CHAPTER

2

Professional Foundations of Midwifery

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Introduction

Midwifery is recognized nationally and globally, with standards for education, practice, and regulation that make it a profession rather than an occupation or vocation. Safe midwifery practice requires skills, knowledge, and judgment in the provision of health care. However, being a safe, legal, independent, interdependent, and successful midwife requires much more than just clinical competence. This chapter provides an overview of the profession of midwifery in the United States and internationally. It reviews the myriad factors that influence midwives' ability to practice, the context in which midwives practice, the business of midwifery, and the breadth of opportunities for midwives.

The Profession of Midwifery

To develop the professionalism of midwifery that has been fostered for decades, midwives have created standards for education and practice; they have also defined the scope of practice of midwives and determined how that scope has been adapted over time. It is important for midwives to be able to answer a critical question: What does it take to be a professional?

According to Ament, "[I]n the United States, the overall objective of protecting the public welfare . . . is accomplished through three interdependent mechanisms: 1) a prescribed, accredited course of study; 2) national certification; and 3) governmental, usually state or other jurisdiction, licensure."[1] In addition, healthcare professionals are expected to codify their body of knowledge in peer-reviewed journals and textbooks.

The American College of Nurse-Midwives publishes a peer reviewed journal, the *Journal of Midwifery & Women's Health*, established in 1955.[2] The primary textbook used in U.S. midwifery programs, *Varney's Midwifery*, was first published in 1980.[3] Through the years, several other books have been developed by midwives to support midwifery education.[4–6] In addition, midwifery leaders and healthcare policy makers are able to rely on the robust set of documents published by the American College of Nurse-Midwives (ACNM) and the Midwives Alliance of North America (MANA) that both define the profession of midwifery, as practiced by certified nurse-midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs), and justify licensure.

There is a difference between being a member of a profession and being a "professional." As Kennedy stated, the "midwife's professionalism is a key factor in empowering women during the childbearing process."[7] Kennedy identified three dimensions of midwifery professionalism:

- The *dimension of therapeutics*, which illustrates how and why the midwife chooses and uses specific therapies when providing care
- The *dimension of caring*, which reflects how the midwife demonstrates that they care for the individuals seeking midwifery care
- The *dimension of the profession*, which examines how midwifery might be enhanced and accepted by "exemplary" practice

Kennedy divided the *dimension of therapeutics* into two qualities that must be held in balance: supporting the normalcy of birth, while simultaneously maintaining vigilance and attention to detail,

intervening only when necessary. Kennedy's approach to support the normalcy of birth is often described as the "art of doing 'nothing'"—that is, appearing calm on the outside while inwardly being actively engaged in data collection and critical thinking.[7]

The *dimension of caring* is demonstrated by respecting the uniqueness of each individual, and by creating respectful settings.[7] Midwives explore and honor each individual's personal history and cultural context. These clinicians work in partnership with patients to achieve the goals of providing emotional support and strengthening their self-confidence. Although it is controversial to say that others can empower an individual, such support can increase self-confidence and facilitate empowerment.

Qualities identified by Kennedy as linked to the *dimension of caring* include "an unwavering integrity and honesty, compassion and understanding, the ability to communicate effectively, and flexibility."[7] Midwives are emotion-workers. For example, exemplary midwives are experts at creating physically and emotionally safe clinical settings; midwives who care for laboring individuals create a peaceful environment that is conducive to a healthy birth process, maternal satisfaction, and immediate postpartum bonding; and midwives providing contraceptive care use the time to develop a trusting relationship and a safe environment that supports disclosure of intimate topics.

The *dimension of the profession* focuses on "the delineation, promotion, and sustenance of midwifery as a professional role."[7] Midwives demonstrate this dimension through evidence-based practice, quality and peer review, continuing education, commitment to and passion for the profession, and nurturing and caring for themselves. The exemplary midwife's focus is not just on the individual; in addition, the midwife is driven to foster the midwifery profession as a whole and to advocate for improving exemplary health outcomes locally and globally.

Professional midwifery in the United States, as practiced by CNMs, CMs, and CPMs, is a dynamic profession. The transition from a focus on individual practice to a focus on the status of a profession within society resembles the evolution of midwifery around the world. In the United States, the scope of midwifery practice is broad, the core knowledge needed to provide safe care has grown at a rapid pace, and the need to promote interprofessional teamwork is well understood. Simultaneously, society has expanded its expectations for all healthcare professionals, and midwives have responded by adopting new standards for education and practice.

Types of Midwives

While an increasing number of people are familiar with and choose care with midwives, most midwives have been asked the following questions about their profession: What is the difference between a CNM, a CM, and a CPM? What is a lay midwife? A direct-entry midwife? An Indigenous midwife? While the answers to these questions continue to evolve, they can be both confusing and controversial. An exploration of the similarities and differences, summarized in **Table 2-1**, among midwives is important to the profession.[8] The regulatory requirements and scope of practice described here were current as of the time of this text's publication. Laws pertaining to midwifery practice vary by state and will, like many other statutes, evolve as the political process reflects broader social and cultural changes.

Terms such as "lay midwife" and "direct-entry midwife" are defined more generally than the certified roles. A lay midwife is an individual who has no formal education as a midwife but may have been trained in an apprenticeship or have participated in self-study. A direct-entry midwife (DEM) is typically considered a midwife who has entered the profession without first becoming a nurse. DEMs may include CPMs, CMs, and any midwife who is not also a nurse. Each state has its own laws regarding the regulation of DEMs. Although many midwives complete degrees in nursing to enter a midwifery program, this pathway requires a large investment of time and money on the part of those who primarily want to be a midwife.

The CM was recognized by the ACNM in 1994 as a vehicle to open the profession to other pathways to midwifery. Nursing and midwifery are two separate professions; that is, one is not dependent on the other to engage in the practice of midwifery. While CMs enter midwifery directly, they are educated in the same programs that educate CNMs and they take the same national certification examination. CNMs and CMs have the same scope of practice and in many states have the same scope of prescriptive privileges. CMs practice in the same locations as CNMs—that is, hospitals, homes, and birth centers. The majority of CMs practice in hospitals. In some states, direct-entry midwife and licensed midwife are categories of licensure that bring together a variety of midwives and are distinct from the licensure of CNMs/CMs. In an optimal scenario, all midwives work together for the safety of their community, and they share resources to do so.

Table 2-1 Types of Midwives in the United States

National Midwifery Credentials in the United States	Certified Nurse-Midwife	Certified Midwife	Certified Professional Midwife
Education			
Minimum degree required for certification	Graduate degree required.		Certification does not require an academic or graduate degree but is based on demonstrated competency in specified areas of knowledge and skills.
Minimum education requirements for the admission to midwifery education program	Bachelor's degree or higher from an accredited college or university AND Earn RN license prior to or within midwifery education program	Bachelor's degree or higher from an accredited college or university AND Successful completion of required science and health courses and related health skills prior to or within midwifery education program	High school diploma or equivalent. Prerequisites for accredited programs vary, but typically include specific courses such as statistics, microbiology, anatomy, and physiology, and experience such as childbirth education and doula certification. There are no specified requirements for entry to the North American Registry of Midwives' (NARM) Portfolio Evaluation Process (PEP) pathway, an apprenticeship process that includes verification of knowledge and skills by qualified preceptors.
Clinical experience requirements	Attainment of knowledge, skills, and professional behaviors as identified by the American College of Nurse-Midwives' (ACNM) Core Competencies for Basic Midwifery Education. Clinical education must occur under the supervision of an American Midwifery Certification Board (AMCB)–certified CNM/CM or other qualified preceptor who holds a graduate degree, has preparation for clinical teaching, and has clinical expertise and didactic knowledge commensurate with the content taught; more than 50% of clinical education must be under CNM/CM supervision.		Attainment of knowledge and skills, identified in the periodic job analysis conducted by NARM. NARM requires that the clinical component of the educational process must be at least 2 years in duration and include a minimum of 55 births in three distinct categories. Clinical education must occur under the supervision of a midwife who must be nationally certified, be legally recognized, and have practiced for at least 3 years and attended 50 out-of-hospital births post-certification. CPMs certified via the PEP may earn a Midwifery Bridge Certificate (MBC) to demonstrate they meet the International Confederation of Midwives (ICM) standards for minimum education.
Education Program Accrediting Organization			
	The Accreditation Commission for Midwifery Education (ACME) is authorized by the U.S. Department of Education to accredit midwifery education programs and institutions. Midwifery education programs must be located within or affiliated with a regionally accredited institution.		The Midwifery Education Accreditation Council (MEAC) is authorized by the U.S. Department of Education to accredit midwifery education programs and institutions. The scope of recognition includes certificate- and degree-granting institutions, programs within accredited institutions, and distance education programs.

(*continues*)

Table 2-1 Types of Midwives in the United States (*continued*)

National Midwifery Credentials in the United States	Certified Nurse-Midwife	Certified Midwife	Certified Professional Midwife
Scope of Practice			
Range of care provided	Midwifery as practiced by certified nurse-midwives (CNMs) and certified midwives (CMs) encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. Midwives provide care for all individuals who seek midwifery care, inclusive of all gender identities and sexual orientations. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; independently prescribe medications including, but not limited to, controlled substances, treatment of substance use disorder, and expedited partner therapy; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order medical devices, durable medical equipment, and home health services. Midwifery care includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling. These services are provided in partnership with individuals and families in diverse settings such as ambulatory care clinics, private offices, telehealth and other methods of remote care delivery, community and public health systems, homes, hospitals, and birth centers.		Midwifery as practiced by CPMs offers expert care, education, counseling, and support to women and their families throughout the caregiving partnership, including during pregnancy, birth, and the postpartum period. CPMs provide ongoing care throughout pregnancy and continuous, hands-on care during labor, birth, and the immediate postpartum period, as well as maternal and well-baby care through the 6- to 8-week postpartum period. CPMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They are trained to recognize abnormal or dangerous conditions requiring consultation with and/or referral to other healthcare professionals. They conduct physical examinations, administer medications, use devices as allowed by state law, and order and interpret laboratory and diagnostic tests.
Practice settings	All settings—hospitals, homes, birth centers, and offices. The majority of CNMs and CMs attend births in hospitals.		Homes, birth centers, and offices. The majority of CPMs attend births in homes and birth centers.
Prescriptive authority	All U.S. jurisdictions	New York, Rhode Island, Maine, Maryland, Virginia, and the District of Columbia	CPMs do not maintain prescriptive authority; however, they may obtain and administer certain medications in selected states.
Third-party reimbursement	Most private insurance; Medicaid coverage mandated in all states; Medicare; TRICARE	Most private insurance; Medicaid coverage in New York, New Jersey, Rhode Island, and the District of Columbia	Private insurance mandated in 6 states; coverage varies in other states; 13 states include CPMs in state Medicaid plans.

National Midwifery Credentials in the United States	Certified Nurse-Midwife	Certified Midwife	Certified Professional Midwife
Certification			
Certifying organization	American Midwifery Certification Board (AMCB)		North American Registry of Midwives (NARM)
	AMCB and NARM are accredited by the National Commission for Certifying Agencies.		
Requirements prior to taking national certification examination	Graduation from a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME); AND Verification by program director of completion of education program AND Verification of master's degree or higher **CNMs must also submit evidence of an active RN license at time of initial certification.*		Completion of NARM's Portfolio Evaluation Process (PEP) OR Graduation from a midwifery education program accredited by the Midwifery Education Accreditation Council (MEAC) OR AMCB-certified CNM/CM with at least 10 community-based birth experiences OR Completion of an equivalent state licensure program. All applicants must also submit evidence of current adult CPR and neonatal resuscitation certification or course completion.
Recertification requirement	Every 5 years		Every 3 years
Licensure			
Legal status	Licensed in 50 states plus the District of Columbia and U.S. territories as midwives, nurse-midwives, advanced practice registered nurses, or nurse practitioners	Licensed in Colorado Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, Virginia, and the District of Columbia	Licensed in 35 states and the District of Columbia
Licensure agencies	Boards of Midwifery, Medicine, Nursing, Nurse-Midwifery, or Departments of Health	Boards of Midwifery, Medicine, Complementary Healthcare Providers, or Departments of Health	Boards of Midwifery, Medicine, Nursing, Complementary Healthcare Providers, or Departments of Health or Departments of Professional Licensure or regulation
Professional Association			
	American College of Nurse-Midwives (ACNM)		National Association of Certified Professional Midwives (NACPM)
Other Midwifery Organizations			
	Midwives Alliance of North America (MANA) International Confederation of Midwives (ICM)		

Note: This table does not address individuals who are not certified and who may practice midwifery with or without legal recognition.

