PART

I

Midwifery

CHAPTER

1

The History and Profession of Midwifery in the United States

HELEN VARNEY BURST

> *And it came to pass, when she was in hard labour, that the midwife said unto her, Fear not….*[1]

The voice of this midwife echoes down to us through history from antiquity. Midwifery is as old as the history of *Homo sapiens*. Fulfilling its meaning of "with woman," midwifery has survived through the centuries as birth—the renewal of life—continues through the ages. Midwives are referred to in many ancient texts, including Chinese, Greek, Roman, Egyptian, and Hebrew texts as well as ancient writings from India, South America, and Africa. It is meaningful that the first known words spoken by a midwife are "fear not."

Definitions and Practice

Today midwifery is an internationally recognized profession with practitioners throughout the world. The following international definition of a midwife and scope of practice was adopted by the International Confederation of Midwives (ICM) during a Council meeting in 2011 and supersedes previous versions:

> A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM *Essential Competencies for Basic Midwifery Practice* and the framework of the ICM *Global Standards for Midwifery Education*; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title "midwife"; and who demonstrates competency in the practice of midwifery.
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> **Scope of Practice**
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> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.
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> The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.[2]

In the United States, midwifery education that meets the standards of the American College of Nurse-Midwives (ACNM) goes beyond the scope of practice defined by ICM to include the primary health care of newborns and of women from puberty through senescence.[3,4] The ACNM defines midwifery and the

scope of practice of certified nurse-midwives (CNMs) and certified midwives (CMs) as follows:

> Midwifery as practiced by certified nurse-midwives (CNMs®) and certified midwives (CMs®) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include the independent provision of primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling. These services are provided in partnership with women and families in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers.[5]

The American College of Nurse-Midwives defines CNMs and CMs as follows:

> CNMs are educated in two disciplines: midwifery and nursing. They earn graduate degrees, complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM.[5]
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> CMs are educated in the discipline of midwifery. They earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by ACME, and pass the same national certification examination as CNMs to receive the professional designation of CM.[5]

Certification gives official recognition to an individual who has met professional standards for safe practice and protects the public. Certification is conferred upon an individual who has met eligibility requirements for and successfully passed the national certification examination of the ACNM-designated certifying agent, currently the American Midwifery Certification Board (AMCB; formerly the ACNM Certification Council). As of January 1, 2011, all CNMs/CMs have time-limited certificates and must renew their certification every 5 years by meeting specific continuing education requirements. Those CNMs/CMs who are permanently retired from practice are in a different category of certification that identifies this nonpractice status. AMCB certification differentiates certified nurse-midwives and certified midwives, and their broad scope of practice, from other types of midwives.[6]

Beliefs Characterizing Midwifery

A number of beliefs are central to midwifery practice and characterize the health care given by midwives. Collectively, these beliefs and their implementation constitute the midwifery model of care. These beliefs include facilitation of natural processes and nonintervention in normal processes; continuity of care; promotion and implementation of family-centered maternity care; advocacy for the woman and her rights and responsibilities; and education of women to facilitate their knowledgeable participation and decision making in their health care and for understanding their bodily processes. Midwives also support preventive health care, the reduction of maternal and infant mortality and morbidity, the role of the midwife within the community, and the contribution of midwifery within the healthcare system. These beliefs are expressed in the Hallmarks of Midwifery in the ACNM Core Competencies for Basic Midwifery Practice.[4]

The philosophy of the American College of Nurse-Midwives states beliefs that support and provide a base for the characteristics of health care given by nurse-midwives:

> We, the midwives of the American College of Nurse-Midwives, affirm the power and strength of women and the importance of their health in the well-being of families, communities and nations. We believe in the basic human rights of all persons, recognizing

that women often incur an undue burden of risk when these rights are violated.

