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CHAPTER 1

Relationships Between CNMs and CMs and Other Midwives, Nurses, and Physicians

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This chapter focuses on the interfaces and relationships between midwives certified under the auspices of the American College of Nurse–Midwives (ACNM) or the American Midwifery Certification Board AMCB and other professionals with whom we have overlapping identities or roles.[1] Although the emphasis is on current intra- and inter-professional relationships and issues, historic information is needed to understand the current and evolving issues, many of which have developed in important new ways during the past few years.

Learning Objectives:

1. Explain the difference between a certified nurse–midwife (CNM) and a midwife who was a nurse before becoming a direct-entry midwife.
2. Identify five significant differences between CNMs and certified professional midwives (CPMs), and three significant differences between CNMs and certified midwives (CMs).
3. Identify and discuss three benefits and three disadvantages associated with nurse–midwifery's strong historical and current association with nursing.
4. Explain why procedural due process is often compromised when CNMs are disciplined by a state board of nursing.

[1] See Chapter 2 for information about the American College of Nurse–Midwives (ACNM). See Chapter 5 for information about the American Midwifery Certification Board (AMCB).

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5. Describe four differences between obstetrician–gynecologists (Ob/Gyns) and family physicians (FPs) that affect their relationships with midwives or reflect differences in their relationships with midwives.

Relationships Between ACNM-, ACC-, or AMCB-Certified Midwives and Other Midwives

Midwifery Around the World

The word "midwife" was derived from the old English "mid," which meant "with," and "wif," which meant "wife" or "woman." The literal meaning—to be with a woman during childbirth—is the *sine qua non* of midwifery. The simplest and most widely understood definition of a midwife is a woman who assists other women during childbirth.[2]

The International Confederation of Midwives (ICM) is an international nongovernmental organization that unites 85 national midwives' associations from over 75 countries. An official international definition of "the midwife" was developed by the World Health Organization (WHO) in 1965. A revised version was adopted by ICM in 1972 and by the International Federation of Gynecologists and Obstetricians (FIGO) in 1973. The current version was adopted by ICM in 2005 (International Confederation of Midwives [ICM], 2005):

> A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> The midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labor and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

A *nurse–midwife* is a graduate of a midwifery education program designed for students who have already achieved the basic knowledge and skills of a professional nurse. In the

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[2] Although a small percentage of U.S. midwives are men, the vast majority are women, and midwifery arose from the role of women. With apology to the few wonderful men who are midwives, I will use only female pronouns in reference to midwives in this chapter.

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United States, nurse–midwives have usually been referred to as "nurse–midwives" rather than "midwives," although there is a trend towards emphasizing the concept of "midwife" and "midwifery." Although most midwives in the United Kingdom (UK) and many other countries are actually *nurse*–midwives, they are usually referred to as "midwives." Their nursing background is seen mainly as an educational prerequisite.

A *direct-entry midwife* is a person who became a midwife through an experiential or formal educational process that was not predicated on the assumption that all of its students are nurses. Direct-entry midwives are usually referred to just as "midwives." Their education must lead to mastery of many skills that nurse–midwives obtain during nursing education.

Whether a country's midwives are mainly nurse–midwives or direct-entry midwives depends on the history of the development of midwifery in that country. Although the midwifery education systems in many of the countries of continental Europe produce mostly direct-entry midwives, the history of midwifery in the United States led to the development of nurse–midwifery as the predominant form of professional midwifery in this country.

Midwives in the United States

Many kinds of midwives practice in the United States. This section describes them and provides information about them and the organizations that support them. Although nurse–midwives are the largest and predominant group of midwives in this country, other chapters in this book describe the ACNM and nurse–midwifery in detail. Thus the description here is very brief. Historically, the main dichotomy in the United States has been between nurse–midwives and direct-entry midwives.

Certified nurse–midwives (CNMs) are midwives who have completed a nurse–midwifery education program accredited by the ACNM and passed the National Certification Examination administered by the ACNM from 1971 through 1991, the ACNM Certification Council (ACC) from 1992 to mid-2005, and the American Midwifery Certification Board (AMCB) since then. CNMs practice legally in every U.S. jurisdiction. Most are licensed as registered nurses (RNs), although their legal authority to practice midwifery may be based on an additional license to practice as a CNM, an advanced registered nurse practitioner (ARNP), a nurse practitioner (NP), or a nurse specialist (Reed & Roberts, 2000).

Services provided by CNMs are covered by Medicaid, Medicare, and most private healthcare insurance programs. CNMs often care for high- as well as low-risk women and provide both reproductive and primary health care to women of all ages. But most CNMs spend the majority of their time in activities related to pregnancy and primary reproductive health care (Schuiling, Sipe, & Fullerton, 2005). They practice within many settings and arrangements including employment by hospitals, health maintenance organizations, and clinics; private practices with physicians; home birth practices; and private midwifery practices with births attended in hospitals or freestanding birth centers. All practice within arrangements that provide for medical consultation and collaborative management or referral of a client to a physician, as needed.

CNMs signed the birth certificates of 7.8% of all infants who were born alive in the United States in 2002, 10.6% of live infants who were born vaginally (not delivered by cesarean section), and 96% of all infants whose birth certificates were signed by any kind of

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midwife during that year. Only 3% of births attended by a CNM occurred in a site other than a hospital (Martin, Hamilton, Ventura, Menacker, & Park, 2002). The proportion of United States births attended by CNMs has increased every year since 1989—the first year for which this information was available.

Direct-Entry Midwifery in the United States

Primarily black, informally trained "granny midwives" attended births in poor and/or rural communities throughout the United States, especially in the southeast, until at least the middle of the 20th century. Women generally became granny midwives in response to a need in their communities. Some were designated by other community members to fill this role; some felt they had been "called." Their primary training was through apprenticeship to older midwives, who were often family members. They were important historically, but are now almost extinct. However, informally trained direct-entry midwives still serve some small populations of women who lack access to mainstream maternity care due to race, poverty, geographic isolation, or religious or other cultural reasons that make care provided in hospitals by male physicians unacceptable. Some states make exceptions to laws that require direct-entry midwives to be licensed to allow unlicensed midwives to provide care to members of particular religious or ethnic subcultures. Examples of this would be midwives who serve members of their own religious communities in the state of Washington and midwives who are part of a cultural tradition that includes the use of indigenous midwives in Alaska. Informally trained indigenous midwives in other countries are usually referred to as *traditional birth attendants* (TBAs).

The main form of direct-entry midwifery in the United States arose from the lay-midwifery/home-birth movement that developed during the 1960s and 1970s as part of a grass roots movement by women to reclaim power over their own bodies and births and because of the criticism of male-dominated, over-medicalized, institutionalized establishment obstetrics (Davis-Floyd, 2005; Gaskin, 1975; Rooks, 1997; Schutt, personal communication, 2005). Direct-entry midwifery is also strongly associated with some religions that emphasize the sanctity of the family and home. Focusing on home births, lay midwifery developed purposefully outside of mainstream medical institutions and authority (Rooks, 1997). During the 1970s, these lay midwives and their supporters organized a variety of means to train direct-entry home-birth midwives, ranging from a formal, vocational school based on the midwifery curriculum used in the Netherlands, to programs to improve the use of apprenticeship as the main means of direct-entry midwifery education (Davis-Floyd, 2005; Rooks, 1997).

In 1982, a group of these midwives founded the Midwives Alliance of North America (MANA) as an organization open to all midwives and their supporters in Canada, the United States, and Mexico (Rooks, 1997). In 1986, MANA established an Interim Registry Board consisting of four direct-entry midwives and one CNM to develop and administer a written test of basic, entry-level knowledge essential for responsible home-birth midwifery practice. The board also established a registry to list the names of midwives who had passed the examination (Rooks, 1997). MANA adopted its own statement of the Core Competencies for Basic Midwifery Practice in 1990 and updated it in 1994 (Midwives

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Alliance of North America [MANA], 2006). The test developed by the Interim Registry Board was administered for the first time in 1991.

Also in 1991, a group of direct-entry midwifery educators founded the Midwifery Education Accreditation Council (MEAC) (http://www.meacschools.org) and charged it with developing a process for accrediting direct-entry midwifery education programs based on the core competencies and guiding principles of midwifery care established by MANA. MEAC began to accredit direct-entry midwifery education programs in 1996. Twelve programs and institutions utilizing a variety of educational models—including one-on-one apprenticeship, distance learning, and classroom-based courses—had been accredited or pre-accredited by January 2005, including schools that give degrees (Midwifery Education Accreditation Council, 2005).[3] Most current direct-entry midwifery educational programs combine a strong apprenticeship/preceptorship component with didactic classes. In 2000, MEAC received federal government recognition as an accrediting agency for direct-entry midwifery schools from the U.S. Department of Education (Davis-Floyd, 2005). Three direct-entry midwifery schools have been approved for both loans and grants through the federal Title IV student financial aid programs (Myers-Ciecko, personal communication, February 2005).

In 1994, the Interim Registry Board became incorporated as the North American Registry of Midwives (NARM). NARM, which is separate from MANA, shifted the focus from registration to certification and began to implement a process for certifying experienced direct-entry midwives in 1995. The process was expanded to include entry-level midwives in 1996.

Certified professional midwives (CPMs) are direct-entry midwives who have met all NARM standards for the professional practice of midwifery based on the Midwives Model of Care used by MANA, MEAC, and NARM,[4] and MANA's statement of the Core Competencies for Midwifery Practice, which is the knowledge and skill required to provide continuity of prenatal, intrapartum, and postpartum/neonatal care to low-risk women and their newborns in out-of-hospital settings. Criteria for certification by NARM include

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[3] The four MEAC-accredited degree-granting institutions are the National College of Midwifery in Taos, N.M.; the Midwives College of Utah, a distance-learning institution headquartered in Orem, Utah; Bastyr University, a naturopathic university near Seattle, Wash.; and Miami-Dade Community College, in Miami, Fla. States grant authority to institutions to grant degrees.

[4] The Midwives Model of Care is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes:

- monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- minimizing technological interventions
- identifying and referring women who require obstetrical attention

The application of this model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

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educational requirements; experience requirements; skills requirements; current certification in adult plus either infant or neonatal cardiopulmonary resuscitation (CPR); and verification that the applicant midwife has developed and uses appropriate practice guidelines, informed consent statements, forms and handouts describing midwifery practice, and a plan for emergency care (North American Registry of Midwives, 2004).

The education requirement can be met by: (1) successful completion of a midwifery education program accredited by MEAC, (2) certification by the ACNM or AMCB, (3) legal recognition by 1 of 12 states whose educational requirements for direct-entry midwifery licensure meet NARM's standards,[5] or (4) completion of an educational process that has been individually assessed through NARM's competency-based Portfolio Evaluation Process (the "PEP program") and judged to meet NARM standards. The midwife's educational background must include both didactic and clinical experience and cover specified content as defined by MANA's Core Competencies statement, content covered in NARM's Written Examination and Skills Assessment, and listed primary references.

The clinical component of an individually evaluated PEP program must be at least one year in duration and include at least 1,350 clinical contact hours under the supervision of a preceptor who is either a nationally certified midwife (e.g., CPM, CNM, or CM) or licensed in any North American jurisdiction as a practitioner who specializes in maternity care. The clinical experience must include prenatal, intrapartal, postpartal, and newborn care provided by the applicant midwife under the supervision of one or more preceptor(s) who were present in the room in which the care was being provided by the applicant. The applicant must have participated in at least 40 births, including 20 in which she functioned as the primary midwife; 10 of those 20 must have taken place in a home or another nonhospital setting. Minimum numbers of prenatal exams, newborn exams, and postpartum exams conducted under supervision are also specified. Candidates seeking CPM certification on the basis of ACNM or AMCB certification must have functioned as the primary midwife or primary midwife under supervision for at least 10 births in homes or other out-of-hospital settings. Candidates using the PEP process must provide three professional letters of reference and pass the NARM Skills Assessment, as judged by an evaluator qualified by NARM.

Midwives with unconventional training and experience may be individually evaluated to determine if their education is equivalent to an educational program acceptable to NARM. Examples include midwives who received most or all of their training in a country other than the United States and midwives with extensive experience who cannot document having had supervision during births. Experienced midwives must have been in primary practice for a minimum of 5 years and have attended 50 births as the primary midwife.

Most CPMs are direct-entry midwives who practice in out-of-hospital settings. The CPM is the only national credential that requires out-of-hospital birth experience. Nineteen of the 21 states that regulate direct-entry midwifery practice require either the CPM credential and/or having passed the NARM Written Examination for licensure, certification, registration, or other forms of legal sanction (MANA, 2005a). As of February 2005, more

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[5] Alaska, Arizona, California, Colorado, Florida, Louisiana, Montana, New Mexico, Oregon, South Carolina, Texas, and Washington as of January 2005.

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than one thousand CPMs have been certified, an average of about 100 per year. Fewer than five CNMs have also been certified as CPMs.