Reproduced and updated with permission from American College of Nurse-Midwives. Comparison of certified nurse-midwives, certified midwives, certified professional midwives clarifying the distinctions among professional midwifery credentials in the U.S. http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000008494/20220418_CNM-CM-CPM%20Comparison%20Chart_FINAL.pdf. Accessed November 1, 2022.

The terms "traditional midwife," "community midwife," and "Indigenous midwife" acknowledge the individuals who follow traditional customs as they attend births in their community. These midwives typically work in areas where they have limited access to the formal education and well-staffed hospitals found in larger cities, but also explicitly value traditional ways of knowing. The World Health Organization uses the term "traditional birth attendant" (TBA) to describe individuals who have not received formal education and training prior to providing perinatal care. Traditional midwives often are, or have learned from, elders who are influential and trusted because they provide care in concert with local belief systems. The practice of Indigenous midwives includes an understanding of the impact of history and colonization on the communities they serve. These midwives use this knowledge to provide culturally safe, respectful care.

The CPM credential, which was first issued in 1994, was originally developed to provide competency-based certification for midwives who were primarily apprentice trained in out-of-hospital births. The natural consequences of creating the CPM certification examination were the obligation to ensure that those who take the examination meet common standards for education and practice, along with the creation of a structure within which to discipline those who do not perform in a manner consistent with the standards. Standards for education, certification, and practice for CPMs have been developed, and CPMs continue to seek to expand licensure in states that do not currently have CPM licensure statutes.[9]

At approximately the same time as the CPM credential was being developed, the board of directors of the ACNM endorsed the development of an alternative educational path to midwifery that did not require a nursing degree. This process led to the creation of the CM credential in 1991. Over the next 7 years, the requirements to accredit education programs and certify graduates who were not registered nurses were designed and tested to ensure that, after graduation and certification, one could not distinguish between the knowledge and skills of a CNM and a CM. The first CM credential, which required passing the same certification examination that is offered to nurse-midwives, was issued in 1998.

Although significant variations between CPMs, CNMs, and CMs still exist (Table 2-1), the collaborations between the three membership organizations for midwives—the ACNM, the MANA, and the National Association of Certified Professional Midwives (NACPM)—focus more on common values and goals than on differences.[10] In the United States, where the consumer may find it difficult to distinguish between the various types of midwives who have different credentials, each individual who uses the title "midwife" assumes responsibility for the image of the entire profession. Since the publication of the International Confederation of Midwives (ICM) standards on education and regulation, the professional organizations representing midwives in the United States have engaged in regular discussions about how to meet and support the ICM standards and increase access to high-quality midwifery care in a variety of settings. These discussions have sought to clarify the differences between CNMs, CMs, and CPMs. Over time, the differences may decrease.

Of course, very few of the midwifery profession's hard-won accomplishments would have moved from internal ideals to cultural norms without consumer support. From the Maternity Center Association (now known as the Childbirth Connection; a program developed by the National Partnership for Women and Families) to Citizens for Midwifery, consumers have provided inspiration, influence, and financial resources to promote and protect access to midwifery care.[11,12] The list of people who created a public demand for midwifery services and stood beside midwifery during some of the profession's difficult times is long and diverse. Families have also been essential to supporting the profession and the continued growth in the practice of midwifery.

Core Competencies in the United States and Abroad

The Core Competencies for Basic Midwifery Practice is an ACNM standard-setting document that describes the fundamental knowledge, skills, and abilities of all new CNMs/CMs.[13] These competencies are utilized in the development of the American Midwifery Certification Board (AMCB) examination and serve as the curricular foundation for midwifery education programs accredited by the Accreditation Commission of Midwifery Education (ACME). Core competencies may also be used by regulatory agencies, policy makers, consumers, and employers.

ACNM is a member organization of ICM and therefore agrees to have core competencies that are inclusive of the ICM's Essential Competencies for Midwifery Practice.[14] This document is a fundamental part of the revision of the ACNM Core

Competencies, which are updated every 5 years in a process guided by a taskforce of ACNM members. The revision process includes a review of the current state of clinical practice through a survey of individuals who were certified by AMCB fewer than 5 years ago (AMCB Task Analysis), member feedback, and expert opinion. Through the years since the Core Competencies were first established, the scope of entry-level clinical practice has expanded to include primary care, and ACNM has clarified important core concepts such as cultural humility, advocacy for health equity, social justice, and—most recently—the midwife's role in the care of gender-diverse individuals.

The Core Competencies not only describe the clinical care and skills of entry-level midwives but also include the Hallmarks of Midwifery, which are considered the defining characteristics of the profession (**Table 2-2**). They identify the philosophical underpinnings of the profession and are considered by many to be unique aspects of the profession. Hallmarks include skills such as "Ability to provide safe and effective care across settings including home, birth center, hospital, or any other maternity care service." Some Hallmarks are knowledge based, such as "Incorporation of evidence-based integrative therapies." Others are value based, such as "Recognition, promotion, and advocacy of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes" and "Promotion of person-centered care for all, which respects and is inclusive of diverse histories, backgrounds, and identities."[13]

Midwives may occasionally find themselves in conflict with these values. Their place of employment may not easily facilitate continuity of care, or a review of current evidence may support an intervention to prevent instead of treating a complication. When in a state of cognitive dissonance, it can be helpful to complete a full review of the Hallmarks of Midwifery and discuss with others if the practice is in alignment with the Hallmarks, personal, and professional values.

Table 2-2 American College of Nurse-Midwives' Hallmarks of Midwifery

1. Recognition, promotion, and advocacy of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes
2. Advocacy of non-intervention in physiologic processes in the absence of complications
3. Incorporation of evidence-based care into clinical practice
4. Promotion of person-centered care for all, which respects and is inclusive of diverse histories, backgrounds, and identities
5. Empowerment of women and persons seeking midwifery care as partners in health care
6. Facilitation of healthy family and interpersonal relationships
7. Promotion of continuity of care
8. Utilization of health promotion, disease prevention, and health education
9. Application of a public health perspective
10. Utilizing an understanding of social determinants of health to provide high-quality care to all persons including those from underserved communities
11. Advocating for informed choice, shared decision making, and the right to self-determination
12. Integration of cultural safety into all care encounters
13. Incorporation of evidence-based integrative therapies
14. Skillful communication, guidance, and counseling
15. Acknowledgment of the therapeutic value of human presence
16. Ability to collaborate with and refer to other members of the interprofessional health care team
17. Ability to provide safe and effective care across settings including home, birth center, hospital, or any other maternity care service

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Ethics

Ethics is defined as a guiding set of principles that inform actions.[15] Midwives must be well versed in the ethics involved in all healthcare interactions.[16,17] Ethical guidelines encourage self-regulation, foster professional identity, protect midwives and clients, and serve as a measure of professional maturity.[18] An ethical framework for practice, beginning with the concept of accountability, is critical to the continuation of midwifery as an independent and respected profession.[16,17] The subject of professional ethics in health care is complex, and the brief introduction presented here is not a comprehensive review of this important topic. Additional resources that address health literacy, health numeracy, values clarification, options counseling, the interface between legal and ethical issues, and ways to communicate risk are listed at the end of this chapter.

The *ACNM Code of Ethics with Explanatory Statements* provides an in-depth review of common ethical dilemmas faced by midwives and provides guidance for resolving these dilemmas.[18] As defined in the *ACNM Code of Ethics*, CNMs and CMs have three ethical mandates directed toward individual recipients of care, the public good, and the profession of midwifery. The *ACNM Code of Ethics* was first published in 1990, and the ICM ethical code was introduced in 1993. These documents, as well as MANA's *Statement of Values*, provide guidance for the ethical behavior of midwives in various roles, including provision of clinical care, education, research, public policy, business management, and financial organization of health services.[19,20]

Ethical Principles

The original foundational ethical norms for clinical practice are to do good (benevolence) and not do harm (nonmaleficence). Over time, other principles have been adopted, such as autonomy, veracity, informed consent, confidentiality, and justice (**Table 2-3**).[21]

Ethics of Care

These modern ethical principles imply an impartiality in decision making and an equality between midwife, client, and institution free of personal bias that is not truly feasible. The reality is that each of us exists within systems of power and decision making; in turn, we are inevitably influenced by how that power is used. One strategy for addressing these biases and power differentials between the midwife and the dependent client is to apply an ethic of care framework that focuses on attentiveness, responsibility, competence, and responsiveness.[22] This framework acknowledges that the relationship is unequal, that individuals seeking care are vulnerable, and that the midwife has a responsibility to demonstrate compassion.[23] An ethic of care can also be used to overcome the ethical dilemmas that occur when institutions prioritize the relationship of the midwife to the institution over the relationship of the midwife to the individual.[24]

Reproductive Justice

A framework particularly relevant to ethical care in midwifery is the reproductive justice framework. It is based on the principles that all people with the capacity to reproduce have a fundamental human right to not have a child or to have a child, and to do so in a safe and healthy environment.[25] This framework addresses historical, social, cultural, and economic factors that contribute to discrimination, particularly in communities of color in the United States. Midwives aiming to provide ethical care to communities must understand how history informs the modern context in which sexuality and reproduction exist in our society. For example, when providing contraceptive care, it is equally important to understand modern laws regarding abortion access and funding for a full spectrum of contraceptive options as it is to understand the history of medical experimentation on enslaved women, forced sterilization, and coercive use of long-acting reversible contraceptives.

Shared Decision Making

Midwives often encounter ethical dilemmas—that is, situations where they "must make a decision and

Table 2-3 Ethical Principles

Benevolence	To do good; to benefit patients and promote well-being.
Nonmaleficence	Do no harm; an obligation to consider both the potential benefit and the potential harm of an intervention, and to choose the options with the least likelihood for harm.
Autonomy	Each individual has worth and therefore the right to self-determination.
Veracity	Truth telling; the obligation to tell the patient all the information necessary to make a decision.
Informed consent	An extension of autonomy; requires that an individual be competent, receive full information, comprehend the information, be free from coercion, and provide consent.
Confidentiality	An obligation not to share confidential information with anyone outside of the care team without the patient's consent.
Justice	Fair and equitable treatment or distribution of resources.

Based on Varkey B. Principles of clinical ethics and their application to practice. *Med Princ Pract.* 2021;30:17-28.

Table 2-4 Agency for Healthcare Research and Quality's SHARE Model

	Step	Sample Conversation Starter
S	Seek the patient's participation.	"Now that we have identified the problem, it's time to think about what to do next. I'd like us to make this decision together."
H	Help the patient explore and compare treatment options.	"Let me tell you what the research says about the benefits and risks of the medicine/treatments that you are considering."
A	Assess the patient's values and preferences.	"When you think about the possible risks, what matters most to you?"
R	Reach a decision with the patient.	"So now that we had a chance to discuss your treatment options, do you have a preference for treatment? Which treatment do you think is right for you?"
E	Evaluate the patient's decision.	"Let's plan on reviewing this decision at our next appointment."

Adapted from Agency for Healthcare Research and Quality. The SHARE approach. https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html. Published July 2014; reviewed February 2017. Accessed on December 10, 2021.

follow through with that decision by taking specific action, but the right action to take may be unclear."[26] Experts agree that ethics education in midwifery should include competencies in clinical ethical decision making such as respect, shared decisions, bias, effective communication, critical thinking, and research.[27] Shared decision making (SDM) is a model of communication in which clinicians and patients share the best available evidence to help explore the available options, and in which patients are supported in communicating an informed decision.[28] Use of an SDM model incorporates key ethical principles and acknowledges the interdependence of the midwife and the decision maker. The midwife is considered an expert who possesses knowledge of evidence related to the risks and benefits of the available options, and the client is the expert on their own personal values and priorities. SDM acknowledges that there is typically no one right decision, only the one that best fits the individual currently. It is important to acknowledge that the midwife exerts power and potential bias in how they present information, as well as that the midwife–client relationship and acknowledged levels of privilege can influence how information is shared.[29]

Several SDM models have been described to facilitate integration into clinical practice. For example, in the *Three Talk Model*, Team Talk, Options Talk, and Decision Talk are utilized in the setting of active listening and deliberation.[30] Team Talk refers to language that encourages active participation in decision making, such as "Let's work together." Options Talk refers to the process of describing available options and the risks and benefits of those options. Decision Talk refers to the process of deciding together, including eliciting the patient's preferences and values. The use of decision aids—that is, tools that depict the options—has been demonstrated to lead to improved knowledge, greater confidence, and more active involvement in decision making.[31]

The Agency for Healthcare Research and Quality (AHRQ) describes a five-step model symbolized by the SHARE acronym (**Table 2-4**).[32] This acronym is a mnemonic intended to help practitioners remember the five-step process, but is not intended to imply a linear process. The steps should all be addressed but may be more of an iterative process.