We believe every person has a right to:

- Equitable, ethical, accessible quality health care that promotes healing and health
- Health care that respects human dignity, individuality and diversity among groups
- Complete and accurate information to make informed health care decisions
- Self-determination and active participation in health care decisions
- Involvement of a woman's designated family members, to the extent desired, in all health care experiences

We believe the best model of health care for a woman and her family:

- Promotes a continuous and compassionate partnership
- Acknowledges a person's life experiences and knowledge
- Includes individualized methods of care and healing guided by the best evidence available
- Involves therapeutic use of human presence and skillful communication

We honor the normalcy of women's lifecycle events. We believe in:

- Watchful waiting and non-intervention in normal processes
- Appropriate use of interventions and technology for current or potential health problems
- Consultation, collaboration and referral with other members of the health care team as needed to provide optimal health care

We affirm that midwifery care incorporates these qualities and that women's health care needs are well-served through midwifery care.

Finally, we value formal education, lifelong individual learning, and the development and application of research to guide ethical and competent midwifery practice. These beliefs and values provide the foundation for commitment to individual and collective leadership at the community, state, national and international level to improve the health of women and their families worldwide.[7]

Individual CNMs and CMs also articulate these beliefs when writing about their practice or service philosophy or presenting to the public or teaching students. Nancy Fleming, CNM, PhD, captured the spirit and substance of a discussion in 1993 by the ACNM Board of Directors of the elements that distinguish midwifery when she wrote *The Heart of Midwifery*:

> The heart of midwifery care for women and newborns lies more in the nature of that care than in its specific components. Midwifery practice has a firm foundation in the critical thought process and is focused on the prevention of disease and the promotion of health, taking the best from the disciplines of midwifery, nursing, public health, and medicine to provide safe, holistic care.
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> Midwives are partners with women in the provision of health care, engaging in a dynamic reevaluation of each woman's unique health needs.
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> Midwives would rather nurture a woman's progress with hands-on care than diagnose her problems from afar,
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> …rather listen than lecture,
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> …rather teach a health principle than treat an illness,
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> …rather empower a woman to join in decision making than decide for her,
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> …rather urge her to speak for herself than to be her advocate,
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> …rather instill a woman with trust in her body than demonstrate the midwife's technical proficiency
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> although midwives will do all these things when necessary.
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> Midwifery is a profession born of a woman's vision, nurtured in an understanding of women's developmental phases, and committed to assuring women in all populations that it is their birthright to be part of this unique care.[8]

These beliefs have had practical application throughout the history of nurse-midwifery in the United States. Through the Maternity Center Association in New York City, nurse-midwives were active in the

1930s in the provision of prenatal care and parent education; they were in the forefront of the early movements in the 1940s related to family-centered maternity care, natural childbirth, and preparation for childbirth and parenthood. In the 1950s and 1960s, nurse-midwives led the efforts to promote breastfeeding, rooming-in, and the inclusion of fathers or significant others in hospital labor and delivery rooms. They also provided leadership in the development of birth centers in the late 1970s and the birth center movement in the 1980s.

More recently, nurse-midwives have been involved in key veins of research. The development of the Optimality Index—United States (adapted from an Optimality Index used in the Netherlands) was undertaken by Patricia Aikens Murphy, CNM, DrPH, and Judith Fullerton, CNM, PhD; it "measures the process of care and associated outcomes in a single index."[9] Moreover, the qualitative research done by Holly Kennedy, CNM, PhD, has identified the practice characteristics and processes of exemplary midwives. From her research, Dr. Kennedy developed a model of exemplary midwifery care that, in her words, "provides structure for future research on the unique aspects of midwifery care to support its correlation with excellent outcomes and value in health care economics."[10]

Early History of Midwifery in the United States

For the purposes of this text, the history of midwifery in the United States begins with the arrival of colonists in the New World. Midwives were among the first women to settle the colonies. Although there were midwives among the Native Americans, their history has not been extensively researched.

