol. In order to dispense samples, the CNM must apply for a certificate to dispense controlled substances, poisons, dangerous drugs, and devices. Issuance of this certificate requires passage of an examination administered by the BON relating to state pharmacy laws and a certificate of registration with the State Board of Pharmacy.

#### **New Hampshire**

Licensure by the BON as an APRN is a requirement for CNM practice. Autonomous prescriptive authority is granted by the BON upon licensure as an APRN. There are no regulatory requirements for a formal relationship with a physician.

#### **New Jersey**

Certified nurse-midwives and certified midwives are licensed as midwives by the Board of Medical Examiners. Licensure as a midwife authorizes CMs and CNMs to administer drugs that have been identified in a clinical practice agreement with a physician who practices obstetrics, during the provision of care. While there is no mechanism for CMs to obtain prescriptive authority, CNMs may apply separately to the Board of Medical Examiners for authorization to prescribe. Upon receipt of authority to prescribe, CNMs may prescribe drugs that have been categorized in a formulary established in mutually agreed upon clinical guidelines. State-issued prescription blanks must be used for all prescriptions.

## New Mexico

Certified nurse-midwives are licensed by the Department of Health and regulated by the Public Health Division of the State Department of Health. Licensure as a CNM provides authorization for the autonomous management of women's health care including prescriptive authority. Certified nurse-midwives are authorized to prescribe medications to treat the partners of their patients who have been diagnosed with a sexually transmitted infection. There are no regulatory requirements for a formal relationship with a physician.

## New York

Certified nurse-midwives and CMs are regulated as licensed midwives (LMs) by the Board of Regents and the New York State Education Department, with the assistance of the State Board of Midwifery. All LMs who have met the educational requirements of the Board of Regents may apply for authorization to prescribe. Receipt of a certificate to prescribe from the New York State Education Department grants LMs prescriptive authority. All LMs are required by law to establish and maintain a collaborative relationship with 1) a licensed physician who is a board-certified obstetrician-gynecologist; or 2) a licensed physician who practices obstetrics; or 3) a hospital that provides obstetric services through a licensed physician with privileges at that hospital and that provides a mechanism for consultation, collaborative management, and referral to meet the health care needs of the LMs' patients. All LMs must maintain documentation of these collaborative relationships, although there is no legal requirement for licensed midwives to submit written documentation of these relationships to the regulatory agency.

## North Carolina

Certified nurse-midwives are regulated by the Midwifery Joint Committee, which is comprised of representatives of the BON and the North Carolina Medical Board. Prescriptive authority is granted by the Midwifery Joint Committee upon receipt of approval to practice midwifery by the committee. Midwifery practice is defined to include only the practice of CNMs, and all aspects of practice, including the writing of prescriptions, must be done under the supervision of a physician in active obstetric practice in accordance with a mutually agreed upon collaborative practice agreement. All legend drugs and controlled substances that will be prescribed or distributed by the CNM must be identified in the collaborative practice agreement.

## North Dakota

Certified nurse-midwives are licensed and regulated as APRNs by the BON. Authority to prescribe is granted by the BON with separate licensure for prescriptive authority. Nurse-midwives with prescriptive authority must participate in a "collaborative prescriptive agreement" with a licensed physician. Prior to issuance of prescriptive authority, the CNM must submit to the BON an affidavit from a licensed physician that acknowledges methods of review and approval of pre-

scriptive practices, including the identification of broad classifications of drugs or devices that will be prescribed by the CNM. Nurse-midwives with prescriptive authority are authorized to prescribe medications to treat the partners of their patients who have been diagnosed with a sexually transmitted infection.

## Ohio

Certified nurse-midwives are granted a certificate of authorization to practice nursing as a CNM by the BON. Nurse-midwives are required to practice in accordance with a Standard Care Arrangement (SCA) that must be entered into with each physician with whom the CNM collaborates. Nurse-midwives who have been issued a certificate of authorization to practice and wish to prescribe legend drugs must apply to the BON for a certificate to prescribe. Upon receipt of the certificate to prescribe, the CNM must undergo a "Certificate to Prescribe Externship" (CTP-E) for 1500 practice hours, of which 500 hours must be spent working under direct on-site supervision. Two hundred of these 500 hours may be supervised by a CNM or any APN who has a certificate to prescribe and who has completed the (CTP-E) 300 hours must be spent under the direct supervision of the collaborating physician. Indirect supervision is required for the remaining 1300 hours. During the (CTP-E), the collaborating physician and/or APN with a certificate to prescribe must review the prescribing activities of the new prescriber; the frequency of this review must be defined in the SCA.