Every SDM approach includes respectful communication, support for autonomy, and respecting the patient's decision to decline intervention even when the evidence clearly supports an intervention. This scenario can strain the midwife–client relationship, but open, honest communication that facilitates SDM can limit the risk of bias and coercion. Megregian and Nieuwenhuijze describe a common scenario in which a pregnant patient chooses to decline the recommended screening test for gestational diabetes.[33] This case study provides an example of how SDM and respectful communication can be utilized to benefit the midwife–client relationship in the setting of informed refusal.

Ethical Dilemmas

Professional ethics dictates that a conflict between two or more moral obligations in a particular situation be addressed through deliberate ethical analysis and decision making, including weighing and balancing principles, and preferably involving and achieving consensus among all affected parties. For

example, one healthcare provider's attempt to "do good," such as performing a cesarean section for a diagnosis of failure to progress, might be interpreted by the recipient of care as "doing harm"—in this case, performing surgery without adequate time waiting for a vaginal birth.

Equally challenging is the fact that midwifery is a field in which the professional attending a birth has two individuals for whom to provide care, the pregnant person and the fetus, whose interests may not be balanced (also known as being in equipoise). However, a person's right to autonomy does not change because they are pregnant. The consensus of modern ethics is that the duty owed to the fetus may be different from that owed to the pregnant individual, and the duty to both changes depending on the gestational age and maternal condition(s).[24]

Examples of ethical scenarios are presented in Table 2-5 and Table 2-6.

Table 2-5 Ethical Scenario 1

A client who has had an uncomplicated pregnancy presents feeling "miserable" and requests an induction at 37 weeks' gestation. They state that they will go elsewhere for their care if the midwife will not induce their labor. The midwife validates the client's feelings and explains the risks of elective induction but supports the position that induction at 37 weeks is not recommended.

The midwife knows that the benefits to the pregnant person and fetus are maximized (beneficence) and harm is minimized (nonmaleficence) with labor later in gestation. This professional must weigh this information with the principle of autonomy, the person's right to make an informed decision about their body and fetus.

Table 2-6 Ethical Scenario 2

During the initial prenatal visit, a client tells the midwife that they are uninsured and do not have many financial resources. Typically, the midwife explains genetic testing options in pregnancy at the first visit. It becomes clear to the midwife during their conversation that the client would not be able to afford any of the costly genetic testing and wonders if counseling should be performed. The midwife decides to provide counseling in the same manner as any other client.

The midwife's decision to provide counseling regardless of ability to pay for genetic testing illustrates the principle of justice.

Workforce Diversity in Midwifery

Characteristics of the U.S. Midwifery Workforce

Descriptive data about members of ACNM have been collected through membership surveys for more than five decades. In 1963, 229 members were mailed a survey and 72% responded.[34] The results revealed a median age of 41 years, the existence of six educational programs, and a geographic distribution of practices primarily clustered on the East Coast. Several states or jurisdictions had laws prohibiting midwifery practice. In 2020, the Bureau of Labor Statistics reported an estimated 7120 CNMs/CMs. Most were employed by physician offices (n = 3050), outpatient care centers (n = 1170), and offices of other healthcare practitioners (n = 580). A small portion were employed by colleges, universities, or other professional schools (n = 110) and governmental agencies (n = 80).[35] The vast majority (99%) of the 13,409 AMCB-certified midwives in the United States are CNMs and only 1% were CMs.[36]

The 2019 ACNM Core Data Survey (N = 1231 respondents) found that midwives employed full-time had the following clinical care responsibilities: antepartum (86%), intrapartum (81%), postpartum (84%), and reproductive services (76%).[37] Primary care services were provided by almost half (49%), but fewer than one-fifth provided newborn care (15%). Midwives' nonclinical roles included midwifery education (29%), midwifery/other administrative work (27%), and research (10%). Most respondents attended births (78%). The primary birth setting was the hospital (89%), but CNMs/CMs also attended births in hospital birth centers (7%), freestanding birth centers (9%), and homes (8%).

The racial diversity of practicing midwives has not changed dramatically over the last half-century.[38,39] Racial disparities in perinatal and early childhood health outcomes have not improved despite a variety of attempts to increase access to and quality of care.[40] The population of the United States is increasingly racially diverse, yet racism, when institutionalized, often goes unrecognized by those not experiencing it. While the midwifery profession has a long history of serving women at risk for poor pregnancy outcomes, one solution remains a challenge for the profession—the evidence that race-concordant care can reduce racial health disparities.[41] While recent evidence shows an increase in the number of new CNMs/CMs who identify as people of color (14.5% in 2013), the ACNM membership remains disproportionally (more than 90%) white. In 2021, the American Midwifery

Certification Board (AMCB) reported that the vast majority of CNMs/CMs are white, non-Hispanic women aged 30 to 69 years.[36] Data collected about race show that only 7.3% of CNMs/CMs identify as Black or African American, 1.7% identify as Asian, and 0.61% identify as American Indian or Alaska Native. Ethnicity data reveal that 5% of CNMs/CMs identify as Hispanic/Latino.

Racial and Ethnic Incongruence

In 2020, CNMs/CMs attended 372,991 births in the United States; in 14.24% of CNM/CM-attended births, the mother's race was identified as Black and in 22.9% of these births the mother's ethnicity was identified as Hispanic.[42] When compared to the AMCB data on CNM/CM race and ethnicity, it is clear that CNMs/CMs are not representative of the childbearing individuals whom they serve.

It is critical for midwives to understand how their own professional history has impacted the health of the communities they serve (see the *Resources on the History of Midwifery* appendix). Midwifery in the United States includes a history of Black granny midwives, Indigenous midwives, and parteras who cared for Black and Brown communities as well as serving white communities. Legislation such as the Sheppard Towner Act was used to eradicate the granny midwives and create public health professionals who laid the foundations for the nurse-midwives found in the United States today.[43] The founding years of the nurse-midwifery profession almost completely excluded Black and Brown individuals from midwifery education and leadership, thereby creating a culturally incongruent healthcare system.[44]

An Institute of Medicine* report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, sought to bring attention to the importance of congruence among patient and provider race and ethnicity. It underscored the evidence showing that a racial and ethnically diverse workforce improves access to care for racialized patients, patient satisfaction, and educational experiences for learners.[45]

In 2010, the Patient Protection and Affordable Care Act included dozens of provisions with the potential to address health equity, including healthcare workforce funding intended to increase the supply and diversity of healthcare professionals, support the safety net and healthcare services provided in community settings, provide training in cultural competency, enable workforce evaluation and assessment, and support pipeline programs for diverse students. The actualization of these programs has been limited, and as of 2016 substantial progress toward implementation had been made on only 7 of 17 of these provisions.[46]

In 2021, the ACNM worked to help introduce the Midwives for Maximizing Optimal Maternity Services Act. If passed, this legislation would have established grants to establish or expand midwifery programs and prioritize funding for institutions that focus on increasing the number of midwives from underrepresented groups. It would have also promoted practice in areas with limited access to professional healthcare services. Finding mechanisms to financially support the work of diversifying the profession is a critical strategy for addressing health inequities.

In addition to workforce strategies, much work can be done to improve the ethical provision of care for Black/Indigenous/people of color (BIPOC) communities. Scott et al. present a framework for the ethical perinatal care of Black individuals that can be applied to many vulnerable populations, thereby dismantling the structural racism of the "Mother Blame" narrative.[47] Their framework describes how social and economic factors can influence behaviors and the physiology that affects health outcomes. The authors emphasize use of interventions known to optimize birth outcomes, such as universal preconception care, nurse–family partnership programs, group prenatal care, and kangaroo care.

In *Setting the Standard for Holistic Care of Black Women*, the Black Mamas Matter Alliance describes eight essential competencies that can be applied to the ethical perinatal care of Black women.[48] (1) "Listen to Black women" refers not only to individual care visits, but also centering the voice of Black women in the design of policy and research that target Black women. By recognizing the (2) "historical experiences and expertise of Black women and families," we have a context for Black women's experiences and interactions with midwives. When providing (3) "care through a reproductive justice framework," midwives can use relationship, collaboration, and prioritization of consent over provider bias. When midwives take the time to listen holistically to Black women and treat them as valuable, loved individuals instead of leaning on stereotypes, it is possible to (4) "disentangle care practices from the racist beliefs in modern medicine." The current healthcare system is often regimented and rushed, but through the implementation models of care that are centered on the

*The Institute of Medicine was renamed the National Academy of Medicine in 2015.

Black woman, and that provide information, access, and opportunities for relationship, we can (5) "replace white supremacy and patriarchy with a new care model." The SDM model addresses the next recommendation—to (6) "empower all patients with health literacy and autonomy." Doing so, however, takes time, trust, and complete honesty.

Some of the most successful models of prenatal care utilize a team model of care that aims to (7) "empower and invest in health paraprofessionals." Paraprofessionals are more likely to be culturally congruent with and socioeconomically like the patients being served. This allows for higher levels of trust and relatability and is an asset to quality health care. The final recommendation is to (8) "recognize that access does not equal quality care." Equitable care does not mean just access to care, but also access to resources that meet the client's needs. When clients are at higher risk of complications owing to race-related exposures, they need access to more supportive services (e.g., midwives, doulas, lactation support, community-based care) that are often not covered by insurance and whose costs may make them unattainable.

The preceding recommendations illustrate the need to address behaviors at the individual provider level and highlight the need to create system-level change. Midwives are perfectly positioned to address change from multiple angles. They are forging new systems of care through the creation of community-based, midwife-owned practices. They are also working within larger institutions lobbying for change, such as improved data collection, support for culturally congruent care providers and learners, awareness-building campaigns, implicit bias training, and social justice advocacy. Midwives are partnering with state perinatal quality associations to implement quality improvement initiatives with an equity focus. They are lobbying for legislative changes such as providing funding for midwifery students from underrepresented backgrounds, improving funding for midwifery care and patient-centered models of care, and increasing autonomous practice for midwives. Midwife researchers are centering their efforts on hearing the voices of Black women to identify areas of need.

Diversity and Inclusion in Gender and Sexual Identity

There is growing awareness of the need for midwifery care to be inclusive and supportive of all who seek midwifery care. Improving care for lesbian, gay, bisexual, queer, and intersex (LGBTQI) individuals is an important facet of improving perinatal care. The number of openly LGBTQI individuals in the United States is increasing, and this trend is likely to continue if individuals feel safe expressing their sexual and gender-related identities in society and healthcare settings. For example, the number of lesbian and same-sex couples accessing fertility treatment and maternity care has increased by as much as 20% each year in the last decade, making this population one of the fastest-growing groups to access fertility and maternity care.

Evidence shows that sexual orientation or gender identity can have a significant impact on physical, mental, and sexual well-being.[49] Transgender and nonbinary individuals (TNB) have a wide range of healthcare needs and face significant obstacles to obtaining needed healthcare services. Research indicates that TNB individuals experience high rates of discrimination and health disparities; however, gender-affirming clinical interventions have been demonstrated to have a positive impact on their physical and emotional well-being.[50–53] Many transgender individuals desire a future pregnancy or are parents already.[54]

Given that the Hallmarks of Midwifery include person-centered, evidence-based care with a focus on shared decision making, the midwifery profession is perfectly positioned to meet the healthcare needs of LGBTQI individuals by offering safe, inclusive care. An exclusive practice focus on care of women ignores transgender and gender-diverse individuals. The ACNM has affirmed that it is within the midwife's scope of practice to provide gender-affirming care such as respecting TNB individuals, becoming knowledgeable about their healthcare needs, advocating for inclusive respectful environments including the use of gender-inclusive language, and providing gender-affirming hormone therapy.[55]

Unfortunately, discrimination based on gender and sexual orientation still occurs in some perinatal healthcare environments, and is an obstacle to advancing the diversity of the midwifery workforce. Practice environments are often not welcoming or are openly discriminatory against midwives who have a gender identity, sexuality, or family structure that differs from the majority of others within the practice or institution. Only about 1% of midwives identify as male, and 0.33% identify as nonbinary; statistics describing the sexuality of midwives are not available in the ACNM Core Data Survey.[37] Improved educational and working environments that welcome diverse individuals and respect their contributions can improve both the midwifery profession and the health care offered to the patients whom midwives serve.