In 2001, the National Association of Certified Professional Midwives (NACPM) was founded as the professional organization for CPMs. By the end of 2004, NACPM had developed and adopted a statement of the organization's philosophy, standards, and the scope of practice of a CPM.

Although most direct-entry midwives have committed themselves to professionalizing out-of-hospital midwifery in the United States, some others oppose state regulation of out-of-hospital midwifery and do not want to be licensed. Some from this group call themselves "plain midwives"; those who are religiously oriented may call themselves "Christian midwives." As mentioned earlier, some states that require licensure make exceptions for midwives who serve particular religious or ethnic populations.

Certified Midwives (CMs)

Members of the ACNM have long debated whether it is necessary for professional midwives in the United States to also be educated and licensed as nurses (Reed & Roberts, 2000). This desire for separation was particularly strong among CNMs in New York, who were educated about this issue by Dorothea Lang, a past president of the ACNM (1975–1977) and long-time director of the Maternal and Infant Care Project of New York City. Dorothea's own birth in Japan in the 1940s was attended by professional midwives who were not nurses. Influenced by her, a committed group of New York CNMs began to envision and later lobby for a bill that would establish midwifery as an independent profession that is not regulated under the board of nursing in New York State (Davis-Floyd, 2005). Such a law was passed in 1992.

Although it does not require licensed midwives (LMs) to have completed a nursing education program, the N.Y. Midwifery Practice Act of 1992 requires applicants who are not nurses to have obtained "nursing equivalency" within their program of midwifery education. The N.Y. State Education Department Office of Comparative Education evaluates the curricula of specific non-nurse midwifery education programs to determine if they meet the state's criteria for nursing equivalency (Davis-Floyd, 2005). Applicants must also pass a written examination.

Influenced by developments in New York, ACNM members participating in the college's 1994 annual business meeting passed a motion urging the ACNM and ACC to develop processes to accredit direct-entry midwifery education programs and test and certify graduates of those programs in order to produce direct-entry midwives who are not nurses but are comparable to CNMs in all other ways. The first direct-entry midwifery education program designed to meet ACNM accreditation standards was opened by the State University of New York (SUNY) Downstate Medical Center in Brooklyn, in affiliation with the North Central Bronx Hospital, in 1996. SUNY Downstate's long-standing nurse–midwifery education program was combined with the direct-entry program as a single postbaccalaureate program with one track for nurses and one for other college graduates. Three new courses were designed to teach specified nursing and health care competencies to the direct-entry students. The two tracks are otherwise identical. A 2-year follow-up

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survey to the SUNY Downstate graduates and their employers elicited very positive feedback about the equivalency of CMs and CNMs (Fullerton, Shah, Schechter, & Muller, 2000). The program has graduated about five direct-entry midwives per year since 1996.

Ultimately, the state of New York contracted to use the ACC's National Certification Examination to test applicants for licensure under the 1992 law. A non-nurse applicant whose educational background is deemed equivalent to nursing education may take the examination, which was administered by the ACC until mid-2005 but is now administered by the AMCB. If she passes, she will be licensed as an LM by the state of New York and certified as a CM by the AMCB. As of January 2005, the ACC had certified 46 CMs, 29 graduates of the SUNY Downstate program, and 17 others, including midwives from other countries and graduates of programs accredited by MEAC.

The nurse–midwifery program at Baystate Medical Center in Springfield, Massachusetts, has also developed a direct-entry track, in this case designed for a physician assistant (PA). Baystate's PA track has been accredited by the ACNM, and its first and, as of 2005, only PA–midwife graduate passed the ACC exam and is now a CM. Baystate is willing to accept additional PAs, although funding is a problem. Although there is federal assistance for graduate-level nursing programs and students who are registered nurses, all federal funding for PA programs goes to basic programs, which don't include specialty education. At this time, no other ACNM-accredited nurse–midwifery education programs are known to be considering a direct-entry track.

Although the ACNM developed the CM credential to produce direct-entry midwives under the authority of the ACNM and ACC, almost 40% of all CMs certified by the ACC through the end of 2004 were not graduates of midwifery education programs accredited by the ACNM. Nevertheless, any ACC- or AMCB-certified CM is welcome to become a full-fledged voting member of the ACNM.

So far, only three states license CMs. New York gives CMs privileges equivalent to those of a CNM, including prescriptive privileges; as with CNMs, most CMs practicing in New York attend births in hospitals. New York suggests that CMs identify themselves as CNM/LMs, CM/LMs, or just as LMs, and does not require CNM/LMs to be licensed as registered nurses (RNs). New Jersey licenses CMs but does not provide prescriptive privileges, which are granted to CNMs under the New Jersey nurse practice act. As of early 2005, no CM had been given privileges by a hospital in New Jersey. Like New Jersey, Rhode Island licenses CMs, but does not provide prescriptive privileges. Students enrolled in a certified midwifery education program are eligible for federal student loans and grants but are not eligible for nurse traineeships or National Health Service Corps (NHSC) scholarships. Students enrolled in nurse–midwifery education programs that lead to a master's degree in midwifery rather than a master's degree in nursing also are not eligible for NHSC scholarships (Lichtman, personal communication, 2005).

Legal Status of Direct-Entry Midwives in the United States

Of 51 U.S. jurisdictions (50 states and Washington, D.C.), 21 require direct-entry midwives to be licensed, registered, permitted, certified, or documented in some way (MANA, 2005b). The most frequent designation is *licensed midwife*, or LM. Licensure is mandated

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in 20 of those 21 states, and is available—but not mandatory—for direct-entry midwives in Oregon, many of whom choose not to be licensed for a variety of reasons, including the very high cost of licensure, which is $1,500 per year. This cost is based on the state's requirement that regulation of trades and professions must be supported by licensing fees. Because relatively few direct-entry midwives have chosen to be licensed, the per-midwife fee is very high. Of 21 states that regulate direct-entry midwives, all but New York require either certification as a CPM or passing of the NARM Written Examination. Licensed or otherwise regulated direct-entry midwives in at least 12 states are permitted to administer a very limited list of drugs (Reed & Roberts, 2000). The scope of practice and prescription authority of CMs and CPMs are identical in New York.

In 22 states, out-of-hospital direct-entry midwifery practice is either not regulated but not prohibited, legal on the basis of judicial interpretation or statutory inference, or legal by statute, even though the state has not established a procedure for granting licenses. Eleven states prohibit anyone except a CNM from practicing midwifery (MANA, 2005a).

The legal status of direct-entry midwives is dynamic. Legislation to regulate direct-entry midwives was under consideration by the legislature of seven states (Illinois, Massachusetts, Missouri, Nebraska, Utah, Virginia, and Wyoming) as this chapter was being written in January 2005 (D. Pulley, personal communication, January 26–February 6, 2005).

Citizens for Midwifery is a nonprofit, volunteer grassroots organization that was founded by several women who had experienced home births with midwives and wanted to promote greater availability of this form of care. It was founded in 1996 and has close ties with MANA, NARM, and MEAC (Citizens for Midwifery, 2005).

Current Status and Number of Direct-Entry Midwives

In addition to 1,000 CPMs certified by NARM, approximately 1,000 other direct-entry midwives were practicing under state licenses as of early 2005—a total of about 2,000 direct-entry midwives with either national certification and/or licensure by a state, in addition to about 1,500 "plain" midwives who have neither state licensure nor national certification (Davis-Floyd, 2005). With few if any exceptions, direct-entry midwives other than SUNY Downstate-graduate CMs continue to attend births only in out-of-hospital settings.[6] Their services are covered by private insurance companies in most states where they are licensed, and by Medicaid in eight states. In most states, home birth attended by a direct-entry midwife is still an out-of-pocket expense. Most direct-entry midwives practice solo or in partnership with one other midwife (David-Floyd, 2005).

Out-of-Hospital Births and Who Attends Them

The United States Standard Certificate of Live Birth—a source of data regarding the numbers and percentages of births attended by midwives—did not distinguish between any kinds of midwives until the 1989 revision, which distinguishes between CNMs and other

[6] In states where they are licensed, a very small number of direct-entry midwives have received hospital privileges; it is very rare.

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midwives. The revisions made in 2003 distinguish between midwives certified by the ACNM or AMCB—CNMs and CMs—and all other kinds of midwives.

Out-of-hospital births have accounted for less than 1% of all births in this country each year since 1989. CNMs attended fewer than 10,000 out-of-hospital births in 2002, of which the majority took place in free-standing birth centers (Martin et al., 2005). "Other midwives" attended almost 13,000 births, the majority of which were home births. Physicians attended almost 4,000 out-of-hospital births, including almost 2,000 in homes. Someone other than a midwife or physician signed the birth certificates of almost 9,000 babies born in out-of-hospital settings, including 7,500 babies born at home. Some of these were precipitous births with the baby caught by whoever was there. Some were planned home births with a family or church member attending; others were midwife-attended home births in which the father signed the birth certificate. The latter is common in states where direct-entry midwifery is unregulated or illegal (Pulley, 2005). Thus, some of those births should be attributed to "other midwives." Out-of-hospital births attended by midwives other than CNMs have consistently accounted for approximately 3 of every 1,000 births (0.3%), although the percentage varies from state to state and is much higher in some states.

Relationships Between Different Kinds of Midwives

There has been a long history of interest, antipathy, empathy, jealousy, competition, and fear between the majority of nurse–midwives, who attend births only in hospitals, and direct-entry midwives, who attend births only in out-of-hospital settings; their has also been much description and analysis of their differences (Burst, 1990; Davis-Floyd, 2005; Huntley, 1999; May & Davis-Floyd, 2005; Rooks, 1997, 1998). A small but important minority of ACNM members began as apprentice-trained midwives and value what they gained through that method of learning (Huntley, 1999). About a third of MANA members are CNMs, many of whom attend out-of-hospital births. Thus, some midwives are members of both organizations. During the mid-1990s some of these midwives, with one foot in each camp, felt the need for mutual support and a desire to increase understanding and respect among all midwives in both groups. In 1997, they formed the Bridge Club as a loosely organized group of midwives and midwifery students who wanted to build a bridge between CNMs and direct-entry midwives "from either side of the bridge" (Huntley, 1999). The Bridge Club convenes a caucus during the annual meetings of both MANA and the ACNM. It is unofficial, and its membership—usually about 100—is fluid.

During the 1998 ACNM Annual Meeting, members of the Bridge Club introduced a motion to recommend the establishment of a joint ACNM-MANA work group. The motion passed, and a formally recognized Liaison Group consisting of three members chosen by the ACNM and three by MANA was established. During its first meeting, held in June 1999, the ACNM-MANA Liaison Group developed a statement that endorsed all options of midwife certification in the United States, including the CPM. The Liaison Group statement was rejected by the ACNM Board of Directors, but was endorsed by MANA. The ACNM's budget was tight, and because the product of the group's work was inconsistent with ACNM positions, the ACNM ended its participation in the group in October 2001. In response to an outcry against this action by members attending the 2002 ACNM

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Convention, the ACNM board of directors re-instituted participation in the Liaison Group with guidelines regarding topics to be addressed by the group and the understanding that ACNM representatives would be self-funded. The group meets at both the MANA and ACNM annual meetings, although more of its members are usually present at the ACNM annual meeting.

As time passes, the original dichotomy—nurse–midwives versus direct-entry midwives—is no longer straightforward. Nor is the evolved dichotomy—midwives educated and certified according to standards of the ACNM and ACC or AMCB (i.e., CNMs and CMs) versus all other midwives—since AMCB certification now extends to a small, but sure-to-grow number of midwives educated through programs accredited by MEAC. Although there is a dichotomy between midwives who attend births only in hospitals and those who attend births in homes and birth centers, nurse–midwives have led the birth center movement in the United States, and the ACNM supports home births. Perhaps we will reach a stage where we no longer feel the need to dichotomize, but we are not there yet. Possibly in time, midwives from both sides of the bridge will agree to distinguish midwives who have met national educational and certification standards defined by their professional peers—currently CNMs, CMs, and CPMs—from those who have not.

Despite deep ideological divisions between ACNM and MANA midwives about professionalism and appropriate midwifery education and scope of practice, there have been many positive relationships between CNMs/CMs and direct-entry midwives, as well as symbiosis that has benefited both groups. Former ACNM President Angela Murdaugh (1981–1983) convened a meeting that led to the founding of MANA in 1982. Former ACNM President Dorothea Lang (1975–1977) helped MANA apply for ICM membership in 1984. Virtually every ACNM president since then has made efforts toward communication and bridge building—many of which were not recognized or appreciated. In her earlier role as chair of the ACNM Division of Accreditation, ACNM President Joyce Roberts (1995–2001) explained the finer points of the ACNM's accreditation process and strategies for preserving the integrity of midwifery education in institutional settings to the direct-entry midwifery educators who went on to create MEAC (Myers-Ciecko, personal communication, 2005).