Midwives were considered vital to colonial community life and were treated with dignity. Special courtesies were extended to midwives, and arrangements were made to provide them with housing, land, food, and salary as payment for their services. This information is noted in town records and charters of the mid-seventeenth century. Birth-related services, however, were just one of many healthcare contributions colonial midwives made to the community. They also often functioned as herbalists, veterinarians, and nurses who tended the sick and the dying and prepared the body after death.[11]

During antebellum slavery from 1800 until the Civil War, the African American midwife provided midwifery and healthcare herbalist services for both black and white women on plantations. Midwives were valued slaves. A slave midwife contributed financially to her owner both as a cost saving for the plantation she was on and through payments for her services on other plantations made to her owner.[12]

During the nineteenth century, pioneer women crossed the plains in covered wagons, followed the Oregon and Santa Fe trails, settled the "Wild West," and bore children with the assistance of other women in the wagon trains, forts, or settlements who functioned as midwives in the situation.[13] Mormon history documents the honorable role and heroic work of midwives during that group's trek from Illinois to Utah in 1846 and 1847.[14]

Despite the initial honor accorded midwives in the colonies and their importance to other segments of the population through the years, a series of factors reduced midwifery from a respected profession to one in disrepute by the early twentieth century. These factors included religious attitudes, economic demands, replacement by physicians, lack of access to education, lack of organization or legal recognition, an influx of immigrants, and the low status of women.

Factors Leading to the Decline of Midwifery: Seventeenth to Late Nineteenth Centuries

Religious restrictions plagued midwives from the beginning. Most of the early midwives came from England, where in the seventeenth century the licensing of midwives took place under the auspices of the Church of England. Criteria were moralistically judgmental; they emphasized good character and granted the ability to denounce sins and to baptize. The midwives' oath included a vow to pressure the mother into naming the true father. The results of such actions were not always appreciated. Conversely, in the Puritan communities, midwives were often suspected of witchcraft, especially if a malformed baby was born.

By the early eighteenth century, there was no organization or authority to establish guidelines for fees. Compensation was not always adequate, so practicing midwifery was no longer economically feasible for many women. This was especially true in the rapidly growing towns and cities.

In European society in the late eighteenth century, it was fashionable to have male midwives (physicians) for lying-in. This trend soon crossed the ocean, where physicians capitalized on it. Historian

Claire Fox offers this analysis of the historical roots of antipathy toward the midwife:

> As the practice of medicine became highly competitive, physicians and medical students were advised that their presence at a delivery would insure the entire family as grateful patients thereafter. For example, the outspoken and highly influential Dr. Walter Channing, of Harvard, objected strongly to the practice of midwifery by women in his "Remarks on the Employment of Females as Practitioners in Midwifery," (1820) and pointed out that "Women seldom forget a practitioner who has conducted them tenderly and safely through parturition—they feel a familiarity with him, a confidence and reliance upon him which is of the most essential mutual advantage.…It is principally on this account that the practice of midwifery becomes desirable to physicians. It is this which ensures to them the permanency and security of all their other business.[15]

Male physicians thus replaced female midwives.

The eighteenth and nineteenth centuries marked a time of rapid development in medical and nursing science and of discoveries and teaching pertinent to obstetric practice. These developments included the end of the Chamberlen family secret of forceps and subsequent refinement of these instruments, technical advances that decreased the risks involved in cesarean section, pioneering efforts in obstetric anesthesia, conquest of puerperal fever, emergence of modern nursing in the 1860s, and inclusion of obstetrics in medical practice. Physician promises of relief from pain during childbirth, the use of chloroform by Queen Victoria during childbirth in 1850, the corresponding evolution of understanding of the nervous system with the development of spinal methods of analgesia and anesthesia,[16] the need for women receiving obstetric analgesia and anesthesia to be in the hospital, and the lack of access to hospitals by midwives all contributed to decreased use of midwives.