Structures

Practice Patterns

Improving the health of clients or patients is a personal, communal, and political responsibility, and midwives work wherever they are needed. While many midwives attend births and provide reproductive health services, they may also work as entrepreneurs, policy makers, and educators. In all of these positions, midwives collaborate with a variety of team members.

In clinical practice, midwives may work for large hospitals or healthcare systems in metropolitan areas, in small private practices in rural communities, and anywhere in between. Midwives may attend births in homes, freestanding birth centers, or hospitals. They may be self-employed in a private business, or they may be employees of physicians or healthcare organizations. CNMs/CMs can provide primary health care or limit their practice to specific populations or conditions, such as family planning, infertility, menopause, incontinence, or pelvic pain. CPMs are typically licensed exclusively to provide perinatal care.

Since the 1960s, the majority of CNMs, and now CMs, who attend births have done so in hospitals and freestanding birth centers, whereas the vast majority of CPMs have attended births in homes or freestanding birth centers. Although these trends may continue, the future may present more workplace opportunities for all midwives.

With so many opportunities, the typical midwife searches for an opportunity that is a good match to their experience, personality, skill set, and lifestyle. When considering an employment position, one of the first actions is for the midwife to perform a personal evaluation: Which work and lifestyle factors are important to the individual midwife? Which skills and talents would be important to stress to a prospective employer? What do employers in the area need or want? When evaluating the positives and negatives of any position, it is important to review various aspects of the business that may contribute to success or frustration—for example, availability of and relationship with physicians and other providers (e.g., dieticians, physical therapists), ancillary support (e.g., billing, office flow), reimbursement for professional expenses (e.g., licenses, certification, and continuing education), payment for malpractice premiums, availability of student loan payments, and retirement benefits. Understanding of certain core concepts and professional structures are necessary to be successful regardless of the setting.

Scope of Practice

Midwifery has a long-standing reputation for focusing on a childbirth experience that honors the physiologic process of birth as well as the transformational power of the childbearing experience.[56] A midwife's scope of practice is determined by multiple factors, including professional practice standard–setting documents, legal jurisdiction, institutional policies, locations of care, collaborative practice agreements, and individual education and experience.[57] State laws and facility bylaws may define the clinical or professional relationship between a midwife and a consulting or collaborating physician. Scope of practice is complex and dynamic for an individual midwife's practice. For example, a midwife's scope of practice has some inflexible boundaries (e.g., the midwife cannot perform services that are prohibited by law) and some flexibility (e.g., advanced clinical skills such as first assisting for cesarean births, may be acquired as needed through a formal process).[58]

Licensure

State laws governing midwifery practice vary. When consistent with the ACNM recommendations for legislation, state laws support the ability of CNMs and CMs to autonomously practice to the full extent of their education, training, and certification. At their most restrictive, state laws require direct physician supervision of midwives. The rules and regulations governing midwifery practice usually are available on state government websites. Professional organizations such as ACNM and MANA provide online summaries of all the states' midwifery laws, and political action groups work to change laws that do not permit midwives to practice to the full scope of their preparation. **Figure 2-1** provides a synopsis of regulations on the practice of AMCB-certified midwives.

In many states, CNMs are licensed as advanced practice registered nurses (APRN). In 2008, through collaboration with more than 70 nursing organizations, a framework for APRN regulation was developed.[59] The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education ("LACE Consensus Model") contains seven elements, covering APRN role recognition, title protection, licensure, education, certification, independent practice, and independent prescribing. Congruence of each individual state nurse practice act with these seven elements would allow APRNs licensed in a participating state to practice in other participating states.

In 2011, ACNM, AMCB, and ACME released a statement on specific points of the LACE Consensus

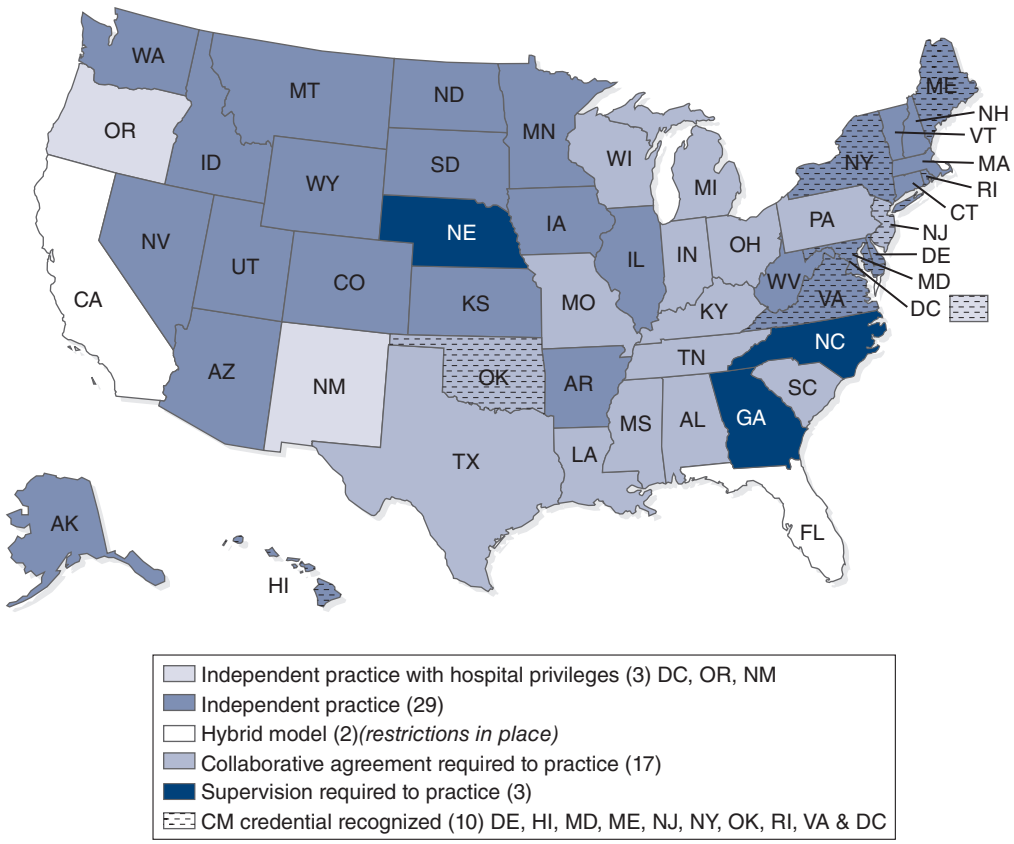

Figure 2-1 Practice environments for AMCB-certified midwives.
Modified with permission from American College of Nurse-Midwives. Practice environments for AMCB-certified midwives—April 2022. https://www.midwife.org/full-practice-authority-stad. Accessed November 27, 2022.

Model as they relate to midwifery.[60] To implement this model, state legislation eliminating mandates for supervision or collaboration would be necessary in many states. Elimination of these mandates has long been a legislative advocacy focus of ACNM state affiliate organizations.

The LACE Consensus Model requires that APRNs be educated in at least one of six population foci, including women's health/gender related. Although the document does describe the CNM scope of practice as including primary care of women and newborns, no one population focus describes the full scope of CNM practice, so concern exists that the full scope of midwifery care may not be included in future legislation. Given that recent updates to the ACNM Core Competencies and Scope of Practice include care of transgender and gender-nonconforming individuals, there are additional concerns that these populations may be omitted from the scope of midwifery care. This concern is likely valid, as other components of the LACE Consensus Model have been misinterpreted at the state level.

The LACE model recognizes that CNMs may be regulated by Boards of Midwifery or Boards of Nurse-Midwifery. This is an important caveat that would allow for the potential expansion of the CM credential into new states. However, the initial version of the LACE Consensus Model contains inconsistent language around education requirements. It describes a requirement for a graduate or postgraduate degree in nursing or nursing-related fields, but some parts of the document simply refer to nursing degrees. Some states have already implemented a requirement for a nursing master's degree. CNMs and CMs may earn graduate degrees in midwifery, public health, or health sciences and are equally prepared for certification, licensure, and practice. Overall, the LACE Consensus Model does provide an avenue to advocate for legislative changes that would be supportive of the goal to expand access to full-scope midwifery.

Hospital Privileges and Credentialing

Midwives who attend births in hospitals and most birth centers are required to be credentialed and

privileged by that healthcare facility. Credentialing refers to the process used to verify an individual's qualifications such as completion of an accredited program of study. Privileging refers to the specific tasks and procedures and patient care services that an individual is permitted to perform. Bylaws, established by the healthcare facility, define the requirements for obtaining privileges, the responsibilities of those who are granted privileges, specific procedures that may be performed by the individual providers, protections offered to those who are privileged, and grounds for removal of privileges. These bylaws may also specify the role and responsibilities of midwives in relation to collaborating physicians and the responsibilities of each party. All privileged providers are expected to adhere to institution bylaws, even if the bylaws are more restrictive than the state law.

The ability to be credentialed by a hospital dictates a midwife's ability to create a practice for hospital birth and to provide continuity of care to patients planning a community-based birth but requiring transfer. Institutional bylaws also determine whether a midwife has voting privileges and can serve on hospital or department committees. Serving on committees provides midwives with the ability to have a voice in facility policies.

Healthcare outcomes are optimized when midwives are fully integrated into the healthcare system. Access to full and independent credentialing and privileging is necessary for full integration. Almost all states have laws allowing midwives to admit patients to hospitals, and most have laws permitting midwives to be members of the hospital medical staff. Nevertheless, individual hospitals or medical staff boards may choose to not privilege midwives or may do so only with supervision or restrictions. In 2020, an ACNM survey of CNMs/CMs found that only 163 out of 435 had full medical privileges and about half (48.8%) had privileges only if they were employed by a physician.[61] In 2022, ACNM was working with members of Congress on the introduction of legislation to amend the Medicare statute and require hospitals to establish equitable procedures for the granting of clinical privileges for midwives, including admission of patients.

The Business of Midwifery

Midwifery Employment

Whether considering one or multiple job opportunities, midwives should analyze several factors that will influence their job satisfaction, some of which are listed in **Table 2-7**. This table describes factors important for midwives interested in joining an existing practice as an employee. The weight of any of the factors will vary based on the individual midwife's desires and needs. The factors are not presented in any specific order, nor is this an exclusive list.

If the prospective employer does not offer a formal contract, asking for a confirmation letter that puts the offered remuneration and job specifics in writing is wise. If the midwife is asked to sign a contract, consultation with an attorney is advised. Even if a contract is considered non-negotiable, the midwife should thoroughly understand the content prior to signing. **Table 2-8** provides a list of topics that should be addressed prior to accepting a position or signing a contract.[62,63]

Midwife Entrepreneurs

Most midwives consider midwifery to be a vocation. Thus, it can be challenging to think of midwifery as "a business"—yet all midwives need to understand the basic principles of running a successful business.

Table 2-7 Factors to Clarify When Considering Joining a Practice

Practice Characteristics	Compensation/Benefits
Location	Salary
Philosophy	Productivity requirements
Clientele (volume, demographics, outcomes of care)	Requirements/bonuses/overtime
Practice providers (physicians, midwives, nurse practitioners, others, and culture of collaboration)	Payment/nonclinical responsibilities
Interaction with learners	Ability to own part of the practice
Support staff (billing, assistants in office, marketing)	Malpractice insurance (type, tail if needed)
Clinical hours	Vacation/paid time off
Environment (equipment, facilities, financial stability)	Maternity/paternity leave (if appropriate)
Birth facility	Other professional benefits (continuing education units, dues, licenses, parking, smartphone)
Orientation plan	Health insurance, retirement
Time needed for credentialing, insurance networks	Student loan repayment
	Opportunity to precept midwifery students

Table 2-8 Topics Usually Found in a Contract

Title of position
Responsibilities, including scope of practice, currency of credentials, expectations of volume and hours
Compensation and benefits, including bonuses, productivity, professional/business expenses, tuition reimbursement, health and malpractice insurance, and paid time off
Duration and requirement for renewal of employment/contract
Reason for termination by employer and/or employee
How to alter or update the contract
Additional Topics That May Be Included
Non-compete clause[a]
Partnership arrangements (buying in or out of a practice)
Termination without cause[a]
Formulae (for bonuses, productivity, quality-based, patient satisfaction, and profit-based)
Ownership of records upon dissolution/termination

[a] Not recommended but often included.