Meetings stimulated and funded by the Carnegie Foundation for the Advancement of Teaching from 1989 through 1994 brought CNMs and direct-entry midwives together to explore common ground—work that ultimately contributed to the establishment of national educational standards and NARM's certification process (Rooks, 1997). In addition, individual CNMs have supported direct-entry midwives in particular states. Current ACNM President Katherine Carr (2004–2006) has done so in her home state of Washington, where she was a founding member of the state midwives association and an early member of the faculty of the Seattle Midwifery School. CNMs are on the faculty and serve as clinical preceptors in most of the accredited direct-entry midwifery education programs; many have been both inspired and challenged by this experience (Myers-Ciecko, personal communication, 2005).

Nurse–midwives and direct-entry midwives work together in many communities—in practice partnerships providing home and/or birth center care and in collaborative relationships in which hospital-based CNMs accept referrals from direct-entry midwives when

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women who had planned to give birth at home or in a birth center need to go to a hospital during labor.

In the longer run, the ACNM may not be able to continue to control standards for entry into professional midwifery in the United States. ACNM Executive Director Deanne Williams has warned that the North American Free Trade Agreement (NAFTA) and other world trade agreements may eventually compel the ACNM to recognize midwife credentials that are endorsed by the United States' trade-partner countries whose educational system and standards for professional midwifery education are not equivalent to those of the ACNM (Williams, 2005).

Nurse–Midwife and ACNM Relationships with Nursing

As with relationships between different kinds of midwives, relationships between midwifery and nursing are products of their very different histories. Professional nursing in Britain and the United States arose within the context of military medicine and the terrible injuries and illnesses of war—the Crimean War, in the case of Florence Nightingale in England, and the Civil War in the United States. Midwifery, in contrast, arose within the context of women assisting and supporting other women during the normal physiologic processes and intrapsychic and social experiences of pregnancy and childbirth. Nursing developed within hospitals, whereas, until the beginning of the 20th century, most births occurred in homes. Physicians are the ultimate authority figures in hospitals, whereas pregnant women and their midwives share authority during a birth that occurs within the mother's home. As a result of these differences, the *culture* of nursing and the *culture* of midwifery have always been quite different, with the exception of public health nursing, which, like midwifery, developed outside of hospitals, with work focused on and within communities and homes.

History

The famous first nurse–midwifery service in the United States was (and still is) the Frontier *Nursing* Service (FNS), not the Frontier *Midwifery* Service. When Mary Breckinridge determined to devote herself to improving the lives of the children of poor families in the coal-mining mountains of Kentucky, she became trained as a *public health nurse.* At the end of the first World War, Breckinridge joined the Red Cross and went to France, where she created the first French Child Hygiene *Visiting Nurse* Service. Although she was impressed by the midwives she observed in France, she thought it odd that they had no background in nursing—exactly opposite from the United States, where nurses had no training in midwifery. Then she went to Britain, where she observed *nurse–midwives*, who she believed had the combination of training needed to help poor families in America. After deciding to start a nursing and midwifery service in Kentucky, she returned to England and Scotland to become trained in midwifery and recruit some British nurse–midwives to help her start the FNS. When she needed additional staff, she sent U.S. *public health nurses* to Scotland to obtain midwifery training.

In 1944, the National Organization for Public Health Nursing (NOPHN) established a section for nurse–midwives. NOPHN was dissolved in 1952 as part of a reorganization that

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resulted in formation of the American Nurses Association (ANA) and the National League for Nursing (NLN). Nurse–midwife Sister Theophane Shoemaker (then director of the nurse–midwifery program operated in Santa Fe, New Mexico, by members of a Roman Catholic order of missionary sisters) wrote to the presidents of the ANA and the NLN, seeking a niche for nurse–midwives within one of the new nursing organizations. Both organizations refused, based on their leaders' beliefs that nurse–midwifery is really part of medicine and thus does not belong in a nursing organization (Rooks, 1997; Tom, 1980). In 1968, the ANA reversed itself by deciding that nurse–midwifery is really a specialty within nursing (Roberts, 1995). The ACNM might never have been founded if nurse–midwifery had been acceptable to the mid-20th-century nursing leaders. In contrast to Americans, the British have always recognized that, although midwives work, and may even be educated, with both physicians and nurses, midwifery is its own profession, and not part of either medicine or nursing.

The second nurse–midwifery service was started by a New York City women's club to provide care to impoverished inner-city women and their babies (Rooks, 1997). In 1918, the City Club program became incorporated as the Maternity Center Association (MCA), a not-for-profit voluntary health agency based in Manhattan. In 1931, MCA opened the nation's first nurse–midwifery educational program in association with Columbia University's Teachers College Department of Nursing Education. The first students had to be public health nurses.

The Frontier Nursing Service was founded in 1925. Although most, perhaps all, nurse–midwifery services established during the following 35 years were paired with a nurse–midwifery education program, only a small proportion of the graduates of those programs could find employment in clinical nurse–midwifery (Rooks, 1997). As childbirth moved from homes to hospitals during the first half of the 1900s, there was a growing need for nurses to staff hospital obstetric units. Nurse–midwives were leaders in the new field of maternity nursing; often their fellow nurses did not even know that they were midwives. Nurse–midwives introduced the concept of family-centered maternity care, played a significant role in the development of childbirth education, demonstrated the radical concept of mother–baby rooming in, and urged mothers to breastfeed at a time when most hospitals were teaching them how to make formula and sterilize bottles. In 1963, the Federal Children's Bureau sponsored the first national survey of nurse–midwives in the United States (Thomas, 1965). Of 535 nurse–midwives living in the country at that time, only 34 (6%) were providing direct clinical midwifery care that included management of childbirth. Most nurse–midwifery education program graduates worked in maternity or public health nursing.

In 1954, even before the founding of the American College of Nurse–Midwifery,[7] members of the Committee on Organization drafted a document that defined a nurse–midwife as a professional who "combines the knowledge and skills of professional nursing and midwifery" (Dawley & Burst, 2005). In 1962, the ACNM approved its first definition of a nurse–midwife as "a registered nurse who by virtue of added knowledge and skill gained through an organized program of study and clinical experience has extended the limits of

[7] The name was changed to the American College of Nurse–Midwives in 1969 (Dawley & Burst, 2005).

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her practice into the area of management of the care of mothers and babies throughout the maternity cycle." In 1978, the ACNM revised the definition to the earlier concept of a nurse–midwife as "an individual educated in the *two disciplines* of nursing and midwifery" (Dawley & Burst, 2005).

Licensure as "Advanced Practice" Nurses

Nurse-anesthetists were the first category of legally recognized nurse specialists in the United States, dating to the 1880s (Texas Association of Nurse Anesthetists, n.d.). Nurse–midwives were the second category, beginning in 1925; pediatric nurse practitioners (NPs) were the third, starting in the mid-1960s, by which time the ANA and NLN were eager to claim nurses with "expanded roles." As other categories of nurse practitioners and specialists were developed, nurse–midwives joined them in working through state nursing associations to promote legislation to legitimize and regulate CNMs and other advanced practice nurses under special subsections of state nurse practice acts (Rooks, 1997). The support of the huge nursing profession, combined with the well-documented excellent outcomes of nurse–midwifery care and the often enthusiastic support from nurse–midwifery clients, made it possible initially to pass and gradually to improve state laws that have benefited many kinds of advanced practice nurses, as well as nurse–midwives, in states throughout the country.

As of January 2000, CNMs were licensed under the state nurse practice act and regulated under the state board of nursing in 42 of the 51 U.S. jurisdictions (Reed & Roberts, 2000). In most of those states, CNMs are licensed as advanced practice nurses (APNs), advanced practice registered nurses (APRNs), nurse practitioners (NPs), or advanced registered nurse practitioners (ARNPs).

Benefits of Nurse–Midwifery's Association with Nursing

The combination of nursing and midwifery education, experience, credentials, licenses, and identities has brought many benefits to nurse–midwives and professional midwifery in the United States during the 80 years since Mary Breckinridge founded the FNS. Midwifery is a small, overworked, widely misunderstood, controversial profession, whereas nursing is huge and has a widely acknowledged and culturally accepted essential role in American health care. It has been politically necessary for nurse–midwives to align themselves with nursing at both the state and national levels in order to win fights for laws that allow them to practice legally, to administer drugs and write prescriptions, to have their services included in third-party payer programs, and to have access to professional liability insurance and government funding for nurse–midwifery education programs and scholarships for nurse–midwifery students.

It has been efficient to have students come to midwifery education with substantial health and health-care knowledge, skills, and experience. A study of factors associated with higher or lower scores on the National Certification Examination found a slight positive influence for each additional year of nursing practice prior to nurse–midwifery education, even though higher age itself (a possible confounding factor) was associated with slightly decreased scores (Fullerton & Severino, 1995). In addition, a substantially dispro-

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portionate number of nurse–midwifery clients have traditionally been low-income women with many socio-economic risks and limited access to health care (Declercq et al., 2001; Scupholme, DeJoseph, Strobino, & Paine, 1992). Many have non-pregnancy-related physical and/or mental health problems that are covered in nursing, but not midwifery education.

There are many more and a much wider variety of nursing positions than of positions in nurse–midwifery; the demand for CNMs is uneven, and the physical demands of providing midwifery care can be exhausting. CNMs who cannot find a nurse–midwifery position in a geographic area in which they prefer or need to live can usually find a position in nursing. Nursing also provides wider options for CNMs who may no longer be able to work the long hours, including nights and weekends, that clinical nurse–midwifery positions often demand. Having a wide fall-back position is often an advantage.

Disadvantages and Disagreements

There are also costs to nurse–midwifery's association with nursing, and important disagreements between nurse–midwifery and nursing regarding some critical issues. Although there are advantages to having a background in nursing, other educational backgrounds are also beneficial to individual midwives and the profession as a whole. By requiring all CNMs to be educated as nurses, nurse–midwifery loses the opportunity to enrich the profession with more midwives who have undergraduate degrees in foreign languages, sociology, anthropology, business, health education, communications, physiology, psychology, international studies, didactics, religion, nutrition, physical therapy, and other relevant courses of study. Requiring nursing as a prerequisite is costly to students in time and money and discouraging to those who complete a nursing program for the sole purpose of entering a program in midwifery. In addition, nursing education may taint pregnancy and birth with an illness orientation and requires students to override the learned nursing role in order to make independent decisions and act on them (Lichtman, personal communication, 2005). Placing nurse–midwifery education programs in schools of nursing also gives enormous power to academic nursing leaders, who may not understand midwifery or who may view it as an autonomous profession (Myers-Ciecko, personal communication, 2005).

Competency-Based Education Versus Degrees

The ACNM and organized nursing diverged on the issue of education from an early period. The ACNM was an early adopter and leader in the use of competency-based education. In contrast, the ANA and NLN educational policies have focused mainly on academic degrees to assure the quality of nursing education. Their current position is that all professional nurses should be educated through programs that lead to a bachelor of science degree in nursing (BSN), and advanced practice nurses should be educated through programs that lead to a master's degree in nursing (MSN). In 2004, the American Association of Colleges of Nursing (AACN) adopted a policy that, by 2015, all categories of advanced practice nurses, including CNMs, should be prepared in educational programs that lead to a *doctorate* in nursing practice (DNP). The rationale for this policy was based on findings from a task force that reviewed nursing curricula for advanced practice nurses (APNs) in

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programs across the country and found that an overwhelming majority of programs granting a master's degree to APNs had credit loads equivalent to doctoral degrees in other health professions (ACNM, 2004). The AACN represents the faculties of nursing education programs that grant baccalaureate and higher degrees in nursing.

Most nurse–midwifery educators in the late 1950s thought of midwifery as a clinical nursing specialty and believed that master's level education was desirable for nurse–midwives, in part because they hoped that the status associated with advanced university degrees would insulate nurse–midwifery from the continuing fall-out flowing from Charles Dickens's 19th-century derisive depiction of Sairey Gamp as a dirty, ugly midwife going to a birth with a bottle of gin and a pack of dirty instruments, an image that had been published in several obstetric textbooks. But only a small proportion of nurses actually had a BSN, and although three of the seven nurse–midwifery education programs operating at that time offered a master's degree in nursing, the four nondegree granting "certificate programs" included the one operated by the Frontier Nursing Service, in Hyden, Kentucky, and the one operated by the Catholic Maternity Institute, near Santa Fe, New Mexico. The need to prepare nurse–midwives for practice in poor rural areas made it necessary to continue to have some education programs that did not require a college degree for admission. Both kinds of programs were needed, and faculty from both kinds of programs worked together to develop educational standards that could be applied in various educational settings (Rooks, 1997).

Nurse–midwife educators were also concerned that the NLN system for accrediting graduate nursing education programs did not evaluate specialty practice (Sharp, 1983). In 1962, the NLN announced that it could not accredit nurse–midwifery education programs because some of them were not in graduate schools of nursing. The ACNM began to develop its own accreditation process, which was in place by 1970. By 1971, the ACNM required graduation from an ACNM-accredited nurse–midwifery education program and a passing score on the ACNM National Certification Examination for certification as a CNM. The first statement of the knowledge and skills essential for safe and effective beginning-level midwifery practice (i.e., the "core competencies" of a nurse–midwife at entrance into the profession) was approved by the ACNM Board of Directors in 1978. Since then, the ACNM core competencies statement has provided a basis for the design of nurse–midwifery education programs at every level, from nondegree certificate programs to doctoral programs; for ACNM certification of both nurse and "basic" (i.e., direct-entry) midwifery education programs; and for the National Certification Examination that is now administered by the American Midwifery Certification Board (Rooks, 1997).