The observations and teachings of William Smellie (1697–1763), who developed teaching manikins and kept meticulous records of his patients, identified the mechanisms of labor and refuted any number of myths and misconceptions. The anatomical studies of William Hunter (1718–1783) included discoveries pertaining to the lymphatic system, placental circulation, and pregnant uterus. William Shippen, Jr. (1736–1808), the first lecturer on obstetrics, and Samuel Bard (1742–1821), author of the first American textbook on obstetrics, are credited with promoting obstetrical teaching in the United States. All made measurable contributions to the science and art of obstetrics.[17,18]

These developments, new knowledge, and teachings were not accessible to the midwife because of the relative isolation of midwives from one another and the lack of schools, national organizations, journals, legal recognition, or other means of communication among midwives. Any one of these structures would have provided a channel for learning. Without them, the knowledge and practice of the midwife became sadly out-of-date even as advanced medicine and modern nursing came to the fore.

Further, women were not considered to have the mental capacity for higher learning and were deliberately excluded from admission to organizations devoted to higher learning. Historian Judy Litoff writes:

> The development of formal medical education in America…provided potential male midwives with a decided advantage over their female counterparts. By the end of the eighteenth century, four medical schools, all restricted to male students, had been established on American soil. This meant that women were being systematically excluded from attaining a medical education at the precise time when knowledge of the scientific advances in obstetrics would have enabled them to become more competent midwives. Once this process had begun, it became increasingly difficult for midwives to keep up with the medical discoveries of the nineteenth century which eventually brought about the development of modern obstetrics.[19]

The Early Twentieth Century

The Industrial Revolution at the end of the nineteenth century brought an influx of immigrants from a number of European countries who formed pockets of cultural communities within cities. Each such community had its own midwives who came from the "old country." The vast majority were well-prepared midwives in their own country[20] but had the combined problems of not speaking English and not having access to the existing healthcare system. Their African American counterparts in the rural South also could not gain access to the formal healthcare system and were poorly educated because of racism and Jim Crow segregation laws. These "granny" midwives frequently passed the practice of midwifery

from mother to daughter, learned through experience, and relied heavily on patience, home remedies, and prayer, as these were the only resources available to them and the women they served.

There were also Caucasian "granny" midwives such as those in Appalachia[21] and in the Ozarks of Southern Missouri.[22] In California and the Southwest, women of Spanish descent—*Californiana* midwives and Mexican *parteras* (midwives)—served their communities in multiple capacities.[23] In Hawaii and the Pacific Northwest were immigrant educated *Sanba* midwives from Japan.[24] Lack of licensure, organization, formal education programs, and a means by which to communicate with one another, as well as the scientific developments and social factors, combined to prevent midwives in all parts of the United States from having access to the official healthcare system during this era.

The low status of women in general at the beginning of the twentieth century also affected the education and work of midwives. Norma Swenson, in her analysis of social factors affecting the history of midwifery in the United States, makes the following comments:

> But the final and I think more significant point was that the status of women at the turn of the century was at a particularly low ebb. At that point in time women were regarded as economically exploitable but at the same time socially and politically incompetent, in the sense that they were perceived as being unfit to exercise good judgment concerning their own affairs or the affairs of others, and in fact were legally prevented from doing so. Paternal domination of home and society was at an all-time high.
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> It was then in this kind of atmosphere that midwives were outlawed and women were, therefore, in effect blamed for the appalling conditions under which mothers and babies died at that time, when in fact women were powerless to control social conditions, and coped as midwives as well as they could with circumstances which were largely the product of a man-made industrial and social revolution.[25]

The "Midwife Problem"

In 1906, a study was done on midwifery practice in New York City. The study specifically looked at ethnicity, length of time in the United States, age, level of education, ability to speak English, midwifery training, indication of economic status, personal and environmental cleanliness, length of time in practice, scope of practice (i.e., inclusion of complications in childbearing, criminal abortion), and contents and cleanliness of the midwifery bag. The study was conducted by a nurse under the auspices of the Public Health Committee of the Association of Neighborhood Workers (an organization of social workers). However, the discussion overstated the findings and the report ended with a diatribe that concluded that 42% (more than 43,000 mothers) of the total number of births reported for 1905 in greater New York were attended by "incompetent, ignorant, unclean midwives."[26] Although the midwives were no more responsible than the physicians for the high maternal and infant mortality rates at that time, they bore the brunt of the blame.[27] This report generated a debate over what became known as the "midwife problem."