## Oklahoma

Prior to receiving authorization to prescribe, CNMs must receive a "certificate of recognition" as a CNM by the BON. Following receipt of this certificate of recognition, CNMs are eligible to apply separately for authorization by the BON to prescribe medications under the supervision of a physician. An *Exclusionary Formula* has been established by the Formulary Advisory Council, which is made up of 4 physicians appointed by the BOM, 4 pharmacists appointed by the Board of Pharmacy, and 4 APNs appointed by the BON. This *Exclusionary Formula* lists drugs and/or devices that may not be prescribed by CNMs and is reviewed annually by the Formulary Advisory Council; recommendations for modification must be submitted for approval by the BON.

## Oregon

The BON authorizes the practice of CNMs who are certified as nurse practitioners, specifically as nurse-midwife nurse practitioners (NMNPs). All applicants who apply for initial certification as an NMNP must meet the requirements for prescriptive authority, which is then granted with initial licensure. There are no regulatory requirements for a formal relationship with a physician.

Nurse-midwives who have been certified as an NMNP are authorized to prescribe antibiotics to treat the partners of their patients who have been diagnosed with sexually transmitted infections. Separate from the authority to dispense drug samples, which is granted with initial certification as an NMNP,

CNMs may also apply for dispensing authority. Such authority requires that NMNPs meet additional regulatory requirements and allows NMNPs to dispense larger quantities of drugs to certain patients, primarily patients with limited access to a pharmacy and limited financial resources.

#### **Pennsylvania**

Licensure to practice midwifery is granted to CNMs who meet the regulatory requirements through the Board of Medicine. Certified nurse-midwives with a master's degree are eligible to receive a separate certificate of prescriptive authority. Nurse-midwives are required to have a collaborative agreement with a physician that is filed with the Board of Medicine and that includes practice guidelines and the categories of drugs from which the CNM may prescribe.

#### **Rhode Island**

Certified nurse-midwives and CMs are licensed to practice by the Department of Health, upon the recommendations of the Advisory Council on Midwifery. Certified nurse-midwives are granted prescriptive authority upon receipt of a license to practice midwifery. There is no provision for prescriptive authority for CMs. Each midwifery practice site must maintain guidelines that include provisions for the prescribing of legend drugs and controlled substances.

#### **South Carolina**

Following licensure by the BON as an APRN, CNMs must apply separately for prescriptive authority. All actions of APRNs, including the prescribing of medications, are considered delegated medical acts and must be performed under the general supervision of a physician pursuant to mutually agreed upon protocols. The application for prescriptive authority must be signed by the supervising physician. Delegated medical acts must be approved by the Board of Medical Examiners and the BON.

#### **South Dakota**

Prescriptive authority is granted to CNMs jointly by the BON and the Board of Medical and Osteopathic Examiners (the Boards) through licensure as a CNM, under the terms of a collaborative agreement that has been approved by and maintained on file with the Boards. This collaborative agreement requirement may be waived by the Boards for licensed CNMs who provide out-of-hospital birth services.

#### **Tennessee**

Certified nurse-midwives must first apply to the BON for certification as an APN. In statute, it would appear that only nurse practitioners are recognized as having the ability to obtain prescriptive authority. However, the *Rules of the Tennessee Board of Nursing § 1000-04-04* clarify that RNs who have a master's degree and national certification as CNMs and who have met the educational requirements set forth by the BON may apply for a "certificate of fitness as a nurse practi-

tioner with privileges to write and sign prescriptions and/or legend drugs." Following receipt of the certificate of fitness, CNMs are granted the same prescriptive authority as nurse practitioners.

#### **Texas**

Certified nurse-midwives must be authorized by the BON to practice as an APN. This authorization grants CNMs the ability to provide controlled substances during the intrapartum and immediate postpartum periods as a delegated medical act. All CNMs who wish to prescribe legend drugs and/or controlled substances must apply for separate licensure as "APRNs with prescriptive authority." Receipt of this separate licensure grants CNMs the ability to prescribe legend drugs and controlled substances as a delegated medical act. Nurse-midwives must maintain, at their place of practice, written authorization to prescribe, which must be signed by the CNM and the delegating physician. The delegating physician must designate, to the Texas Medical Board, the CNMs to whom the physician has delegated the authority to sign prescriptions. Nurse-midwives who are licensed as APRNs with prescriptive authority may write prescriptions to treat the partners of their patients who have been diagnosed with sexually transmitted infections.