In 1996, the ACNM Division of Accreditation (DOA) announced that by June 1999, all ACNM DOA accredited education programs must either require a baccalaureate degree for entrance into the program or grant no less than a baccalaureate degree at graduation from the program. Until March 2006 the ACNM had opposed all mandates for higher-level degrees, a policy that had been based in part on studies that have shown that higher academic degrees are not associated with either better performance on the National Certification Examination or greater clinical competence or success of a midwife certified by the ACNM or ACC (Rooks, Carr, & Sandvold, 1991). The similarity of outcomes regardless of degrees reflects the ability of all ACNM-accredited midwifery education programs to

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prepare competent beginning midwife practitioners. Other concerns about state mandates for higher degrees for licensure of CNMs included reluctance to reduce the pool of nurses who can afford to complete a midwifery education program, particularly a reluctance to reduce access to midwifery education for nurses who live in small towns and rural areas, and a desire to avoid educational mandates that increase the cost and length of midwifery education without improving the safety and effectiveness of midwifery care. Nevertheless, in March 2006 the ACNM adopted a policy that will require a graduate (master's or higher) degree for certification of CNMs and CMs who complete their midwifery education during or after 2010 (ACNM, 2006).

The most recent analysis of factors that predict performance on the National Certification Examination for nurse–midwives found that those whose highest degree was a baccalaureate degree performed slightly better than candidates with no degree or candidates with graduate degrees. Candidates who obtained their midwifery education in a certificate program performed slightly better than those whose programs led to a master's degree (Fullerton & Severino, 1995). There are some disadvantages to preparing midwives through a program that leads to an MSN degree, which, in addition to teaching the ACNM core competencies, has additional education objectives related to nursing theory, research methods, and other courses that must compete for the students' time and attention (Rooks et al., 1991).

Problems Deriving from Regulating Nurse–Midwifery Practice under State Boards of Nursing

Problems Caused by Nursing's Demands for Academic Degrees

Oregon was the first state to require CNMs to have a master's degree in nursing. It provides an example of some of the problems to which nurse–midwifery is vulnerable because so many states license and regulate CNMs as nurses.

Oregon CNMs are licensed and regulated by the state under the nurse practitioner (NP) part of the nurse practice act, which is administered by the board of nursing (BON). Rules requiring NPs to have academic degrees in nursing were approved in 1979, although they were not scheduled to be implemented right away. Although the new rules would not apply to NPs (including CNMs) who were already licensed to practice in Oregon, those seeking licensure in or after 1981 would be required to have at least a bachelor's degree in nursing; those applying for licensure in or after 1986 would have to have a master's degree in nursing (Howe, personal communication, 2005). The time for implementation seemed far away when the law was enacted, and the "grandmother" clause provided an escape hatch for CNMs and NPs who were living and working in Oregon when the rules were being considered. Nursing boards often use those tactics to allow time for the profession to prepare for new rules and lessen opposition to problematic proposals.

A master's degree was the highest degree for 54% of ACNM members surveyed in 2003; a baccalaureate was the highest degree for 28% (Schuiling et al., 2005). The proportion of CNMs with doctorates has varied between 3% and 5% since 1999. Of the more than 3,400 CNMs whose highest degree was at the master's level in 2003, approximately 2,800 had master's degrees in nursing. Among the more than 600 who had master's degrees in other

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disciplines, 263 had a master's degree in public health, 169 in a basic science, 36 in midwifery, 33 in education, and 29 in a health-related field other than nursing or midwifery. The Oregon BON does not accept a master's degree in midwifery as meeting the requirement for a master's degree in nursing (Sullivan, personal communication, 2003). This position raises questions of inconsistency in the positions of the Oregon board of nursing, which sees nurse–midwifery as a specialty of nursing but does not accept a master's degree in midwifery as equivalent to a master's degree in nursing. If nurse–midwifery is a specialty of nursing, a midwife with a master's degree in midwifery has a master's degree in nursing. If a master's degree in midwifery is not a master's degree in nursing, midwifery is not a specialty of nursing and should not be regulated by the board of nursing.

In 2003, the Oregon Board of Nursing passed a rule requiring nurse practitioners who graduate from an NP program during or after 2005 to have obtained their NP specialty education from a master's or post-master's program accredited by either the NLN or the Commission on Collegiate Nursing Education (CCNE). The Oregon Nurses Association supported adoption of this rule. Many ACNM-accredited nurse–midwifery education programs are based in graduate schools or departments of nursing and can also be accredited by one of these two nursing accreditation organizations. However, this rule would have made it impossible for graduates of any of the many ACNM-accredited education programs that are not based in schools or departments of nursing to practice midwifery in Oregon (Carol Howe, personal communication, 2005). Two CNMs with doctorates who teach at the Oregon Health and Science University in Portland were eventually able to convince the Oregon BON to accept graduates of nurse–midwifery programs accredited by either the ACNM or one of the two nursing accreditation organizations.

State BONs derive their authority from their mission of protecting the health of the public. The Oregon BON must believe that requiring CNMs to have master's degrees in nursing provides more protection, despite a lack of research-based support for that position. But despite its interest in protecting the public, the Oregon BON does not require nurse–midwives to be certified by the ACNM, ACC, or AMCB. This means that a nurse–midwifery education program graduate who fails the certification examination in nurse–midwifery/midwifery repeatedly and is never certified could be licensed in Oregon if she has an MSN. It is surprising that any state BON would not accept the ACNM/AMCB processes as adequate to protect the public, and alarming that a state BON would not require an individual nurse–midwife to have met the ACNM standards, which are nationally recognized and associated with the many positive outcomes that have been documented for nurse–midwifery practice in this country. Yet, Oregon is not alone; as of 2000, 24 US jurisdictions did not require certification by the ACNM, ACC, or AMCB (Reed & Roberts, 2000). Are some boards of nursing (despite being responsible for regulating nurse–midwifery) unaware of the ACNM/AMCB excellent quality-assurance structure? Or are these state BON decisions influenced by a desire to enhance the power of nursing and control the education and practice of nurses, combined with a lack of both understanding about and identification with midwifery?

If most CNMs continue to be licensed under state nurse practice acts and rules established by boards of nursing, it is difficult to see how nurse–midwifery will be able to adapt to current nursing leaders' visions regarding the education credentials of advanced nurse

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practitioners. This includes mandatory doctorates in nursing for all nurse practitioners within 10 years. In the 1950s and 1960s the ANA determined that eventually all registered nurses (RNs) should enter the profession through an educational program that grants a bachelor of science degree in nursing (BSN), and that became their policy. Yet by 1995, only about one third of all RNs actually had a BSN (U.S. Department of Labor, 2005). Nursing leaders, who have not been able to dictate the educational level of the more than 2 million employed RNs, are now trying to impose their vision of doctoral degrees for the much smaller numbers of nurse–midwives and nurse practitioners.

In addition, the ACNM now accredits midwifery education programs that do not require students to be nurses, and the AMCB now examines and certifies graduates of those programs—who are not RNs—to practice midwifery. The number of CMs is small, but the ACNM's commitment to professional direct-entry midwifery as well as nurse–midwifery is a major turning point for professional midwifery in this country. Sooner or later the ACNM and its members will have to begin the difficult work of bringing the licensure of midwives educated and certified under the authority of the ACNM, ACC, or AMCB into congruence with its mid-1990s decisions and actions leading to the education and certification of CMs.

The Importance of Peer Review in the Discipline of CNMs

Historically, as well as in our own time and country, midwives have been subjected to unfounded accusations based on ignorance, bias, and misinformation. Although midwives are no longer burned at the stake, there is still a need to protect individual midwives against unwarranted loss of reputation and the right to practice resulting from inadequate disciplinary processes. There is also a serious responsibility to protect mothers, babies, and the public in general from incompetent or reckless unsafe midwives, and to protect the profession from the fall-out of unsafe midwifery practice.

In order to avoid erroneous discipline while preventing unsafe midwives from practicing, the processes by which a midwife could lose either her national certification or her license to practice in a particular state must embody high standards of due process. If disciplinary processes follow the fundamental principles of justice, we can rely on them to be both fair to individual midwives and effective in protecting individual women and babies and the reputation of midwifery.

More than two thousand years ago, Aristotle wrote that, "As a physician ought to be judged by the physician, so ought men to be judged by their peers" (Aristotle translated by Jowett, 1994). That concept was embodied in the British Magna Carta and carried down into the Constitution of the United States as an inherent aspect of due process, other aspects of which require that a law or regulation with the force of law be clear, fair, and have a presumption of innocence, and that accused persons have an opportunity to hear what they have been accused of, to face their accusers, and to present arguments and evidence to defend themselves, including cross-examination of those who testify against them. The law or regulation must be applied in a competent manner, and the jury must be impartial.

The due process standard should be particularly high when a person is at risk of losing her or his freedom (criminal justice), or when a professional is at risk of losing the right to practice her or his profession (professional discipline). Case law in at least one state has

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identified the legal processes by which a professional (a physician, in that case) risks losing his or her license to practice as "quasi criminal proceedings" that are "unavoidably punitive" (*Nguyen v. Medical Quality Assurance Commission*, 2001).

Although most CNMs practice under a state BON, it is rare for even one CNM to serve as either a member of the board or on the staff of a state BON. As of October 1998, CNMs served on the board of nursing in just 3 of the 42 states in which nurse–midwives were regulated under nursing.[8] As a result, there is often a lack of midwifery expertise and experience among key decision makers when a CNM is investigated through a disciplinary process under a BON. Physicians are disciplined by panels consisting entirely or primarily of other physicians under the authority of state boards of medicine, and nurses are disciplined by panels consisting entirely or primarily of other nurses. Few CNMs are disciplined, but those who are—including some who are guilty of incompetence or recklessness and some who are not—are at high risk of being judged by nurse practitioners or other advanced registered nurse practitioners who are not nurse–midwives and do not understand the standards for a nurse midwife or the circumstances surrounding the events they are expected to review.

This is not just an academic consideration; several CNMs have lost their ability to practice midwifery in their home states in recent years, including a very senior, highly regarded Fellow of the American College of Nurse–Midwives (FACNM).[9] Her care in the case that stimulated the disciplinary hearing was not considered to be in error—or even questionable—in the view of the physicians involved in the situation, the quality-assurance committee of the hospital in which the care took place, several tort lawyers (who refused to bring a malpractice suit against her), and the only member of the board of nursing who was an obstetric nurse or had any experience in labor and delivery, whose recommendation that the board dismiss its charges against the CNM was not supported by the board.

NURSING CONCERN ABOUT ACNM'S DEVELOPMENT OF THE CM

Passage of the New York Midwifery Practice Act of 1992 and SUNY Downstate's development of a direct-entry track within its midwifery education program were major events in the history of the relationship between the ACNM and organized nursing. There have already been very significant adaptations on the part of the ACNM, including omission of the word "nurse" from most ACNM documents that had referred to "nurse–midwifery," and changing the title of the *Journal of Nurse–Midwifery* to the *Journal of Midwifery and Women's Health.* These changes have been seen with alarm by our colleagues in academic nursing. A 2003 paper published in *Nursing Outlook* by two advanced practice nursing leaders identified nurse–midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSes), and nurse practitioners (NPs) as the four distinct roles that comprise advanced practice nursing, and complained that CNMs do not re-

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[8] The three states were Washington (Fletcher, personal communication, July 2004), Maryland, and Michigan (Reed & Roberts, 2000).

[9] Fellowship in the ACNM is an honor bestowed upon members whose professional achievements, outstanding scholarship, clinical excellence, and/or demonstrated leadership has been recognized both within and outside of the midwifery profession. Midwives elected into the ACNM Fellowship are Fellows of the ACNM and have the right to use "FACNM" after their names.

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quire their specialty education to be provided through programs that lead to a master's degree in nursing (Hanson & Hamric, 2003). Nurse–midwifery's aberrancy from this otherwise unified front was described as a challenge that needs to be addressed in order to strengthen advanced practice nursing.

Nurse–midwifery is described as being in a transitional period, as compared to the other three components of advanced nursing practice, because not all midwives are nurses, and not all nurse–midwives are prepared at the master's level.

> "The current issues within nurse–midwifery are causing chasms within the APN world. The movement of the American College of Nurse Midwives to include midwives who are not nurses but who complete a certified midwifery program that is not nurse driven makes for confusion. . . . It is a professional imperative for ACNM leaders to differentiate the competencies expected of APN midwives from those expected of midwives who are not nurses or who lack graduate degrees. This differentiation is necessary to drive different certification and regulatory requirements for APN midwives versus other midwives. (Hanson & Hamric, 2003, p. 206)

The Self-Identify of the ACNM and CNMs

The ACNM is an active and leading member of the International Confederation of Midwives, which it joined in 1956 (Dawley & Burst, 2005). It is not a member of the International Council of Nurses.