All too soon, the various factors that contributed to the decline and disrepute of midwifery converged. Between 1912 and 1914, the licensing and practice of midwives became a topic of heated debate. During this time, medical schools began to include obstetrics in their curricula, and by 1930, obstetrics had become an established medical specialty. Obstetric care began to move out of the home and into the hospital, and laws were passed to regulate the practice of the indigenous midwives.

On one side of the debate were a majority who believed that all midwifery should be abolished; on the other side were those who believed midwives could perform a valuable function. The former feared the status midwives would gain if they achieved legal recognition and promoted the idea that improving the practice of midwives was an impossible task. Those in favor of continuing midwives' practice suggested that midwifery was a feasible option if these providers were given proper training, licensing, and supervision.

One significant event that influenced the outcome of the debate over the "midwife problem" took place while the debate raged. This event grew out of reality. Some states had already passed laws granting legal recognition to midwives that included requirements and specifications aimed at control of their practice. These laws were passed in an effort to reduce high mortality rates, as it was evident that the medical profession could not assume the entire task of obstetric care. In the South, licensure, education, and supervision of African American midwives was facilitated by the Sheppard-Towner Act from 1921 to 1929.[28] This legislation assigned money, administered through the

Children's Bureau, for providing better maternal–infant care. Included in the Act was the specification that public health nurses should be employed for the instruction of untrained midwives.

As a result of laws to regulate midwifery practice, a number of midwifery schools were established. The best known of these institutions were the Bellevue School of Midwifery in New York City and the Preston Retreat Hospital in Philadelphia. The Bellevue School of Midwifery, designed to instruct immigrant midwives in meeting requirements for practice, operated from 1911 until 1935, when it was closed by order of the New York City Commissioner of Hospitals, a physician. In his opinion, changing social and medical standards rendered the school superfluous and an unnecessary expense to the city. To support his action, he cited a decrease in the number of midwives as deliveries in hospitals had increased to 81% of all births in New York City.[29] The Preston Retreat was a maternity hospital founded in 1836. In 1916, a practical nurse education program was started there, and in 1923 a course in midwifery was introduced that eventually had both practical nurses and registered nurses for students. Enrollment dwindled, but the midwifery course continued until 1960. It is not known when registered nurses (RNs) were first admitted to the course.[30]

Although midwives were first placed under physician control in Illinois in 1896, the word "supervision" in relation to their practice does not appear until the 1907 report of the 1906 study of midwifery in New York City and subsequently in New York City statutes the following year. Thereafter, "supervision" appeared with increasing frequency in both the literature and regulations, and the concept was well established by the time nurse-midwives came into existence in the United States during the 1920s and 1930s.[31]

The debate over the "midwife problem" culminated in the legal registration, regulation, and restriction of midwives and the practice of midwifery; the introduction of nurse-midwives from Europe; and the development of nurse-midwifery in the United States. However, the price for the introduction of nurse-midwifery in the United States was the loss of autonomy that midwives originally had in exchange for credibility and access to the healthcare system.[32]

When nurse-midwifery began in the United States in the 1920s, it faced rancorous opposition. The profession was allowed to exist *only* if it was attached to nursing and *under* the auspices of medical supervision and control. It is necessary to be knowledgeable about this context within which nurse-midwifery developed to understand that the compromises made at that time were necessary for midwifery to survive in the United States. Those compromises made nearly a century ago still influence current-day philosophical, interprofessional, and practice issues.[32]