#### **Utah**

Certified nurse-midwives are regulated by the Division of Occupational and Professional Licensing of the Department of Commerce, upon the recommendations of the CNM Board. Licensure as a CNM includes prescriptive authority; however, CNMs who choose to prescribe controlled substances must apply separately for a Utah controlled substance license. Nurse-midwives who prescribe Schedule II-III controlled substances must have a Consultation and Referral Plan, which has been signed by the consulting physician, on file at the clinical practice site. Certified nurse-midwives who engage in intrapartum practice must have a Practice and Referral Plan, which has been signed by the consulting physician, on file at the clinical practice site. Certified nurse-midwives are authorized to prescribe medications to treat the partners of their patients who have been diagnosed with a sexually transmitted infection.

#### **Vermont**

Prescriptive authority is granted to CNMs who are licensed by the BON as APRNs. Upon licensure, CNMs function within a collaborative practice based upon practice guidelines that include the medications the CNM is authorized to prescribe and that are mutually agreed on by the CNM and collaborating physician.

#### **Virginia**

Prescriptive authority is regulated by the Committee of the Joint Boards of Nursing and Medicine, which is made up of 3 members of the Board of Medicine and 3 members of the BON. Nurse-midwives are recognized in statute as I category

of licensed nurse practitioner and are licensed as nurse practitioners by the Committee of the Joint Boards of Nursing and Medicine. Prescriptive authority is granted, through separate licensure, to CNMs who are licensed as nurse practitioners. A written practice agreement, which is required for prescriptive authority, must be approved by the Committee of the Joint Boards of Nursing and Medicine and must include an authorization for categories of drugs to be prescribed.

### Washington

The Washington State Nursing Care Quality Assurance Commission regulates CNMs as a designated category of ARNP. Full prescriptive authority is granted to CNMs who are licensed as an ARNP and who have been granted such authority by the Commission. There are no regulatory requirements for a formal relationship with a physician. Prescriptions must be written on tamper-resistant prescription pads and must be hand printed or type written. The *Revised Code of Washington §69.51A* recognizes ARNPs as a category of health care professional authorized to recommend the use of medical marijuana.

### West Virginia

Certified nurse-midwives are licensed to practice by the Board of Examiners for Registered Professional Nurses. Prescriptive authority is granted, by the Board, to licensed CNMs who meet the qualifications and apply for separate approval to prescribe legend drugs and/or controlled substances. A policy statement issued by the Board of Medicine on May 10, 2010, recommends that the medications CNMs are authorized to prescribe be included in a collaborative agreement.

### Wisconsin

Certified nurse-midwives are licensed by the BON as CNMs. In order to practice and to prescribe medications, CNMs are required to have a written practice agreement with a physician and to carry malpractice insurance coverage in the amount of \$1 million per claim/\$3 million annual aggregate. Prescriptive authority is granted only to CNMs who are licensed separately by the BON as advanced practice nurse prescribers (APNPs). Certified nurse-midwives must demonstrate an understanding of medication use and prescribing practices through passage of a jurisprudence examination for APNPs as a requirement for such licensure.

### Wyoming

The BON regulates CNMs who are licensed as RNs and recognized as APRNs. Separate from the application for APRN recognition, CNMs must submit an application for prescriptive authority. Full prescriptive authority is granted by the BON upon issuance of the license for prescriptive authority. There are no regulatory requirements for a formal relationship with a physician.

### DISCUSSION

This review of state statutes and administrative rules reveals wide variation across states regarding the regulatory require-

ments for CNMs and that CNMs are only authorized to prescribe in a single state. While CNMs in several states are authorized to prescribe independently, CNMs in most states continue to face restrictions on their ability to prescribe medications for patients. Further, as identified in Table 2, there are regulatory requirements for CNM to physician ratios that limit the ability of CNMs to establish the CNM-physician relationships that are mandated by law in many states. Inconsistencies across states also exist with regard to statutory requirements to carry medical malpractice insurance and statutory permission to treat the partners of patients with sexually transmitted infections.