In a 1990s study of how CNMs define themselves in relation to nursing, medicine, and midwifery, Scoggins found that nurse–midwives identify occupationally with midwifery, rather than nursing or medicine, even though there is some alliance with both of the other professions. The variables most strongly associated with identification with midwifery were philosophical agreement with nurse–midwifery ideologies of advocacy and the normalcy of pregnancy and birth. The tendency to differentiate themselves from both physicians and nurses was also associated with increased years of nurse–midwifery practice (Scoggin, 1996).

ACNM and CNM/CM Relationships with Medicine

Because even low-risk pregnant women may develop serious diseases and pregnancy complications, every midwife must have a functional professional relationship with one or more physicians. The primary purposes of midwifery are to educate, attend, and comfort women and their families during pregnancy, birth, and the period of family formation and reformation that follows every birth, and to maximize and protect the health of the mother and baby and the normal processes of human reproduction. The primary purposes of medicine are to prevent, diagnose, treat, control and palliate the human experience of injury and disease. Midwifery and medicine have different but complementary purposes, philosophies, and perspectives on pregnancy and birth, and different but overlapping sets

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of skills and bodies of knowledge (Rooks, 1999). They are separate but complementary professions. But the status and authority of physicians are much greater than that of midwives; actual working relationships depend on the circumstances of specific situations, which are more often controlled by physicians.

Early History of Medicine and Midwifery in America[10]

Midwives were among the first colonists to arrive in North America; a midwife attended three births during the *Mayflower*'s first voyage to the new world. But most of the early colonists were British, and midwifery was much slower to become professionalized in the British Isles than on the continent of Europe. A law requiring midwives to be licensed was passed in Paris in 1560. Formal, state-supported education of midwives was started. Midwives studied in the most famous obstetric hospital in France, wrote books, and developed their apprenticeship system into a full-fledged midwifery education program. By the 1800s, French midwives were teaching normal obstetrics to medical students. Midwives in the Netherlands have had to pass a rigorous examination since at least 1700. In contrast, the first law requiring British midwives to be licensed was not passed until the early 1900s—only about 100 years before publication of this book. Although midwives attended most births in the American colonies and were respected members of their communities, they did not develop schools. Some were well trained, but many were steeped in folklore. They practiced from their homes and passed their skills from one woman to another informally.

Although most of the best trained midwives came from continental Europe, they didn't speak English and stayed in their own communities. West African midwives came to America with the first boatloads of slaves. Eventually there were 4 million slaves in this country, including many black African midwives. After emancipation, they became the "Granny midwives" who took care of both black and white poor women in the South. Although midwifery was a good job for a woman, it did not develop as a profession.

Medicine was also slow to develop in America. Few colonists or immigrants came from the educated classes, so there were few university-educated physicians. Most American doctors were apprentice trained, had not attended medical school, and were in competition with homeopaths and midwives. Medicine did not become professionalized in the United States until the last half of the 1800s. When it did, it did so in a spirit of competition and the absence of a formal midwifery profession.

The 1910–1935 Campaign to Eliminate Midwives[11]

The period between 1910 and 1935 was marked by controversy about midwifery and a physician-led campaign to eliminate midwives as appropriate care for any woman who could afford a doctor. A series of events between 1910 and 1920 seem almost designed to entrench a pathology-oriented medical model of childbirth in this country. The Flexner

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[10] This history is described in greater detail in Rooks, 1997, pp. 12–36.

[11] See Rooks, 1997, pp. 22–26, 451–452.

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Report on Medical Education was published by the Carnegie Foundation for the Advancement of Teaching in 1910. After visiting every medical school in the United States and Canada, Flexner concluded that America was oversupplied with badly trained doctors and recommended that most existing medical schools be closed, leaving only the best, which should be modeled after the school at Johns Hopkins. Flexner singled out obstetrics as making the worst showing.

In 1911, Dr. J. Whitridge Williams, the leading obstetrics professor at Hopkins (and first author of *Williams Obstetrics*), conducted his own study, which confirmed Flexner's findings. The obstetric professors who responded to Williams's survey thought most women were safer with midwives than with general physicians. In 1912 Williams published his findings in the *Journal of the American Medical Association* (Williams, 1912). To improve obstetrics training, he recommended hospitalization for all deliveries and gradual abolition of midwives, who should be replaced by "obstetrical charities," which would serve as sites for training doctors.

Twilight sleep was introduced in 1914. Upper-class women eager to bring the miracle of pain relief to all women formed "twilight sleep societies." Obstetric anesthesia became a symbol of the progress possible through medicine.

In 1915, Dr. Joseph DeLee, author of the most important obstetric textbook of that time, published a paper in which he described childbirth as a pathologic process. "Obstetrics has a great pathologic dignity," he wrote. "Even natural deliveries damage both mothers and babies, often and much. If childbearing is destructive, it is pathogenic . . . if it if is pathogenic it is pathologic. . . . If the profession would realize that parturition viewed with modern eyes is no longer a normal function, but has imposing pathologic dignity, the midwife would be impossible even of mention" (DeLee, 1915, p. 134).

The first issue of the *American Journal of Obstetrics and Gynecology*, published in 1920, included an article in which DeLee proposed a sequence of interventions—including routine use of sedatives, ether, episiotomies, and forceps—designed to save women from the "evils natural to labor" (DeLee, 1920, p. 140). DeLee changed the focus from responding to problems as they arise to preventing problems through routine use of interventions to control the course of labor.

Maternal mortality and infant deaths from birth injuries increased as physicians engaged this active role. Historians analyzing data from this era associated the increases with an "orgy" of obstetrical interference in birth (Loudon, 1992). The 1925 White House Conference on Child Health and Protection concluded that "untrained midwives approach, and trained midwives surpass, the record of physicians in normal deliveries." The conference report ascribed this to "the fact that . . . many physicians . . . employ procedures which are calculated to hasten delivery, but which sometimes result harmfully to mother and child. On her part, the midwife is not permitted to and does not employ such procedures. She waits patiently and lets nature take its course" (White House Conference on Child Health and Protection, 1930).

The themes of the campaign to eliminate midwives were that midwives were untrained and incompetent, that pregnancy is a dangerous condition requiring complicated care available only from highly trained medical specialists, and that physicians needed better training in obstetrics and midwives' clients—mainly relatively poor women—were needed

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as "teaching material." Midwives attended approximately half of all births in 1900, but less than 15% in 1935. By the early 1930s, most practicing midwives were black or poor white granny midwives working in the rural south.

Nurse–Midwifery and Obstetrics, 1925–1970[12]

Mary Breckinridge founded the Frontier Nursing Service (FNS) in 1925, in the midst of the campaign to eliminate midwives. One of her first actions was to recruit a medical director and write protocols defining the clinical relationship between nurse–midwives and physicians.

The second nurse–midwifery service was established by the Maternity Center Association (MCA) in New York City in 1931. MCA began in 1918 as an outgrowth of a Women's City Club program to provide prenatal care and education in one zone of the city. By 1920, MCA was supervising 30 neighborhood centers in and from which public health nurses working under the direction of physicians provided prenatal care and education to pregnant women. MCA's Board of Directors soon realized that the nurses weren't adequately prepared for this work and that better homebirth care was also needed, and sought permission to open a school of nurse–midwifery. But midwifery was very controversial, and permission was hard to come by. In 1930, a group of MCA board members and others, including Mary Breckinridge, incorporated themselves as the Association for the Promotion and Standardization of Midwifery; after much work, MCA opened a nurse–midwifery service and school in Manhattan. Although the objectives specified that midwives prepared through the school would "accept responsibility for the care of normal maternity patients delegated by the obstetrician after a complete physical examination had been done" and would not be in private practice, MCA's plans drew harsh opposition, resulting in the resignations of several obstetrician members of MCA's Medical Board.

Invited into Hospitals to Help Care for the Poor[13]

The FNS was established to serve the poor in a rural area of Kentucky. MCA's nurse–midwifery service was established to serve the urban poor in Harlem, New York. The third nurse–midwifery school and service were developed to prepare nurse–midwives to meet the needs of poor black women in isolated parts of Alabama. The fourth school was a short-lived program to train black nurse–midwives in New Orleans, Louisiana. The fifth was opened by an order of Catholic sisters to serve Spanish-speaking families in a rural part of New Mexico. All of the first five schools were developed in association with midwifery services designed to meet the needs of families that lacked medical care due to geography, poverty, culture, and/or race.

Nurse–midwives did only home births until the mid-1950s, when a few midwives were invited into several of the nation's leading inner-city teaching hospitals. Obstetric leaders initiated these services to help the obstetric residents and faculty cope with the post-war

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[12] See Rooks, 1997, pp. 36–42.

[13] See Rooks, 1997, pp. 36–45.

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"baby boom" and to improve the quality of care in those hospitals. An OB department chairman speaking at a conference in the 1960s described the "shameful and humiliating circumstances" experienced by poor, black women in "our great public hospital clinics," including "attitudes of callousness" that "almost defy description," and described the competence and dedication of the nurse–midwives he had worked with during his residency and the need to introduce those attitudes into all charity-hospital obstetric services. But everyone at the meeting—including some leading nurse–midwives—agreed that nurse–midwives should be restricted to caring for the poor (Josiah Macy, Jr. Foundation, 1968).

In time, the obstetric departments of large public or charity teaching hospitals became major employers of American nurse–midwives. Nurse–midwives working in obstetric departments associated with medical schools were taught and expected to use many obstetric interventions.

What Relationship Is Required by ACNM Standards?

The 2003 version of the ACNM Standards for the Practice of Midwifery require CNMs and CMs to adhere to the following standards in regards to their relationships with physicians (ACNM, 2003). They must:

- "practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client,"
- "demonstrate a safe mechanism for obtaining medical consultation, collaboration, and referral,"
- practice "in accord with service/practice guidelines that meet the requirements of the particular institution or practice setting," and
- develop written practice guidelines that describe "the parameters of service for independent and collaborative midwifery management and transfer of care when needed."

ACNM/ACOG Joint Statements

In 1971 the ACNM, the American College of Obstetricians and Gynecologists (ACOG), and the Nurses Association of the American College of Obstetricians and Gynecologists (now the Association of Women's Health, Obstetric and Neonatal Nurses, or AWHONN) approved a "Joint Statement on Maternity Care" which asserted that the need for quality maternity care can best be met by the cooperative efforts of physicians, nurse–midwives, obstetric nurses, and other health personnel working in teams directed by obstetrician–gynecologists. This was the first official recognition and acceptance by ACOG of the role of CNMs in the "improvement and expansion of health services" for women (Roberts, 2001). Its emphasis on the benefits of collaboration between nurse–midwives and physicians helped open the door to more private sector clinical practice positions for nurse–midwives.

In 1975, the statement was revised to expand upon and clarify "obstetrician direction of the team." The revision recognized that an obstetrician does not always need to be physically present when care is rendered, and called for representatives of each of the separate

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disciplines to work together to develop written agreements that specify the consultation and referral policies and "standing orders." This was the first formal agreement between the ACNM and ACOG regarding appropriate collaboration between nurse–midwives and obstetricians.

Nearly a decade later, ACOG and ACNM revised the 1975 statement as "The Joint Statement of Practice Relationships between Obstetricians and Gynecologists and Certified Nurse–midwives" (Rooks, 1997, p. 207). The 1982 statement emphasized the interdependence of obstetrician–gynecologists and CNMs working in a relationship of "mutual respect, trust and professional responsibility" and that appropriate CNM practice "includes the participation and involvement of the obstetrician/gynecologist." Although the statement urged Ob/Gyns to respond when CNMs ask for their participation, the "interdependence" between CNMs and obstetricians is not mutual and thus is not true interdependence. Physicians have support from nurses in their offices and in the hospital and can practice without collaborating with a midwife. A nurse–midwife, in contrast, cannot practice if no physician is willing to work with her. Many potential nurse–midwifery practices and birth centers have been unable to open, and others have closed because no physician in the community was willing to collaborate. Although the 1982 statement was an improvement, some people interpreted it as requiring direct physician supervision of CNMs (Roberts, 2001).