Based on Buppert C. *Nurse Practitioner's Business Practice and Legal Guide.* 6th ed. Burlington, MA: Jones & Bartlett Learning; 2018; Bryant C. *An Administrative Manual for Midwifery Practices.* 5th ed. Silver Spring, MD American College of Nurse-Midwives; 2022.

There is a growing need for midwives to become accomplished administrators and business managers.

Many midwives have, either independently or in groups, become business owners. The opportunity to avoid the limitations imposed by the business model or clinical guidelines developed by others, such as physicians, hospitals, and community clinics, can be very tempting, and in some cases, may be a necessity. For midwives who want to start their own business, the advice offered by successful entrepreneurs is consistent—namely, consult experts, invest in marketing, develop competence in billing, and collect and analyze data. Each of these aspects of running an independent midwifery practice is an important factor that can facilitate long-term success.

Business Advice from Experts

It is unwise to open a business without seeking the expertise of, at a minimum, an attorney and an accountant. The legal structure of a midwifery business (e.g., sole proprietorship, partnership, or limited liability company) will have short- and long-term personal and financial consequences. Midwife business owners should be experts on the laws and regulations that govern midwifery practice, and should also know how the laws governing medical practice, the corporate practice of medicine, and pharmacy regulations might affect their plans. Midwives providing care during home and freestanding birth center births must comply with health department regulations, birth center requirements, building codes, and a variety of business regulations. Midwives who employ others must determine how they will compensate those employees and follow the relevant employment tax codes and antidiscrimination policies. Beyond malpractice insurance coverage, new business owners are often surprised to learn how many insurance policies need to be purchased and how many business contracts need to be finalized. In all of these areas, good advice can save money, protect investments, and enable midwives to provide high-quality care.

Table 2-9 Content for a Typical Business Plan

Cover page with name of business and contact information
Description of practice
Services
Clientele
Relationships
Company strategies
Market research
Fiscal outlook
Plans (marketing, operating, and financial)
Anticipated team and schedule

Modified from Bryant C. *An Administrative Manual for Midwifery Practices.* 5th ed. Silver Spring, MD American College of Nurse-Midwives; 2022.

Preparing a business plan and seeking guidance from an accountant on the costs of doing business can provide clarity for all involved and are requirements when seeking loans to help establish a business. Common elements found in a business plan are listed in **Table 2-9**.[63] The time spent establishing a reporting system for revenues versus expenses is a good investment, as such a system provides a way to measure of financial success.

Given that independent business ownership is valued highly in the United States, many types of support exist for small business owners, including

information on how to formulate business plans and where to apply for small business loans. Midwives who are business owners often agree to mentor a new entrepreneur. The Business Section of the ACNM Division of Standards and Practice is committed to sharing information, providing support to midwives interested in the business aspects of midwifery, and increasing the number of midwife-owned practices. The Business Section partners with ACNM to sponsor the annual conference Midwifery Works, and to publish the *Administrative Manual for Midwifery Practices*.[63] The American Association of Birth Centers also offers workshops on how to open a birth center, during which many of these concepts are covered in depth. Other business guides in areas outside of midwifery may provide additional useful information.[62]

Midwifery Practices Within Institutions

Midwifery practices that are not independent businesses still have business and administrative work that must be addressed. No matter the number of employees, a midwifery service must reach an agreement on scheduling, compensation, records management, monitoring of financial statements, negotiation of collaborative agreements, peer review, and strategies to handle personal and professional adversity. While responsibilities for the success of the service are shared, there needs to be a designated leader or service director, who serves as the primary contact, assumes responsibility for participating in department- or corporate-level committees, is able to describe the success of the service in corporate terms, and knows how to move an agenda forward within the organization. Midwives place a high value on building relationships with their clients and on positive feedback from the individuals for whom they provide care. Those skills can be extrapolated into the business arena and will serve midwives well.

Data Collection

Collection of data on outcomes for labor and birth has long been valued. Birth registries have been used to not only record births, but also address the impact of public health interventions.[64] In modern times, the ACNM has recognized the need to provide data that demonstrate the quality of care provided by practicing midwives. As early as 1982, recommendations were being made to promote national data collection.[65] Several readily accessible mechanisms for collecting and collating practice-specific and national data exist that can be used to describe the care provided by midwives. Members of ACNM can join in the ACNM Benchmarking Project, which allows participants to examine their practices and compare them to other, like practices across the United States.[66] The MANA Division of Research, with its MANA Stats system, and the American Association of Birth Centers, with its Perinatal Data Registry (PDR), have developed web-based data collection tools that can be used by individuals to contribute data to a national database on the outcomes of midwifery care in all settings.[67,68]

Marketing

Many advisors encourage early attention to a marketing plan when starting a new business. Without a coherent, consumer-friendly message about the services offered and an identified medium for reaching the target population, the business may not have enough clients to sustain itself. Not every practice can afford an extensive marketing campaign, but all midwives can develop marketing skills.

Today, using social media may be the most effective, and least expensive, marketing strategy. Clients expect practices to have an up-to-date website. Regular posts from midwives can provide reminders about healthy behaviors. To be successful, practices should engage with a variety of social media, while maintaining awareness of all their clients' privacy.[69,70]

Professional organizations are often a source of marketing advice and materials. Several organizations are involved in national marketing campaigns that can be adapted to local settings, such as the *ACNM Discover Midwives* consumer-facing PowerPoint presentation.[71]

Billing for Services

A midwifery practice cannot continue to exist over the long term without financial stability. One of the first financial lessons in the healthcare business is that what is billed for a service is never what the insurance company will pay. Actual reimbursement rates are always lower—a factor that must be taken into consideration when calculating a budget. Whenever the services provided by midwives are billable, the services provided must be clearly documented and the billing process must be completed. The midwife is responsible for fulfilling the requirements for documentation that support the billing codes. For example, the amount paid for an examination will vary based on the intensity of the examination as measured by the number of systems included in the physical assessment, the types of problems identified, and the amount of time spent providing and coordinating care. If this content is not thoroughly

documented in the healthcare record, payment may be reduced or even denied.

Regardless of how the billing is performed, the owner(s) of the practice is (are) responsible for establishing a system of checks and balances that monitors the accuracy and timeliness of the billing process and limits the opportunity for fraud. The time and money spent establishing a viable healthcare record and billing systems are necessary outlays to ensure the ongoing business success. Even midwives who are employees should be informed about the business revenue and expenses, so they will understand the financial stability of the practice.

Malpractice Insurance Coverage

While the terms "medical malpractice insurance" and "professional liability insurance" are often used interchangeably, these types of insurance coverage are not the same. Medical malpractice insurance provides coverage for patient injury caused by healthcare professionals, including midwives and nurses. Professional liability insurance provides compensation for actual or alleged negligent injury resulting from professional services. Professional liability insurance offers the benefit of additional coverage for allegations such as slandering another healthcare provider or inadequately training an assistant. While medical malpractice insurance covers only injury to patients, professional liability insurance also covers acts, errors, and omissions in the provision of professional services in addition to patient injury.[72]

In a 2018 national survey of ACNM members, one-third of members reported being named in a lawsuit at some point in their professional careers[72]; 64.2% of these lawsuits pertained to care received in a hospital setting, 25.4% in a clinic setting, 8.7% in a freestanding birth center, and 2.0% in a home setting. Fetal assessment and shoulder dystocia remain the most common reasons for claims made during the intrapartum period, whereas claims made against home and birth center midwives most often involve transfer of care to a hospital.

It is recommended that all midwives carry professional liability insurance and familiarize themselves with their obligations, rights, and responsibilities under this insurance contract. Midwives should understand any exceptions to coverage listed by the insurance policy and be aware of when their practice is outside of the bounds of their contract coverage.[72]

Sources of professional liability insurance coverage include ACNM insurance services, self-insurance, joint underwriting associations, and the Federal Tort Claims Act. ACNM insurance services include advice and sharing of information from colleagues, affiliates, and leadership of ACNM about insurance companies based on experiences within the midwifery community. Self-insurance occurs when individuals in similar situations and institutions purchase insurance coverage that is tailored to their circumstances. For example, a large hospital or university may offer its employed midwives insurance coverage through its self-insurance program. Self-insurance organizations set aside funds and invest the capital themselves, with the goal of accruing enough income to pay future claims.

Joint underwriting associations (JUAs) are chartered through state legislation to provide insurance when other sources are not obtainable. JUAs have been formed by several commercial insurance companies that are compelled by states to offer insurance. Texas, Minnesota, Pennsylvania, South Carolina, and Florida all have established JUAs through legislation.

Finally, midwives employed by federally qualified health centers and government institutions, such as military hospitals, often have professional liability insurance provided at no cost through the Federal Tort Claims Act. Under this act, claims that occur during the time of employment or coverage will be covered regardless of when the claim is filed.[72]

Types of insurance policies include occurrence policies, claims-made policies, slot policies, and shared limits policies (**Table 2-10**). Occurrence policies are the most comprehensive—and most expensive—type of insurance policies. Events that occur during the policy period are covered with such policies, regardless of the date of discovery or the date when the claim is filed. With occurrence policies, it does not matter if the claim is made years after the event occurred or if the midwife is no longer employed by that employer or no longer in practice.

Claims-made policies are less expensive, but more limited in scope than occurrence policies. Claims-made policies cover only claims that are made while the insurance policy is active. Once the policy ends, it no longer covers claims made that occurred during the time the policy was active. In such a case, the midwife may need to purchase tail coverage if they leave their place of employment or cease practicing. Tail coverage provides coverage for events that occur during the time the policy was in effect. Tail coverage does tend to be expensive, and the annual premium increases each year until the fifth year of coverage, when it will then remain stable. The length of the tail coverage can vary between

Table 2-10 Important Information When Purchasing Malpractice Coverage

Terms	Explanation	What the Midwife Needs to Know
Indemnification	Large healthcare organizations can be self-insured, meaning they indemnify employees who are named in a malpractice lawsuit. Coverage typically does not extend to work settings not owned by the organization.	What are the payout limits of the policy? The midwife is covered only when their actions are consistent with the job description. Is the policy an occurrence or claims-made policy? Pros and cons of purchasing a second policy?
Malpractice policy	Purchased from private insurance companies. Individuals can purchase as an individual, and sometimes midwives are covered as an employee of a physician. Need to be clear regarding the circumstances when the policy will end.	Do I need and can I get prior-acts coverage? Do I need to have my own policy or am I named as an employee on a physician policy? Is this an occurrence policy or a claims-made policy? I have an occurrence policy now; can I purchase prior-acts coverage under my new policy? Can I purchase a tail when I no longer need the policy? If yes, how is that priced?
Claims-made coverage	More limited in scope and less expensive than occurrence policies. The insured has malpractice coverage only for claims that are made when the policy is in effect. The midwife will need to obtain tail coverage when a claims-made policy ends or upon leaving their position of employment.	Can I purchase a tail when I no longer need this policy? If yes, how is that priced and how long will the tail policy cover?
Occurrence coverage	Most comprehensive. The insured is covered during the policy period, regardless of the date of discovery or the date the claim is filed. Typically, the most expensive type of insurance.	If employment ends, coverage for future events ends but coverage is still in place for events that occurred when the policy was in place. Tail coverage should not be needed.
Going bare	The individual midwife decides to not carry malpractice insurance.	While some consider this approach unethical, the rising cost of premiums often brings up this discussion. Two major concerns need to be considered: (1) Your personal or family savings and property may be at risk and (2) if you apply for hospital privileges in the future, a period of clinical practice without malpractice coverage may lead to denial of privileges.
Limits of coverage	Professional liability policies have two sets of limits: a per-claim or per-incident limit and the aggregate limit that the insurer will pay during the policy period (usually 1 year). Example: $1 million per claim/$3 million per policy period	Do state law and/or hospital bylaws dictate the minimum coverage a midwife must carry?

Data from Page K. *Midwives' Guide to Professional Liability.* 3rd ed. Silver Spring, MD: American College of Nurse-Midwives; 2020.

insurance companies. The statute of limitations for an adverse birth outcome is usually 2 years in most states, but some states permit claims for adverse birth outcomes to be filed as late as 21 years following birth. Therefore, it is important to know the length of coverage provided by the tail insurance.