In addition to wide variation in regulatory requirements for prescriptive authority across states, there is also apparent variation regarding the way in which regulatory boards and agencies implement state laws. For example, careful review of the *Tennessee Code Annotated* and the *Rules of the Tennessee Board of Nursing* revealed no reference to a requirement for a physician signature on documents submitted for receipt of a certificate of fitness to prescribe.<sup>10,11</sup> However, APNs who hold certificates of fitness are required by the BON to submit a "notice and formulary" for every supervising physician with whom they work. Required by the BON on this notice and formulary is the notarized signature of the supervising physician. Readers are cautioned to review all essential documents required for receipt of prescriptive authority for additional barriers to practice imposed by regulatory bodies.

The intent of this review is to provide an overview of regulations for CNMs/CNMs as they pertain to prescriptive authority. Beyond the regulation of prescriptive authority, statutes and rules relative to initial licensing, licensure renewal, and midwifery practice vary widely from state to state and are beyond the scope of this review. Readers are strongly encouraged to examine the entire body of law that regulates the

State	Limit CNM/Physician Ratios	CNM FTE/Physician Ratio Allowed
Alabama	3:1	
California	4:1	
Florida <sup>a</sup>	4:1	
Georgia <sup>b</sup>	4:1	
Missouri	3:1	
Ohio	3:1	
Oklahoma	2:1 <sup>c</sup>	
South Carolina <sup>d</sup>	3:1	
South Dakota	4:1	
Texas <sup>e</sup>	4:1	
Virginia	4:1	
West Virginia <sup>f</sup>	3:1 <sup>g</sup>	

Abbreviation: CNM, certified nurse-midwife; FTE, full-time equivalent.

<sup>a</sup> Limitations placed on the number of offices where CNMs provide primary care. Certain facilities are exempt from this limitation.

<sup>b</sup> Ratio applies only to the supervision of CNMs with prescriptive authority.

<sup>c</sup> Board of Nursing and Board of Medicine must evaluate adequacy of supervision. Physician may apply for a waiver.

<sup>d</sup> Based on a recently released Board of Medicine policy statement.

<sup>e</sup> For indigent populations or federally qualified health centers, ratio is 4:1.

practice of CNMs/CMs for each state of interest in order to gain a complete understanding of the regulatory requirements for CNMs/CMs. A list of Web-based sources of information regarding the regulation of CNMs/CMs, all of which were used for this review, can be found in Appendix 1. Particular attention should be paid to requirements for number of hours in clinical practice, continuing education, quality assurance, notification of the regulatory board regarding a change in consulting physician, and recertification/certificate maintenance. Most states require each of these, in varying degrees, for the maintenance of prescriptive authority. Close attention should also be paid to the language used in statutes and rules. Words like *may*, *can*, and *should* are generally permissive, while *shall*, *must*, and *will* generally signify a mandate; each statute and rule should contain a list of definitions that aid in interpretation. Different terminology is also used to describe the manner in which medications are provided for patients. Readers should remain alert for the varying definitions of dispense, provide, prescribe, distribute, and furnish.

Clearly, change in both statutes and rules will be necessary before CNMs/CMs achieve autonomous prescriptive authority throughout the United States. Recent events suggest that change may be on the horizon. In October 2010, the Institute of Medicine released the consensus report *The Future of Nursing: Leading Change and Advancing Health*, in which CNMs were recognized as primary care providers whose role will be essential in improving access to health care.<sup>6</sup> The Institute of Medicine has recommended that in order to capitalize on nurses' ability to play a key role in transforming the health care system, "the constraints of outdated policies, regulations, and cultural barriers, including those related to scope of practice, will have to be lifted, most notably for advanced practice registered nurses."<sup>12</sup> Recognizing inconsistencies that exist between the care APRNs are capable of providing and the care they are statutorily allowed to provide, Safriet<sup>13</sup> has classified the causes of restrictive practice conditions for APRNs (which she refers to as APNs) in 3 separate categories: "1) purposeful or inertial retention of the dysfunctions resulting from the historical evolution of state-based licensure, 2) lack of awareness of APNs' roles and abilities, and 3) organized medicine's continued opposition to expanding the authority of other providers to practice and be paid directly for their services." The consequences of restrictive practice conditions for APRNs include increased health care costs and decreased access to care. Safriet contends that "freeing APNs from unnecessary [practice] constraints... will better enable Americans to receive much needed health services at a cost they can afford, begin to remedy the systemic unfairness that has distorted many aspects of the healthcare delivery system, and will serve as a model for comprehensive reform of our entire regulatory framework by focusing on the evolving ability and competence of all providers rather than on rigid proprietary prerogatives."<sup>14</sup>