In 2001, ACOG and ACNM approved a fourth joint statement between the two organizations. The 2001 joint statement:

- Referred to CMs, as well as CNMs; every aspect of the agreement applies to all midwives certified by the ACNM or ACC
- Edited a sentence that had seemed to limit direction of a maternity care team to board-certified Ob/Gyns to also include other physicians whose hospital privileges allow them to provide complete obstetric care, such as family physicians (FPs), who work with CNMs/CMs in many rural areas
- Qualified the meaning of a supervisory relationship by placing clear responsibility for the outcomes of care with the person who directly manages the care—an important change to reduce the physician's risk of vicarious liability
- Discouraged statutory or regulatory language requiring medical supervision of CNMs/CMs
- While continuing to endorse the development of mutually agreed upon medical guidelines/protocols for CNM/CM clinical practice, used the ACNM's definitions of consultation, collaboration, and referral and referred to ACOG's *Guidelines for Implementing Collaborative Practice* in describing a pattern of collaborative care that reflects "a relationship of mutual respect, trust and professional responsibility"

One year later, a much shorter version was approved by both organizations. It consists of two simple paragraphs that should allow practices to negotiate their own clinical guidelines as appropriate for their settings:

> **2002 Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse–Midwives/Certified Midwives**
>
> The American College of Obstetricians and Gynecologists (ACOG) and

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> the American College of Nurse–Midwives (ACNM) recognize that in those circumstances in which obstetrician–gynecologists and certified nurse–midwives/certified midwives collaborate in the care of women, the quality of those practices is enhanced by a working relationship characterized by mutual respect and trust as well as professional responsibility and accountability. When obstetrician–gynecologists and certified nurse–midwives/certified midwives collaborate, they should concur on a clear mechanism for consultation, collaboration and referral based on the individual needs of each patient.
>
> Recognizing the high level of responsibility that obstetrician–gynecologists and certified nurse–midwives/certified midwives assume when providing care to women, ACOG and ACNM affirm their commitment to promote appropriate standards for education and certification of their respective members, to support appropriate practice guidelines, and to facilitate communication and collegial relationships between obstetrician–gynecologists and certified nurse–midwives/certified midwives.
>
> *Source:* American College of Nurse-Midwives, 2002a.

In 1986, Dr. Irving Cushner, a distinguished obstetrician–gynecologist and public health leader, addressed the relationship between CNMs and Ob/Gyns during a National Colloquium on Nurse–Midwifery in America (Rooks, 1997, pp. 83–84). He spoke of a developing surplus of obstetricians and the reality that nurse midwives, family practice physicians, and obstetrician–gynecologists compete to be the primary-care providers for low-risk pregnant women. Although he said that the leadership of ACOG stood behind every word of the ACOG/ACNM Joint Statement, he noted that those leaders comprised only about 50 people in an organization with approximately 25,000 members. "We cannot assume that all of the members of ACOG agree with the joint statement. Many, if not most of them, may disagree with it." At that time, approximately 8% of obstetrician–gynecologists surveyed by ACOG employed nurse–midwives in full- or part-time staff positions.

Family Physicians

Some CNMs work with family physicians, who are the only other medical specialty with an important role in primary maternity care. ACOG estimated that FPs delivered between 15% and 20% of the babies born in 1989. Although the proportion of FPs who include obstetrics in their practice is declining, their role is significant in many rural areas, especially in the West North Central region of the country (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota), as determined by a survey conducted by the American Academy of Family Physicians (AAFP) in 1988 (Schmittling & Tsou, 1989). As of 1993, almost 40% of rural FPs provided maternal and newborn care as part of their practice.

FP practice is family-centered, and FP attitudes and beliefs about pregnancy and childbirth are, at least theoretically, relatively congruent with those of midwives. A study published in 1993 asked all midwives registered in one Canadian province and a sample of FPs and OBs working in a teaching hospital in that province about their practices, attitudes, and

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beliefs about childbirth (Reime et al., 2004). Cluster analysis identified three distinct clusters based on similar responses to the questions. The midwifery cluster included all of the midwives and 26% of the FPs. The OB cluster included 79% of the OBs and 16% of the FPs. The FP cluster included 58% of the FPs and 21% the OBs. Members of the OB cluster more strongly believed that women had the right to request a caesarean section without maternal/fetal indication and that increasing caesarean rates signaled improvement in obstetrics. They were also more likely to say that they would induce women as soon as possible after 41 weeks + 3 days of gestation and least likely to encourage use of birth plans. The midwifery cluster's views were opposite those of the OB cluster, while the FP cluster's views fell between those of the other two clusters. The authors concluded that obstetricians and midwives generally follow very different approaches to maternity care, while FPs' attitudes and practices are more heterogeneous; some practice more like midwives and some more like obstetricians.

Several studies have measured actual differences in care provided by FPs compared to Ob/Gyns and, in some studies, CNMs practicing in the same facilities or areas, with some mechanism to assure approximate comparability of the women cared for by each kind of clinician. Two studies conducted in Canada from the mid-1980s through the early 1990s found that family physicians were less likely than obstetrician–gynecologists to rupture the membranes, induce or augment labor, use continuous electronic fetal monitoring or forceps or vacuum, administer narcotics or provide for epidural anesthesia, cut episiotomies, or administer postpartum oxytocin (MacDonald, Voaklander, & Birtwhistle, 1993; Reid, Carroll, Ruderman, & Murray, 1989). A similar study of care provided by FPs and Ob/Gyns to women during childbirth in five sites in the United States reported that FP clients were less likely to have epidural anesthesia or episiotomies during vaginal births and had fewer cesarean sections, mainly due to less frequent diagnoses of cephalopelvic disproportion (Hueston, Applegate, Mansfield, King, & McClaflin, 1995). A study that compared maternity care provided by CNM and FP members of a co-practice in a rural hospital in Kentucky in the early 1990s found much similarity in their management of labor and delivery, except that the family physicians cut more episiotomies (Hueston & Rudy, 1993).

Nevertheless, a study of care provided to low-risk women by random samples of Ob/Gyns, FPs, and CNMs practicing in Washington State during the late 1980s found that, although CNMs were less likely than either kind of physician to use continuous electronic fetal monitoring, labor induction or augmentation, and epidural anesthesia, there was little difference between the practice patterns of obstetricians and family physicians (Rosenblatt et al., 1997). A study conducted in Michigan during the same period found that younger FPs and those affiliated with an academic family medicine department have a more family-centered approach to maternity care and use fewer intrusive practices (Smith, Green, & Carothers, 1989).

Primary maternity care in many other wealthy Western, industrialized countries is provided mainly by midwives and general practitioners—the international equivalent of North American family physicians—with a much smaller proportion provided by obstetrician–gynecologists, who practice as specialists rather than as primary care providers. A similar pattern prevails in some parts of North America. Residents in family medicine programs

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in the United States and Canada can choose to become trained in surgery, which is necessary if they plan to include obstetrics in their practice. A number of very successful FP/CNM practices have been described in journals of nurse–midwifery, rural health, or family medicine (Hueston & Murray, 1992; Payne & King, 1998; Reid & Galbraith, 1988; Wingeier, Bloch, & Kvale, 1988). Payne and King described a very successful CNM/FP collaboration in which a CNM joined the faculty of an academic department of family medicine that provides medical consultation and referral for a birth center sponsored by a federally funded community health center and for a CNM/family nurse-practitioner practicing in a rural area.

A later paper published by these authors—a nurse–midwife and a family physician—described the benefits for both parties of a midwifery/family medicine collaboration (Payne & King, 2001). CNMs teach management of normal childbirth to medical students and residents in most academic medical centers and are almost as likely to teach family practice residents as residents in Ob/Gyn (Harman, Summers, King, & Harman, 1998).

The American Academy of Family Physicians' Position on Nurse–Midwives

In 2003 and 2004, the American Academy of Family Physicians (AAFP) adopted policies that acknowledge the long-standing role of midwives in the provision of maternity care in the United States and encourage "cooperative and collaborative relationships among obstetricians, family physicians and nurse midwives" as "essential for provision of consistent, high-quality care to pregnant women" (AAFP, 2004). CNMs should be RNs before undergoing specific training for certification as a CNM and "only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician qualified in maternity care." AAFP "supports the concept of patient and third-party reimbursement for services of certified nurse midwives where services are provided in an integrated practice arrangement" (AAFP, 2003).

The AAFP recognizes the educational benefits of providing opportunities for family physicians to learn from and with midwives. CNMs have taught an extremely well-received workshop on nonpharmacologic methods to lessen pain and promote labor progress during the academy's annual Family-Centered Maternity Care course every year since 1997. At the same time, hundreds of CNMs have completed the AAFP program on Advanced Life Support Obstetrics (ALSO), and some have completed a course to prepare instructors for this course.

Physicians and Out-of-Hospital Birth

The movement of births from homes to hospitals was concurrent with the ascendancy of the role of physicians in childbirth. Thus, a small increase in—and much hoopla about—home births attended by lay midwives in the early 1970s was of great concern to many obstetricians, particularly because the home-birth/lay midwife phenomenon was part of a more general social and cultural upheaval that included a loud feminist critique of high-tech interventionist obstetrics, and because many of the women having midwife-attended home births were educated middle- or professional-class women (Rooks, 1997).

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Although hospitalization for childbirth was almost universal by 1960, about 1% of births continued to be out-of-hospital for a variety of reasons, including geographic and financial lack of access to hospital care. The small but persisting residual of out-of-hospital births received little attention until lay-midwife home births moved into the limelight during the 1970s. Despite increasing interest in home births, the proportion of U.S. births occurring somewhere other than a hospital remained steady at between 0.9 and 1.1% until it peaked at 1.5% in 1978.[14] By 1980 it had fallen back to its usual 1%. The small, short-lived increase evoked a vituperative over-reaction by ACOG, which held press conferences in which obstetricians referred to home births as "maternal trauma" and "child abuse" and urged physicians and public safety authorities to be alert for deaths resulting from home births.

Despite no lasting increase in the proportion of out-of-hospital births, the role of physicians vis-à-vis midwives in home births did change during the 1970s. Physicians delivered about 40% of babies born in out-of-hospital settings in 1975, compared to about 30% attendance by midwives; another 30% were attributed to "other" or "unknown" birth attendants. By 1980, physicians and midwives had switched places, with midwives attending about 40% of out-of-hospital births, compared to 30% for physicians. The proportion attributed to other or unknown attendants has remained at about 30% over many decades. The role of physicians in out-of-hospital births has dropped continuously since 1975, while the role of midwives has increased. By 2002 (the most recent year with published data), physicians accounted for only 11% of out-of-hospital births, compared to 63% for midwives. Data to distinguish between CNMs and "other midwives" were not available until a change in the US Standard Certificate of Live Birth was implemented in 1989. CNMs accounted for 20% of out-of-hospital births in 1989, other midwives accounted for 26%, and physicians accounted for 27%. By 2002, CNMs' share had increased to 27%, other midwives' share had increased to 36%, and the physicians' share had dropped to 11%.

Many if not most physicians are both leery and disdainful of out-of-hospital births, of which few have had any first-hand experience. Most physicians' only experience with out-of-hospital births occurs when a mother or newborn is transferred to a hospital at some point during or shortly after the birth; that is, they see only the problems and none of the successes. Difficulty arranging for reliable physician consultation, collaboration, and referral for CNM/CM attended births in homes and birth centers is a perennial problem.

Professional Liability Concerns[15]

Many physicians—as well as hospitals, physician–hospital organizations, preferred provider organizations, health maintenance organizations, and companies that sell professional liability insurance—believe that physicians who work with midwives and hospitals that give midwives privileges are exposed to any liability incurred by negligence or malpractice on the part of the midwives. This concept is referred to as vicarious liability, that is legal liability that is based upon a relationship rather than actual conduct.

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[14] Data on out-of-hospital births are based on National Center for Health Statistics reports of final natality statistics for 1975, 1978, 1980, 1985, 1990, and 2002.

[15] See Jenkins, 1994.

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The doctrine of vicarious liability is based on the assumption of control. Although hospitals and physicians will usually be liable for damage resulting from the conduct of any person in their actual employ, if a midwife is not a direct employee—and thus not under the control of the physician or hospital—the physician or hospital should not be subject to vicarious liability.

Hospitals have a duty to retain only competent professional staff and to oversee provision of services within their walls by use of ongoing mandatory quality-assurance mechanisms and periodic review and renewal of delineated clinical privileges for all staff members. Except when a hospital has failed to exercise due diligence in credentialing or monitoring the performance of a member of its professional staff, hospitals have rarely been held liable for care provided by physicians who are not employed by the hospital. A hospital's liability for the conduct of a state-licensed, ACNM-, ACC-, or AMCB-certified midwife who is not employed by the hospital but has been granted clinical privileges as an independent practitioner is conceptually the same as it would be for an attending physician with staff privileges.

Malpractice cases are usually highly fact specific. Determination of vicarious liability also depends on the facts of each situation. Professional consultation and collaboration per se do not imply control. But *supervision* does imply at least the right—and possibly the responsibility—of one party to control the other. A physician who consults or collaborates with a midwife may share liability depending on the facts of a particular case. In 1994, ACNM staff attorney Susan Jenkins published the article on which this discussion is mainly based. In conducting research for that article—including examination of electronic legal databases—Jenkins did not find a single case anywhere in the United States in which a physician had been held vicariously liable for the negligence of a CNM.