Slot policies are a mixture of occurrence and claims-made policies. The employer purchases a certain number of "slots," and each full-time midwife in the practice is assigned to a slot, receiving an individual policy. In some cases, part-time midwives may share a single slot. When a midwife occupying one slot leaves the practice, no tail is due unless the practice closes the slot; then the normal tail rate applies. If the midwife leaving the practice is replaced, the new midwife now occupies the slot.

The previous midwife remains covered for the period during which the slot was occupied.

Finally, with shared limits policies, multiple midwives within a practice share a single policy with defined limits. The policy is priced depending on the size of the group and the risk of lawsuit. Tail coverage does not need to be purchased when a midwife leaves the practice.[72]

Other Opportunities Within Midwifery

Midwives often engage in many types of activities at any one time. They can use their various skill sets to not only provide clinical care, but also support and advance the profession itself. These activities may include participation in policy making, education, and team development. Any or all of these roles may be assumed as a midwife in clinical practice or may be the primary area of expertise of a midwife not in clinical practice.

Engagement in Policy

The building blocks of the midwifery profession (standards for education, certification, licensure, and practice) are key policy decisions with far-reaching influence. Federal, state, and institutional policies determine which healthcare services and birth settings are available to clients, as well as who will be reimbursed and at what rate. Which education programs receive government funding is also a matter of policy. Hospitals, clinics, and employers all write policies that influence access to and provision of midwifery care. With so much at stake for the profession and the clients cared for by midwives, every midwife needs to be knowledgeable about and engaged in policy-making processes. **Table 2-11** lists ICM's tips for midwives participating in advocacy.[73]

Professional organizations remain dependent on work from members to keep policies relevant. Meeting the policy needs of the profession is a labor of love and shows determination to turn a vision into reality. Opportunities to engage in policy work with the professional association can be personally rewarding—and for some, may become a full-time endeavor. Many of the midwives who successfully work in policy making initially doubted their abilities or hoped someone else would do it.[74] The midwifery profession is filled with successful midwife role models, and guidance on how to make this transition is available (**Table 2-12**).

Social media, when used effectively, can help reach more people when advocating for new policies or policy change. Suggestions from the ICM about using social media for advocacy purposes appear in **Table 2-13**. While social media can be helpful in amplifying your message, comments to posts need to be monitored and offensive content quickly removed. All social media posts should be sensitive to the need to protect patient identity.

In spite of many past successes, considerable policy work remains to be done in relation to midwifery. Some physician associations are opposed to laws that recognize advanced practice clinicians and midwives as independent providers; instead, they advocate for physician supervision. Many state laws governing the practice of midwifery need to be

Table 2-11 International Confederation of Midwives' Tips for Advocacy in Midwifery

1. Take responsibility. Each person in a problematic situation must understand their responsibility in creating that problem. It is imperative that we take responsibility for our own part.
2. Never give up. While politicians and policymakers are knowledgeable, they need information. Keep it simple and precise.
3. Get the support of the persons for whom we provide care. The population midwifery serves need to know that midwifery exists and demand it. Build the grassroots base.
4. Be one team, with one voice. Join midwifery associations to combine efforts, knowledge, and skills.
5. Collaborate. Policy cannot be tackled alone! Develop relationships with key potential partners. Utilize social media platforms, raise awareness, and speak up!
6. Be convincing. Inform yourself well about maternal and newborn health issues in your community, state, nation, and world. Arm yourself with convincing facts and information.
7. Use evidence and stay positive. Collaboration, cooperation, the use of evidence, being politically astute, and being skilled in the use of media are all important factors in creating change.
8. Be strategic. Be specific; do not be too broad or too complex. Multiple small, effective campaigns are better than one great idea that is not concrete enough or too broad to get off the ground.
9. Stay focused on the population midwifery serves; let others see the commitment.
10. Be bold and speak without fear. Start with the desire and interest to make a change. Do not let fear be the barrier.

Modified from International Confederation of Midwives. ICM advocacy toolkit for midwives. https://www.internationalmidwives.org/assets/files/advocacy-files/2020/03/icm_midwivesadvocacytoolkit_final_2019.pdf. Published 2019. Accessed November 20, 2022.

Table 2-12 How to Influence the Policy-Making Process: Volunteer, Observe, and Practice

Institutional policies: Write policies for your midwifery practice, hospital, and/or local midwifery organization.
• Is there a template to follow? • What must be done to have the policy approved?
Legislative policies: Observe legislative policy in action by attending a hearing that addresses a regulatory issue that affects your practice.
• Who seems to be the most effective legislator and why? • What is common etiquette and the standard for appearance and dress? • Was the speaker effective? How did you know? • How did the committee respond?
Identify a mentor.
• Get help preparing statements.
Come prepared and speak a language the audience can understand.
• Create the draft for discussion so others have to respond to your ideas. • Stay on topic.
Know your strengths.
• Offer a lived experience. • Be the voice of a midwife or support a client or family member who agrees to speak.
Know your opposition and do not attend alone. Leave the door open for your return.
• Make friends in the room. • Defer to other experts.
If you can't do policy, support your colleagues who can do this work, including financially.

Modified with permission from Williams DR. We need to say in unison: we are midwives, and we do policy! [Editorial]. *J Midwifery Women's Health.* 2008;53(2):101-102. © 2008, with permission from Wiley.

Table 2-13 Strategies for Utilizing Social Media for Advocacy

Social Media Platform	Strategies
Facebook	Use midwifery-themed photos as profile or cover photos
	Set up a page about your intended policy or event
	Post messages
	Share pictures and videos
	Invite friends to attend events
	Engage with followers by asking questions and sending messages
Twitter	Post messages using the hashtag #Midwives
	Share pictures
	Change the profile photo and header photo to midwife-themed photos
	Announce an event
	Share live and unfolding updates
	Post links to midwifery content such as blogs, articles, and videos
	Retweet, comment on, and like tweets about #Midwives
Instagram	Promote events through photos and videos
	Share high-quality photos and videos from events or activities
	Request engagement with your posts by asking questions
	Post messages using hashtags such as #Midwives, #GenderEquality, etc.
	Share midwifery messages, visuals, and videos
	Use a midwifery-themed profile photo
Blog posts	Typically short articles or editorials
	Often tell a personal story
	Can be used to respond in depth to current events or previously published information

Based on International Confederation of Midwives. ICM advocacy toolkit for midwives. https://www.internationalmidwives.org/assets/files/advocacy-files/2020/03/icm_midwivesadvocacytoolkit_final_2019.pdf. Published 2019. Accessed November 20, 2022.

changed to permit independent practice. The midwifery profession will also continue to adapt in response to federal and state legislation.

In addition, the midwifery profession has some major decisions looming. These include decisions about whether (1) CNMs should promote midwifery practice acts that are separate from nursing and include their CM colleagues or stay under the APRN umbrella; (2) CNMs/CMs and CPMs should

be licensed under the same practice act; and (3) a doctoral degree should be required for CNM/CM certification.

Education

All midwives are educators. Policy makers, potential employers, and consumers need to learn about the unique and valuable midwifery approach to care. Many clients seek out midwives because they want to learn more about how to care for their own bodies and how to safely prepare for puberty, pregnancy, menopause, and all the points in between. Consumer-oriented materials often are used for this purpose, and many materials are written by midwives. For example, the *Journal of Midwifery & Women's Health* publishes a health education handout series titled *Ask the Midwife*. These copyright-free handouts, targeted to midwifery clients, review important clinical topics using appropriate language and illustrations for all levels of health literacy. Some handouts are also available in Spanish.

Because many midwives are committed to precepting students, the midwifery profession continues to flourish. The legacy of midwifery depends on mentoring midwifery students as they enter into this role. For those who choose an academic career devoted to teaching midwifery students, there are more than 40 midwifery education programs accredited by ACME. Midwives who serve as faculty for schools of nursing and medicine have a unique opportunity to prepare the next generation of healthcare providers.

Quality Improvement

The importance of data collection was discussed earlier in this chapter. Once data are collected, the question remains regarding what to do with these data. Benchmarking is an excellent means of comparing outcomes for similar-size practices to reward success and determine areas for improvement. Quality improvement science provides the tools for implementing and evaluating change. The Institute for Healthcare Improvement (IHI) is a resource for midwives worldwide to develop skills in the science of improvement.[75] The IHI process focuses on establishing a goal or aim, deciding how to define improvement, and producing concrete steps to create change. This is partnered with rapid tests of change in the form of plan–do–study–act cycles.

Midwives can serve as leaders and partners in implementing change in their practices and facilities. The Alliance for Innovation on Maternal Health, for example, has published patient safety bundles to assist perinatal care providers in improving the processes of care and patient outcomes.[76] ACNM members have served as authors of many of these patient safety bundles, and many ACNM state affiliates partner with state perinatal quality collaboratives to implement these bundles.

Research and Research Implementation

Midwifery has a long tradition that includes learning by watchful waiting; sharing empirical knowledge via oral traditions; defining and protecting the physiologic birth process; and actively challenging "the evidence." These characteristics have served midwives well, especially when research has validated the midwifery approach to care. Examples where midwives have had a strong influence in the evolution of best practices include elimination of routine episiotomies,[77] redefinition of the Friedman labor curve,[78,79] promotion of early and prolonged breastfeeding for neonatal and maternal health,[80] delayed cord-clamping,[81,82] immediate skin-to-skin contact between mother and newborn,[83] water immersion during labor,[84] an alternative pain assessment tool for those in labor,[85] and nonpharmacologic methods of pain control.[86]

A 2017 American College of Obstetricians and Gynecologists (ACOG) Committee Opinion, *Approaches to Limit Intervention During Labor and Birth*, has the potential to improve labor management.[87] Acknowledging that "many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor," this document makes 11 evidence-based recommendations intended to decrease unnecessary interventions and increase maternal and family satisfaction. These recommendations closely align with ACNM recommendations.[88]

In 2000, Sackett et al. concisely defined evidence-based practice (EBP) as the "integration of the best research evidence with clinical expertise and patient values."[89] Not all midwives need to actively conduct research, but all need to understand relevant research and implement evidence-based care. The call for systematic use of evidence in perinatal care is often credited to the 1989 publication of *Effective Care in Pregnancy and Childbirth*.[90] In this ground-breaking treatise, the authors carefully evaluated existing research and identified those clinical practices supported by research as well as those not based on evidence.

Several databases that summarize the most recent evidence on a multitude of clinical topics are available to sexual and reproductive and perinatal healthcare providers. One important evidence-based database is the Cochrane Library. Cochrane

Reviews are systematic reviews of primary research in human health care and health policy and are widely recognized for the quality of the reviews.[91] Other sources of research that midwives often use include PubMed, the Up-to-Date Database, and DynaMed.

When assessing research data and results, it is important to remember that not all evidence is equal. As detailed in *the Interpreting Published Research Data with a Clinical Midwifery Lens* appendix, evidence is evaluated to determine its strength.[92] Several rating criteria have been developed to evaluate the strength and quality of research. One of the most commonly used rating scales is that used by the U.S. Preventive Services Task Force, which is discussed in the *Health Promotion Across the Lifespan* chapter.

Systematic reviews of the literature have documented that midwifery-led care (care in which the primary provider is the midwife) for essentially healthy women is equivalent to the care provided by physicians. For several outcome measures, midwifery care has been found to be associated with improved outcomes compared to physician care. A 2008 Cochrane meta-analysis reviewed 11 trials including 12,276 women and found several statistically significant differences in outcomes for those women who received midwife-led care.[93] All of the studies included in this systematic review were randomized controlled trials; in addition, the studies were not limited to one country. The findings showed that midwife-led care resulted in fewer prenatal hospitalizations, less use of regional analgesia, fewer episiotomies, and fewer instrument deliveries. In addition, women who received midwife-led care were more likely to experience no intrapartum analgesia/anesthesia, spontaneous vaginal birth, feeling in control during childbirth, attendance at birth by a known midwife, and initiation of breastfeeding. Finally, the newborns of women who had midwife-led care were more likely to have a shorter length of hospital stay. The authors concluded that "most women should be offered midwife-led models of care, and women should be encouraged to ask for this option although caution should be exercised in applying this advice to women with substantial medical or obstetric complications."[93]

Similar results were highlighted in a 2011 systematic review that examined outcomes for APRNs in the United States. For the purposes of this study, the authors defined certified nurse-midwives as a type of APRN, and CNM birth outcomes from 1990 to 2008 were examined separately from those of other groups of providers who were not CNMs.[94] This review summarized the results from all levels of studies, including observational studies, and studies were limited to the United States. A high level of evidence was found that patients of CNMs, as compared to patients of physicians, had lower rates of cesarean section birth, episiotomy, operative birth, labor analgesia, and perineal lacerations, and equivalent rates of labor augmentation, low Apgar scores, and low-birth-weight infants. The systematic review also demonstrated a moderate level of evidence that care by CNMs is associated with lower rates of epidural use and induction of labor, comparable or higher rates of vaginal births, comparable or lower rates of newborn intensive care unit admissions, and higher rates of breastfeeding than care from other professionals.[94]

In 2016, the Cochrane Pregnancy and Childbirth Group published a review comparing midwife-led continuity models and other models of care,[95] updating the 2008 systematic review conducted by Hatem et al.[93] Fifteen trials involving 17,674 women were reviewed. In all trials, the pregnant women were randomly assigned to midwife-led continuity models of care or other models of care. In short, women who received the midwife-led continuity model of care were less likely to experience interventions, were more likely to be satisfied with their care, and had at least comparable rates of adverse outcomes compared to women who received other models of care. The major findings from this review are summarized in **Table 2-14**.