The Start of Nurse-Midwifery

The early supporters and proponents of midwifery clearly saw that midwifery, on its own, would not be able to survive as a profession in the United States. The concept of nurse-midwifery was first promoted around 1911–1914. The combination of nursing and midwifery represented a natural marriage of women's professions. Nursing was an established profession with access to the healthcare system; it was also a means by which women could obtain an education. The idea was to teach nurses to perform midwifery services in normal cases. Nursing was interested in midwifery from a public health viewpoint because maternity care was abysmal at that time. Even opponents of midwifery were supportive of nurse-midwifery as a lesser evil.[32]

The first two decades of the twentieth century are notable for the recognition of the woeful inadequacy of maternity care and subsequent actions taken to improve this care. The establishment of the Children's Bureau in Washington, D.C., in 1912 and the Maternity Center Association in New York City in 1918 had an immense influence on improvements in maternal–infant health care and the introduction of nurse-midwifery.

The Children's Bureau

In 1903, Lillian Wald, a nurse and founder of the Henry Street Settlement and the Visiting Nurse Association in New York City, suggested the formation of a federal children's bureau. President Theodore Roosevelt recommended a bill to establish such a bureau in 1909, but it was not until 1912 that the U.S. Congress passed a bill, which President Taft signed, establishing the Children's Bureau.

The stated purpose of the Children's Bureau was to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people."[33] The first act of the Children's Bureau was to conduct a study of infant deaths, which, according to available statistics, documented an infant mortality rate of approximately 124 deaths per 1000 live births.[27] It is to the Children's Bureau's credit that in analyzing the data from its first study, the organization identified the inescapable link between infant health and maternal health during

the maternity cycle. The Children's Bureau then conducted studies of maternal mortality and conclusively established the importance of early and continuous prenatal care in reducing both maternal and infant mortality.[34] Thanks to the publication of this information, the idea of prenatal care gained respectability and the concept of health care throughout the intraconceptional period began to grow.

The Maternity Center Association

In 1915, the New York City Health Commissioner made another study of maternal and infant mortality. The findings of this study, which again demonstrated the connection between mortality and lack of prenatal care, led to the formation of a plan whereby the city was zoned and a maternity center was established in each zone. The first such maternity center opened in 1917. The need for central organization quickly became evident, and the Maternity Center Association (MCA) was established in 1918. By 1920, MCA had 30 maternity centers in New York City. From this network grew MCA's first endeavors in developing teaching materials and educational exhibits for use by individuals and agencies. In 1921, the association decided to concentrate its efforts on a demonstration of providing complete maternity care in one district and to cease the scattered efforts being carried out in its many centers, although some of the other clinics were maintained for a while longer. This decision was based on the belief that most nursing agencies and hospitals caring for families were now giving sufficient emphasis to prenatal care in their healthcare services.[35]

In the meantime, MCA and the Henry Street Visiting Nurse Association collaborated on a study that illustrated the value of specialized maternity care within a generalized public health nursing program. Subsequently, MCA embarked on an intensive educational program in maternity care for both the public and professional health personnel, especially physicians and public health nurses. When requests for assistance on this front from all over the country became too numerous to accommodate them all in New York City, MCA developed Maternity Institutes, taught by a traveling MCA nurse equipped with a duplicate of the teaching materials used at MCA. By 1935, half of all employed public health nurses in the country had attended a Maternity Institute either in their own community or in New York City.[35,36]

MCA also expanded its efforts beyond New York City to supply information about the need for maternity care to expectant parents throughout the United States. Mother's Day was dedicated to this endeavor for several years, with an emphasis on saving mothers' lives. The mayors of cities made Mother's Day proclamations regarding saving mothers' lives, and ministers preached their Mother's Day sermons on the subject, using packets of educational materials sent by MCA.[36]