In addition, a key objective of the consensus model for APRN regulation is to establish a uniform model for the regulation of APRNs across states. Among other things, this model calls on state boards of nursing to license APRNs as "independent practitioners with no regulatory requirements for collaboration, direction, or supervision."<sup>17</sup> Currently, CNMs

are regulated by boards of nursing in 38 states and recognized as APRNs (or 1 of several variations on that title) in 42 states. Therefore, it will be important for CNMs to be actively involved in the process of rule making and policy change as boards of nursing modify existing regulations. Doing so will ensure that the CNM's scope of practice is represented at the policymaking table. Regardless of the regulatory body for CNMs/CMs, it will be important for midwives in all 50 states to be involved in these policy changes so that regulatory boards and agencies do not implement changes in current law that may restrict the scope of practice for CNMs. Steps must also be taken to advance the licensure of CMs in 47 states and advance prescriptive authority for CMs in 49 states.

One of the strengths of this review is that it provides a national overview of regulatory requirements for CNMs/CMs, relative to prescriptive authority, in a single document. Further, the examination of statutes and rules was conducted by a single reviewer, negating the possibility of poor inter-reviewer reliability. A limitation of this review is that it was virtually impossible to conduct reliability checking with the individual state regulatory bodies for 2 reasons: 1) members of regulatory boards change on a regular basis with gubernatorial appointments, and locating a board member with a working knowledge of CNM/CM regulations who was willing to conduct a timely review presented an incredible challenge; and 2) contacting attorneys on individual state legislative reference bureaus, who would also be able to check for accuracy, required waiting time that was so lengthy that this form of reliability checking was not possible. Therefore, reliability checking was conducted with CNMs and APRNs who have a working knowledge of the regulations in each individual state.

The policymaking process is ongoing. This review identified state statutes and administrative rules that govern the prescriptive authority of CNMs and CMs at a single point in time. It is anticipated that as CNMs/CMs pursue regulatory reform and as policymakers recognize the integral role CNMs/CMs have in meeting the demand for primary care providers, there will be modifications in both statute and rule to remove barriers to practice and increase access to midwifery care. Readers are encouraged to contact the author as laws regulating prescriptive authority for CNMs/CMs are revised and updated or to suggest corrections to or clarification of the information presented in this review.

## CONCLUSION

Certified nurse-midwives and CMs provide primary care for women, including the provision of all essential elements of primary care and case management: evaluation, assessment, treatment, and referral as necessary.<sup>15</sup> Prescribing medications is an essential component of the treatment of patients. Regulatory requirements that constrain the ability of CNMs/CMs to prescribe medications should be viewed not only as a barrier to practice but also as a limitation on the ability of patients to access necessary services. As illustrated in this review, much work is yet to be done to update numerous state laws and remove unnecessary barriers to the practice of CNMs and CMs in order to increase access to comprehensive health care services for patients.

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## CONFLICT OF INTEREST

The author has no conflict of interest to disclose.

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**Appendix 1. Web-based Resources Regarding the Regulation of Prescriptive Authority for Certified Nurse-Midwives and Certified Midwives**