Midwives do not work in isolation, but frequently collaborate with and refer to other perinatal healthcare professionals. In 2018, a multidisciplinary team analyzed data across 50 states examining midwifery practice and interprofessional collaboration.[96] Differences across states in scope of practice, autonomy, governance, and prescriptive authority, as well as restrictions that can affect patient safety, quality, and access to maternity providers across birth settings, were analyzed. The results showed that state regulatory environments that supported greater integration of midwives into the health system were significantly associated with greater access to maternity services, higher rates of spontaneous vaginal birth, vaginal birth after cesarean section (VBAC), and breastfeeding at birth and at 6 months, as well as lower rates of obstetric interventions, preterm birth, low-birth-weight infants, and neonatal death. In the state-by-state comparison, the best outcomes for mothers and babies occurred in states where all types of midwives were integrated into the healthcare system regardless of birth setting.[96] Furthermore, a *Lancet* analysis of

Table 2-14 Systematic Review of Midwife-Led Continuity of Care, 2016

Outcome or Subgroup Title	Number of Studies; Quality of Evidence	Number of Participants	Relative Risk (95% Confidence Interval)
Primary Outcomes: Significant Risk Reductions Found for Patients of Midwives			
Regional anesthesia	14; high quality	17,674	RR = 0.85 (0.78–0.92)
Instrumental vaginal birth	13; high quality	17,501	RR = 0.90 (0.83–0.97)
Preterm birth: less than 37 weeks' gestation	8; high quality	13,238	RR = 0.76 (0.64–0.91)
Less all fetal loss before and after 24 weeks' gestation plus neonatal death	13; high quality	17,561	RR = 0.84 (0.71–0.99)
Patients of Midwives Were More Likely to Experience			
Spontaneous vaginal birth	12; high quality	16,687	RR = 1.05 (1.03–1.07)
No difference between groups for cesarean birth and intact perineum.			
Secondary Outcomes: Significant Risk Reductions Found for Patients of Midwives			
Amniotomy	4	3253	RR = 0.80 (0.66–0.98)
Episiotomy	14	17,674	RR = 0.84 (0.77–0.92)
Fetal loss less than 24 weeks' gestation and neonatal death	11	15,645	RR = 0.81 (0.67–0.98)
Patients of Midwives Were More Likely to Experience			
No intrapartum analgesia or anesthesia	7	10,499	RR = 1.21 (1.06–1.37)
Longer length of labor	3	3328	RR = 0.50 (0.27–0.74)
Attended at birth by known midwife	7	6917	RR = 7.04 (4.48–11.08)

Based on Sandall J, Soltani H, Gates S, et al. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev.* 2016;4:CD004667. doi:10.1002/14651858.CD004667.pub5.

maternal health policy performed in 2014 revealed that countries with a sustained 20-year decrease in maternal mortality had increased country-wide access to health care through targeted investment in midwifery care.[97]

In addition to these large reviews, numerous other published research studies have focused on specific practices of midwives that may account for differences in maternal and neonatal outcomes. In 2019, ACNM updated a PowerPoint slide set titled "The Pearls of Midwifery," which communicates the evidence for midwifery care.[88] This presentation serves as a resource for sharing the evidence for midwifery practices such as continuous labor support and intermittent auscultation with both providers and families.

Interprofessional Team Collaboration

All healthcare providers work within a healthcare system that includes professionals who have different scopes of practice, professional cultures, and professional roles. Being a team member in the healthcare system does not imply assumption of a subservient role: In some situations, a midwife is the team leader; in others, the midwife is a colleague on an interprofessional team. Factors that make interprofessional relationships work well are critically important when a patient develops complications or conditions that extend beyond the scope of midwifery practice. Although it has long been recognized that interprofessional teams provide better care than single-disciplinary groups for individuals

Table 2-15 Guiding Principles of Team-Based Care

The patients and families are central to and actively engaged as members of the healthcare team.
The team has a shared vision.
Role clarity is essential to optimal team building and team functioning.
All team members are accountable for their own practice and to the team.
Effective communication is key to the creation of high-quality teams.
Team leadership is situational and dynamic.

Based on Jennings J, Nielsen P, Buck ML, et al. Executive summary: collaboration in practice: implementing team-based care: report of the American College of Obstetricians and Gynecologists' Task Force on Collaborative Practice. *Obstet Gynecol.* 2016;127(3):612-617.

with complex healthcare needs,[98,99] interprofessional collaboration and communication have only recently been the focus of research, education, and clinical initiatives.[100,101] Guiding principles of interprofessional team–based care are summarized in **Table 2-15**.

In 1999, a ground-breaking report from the Institute of Medicine, *To Err Is Human*, reported an estimated that 45,000 to 98,000 individuals die each year in U.S. hospitals due to healthcare errors.[102] Subsequent safety reports have highlighted poor communication and inadequate team coordination as the source of many of these errors. For example, a Joint Commission sentinel event analysis on preventing infant death and injury during birth identified communication problems as the root cause of the healthcare delivery error in 72% of the cases analyzed.[103] In the same analysis, 55% of the organizations studied cited organizational culture, including "hierarchy and intimidation, failure to function as a team, and failure to follow the chain-of-communication," as commonly encountered barriers to effective communication and teamwork.[103]

In the years following these publications, much work has been done to identify ways to foster and support teamwork in healthcare delivery. Successful interprofessional collaboration in care during pregnancy, for example, has been associated with improved outcomes, a high degree of client satisfaction, fewer cesareans, and lower costs.[104] According to the ICM's *Essential Competencies for Basic Midwifery Practice*, "The midwife . . . works collaboratively (teamwork) with other health workers to improve the delivery of services to women and families."[14] Moreover, "[the] midwife has the skill and/or ability to . . . identify deviations from normal during the course of pregnancy and initiate the referral process for conditions that require higher levels of intervention."[14]

ACNM recognizes that midwives are independent practitioners who function within a complex healthcare system, which includes collaboration with multiple healthcare professionals, to ensure the health and safety of patients and their newborns.[105] The levels of collaborative management as defined by ACNM include consultation, collaboration, and referral. The definitions for each of these levels often serve as guidelines for similar language within state laws and hospital bylaws. While the ACNM definitions address the midwife–physician relationship, the expertise of many other healthcare professionals may be needed to provide the best care possible. It is imperative that all members of the team understand their role in caring for a specific patient (**Table 2-16**).[106]

The 2022 ACNM and ACOG *Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives* declares that "health care is most effective when it occurs in a system that facilitates communication across care settings and among clinicians."[106] NACPM and MANA have published documents that address the relationship between CPMs and physicians.[9,107] In these documents, midwifery practice is described as autonomous and CPMs are expected to collaborate, refer, and transfer care in critical situations. Essential components of communication and teamwork are summarized in **Table 2-17**.[108–110]

Teamwork and communication are skills that can be learned.[111–113] Although healthcare outcomes following simulation training have not yet fully been determined, it appears that simulation training improves teamwork, team coordination, and interprofessional communication.[114–116]

ACNM and ACOG, with funding from the Josiah Macy Jr. Foundation, have partnered in the development of interprofessional education models that aim to increase the number of midwives educated alongside obstetrician-gynecologist residents. Through this project, modules were created on topics such as guiding principles of team-based care, patient-centered care, roles of scopes of practice on midwives and obstetrician-gynecologists, collaborative practice, history of both professions, care transitions, and difficult conversations.[117] Learners participating in these modules have reported an overall improvement in their ability to collaborate and especially valued the team-based experiences.[118]

Table 2-16 The Continuum of Collaborative Management in Midwifery Care

Type of Collaborative Management	Definition	Primary Responsibility for Care	Midwife's Role	Collaborator's Role	Comments
Consultation	"The process whereby a CNM or CM seeks the advice or opinion of a physician or another member of the healthcare team."	Midwife	Primary provider	Advisor/ consultant	Prepare for the consultation. Know the client's health history. Review the basics for management of the diagnosis or problem. Understand the social and psychosocial factors underlying their health. Understand the practice setting and scope of practice. Remember the Midwifery Management Process.
Collaboration	"The process whereby a CNM or CM and physician jointly manage the care of a patient or newborn who has become medically, gynecologically, or obstetrically complicated."	Collaborative management; depending on the severity of the complication, the midwife may remain the primary care provider	Normal processes, coordination of care, continuity with the individual	Care for the perinatal, gynecologic, or neonatal complications	Use interprofessional communication techniques such as SBAR and closed-loop communication. Clearly delineate roles to ensure all aspects of the POC are considered. Communicate with the client and their family about the relationship.
Referral[a]	"The process by which the CNM or CM directs the client to a physician or another healthcare professional for management of a particular problem or aspect of the client's care."	Physician or other referral provider	Coordination of care, timely and full transfer of care, continuity of services	Assumes the primary responsibility for care of the individual	Ensure that referral/transfer is the best POC for the individual. Ensure that the client understands that they have been transferred to another provider's care and that they have access to appointment and contact information. Consider the potential problem of abandonment of the client and/or "punting" of a difficult-to-care-for client. Let the client and provider know if the client can return to midwifery care when/if the condition resolves. Use interprofessional communication techniques within a formal handoff.

Abbreviations: CM, certified midwife; CNM, certified nurse-midwife; POC, plan of care; SBAR, Situation, Background, Assessment, Recommendation.

[a]Referral in this continuum refers to transfer of care. Referral in the context of insurance is providing an individual with a reference to a specialty provider.

Based on the American College of Nurse-Midwives. Position statement: collaborative management in midwifery practice for medical, gynecologic, and obstetric conditions. https://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000058/Collaborative-Mgmt-in-Midwifery-Practice-Sept-2014.pdf. Published September 2014. Accessed February 17, 2022.

Table 2-17 Essential Components of Successful Collaboration and Teamwork[a]

Professional competence of each member of the team (common body of knowledge, shared language, similarities in treatment modalities)
Common orientation to the client or newborn as the primary unit of attention
Shared mental model: Every member of the team can anticipate the needs of the others
Recognition and acknowledgment of interdependence among all members of the team
Interprofessional respect and mutual trust
Formal system of communication between providers
Effective communication based on the goal of reaching consensus (an interest in solutions that maximize the contributions of all parties)
Mutual performance monitoring (identification of mistakes and provision of feedback within the team to facilitate self-correction)
Identified team leader for each situation
Situation monitoring and adaptability as the situation changes
Ability to shift work responsibilities as needed to under-utilized team members

[a] This list is compiled from different analyses of essential characteristics for teams in general and for teams in specific urgent or emergency situations. It is not designed to be complete or the components placed in rank order; rather, the intent is to identify some characteristics that are essential for successful interprofessional team function. Midwives are always members of interprofessional teams.

Based on Interprofessional Education Collaborative Expert Panel. *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel.* Washington, DC: Interprofessional Education Collaborative; 2011; Ivey S. A model for teaching about interdisciplinary practice. *J Allied Health*. 1988;17: 189-195; King TL, Laros RK, Parer JT. Interprofessional collaborative practice in obstetrics and midwifery. *Obstet Gynecol North Am*. 2012;39:411-422.

AHRQ has developed a series of materials and training curricula, collectively titled TeamSTEPPS, that can be used in healthcare settings to help foster successful teamwork.[119] The TeamSTEPPS curricula emphasize the development of four core competencies: communication, mutual support, situation monitoring, and leadership.