MD Liability Insurance Policy Surcharges[16]

The 1980s professional liability insurance crisis had several negative impacts on CNMs, including the imposition of liability insurance policy surcharges charged to some physicians who worked with midwives. A surcharge is an additional cost to purchase insurance coverage. This practice was based on the assumption that a physician is exposed to additional liability risk by working with a midwife. A survey conducted in 14 states and the District of Columbia in 1988 found that, although some surcharges were low, some amounted to more than a 25% increase in the physician's annual insurance premium—an increase of up to $23,000 in the cost of insurance per nurse–midwife per year in at least one case. A 1992 survey conducted by ACOG found that 60% of Ob/Gyns working with CNMs were paying some kind of liability insurance surcharge. These kinds of costs, as well as the underlying assumption that working with a midwife increases a physician's risk of being sued, created a formidable barrier to physicians' openness to working with CNMs.

Nurse–midwives in Illinois and Washington, D.C., challenged the legitimacy of the surcharges in court, and the problem seemed to diminish. By 1996, less than a third of ACOG members working with CNMs reported that they had been required to pay a liability

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[16] See the ACNM Web site page on Professional Liability Information at http://www.midwife.org/education.cfm?id=202. Part 2 (Physician Surcharge) of the Professional Liability Information Packet can be downloaded directly from http://www.midwife.org/siteFiles/about/ProfessionalLiability_RP2.pdf.

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insurance surcharge. However, as malpractice liability problems have again become a problem of crisis proportions, physician insurance policy surcharges are returning as an important problem for CNMs and CMs. Some physicians refuse to work with midwives and some hospitals refuse to grant clinical privileges to midwives based on vicarious liability concerns.

Vicarious liability concerns also contribute to other barriers to cost-effective CNM practice. Some insurers and hospitals require physicians to provide stringent in-person "supervision" of midwives based on the fear of vicarious liability. This sets up a circumstance that actually increases the risk that a physician or hospital could be held accountable for problems related to the practice of the midwife, because supervision, unlike consultation, is based on the assumption of the right to exercise control.

ACOG Data on the Problem

Data on nurse–midwives as employees and co-defendants in liability claims are available from ACOG Professional Liability surveys conducted in 1992, 1996, 1999, and 2003. Almost 8% of Ob/Gyns who participated in the 1992 survey employed at least one CNM; by 1999, almost 18% of the respondents employed CNMs. Compared to the increase between 1992 and 1999, the increase between 1999 and 2003 was modest; more than 19% of Ob/Gyns participating in the 2003 survey employed CNMs, which is almost 1 of every 5.

CNMs were named in between 2% and 3% of malpractice claims against Ob/Gyns that were either open in 1990 or were opened during the decade of the 1990s. The 2003 survey respondents were asked to identify every category of labor and delivery care provider who had been named as a co-defendant in suits brought against the Ob/Gyn between 1999 and 2002. The most frequent co-defendants were obstetricians in the same practice as the survey respondent (27%), obstetricians not associated with the respondent's practice (11.6%), residents in training (16.3%), nurses (7.1%), anesthesiologists (5.2%), pediatricians and neonatologists (3.5%), and family physicians (3.3%), with the least involvement by nurse–midwives (2.6%). ACOG has documented that Ob/Gyns who work with CNMs experience a lower average number of malpractice claims, compared to ACOG members who do not work with CNMs (Reed & Roberts, 2000).

State Laws Regarding CNM/MD Relationships[17]

The information in this section is based on an analysis of laws regulating the practice of CNMs and CMs in all U.S. jurisdictions in 2000. At that time, CNM practice in two states (New Jersey and Pennsylvania) was under the authority of each state's board of medicine. The board of nursing and board of medicine shared responsibility for regulating nurse–midwifery in five states—Alabama, Nebraska, North Carolina, South Dakota, and Virginia.

Forty states defined the required relationship between CNMs and physicians: 28 states required "consultation, collaboration and referral," and 12 states required physicians to supervise or direct the care provided by CNMs. Four of those 40 states specified that the ratio of CNMs per consultative or supervisory physician cannot be greater than 3:1 (Alabama,

[17] See Reed & Roberts, 2000.

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Nevada, and South Carolina) or 4:1 (South Dakota). Four other states limited the number of CNMs who can consult with a single physician in regards to prescriptions (California, Colorado, Oklahoma, and Virginia).

The laws of 11 states did not describe the inter-professional relationship between midwifery and medicine.

Cross-Pollination between Midwifery and Medicine

Although there are important differences between the philosophies and care provided by physicians as compared to midwives, there is also common ground (Rooks, 1999). The knowledge and skills of midwives, obstetricians, and family physicians overlap. Midwives read books and articles written by obstetricians and use information based on their research. Midwives do their own research and write their own articles and books, which are available to, though probably less often read by, obstetricians. Many important improvements in obstetric practice during the past 30 years have resulted from obstetricians adopting some of the beliefs and methods associated with midwifery. When a physician practices them, they become part of his or her *medical* practice. CNMs and CMs have also incorporated many aspects of the medical management of pregnancy into their practices. Unfortunately, this has led to over- (i.e., unnecessary) use of some obstetric interventions by CNMs.

Physicians participate in teaching students in many nurse–midwifery programs, and CNMs teach management of normal childbirth to medical students and residents in most academic medical centers (Harman, Summers, King, & Harman, 1998). Medical students and residents interact with CNMs in the obstetric services of many teaching hospitals. Direct experience with CNMs during medical education clinical rotations has a positive effect on medical students, including better understanding of CNMs' authority to prescribe medications and more interest in working with CNMs in the future (Hanson, Tillett, & Kirby, 1997).

The Importance of Midwives' Relationships with Physicians

During the mid-1980s, the ACNM Foundation conducted a study to identify factors associated with success or failure of a nurse–midwifery practice (Haas & Rooks, 1986). The CNMs who participated in the study identified suitable physician collaboration and a good relationship between CNMs and physicians as the most important factors for success, and opposition from physicians as one of the most important obstacles. Practices without direct physician involvement were least able to attract an adequate number of clients. In 1992, the Office of the Inspector General of the Department of Health and Human Services conducted a survey to determine what CNMs perceived to be the most significant problems impeding a successful practice. Nurse–midwives who participated in that study considered attitudes and perceptions of the medical community to be the most significant barrier. The government investigators concluded that physicians probably have an impact on most of the other barriers reported by some nurse–midwives, especially inability to prescribe medications and obtain hospital privileges.

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The nature of the personal working relationships between individual midwives and individual physicians depends on many factors and experiences, including the usually private assessments and judgments that professionals make of one another. In a study reported in a state medical association journal in 1994, two physicians in Oklahoma noted that, although the outcomes of maternity care provided by obstetricians, family physicians, and nurse–midwives have not been shown to differ, the attitudes and perceptions of different kinds of physicians about midwives and each other may impact access to care (Cooper & Lawler, 2001). They mailed a survey with questions on competency, attitudes, and demographics to a randomized list of 3,000 Ob/Gyns and 3,000 FPs obtained from the American Medical Association. Although the response rate was low—suggesting the possibility of bias—the findings were interesting. Both kinds of physicians expressed high confidence in the ability of Ob/Gyns to provide obstetrical care to low-risk women. FPs were not perceived to be as competent as Ob/Gyns, although FPs who were actually providing low-risk obstetrical care were more confident than Ob/Gyns of FPs' competence in low-risk obstetrics. CNMs were generally perceived as competent by both groups of physicians, who also thought that CNMs should have access to hospital privileges.

Chapter Exercises

Many of the issues described and discussed in this chapter are controversial within the profession. The following exercises are suggested to prepare you to engage these controversies from a basis of knowledge and understanding:

1. Join the American College of Nurse–Midwives.
2. Make plans to attend the next annual meeting of the American College of Nurse–Midwives.
3. Creating educational and certification pathways for direct-entry midwives has resulted in problems, challenges, and opportunities. Divide the class into two groups, one to research and present the benefits of the CM's and the ACNM's about-face in accepting the concept of direct-entry midwifery, and one to research and present the costs and risks of that action. Each team should then present its findings and conclusions, after which there should be time for questions and discussion.
4. Nurse–midwifery's historical and current associations with nursing have resulted in both benefits and disadvantages. Divide the class into two debate teams, one of which takes the position that the ACNM should retain and seek to strengthen its associations with nursing, the other of which takes the position that the ACNM should seek to unravel nurse–midwifery's educational and legal relationships with nursing. Each team should prepare itself for a debate and then have a debate on that issue.
5. Divide the class into two debate teams, one of which takes a position of support of the American Association of Colleges of Nursing's 2004 policy that, by 2015, nurse practitioners and other advanced practice nurses, including CNMs, should be prepared in educational programs that lead to a doctorate in nursing practice (DNP), and one of which takes the op-

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posite position. Each team should prepare itself for a debate and then have a debate on that issue.

References

American Academy of Family Physicians (AAFP). (2003). *Nurse midwives, certified.* Retrieved March 22, 2006, from http://www.aafp.org/x6945.xml

American Academy of Family Physicians (AAFP). (2004). *AAFP-ACOG joint statement on cooperative practice and hospital privileges.* Retrieved March 22, 2006, from http://www.aafp.org/x6949.xml

American College of Nurse–Midwives (ACNM). (2002a). *Joint statement of practice relations between obstetrician-gynecologists and certified nurse–midwives/certified midwives*. Retrieved January 30, 2006, from http://www.midwife.org/display.cfm?id=471

American College of Nurse–Midwives. (2002b). *Professional liability information packet, Part 2 (physician surcharge*). Retrieved January 30, 2006, from http://www.midwife.org/siteFiles/about/ProfessionalLiability_RP2.pdf

American College of Nurse–Midwives. (2003). *Standards for the practice of midwifery.* Retrieved March 22, 2006, from http://www.midwife.org/display.cfm?id=485

American College of Nurse–Midwives. (2004). Doctor of nursing practice: AACN adopts practice doctorate. *Quickening, 35*(7), 23.

American College of Nurse–Midwives. (2006). *Mandatory degree requirements for entry into midwifery practice.* Retrieved June 6, 2006, from http://www.acnm.org/siteFiles/position/Mandatory_Degree_Requirements_3.06.pdf

Citizens for Midwifery. (2005). *What Is Citizens for Midwifery?* Retrieved February 6, 2006, from http://www.cfmidwifery.org/whatis

Cooper, C. F., & Lawler, F. H. (2001). Physician perceptions regarding competence of obstetrical providers and attitudes about other issues in obstetrical care. *Journal of the Oklahoma State Medical Association*, *12*, 554–560.

Curtin, S. C. (1999). Recent changes in birth attendant, place of birth, and the use of obstetric interventions, United States, 1989–1997. *Journal of Nurse Midwifery*, *44*(4), 349–354.

Davis-Floyd, R. (1999, Spring). Some thoughts on bridging the gap between nurse- and direct-entry midwives. *Midwifery Today, 49*, 15–17.

Davis-Floyd, R. (2005). ACNM and MANA: Divergent histories and convergent trends. In R. Davis-Floyd & C. Johnson (Eds.), *Mainstreaming midwives: The politics of professionalization* (Chap. 1). New York: Routledge.

Dawley, K., & Burst, H. V. (2005). The American College of Nurse-Midwives and its antecedents: A historic time line. *Journal of Midwifery and Women's Health, 50*, 16–22.

Declercq, E. R., Williams, D. R., Koontz, A. M., Paine, L. L., Streit, E. L., & McCloskey, L. (2001). Serving women in need: Nurse–midwifery practice in the United States. *Journal of Midwifery and Women's Health*, *46*(1), 11–16.

DeLee, J. B. (1915). Progress toward ideal obstetrics. *Transactions of the American Association for the Study and Prevention of Infant Mortality, 6*, 114–138.

DeLee, J. B. (1920). The prophylactic forceps operation. *American Journal of Obstetrics and Gynecology, 1*, 34–44.

© Jones and Bartlett Publishers. NOT FOR SALE OR DISTRIBUTION

Fullerton, J. T., & Severino, R. (1995). Factors that predict performance on the national certification examination for nurse–midwives. *Journal of Nurse Midwifery*, *40*(1), 19–25.

Fullerton, J. T., Shah, M. A., Holmes, G., Roe, V., & Campau, N. (1998). Direct entry midwifery education: Evaluation of program innovations. *Journal of Nurse Midwifery, 43*, 102–105.

Fullerton, J. T., Shah, M. A., Schechter, S., & Muller, J. H. (2000). Integrating qualified nurses and non-nurses in midwifery education: The two-year experience of an ACNM DOA Accredited Program. *Journal of Midwifery and Women's Health*, *45*(1), 45–54.

Gaskin, I. M. (1975). *Spiritual midwifery*. Summertown, TN: The Book Publishing Co.

Haas, J. E., & Rooks, J. P. (1986). National survey of factors contributing to and hindering the successful practice of nurse–midwifery. Summary of the American College of Nurse–Midwives Foundation Study. *Journal of Nurse Midwifery, 31*(5), 212–215.

Hanson, C. M., & Hamric, A. B. (2003). Reflections on the continuing evolution of advanced practice nursing. *Nursing Outlook*, *51*, 203–211.

Hanson, L., Tillett, J., & Kirby, R. S. (1997). Medical students' knowledge of midwifery practice after didactic and clinical exposure. *Journal of Nurse Midwifery*, *42*(4), 308–315.