- Alabama: <http://www.abn.state.al.us/Content.aspx?id=263>
- Arkansas: <http://www.arshn.arkansas.gov/laws/Rules/Pages/default.aspx>
- Alaska: <http://www.commerce.state.ak.us/occ/pnur.htm>
- Arizona: <http://www.azbn.gov/Nurse/PracticeAct.aspx>
- California: <http://www.in.ca.gov/regulations/practice.shtml>
- Colorado: <http://www.dora.state.co.us/nursing/statutesrulespolicies.htm>
- Connecticut: <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389418>
- Delaware: <http://dpr.delaware.gov/boards/nursing/apnllicense.shtml>
- District of Columbia: <http://hpla.doh.dc.gov/hpla/cwp/view,A,1195,Q,498298.asp>
- Florida: [http://doh.state.fl.us/inqa/nursing/nur\\_statutes.html](http://doh.state.fl.us/inqa/nursing/nur_statutes.html)
- Georgia: <http://www.sos.georgia.gov/plb/rn/>
- Hawaii: <http://hawaii.gov/dca/pvl/boards/nursing/>
- Idaho: <http://www.adm.idaho.gov/adminrules/rules/rdapa23/23index.htm>
- Illinois: <http://www.idfpr.com/dpr/who/nurs.asp>
- Indiana: <http://www.in.gov/pla/nursing.htm>
- Iowa: <http://www.iowa.gov/nursing/>
- Kansas: <http://www.ksbn.org/>
- Kentucky: <http://www.kbn.ky.gov/>
- Louisiana: <http://www.lsbn.state.la.us/>
- Maine: [http://www.maine.gov/boardofnursing/rules\\_files/rules.html](http://www.maine.gov/boardofnursing/rules_files/rules.html)
- Maryland: [http://www.mbon.org/main.php?v=nom&p=0&c=adv\\_prac/index.html](http://www.mbon.org/main.php?v=nom&p=0&c=adv_prac/index.html)
- Massachusetts: <http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Provider&L2=Certification%2C&plusmn;License%2C&plusmn;and&plusmn;Registration&L3=Occupational&plusmn;and&plusmn;Professional&L4=Nursing&sid=Eoehs2>
- Michigan: [http://www.michigan.gov/lara/0,1607,7-154-27417\\_27529\\_27542&mdash;00.html](http://www.michigan.gov/lara/0,1607,7-154-27417_27529_27542&mdash;00.html)
- Minnesota: <http://www.state.mn.us/portal/mn/jsp/home.do?agency=NursingBoard>
- Mississippi: <http://www.msbn.state.ms.us/>
- Missouri: <http://pr.mo.gov/nursing-advanced-practice-nurse.asp>
- Montana: [http://bsd.dli.mt.gov/license/bsd\\_boards/nur\\_board/board\\_page.asp](http://bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp)
- Nebraska: <http://www.hhs.state.ne.us/crl/nursing/midwife/midwife.htm>
- Nevada: <http://www.nursingboard.state.nv.us/>
- New Hampshire: <http://www.nh.gov/nursing/index.html>
- New Jersey: [http://www.njconsumeraffairs.gov/midwives/mid\\_rules.htm](http://www.njconsumeraffairs.gov/midwives/mid_rules.htm)
- New Mexico: <http://www.nmcp.state.nm.us/nmac/parts/title16/16.011.0002.htm>
- New York: <http://www.op.nysed.gov/prof/midwife/>
- North Carolina: <http://www.nchon.com/content.aspx?id=628>
- North Dakota: [http://www.ndbn.org/license/advanced\\_practice.asp](http://www.ndbn.org/license/advanced_practice.asp)
- Ohio: [http://www.nursing.ohio.gov/Law\\_and\\_Rule.htm](http://www.nursing.ohio.gov/Law_and_Rule.htm)
- Oklahoma: <http://www.ok.gov/nursing/rules.html>
- Oregon: [http://www.oregon.gov/OSBN/Advanced\\_practice.shtml](http://www.oregon.gov/OSBN/Advanced_practice.shtml)
- Pennsylvania: [http://www.portal.state.pa.us/portal/server.pt/community/state\\_board\\_of\\_medicine/12512](http://www.portal.state.pa.us/portal/server.pt/community/state_board_of_medicine/12512)
- Rhode Island: <http://www.health.ri.gov/licenses/healthcare/>
- South Carolina: <http://www.lh.state.sc.us/POL/Nursing/>
- South Dakota: <http://legis.state.sd.us/statutes/DisplayStatute.aspx?Statute=36-9A&Type=Statute>
- Tennessee: <http://health.state.tn.us/boards/Nursing/legislative.htm>
- Texas: <http://www.bon.state.tx.us/nursing/law/tr.html>
- Utah: [http://dopl.utah.gov/licensing/certified\\_nurse\\_midwife.html](http://dopl.utah.gov/licensing/certified_nurse_midwife.html)
- Vermont: <http://vtprofessionals.org/opr/1/nurses/>
- Virginia: [http://www.dhp.virginia.gov/nursing/nursing\\_laws\\_regs.htm](http://www.dhp.virginia.gov/nursing/nursing_laws_regs.htm)
- Washington: <http://www.doh.wa.gov/hsga/Professions/Nursing/practice.htm>
- West Virginia: [http://www.wvrnboard.com/default2.asp?active\\_page\\_id=74](http://www.wvrnboard.com/default2.asp?active_page_id=74)
- Wisconsin: [http://www.dl.state.wi.us/profession\\_list.asp?locid=0](http://www.dl.state.wi.us/profession_list.asp?locid=0)
- Wyoming: <https://nursing-online.state.wy.us/>