Communication Techniques for Successful Collaboration

Direct and deliberate communication techniques include SBAR, closed-loop communication, and the handoff. SBAR—an acronym for Situation, Background, Assessment, and Recommendation—is a structured communication tool that has been shown to significantly improve the quality of communication between healthcare providers and to reduce errors.[112] The SBAR approach omits the nonessential elements of a patient's history, distills the most pertinent information, and clarifies what is needed. The midwife can use the SBAR approach to obtain a consultation from a specialist (**Table 2-18**) or to communicate during an emergency (**Table 2-19**).

Table 2-18 Example of SBAR Used for a Consultation

A midwife at an office is caring for a female patient who is at 33 weeks' gestation and was diagnosed earlier in the pregnancy with gestational diabetes. When reviewing their blood glucose log, the midwife observes that more than 20% of her values are high and calls the consulting maternal–fetal medicine physician and requests consultation using SBAR.
S: I want to consult with you about a female patient with uncontrolled gestational diabetes.
B: MG is a 24-year-old primigravida at 33 weeks by LMP consistent by 19-week ultrasound. Her 1-hour glucose tolerance test was 150 mg/dL and her 3-hour glucose tolerance test had two elevated values. She was sent to the diabetes education center, where she received diet and glucose monitoring education as well as information on regular exercise. Over the last 2 weeks, 20% of her values are out of range, with five fasting levels between 100 mg/dL and 110 mg/dL and five 2-hour postprandial levels higher than 150 mg/dL, the highest being 180 mg/dL. She had a reactive NST today, the fetus is size equal to dates, and her urinalysis was negative for glucose.
A: My concern is that the dietary changes and exercise have been inadequate to control glucose levels, and I believe she needs medication.
R: I would like to schedule her to see you for a consultation within the next few days.

Abbreviations: LMP, last menstrual period; NST, nonstress test; SBAR, Situation, Background, Assessment, Recommendation.

In closed-loop communication, the midwife directs the message to a particular team member, the team member repeats the order or request aloud, and the midwife confirms that the team member heard correctly. This communication approach is particularly important during times of stress, as it allows the entire team to hear the orders and correct any errors before the orders are

Table 2-19 Example of SBAR Used in an Emergency Situation

A midwife at a small community hospital is caring for a client who is bleeding heavily immediately after giving birth and has called for physician assistance from a provider in the next room. When the physician arrives, the midwife says:

S: M.T. is having a postpartum hemorrhage.

B: M.T. gave birth to her fifth child 15 minutes ago over an intact perineum. The total EBL is 800 mL. We gave 40 IU of oxytocin (Pitocin), 0.2 mg of ergonovine (Methergine), and 250 mcg of carboprost (Hemabate). The placenta appeared intact, and there are no clots in the lower uterine segment.

A: Severe uterine atony is present, and I think I feel some placental tissue in the anterior portion of the fundus.

R: I need you to put on gloves and assist me.

Abbreviations: EBL, estimated blood loss; SBAR, Situation, Background, Assessment, Recommendation.

executed. Closed-loop communication tools such as the *call-out* and the *check-back* can be used to communicate critical information to all members of the team, thereby allowing them to anticipate what will be needed next. Use of such techniques also requires that team members communicate what they intend to do and have done with the information.

When a patient needs to be transferred to another provider for care, especially for a higher level of care, a formal note should be written in the health record and shared with the new provider. The goal of this communication is to give the new provider all the pertinent information needed to safely care for the patient and family. In several of the chapters in this text, *critical elements* are listed for conditions that typically require a transfer of care. In some situations, a midwife may receive a transfer from another provider. In that case, the midwife who receives the transfer should communicate, either verbally or in writing, with the referring provider to acknowledge that the patient has been seen and provide a summary of the course of care. Table 2-20 provides an overview of the content of a transfer or handoff note and the critical elements it should contain. Strategies for a safe transfer from a community-based setting to a hospital are described in the *Home Birth Summit: Best Practice Guidelines Transfer from Home Birth to Hospital*, and a companion resource includes model home birth transfer forms.[120,121]

Table 2-20 Sample Critical Elements for a Transfer Note from Community to Inpatient Care

Record time and destination, method of transportation, and who is accompanying the birthing person/newborn when care is transferred.

Identify the birthing person/neonate and the transferring provider; as well as the receiving provider.

The critical elements are customized to the individual and the situation but generally include:

1. Risk factors for the current situation/disorder requiring transfer
2. Signs and symptoms indicating need for transfer
3. Care provided before transfer: procedures and results; laboratory results or if pending; medications (dosage, route, and time of last dose); response to treatment
4. Assessment/diagnosis of the situation
5. Summary of the rationale for the transfer
6. Statement on whether the person can return to midwifery care after the issue has resolved
7. Request for information about the treatment plan for follow-up

Communication skills such as SBAR, closed-loop communication, and the handoff are like any clinical skill: They must be adapted to individual settings and practiced until they become second nature.

The Midwifery Profession Globally

Midwives' commitment to providing personalized care that is responsive to each individual's needs and their significant improvements of communities' health outcomes has resulted in recognition of the value of midwives' role among the global community of healthcare professionals. This multilayered approach—from the individual, to the profession, to evidence-based practice, to individuals wherever they need care—is reflected throughout this text.

For many years, midwives in the United States and many countries around the world were undervalued by the policy makers who designed and funded healthcare systems. Most would agree that this lack of recognition, and the accompanying low pay, was a direct reflection of the value that policy makers assigned to women, gender-diverse people, and sexual/reproductive health care. In a trajectory that closely follows the change in rights of women

and gender-diverse individuals, midwives have found their collective voice, established professional standards for education and practice that compare favorably to those of their physician colleagues, and proved their value to modern society.

While public acceptance and legal recognition of midwives as professional and autonomous healthcare providers has varied by state in the United States as well as by country internationally, the global community of midwives is increasingly united around the need to earn and seek this recognition. The ICM is a global federation of midwifery associations that has worked for more than 100 years to support, represent, and strengthen professional associations of midwives throughout the world.

ICM initially provided a much-needed forum for midwives to learn from each other and expand access to midwifery care. Nevertheless, it was not until 1972 that the confederation agreed to set standards for who should be able to use the midwife title. The original focus of this organization—to increase the number of midwives—reflected an understanding that too many people were dying during childbirth because they were giving birth unattended. Over time, it became clear that a lack of common standards for the preparation and practice of midwives could also put the lives of women at risk.

Many midwives feared that setting standards for midwifery education and practice would isolate traditional midwives and decrease access to care. Others emphasized the value for midwives of setting their own standards and using these standards as the justification to fund education for midwives, especially in countries with limited resources. In 1972, the ICM published its first *Definition of a Midwife*; it was most recently updated in 2017. In 2010, ICM published the *Essential Competencies for Basic Midwifery Practice*; it was most recently updated in 2019.[14] In addition, ICM has highlighted the importance of Indigenous midwives to the health and well-being of Indigenous communities.[122] It recognizes the need to ensure that Indigenous midwives are legally recognized and to advocate for funding of Indigenous midwives who are educated and regulated to their community standards.

Between 2008 and 2011, the ICM accepted the difficult challenge of formally describing the three pillars of midwifery: education, regulation, and essential core competencies for midwifery practice. These core ICM documents have an important impact on midwifery in all nations.[14,123] For example, the Midwifery Education, Regulation, and Association work group,[124] a collaboration of the seven midwifery professional associations in the United States, has worked to adapt the ICM documents for midwifery in the United States. The 2015 publication of *Principles for Model U.S. Midwifery Legislation and Regulation* is one of the outcomes of this collaboration.[10] ICM now publishes multiple gap analysis tools and curriculum guidelines designed to assist midwifery associations and policy makers in actualizing their support for professional midwifery practice. ICM continues to evolve its support for midwifery globally. In 2021, ICM updated its Midwifery Framework to expand on the three pillars of midwifery, including an additional seven elements: the midwifery philosophy, essential competencies for midwifery, research, midwife-led continuity of care model of practice, leadership, enabling environment, and commitment to gender equality, justice, diversity, and inclusion.[125] Since its launch in the early 1900s, ICM has expanded to include, as of 2023, 140 midwifery associations from 119 countries, representing 1 million midwives globally.[125]

The ACNM has been a member of ICM since 1956. The ACNM and many CNMs/CMs have made significant contributions to ICM's mission by strengthening midwifery associations globally, publishing training materials for midwives such as the *Life-Saving Skills Manual for Midwives*[126] and *Home-Based Skills Manual for Midwives*,[127] and advocating for reduction of preventable pregnancy-related and neonatal deaths globally.

Conclusion

In the twenty-first century, midwifery is an evolving profession with a strong, inspirational foundation; a mature infrastructure to promote policies that improve access to high-quality midwifery care; highly educated individuals who are defining best practice; and plenty of unfulfilled potential. Midwives have demonstrated their capacity to do the hard work of profession building, critically evaluate traditional models of care, challenge policies based on flawed research and practices, and pursue a more just healthcare delivery system. Future changes and growth in the profession will reflect the innovation and expertise of the next generation of midwives, what brings them to the profession, their educational experiences, and their desire to contribute to furthering the profession of midwifery and to partnering with their clients in creating a world where all persons receive the best care possible.

Resources

Midwifery and Related Organizations

Organization	Description
American Association of Birth Centers (AABC)	A multidisciplinary membership organization dedicated to the birth center model of care.
American College of Nurse-Midwives (ACNM)	Professional organization for certified nurse-midwives and certified midwives in the United States. The Hallmarks of Midwifery can be found on its website.
American College of Obstetricians and Gynecologists (ACOG)	Founded in 1951, ACOG is the specialty's professional membership organization dedicated to the improvement of women's health.
American Nurses Association (ANA)	ANA advances the nursing profession and advocates on healthcare issues that affect nurses and the public.
American Public Health Association (APHA)	APHA works to strengthen the profession and to speak out for public health issues and policies supported by science.
Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)	AWHONN works to improve and promote the health of birthing persons and newborns, and to strengthen the nursing profession.
Black Mamas Matter Alliance (BMMA)	BMMA is a Black women–led cross-sectoral alliance that centers Black mothers and birthing people to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice.
Childbirth Connection	Founded in 1918 as the Maternity Center Association, this organization is now a program in the National Partnership for Women and Families. It works to improve the quality and value of maternity care through consumer engagement and health system transformation. Childbirth Connection promotes safe, effective, and satisfying evidence-based maternity care and is a voice for the needs and interests of childbearing families.
Coalition for Quality Maternal Care (CQMC)	In April 2011, nine national professional, consumer, and human rights organizations announced the formation of this coalition to champion the urgent need for national strategies to improve the quality and value of maternal and newborn health care in the United States.
International Confederation of Midwives (ICM)	This global federation of midwifery associations has worked for more than 100 years to support, represent, and strengthen professional associations of midwives throughout the world.
Midwives Alliance of North America (MANA)	The mission of MANA is to unite, strengthen, support, and advocate for the midwifery community and to promote educational, economic, and cultural sustainability of the midwifery profession.
National Association of Certified Professional Midwives (NACPM)	Professional organization for CPMs in the United States.
National Association of Nurse Practitioners in Women's Health (NPWH)	NPWH works to ensure the provision of quality primary and specialty health care to women of all ages by women's health and women's health–focused nurse practitioners.
National Association to Advance Black Birth (NAABB)	NAABB's mission is to combat the effects of structural racism within maternal and infant health to advance Black birth outcomes.
National Birth Equity Collaborative (NBEC)	NBEC creates transnational solutions that optimize Black maternal, infant, sexual, and reproductive well-being. It aims to shift systems and culture through training, research, technical assistance, policy, advocacy, and community-centered collaboration.

Organization	Description
National Black Midwives Alliance (NBMA)	The mission of NBMA is to establish a representative voice at the national level that organizes, advocates, and brings visibility to the issues impacting Black midwives and the communities they serve.
National Partnership for Women and Families (NPWF)	Founded in 1971 as the Women's Legal Defense Fund, NPWF promotes fairness in the workplace, reproductive health and rights, access to quality, affordable health care, and policies that help individuals meet the dual demands of work and family.
National Women's Health Network (NWHN)	Feminist health activists who use policy analysis as a tool. Starting in 1940 with a protest about the risks of estrogen, NWHN has sought to bring the voice of people concerned about women's health to the decision makers who create and implement health policies.
White Ribbon Alliance	International organization with a mission to catalyze and convene advocates who campaign to uphold the right of all women to be safe and healthy before, during, and after childbirth.

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