Harman, P. J., Summers, L., King, T., & Harman, T. F. (1998). Interdisciplinary teaching: A survey of CNM participation in medical education in the United States. *Journal of Nurse–Midwifery, 43*, 27–37.

Hueston, W., & Murray, M. (1992). A three-tier model for the delivery of rural obstetrical care: Using a nurse–midwife and family physician co-practice. *Journal of Rural Health, 3*, 283–290.

Hueston, W. J., Applegate, J. A., Mansfield, C. J., King, D. E., & McClaflin, R. R. (1995). Practice variations between family physicians and obstetricians in the management of low-risk pregnancies. *Journal of Family Practice*, *40*(4), 345–351.

Hueston, W. J., & Rudy, M. (1993). A comparison of labor and delivery management between nurse midwives and family physicians. *Journal of Family Practice, 37*(5), 449–454.

Huntley, A. (1999, Spring). Build bridges, not walls. *Midwifery Today, 49*, 12–13.

International Confederation of Midwives (ICM). (2005). *Definition of the midwife.* Retrieved February 28, 2006, from http://www.medicalknowledgeinstitute.com/files/ICM%20Definition%20of%20the%20Midwife%202005.pdf

Jenkins, S. M. (1994). The myth of vicarious liability: Impact on barriers to nurse–midwifery practice. *Journal of Nurse Midwifery, 39*, 98–106.

Josiah Macy, Jr. Foundation. (1968). *The midwife in the United States: Report of a Macy conference*. New York: Author.

Jowett, B. (1994). *Politics by Aristotle: An eight-part English translation of Aristotle's Politics*. The Internet Classics Archive. Retrieved July 25, 2004, from http://classics.mit.edu/Aristotle/politics.html

Kennedy, H. P. (2000). A model of exemplary midwifery practice: Results of a Delphi study. *Journal of Midwifery and Women's Health, 45*(1), 4–19.

Loudon, I. (1992). *Death in childbirth: An international study of maternal care and maternal mortality 1800–1950.* Oxford: Clarendon Press.

MacDonald, S. E., Voaklander, K., & Birtwhistle, R. V. (1993). A comparison of family physicians' and obstetricians' intrapartum management of low-risk pregnancies. *Family Practice, 37*(5), 457–462.

Martin, J. A., Hamilton, B. E., Ventura, S. J., Menacker, F., & Park, M. M. (2002). Births: Final data for 2000. *National Vital Statistics Reports, 50*(5). Hyattsville, MD: National Center for Health Statistics.

© Jones and Bartlett Publishers. NOT FOR SALE OR DISTRIBUTION

May, M., & Davis-Floyd, R. (2005). Idealism and pragmatism in the creation of the certified midwife: The development of midwifery in New York and the New York Midwifery Practice Act of 1992. In R. Davis-Floyd & C. Johnson (Eds.), *Mainstreaming midwives: The politics of professionalization*. New York: Routledge.

Midwifery Education Accreditation Council. (2005). *List of midwifery schools.* Retrieved Febraury 6, 2006, from http://www.meacschools.org/programs/programs.html

Midwives Alliance of North America (MANA). (2005a). *Direct-entry midwifery state-by-state legal status.* Retrieved February 6, 2006, from http://www.mana.org/statechart.html

Midwives Alliance of North America (MANA). (2005b). *Direct-entry state laws and regulations.* Retrieved February 6, 2006, from http://www.mana.org/laws.html

Midwives Alliance of North America (MANA). (2006). *MANA core competences for basic midwifery practice.* Retrieved February 7, 2006, from http://mana.org/manacore.html

Nguyen v. Medical Quality Assurance Commission. (2001). 144 Wn.2d 516, 29 P.3d 689.

North American Registry of Midwives. (2004). *Position statement: Educational requirements to become a certified professional midwife* (CPM). Retrieved February 6, 2006, from http://www.narm.org/htb.htm#edrequirements

Payne, P. A., & King, V. J. (1998). A model of nurse–midwife and family physician collaborative care in a combined academic and community setting. *American Journal of Nurse–Midwifery, 43*, 19–26.

Payne, P. A., & King, V. J. (2001). What can midwives teach family physicians? *Clinics in Family Practice, 3*, 349–364.

Reed, A., & Roberts, J. E. (2000). State regulation of midwives: Issues and options. *Journal of Midwifery & Women's Health, 45*(2), 130–149.

Reid, A., & Galbraith, J. (1988). Midwifery in a family practice: A pilot study. *Canadian Family Physician, 34*, 1887–1890.

Reid, A. J., Carroll, J. C., Ruderman, J., & Murray, M. A. (1989). Differences in intrapartum obstetric care provided to women at low risk by family physicians and obstetricians. *Canadian Medical Association Journal, 140*(6), 625–633.

Reime, B., Klein, M. C., Kelly, A., Duxbury, N., Saxell, L., Liston, R., et al. (2004). Do maternity care provider groups have different attitudes towards birth? *British Journal of Obstetrics and Gynecology, 111*(12), 1388–1393.

Roberts, J. (1995). The role of graduate education in midwifery in the USA. In T. Murphy-Black (Ed.), *Issues in midwifery* (Vol. 1, pp. 119–161). New York: Churchill Livingstone.

Roberts, J. (2001). Revised "joint statement" clarifies relationships between midwives and physician collaborators. *Journal of Midwifery & Women's Health, 46*(5), 269–271.

Rooks, J. P. (1997). *Midwifery and childbirth in America*. Philadelphia: Temple University Press.

Rooks, J. P. (1998). Unity in midwifery? Realities and alternatives. *Journal of Nurse–Midwifery, 43*, 315–319.

Rooks, J. P. (1999). The midwifery model of care. *Journal of Nurse–Midwifery, 44*, 370–374.

Rooks, J. P., Carr, K. C., & Sandvold, I. (1991). The importance of non-master's degree options in nurse–midwifery education. *Journal of Nurse–Midwifery, 36*, 124–130.

Rosenblatt, R. A., Dobie, S. A., Hart, L. G., Schneeweiss, R., Gould, D., Raine, T. R., et al. (1997). Interspecialty differences in the obstetric care of low-risk women. *American Journal of Public Health, 87*(3), 344–351.

© Jones and Bartlett Publishers. NOT FOR SALE OR DISTRIBUTION

Sakala, C. (1988). Content of care by independent midwives: Assistance with pain in labor and birth. *Society of Scientific Medicine, 26*, 1141–1158.

Sakala, C. (1993). Midwifery care and out-of-hospital birth settings: How do they reduce unnecessary cesarean section births? *Society of Scientific Medicine, 37*, 1233–1250.

Schmittling, G., & Tsou, C. (1989). Obstetric privileges for family physicians: A national study. *Journal of Family Practice, 29*(2), 179–184.

Schuiling, K. D., Sipe, T. A., & Fullerton, J. (2005). Findings from the analysis of the American College of Nurse–Midwives member surveys: 2000–2003. *Journal of Midwifery & Women's Health, 50*, 8–15.

Scoggin, J. (1996). How nurse–midwives define themselves in relation to nursing, medicine, and midwifery. *Journal of Nurse–Midwifery, 41*(1), 36–42.

Scupholme, A., DeJoseph, J., Strobino, D. M., & Paine, L. L. (1992). Nurse–midwifery care to vulnerable populations. Phase I: Demographic characteristics of the national CNM sample. *Journal of Nurse–Midwifery, 37*(5), 341–348.

Sharp, E. S. (1983). Nurse–midwifery education: Its successes, failures, and future. *Journal of Nurse–Midwifery, 28*(2), 17–23.

Smith, M. A., Green, L. A., & Caruthers, B. (1989). Family practice obstetrics: Style of practice. *Family Medicine, 21*(1), 30–34.

Smucker, D. R. (1988). Obstetrics in family practice in the State of Ohio. *Journal of Family Practice, 26*, 165–168.

Texas Association of Nurse Anesthetists. (n.d.). *History of nurse anesthetists.* Retrieved February 6, 2006, from http://www.txana.org/AboutTANA/HxofNurseAnesthetis0973.asp

Thomas, M. W. (1965). *The practice of nurse–midwifery in the United States*. Washington, DC: Children's Bureau, U.S. Department of Health, Education, and Welfare.

Tom, S. (1982, December). Nurse–midwifery: A developing profession. *Law, Medicine and Health Care*, pp. 262–282.

Tom, S. A. (1980). Agnes Shoemaker Reinders: A biographical tribute. *Journal of Nurse–Midwifery, 25*(5), 9–12.

Tom, S. A. (1982). The evolution of nurse–midwifery: 1900–1960. *Journal of Nurse–Midwifery, 27*, 4–13.

U.S. Department of Labor, Bureau of Labor Statistics. (2005). *Registered nurses.* In *Occupational Outlook Handbook, 2004–2005*. Retrieved January 27, 2005, from http://stats.bls.gov/oco/pdf

Weaver, P., & Evans, S. K. (1998). *Practical skills guide for midwifery* (3rd ed.). Chugiak, AK: Morningstar Publishing.

White House Conference on Child Health and Protection (1930: Washington, D.C.). Eugene L. Bishop White House Conference on Child Health and Protection Collection. 1929–1931. Located in: Modern Manuscripts Collection, History of Medicine Division, National Library of Medicine, Bethesda, MD; MS C 266.

Williams, D. (2005). Professional midwifery in the United States: The American College of Nurse–Midwives turns 50. *Journal of Midwifery and Women's Health, 50*(1), 1–2.

Williams, J. W. (1912). Medical education and the midwife problem in the United States. *Journal of the American Medical Association, 2*, 180–204.

Wingeier, R., Bloch, S., & Kvale, J. (1988). A description of a CM-family physician joint practice in a rural setting. *Journal of Nurse–Midwifery, 33*, 86–92.

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Table 1–1 For Your Professional Files

Name	*Abbreviation*	*Contact*	*Web*
American Academy of Family Physicians	AAFP	P.O. Box 11210 Shawnee Mission, KS 66207-1210 Tel: (800) 274-2237	www.aafp.org
American College of Nurse–Midwives	ACNM	8403 Colesville Road, Suite 1550 Silver Spring, MD 20910 Tel: (240) 485-1800	info@midwife.org www.midwife.org
American College of Obstetricians and Gynecologists	ACOG	P.O. Box 96920 Washington, DC 20024-6920 Tel: (202) 638-5577	www.acog.org
American Midwifery Certification Board	AMCB	849 International Drive, Suite 205 Linthicum, MD 21090	www.amcbmidwife.org
Citizens for Midwifery	CfM	P.O. Box 82227 Athens, GA 30608-2227 Tel: (888) 236-4880	info@cfmidwifery.org www.cfmidwifery.org
International Confederation of Midwives	ICM	Eisenhowerlaan 138 2517 KN The Hague The Netherlands Tel: +31 70 3060520 Fax: +31 70 3555651	info@internationalmidwives.org www.internationalmidwives.org
Journal of Midwifery & Women's Health	*J Midwifery Women's Health*	8403 Colesville Road, Suite 1550 Silver Spring, MD 20910 Tel: (240) 485-1815	www.jmwh.org www.medscape.com/viewpublication/870
Midwifery Education Accreditation Council	MEAC	20 E. Cherry Flagstaff, AZ 86001 Tel: (928) 214-0997	info@meacschools.org www.meacschools.org
Midwives Alliance of North America	MANA	375 Rockbridge Road Suite 172-313	info@mana.org www.mana.org

continues

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		Lilburn, GA 30047 Tel: (888) 923-6262	
National Association of Certified Professional Midwives	NACPM	243 Banning Road Putney, VT 05346 Tel: (866) 704-9844	lawcing@sover.net www.nacpm.net
National Center for Health Statistics, source of data on number of births attended by birth attendant and place of birth, United States, by year	NCHS	3311 Toledo Road Hyattsville, MD 20782 Tel: (301) 458-4000	www.cdc.gov/nchs
North American Registry of Midwives	NARM	5257 Rosestone Dr. Lilburn, GA 30047 Tel: (888) 842-4784	info@narm.org www.narm.org

Document	*Link*
AAFP Policy on Nurse–Midwives	www.aafp.org/x6945.xml
ACNM Standards for the Practice of Midwifery	www.midwife.org/display.cfm?id=485
Jenkins, S.M. (1994). The myth of vicarious liability: Impact on barriers to nurse-midwifery practice. *J Nurse Midwifery, 39*, 98–106.	www.midwife.org/display.cfm?id=495
ACNM Professional Liability Information Packet	www.midwife.org/siteFiles/about/Professional Liability_RP.pdf
International definition of "midwife"	www.medicalknowledgeinstitute.com/files/ICM%20 Definition%20of%20the%20Midwife%202005.pdf
MANA's Statement of the Core Competencies for Basic Midwifery Practice	www.mana.org/manacore.html
Legal status of direct-entry midwives in the US	Direct-entry laws by state: www.mana.org/laws.html Direct-entry legal status by state: www.mana.org/statechart.html