On the basis of its demonstration of the benefits of providing complete maternity care, its collaboration with the Henry Street Visiting Nurse Association, the study of maternity care in other countries, and the enthusiasm of public health nurses who had attended the Maternity Institutes, MCA concluded that there was a need to prepare nurses to handle normal obstetric care and discussed opening a school of nurse-midwifery. This idea was temporarily thwarted in the early 1920s by bitter opposition from both medicine and nursing and by a lack of cooperation from the New York City Commissioner of Welfare.[36]

In the meantime, Mary Breckinridge was preparing to introduce nurse-midwives from Europe. Nurse-midwives had proved their effectiveness in European countries, where they were an established part of the healthcare system.

The Frontier Nursing Service

The first nurse-midwives to practice in the United States were British-trained nurse-midwives brought to this country in 1925 by Mary Breckinridge as part of her plan to provide health care for families in the remote rural areas of the Kentucky mountains. This endeavor was organized as the Kentucky Committee for Mothers and Babies in May 1925; through a change in its articles of incorporation, it became the Frontier Nursing Service (FNS) in 1928.[37] Thus FNS traces its history back to, and dates itself from, 1925.

Mary Breckinridge was admirably suited for the task she undertook. Her qualifications included a family background and upbringing that gave her a wealth of influential contacts. Her professional preparation as a registered nurse at St. Luke's Hospital in New York City; study of public health at Teacher's College, Columbia University; and work as a traveling lecturer for the Children's Bureau[38] had brought her into contact with advocates for public health nurses becoming midwives and related developments in New York City. She also trained as a state-certified midwife in England. Mrs. Breckenridge conducted a carefully self-designed program of observation and study of the Highlands and Islands Medical and Nursing Service in Scotland, concentrating on the Outer Hebrides, with further study in England. From this background and her experiences abroad, she developed a plan involving outpost nursing centers staffed by nurse-midwives and backed by a medical director located at a small, local, rural

hospital. Her program was to be administered by a director, overseen by an executive committee and board of trustees, and supported by local committees throughout the United States. Before the work began, a survey of births and deaths in the region where the nurse-midwives planned to work was conducted to provide baseline data for subsequent statistics and research. In her book *Wide Neighborhoods,*[37] Mary Breckinridge wrote in fascinating detail of the myriad activities, people, concerns, and problems involved in bringing her plan to fruition.

The work and record of the Frontier Nursing Service (**Figure 1-1**) are legendary. The records kept during the earlier years were in accord with a statistical system set up by the Carnegie Corporation and tabulated by statisticians from the Metropolitan Life Insurance Company. In 1951, the FNS statistics showed that 8596 registered nurse-midwifery clients had been delivered since 1925, 6533 of whom were delivered in mostly primitive homes, with a gross maternal death rate of 1.2 per 1000 (or 12 per 10,000 live births) for the 25 years studied.[37(p311)] This mortality rate was in contrast to national maternal mortality rates of 66.1 per 10,000 live births in 1931, 37.6 per 10,000 live births in 1940, and 8.3 per 10,000 live births in 1950.[39] The total number of FNS maternal deaths was 11, which included 2 deaths that were actually due to cardiac conditions but occurred within the puerperal period. Subtracting those 2 deaths gives FNS a puerperal death rate of 9.1 per 10,000 live births—far less than the national puerperal death rate of 34 deaths per 10,000 live births among white women for the same period (1925–1954), during which there were 10,000 FNS confinements.[40]

In addition to providing maternity care, the FNS brought a comprehensive scope of healthcare services to its target rural population. These services included general dental, pediatric, medical, and surgical services; general eye, tonsil, and worm treatment services; special tuberculosis and trachoma services; and social services supported by Alpha Omicron Pi, the national sorority of social workers, as its national philanthropic project.[37]

World War II had a large impact on the Frontier Nursing Service, both in staffing levels and in the direction the war mandated for nurse-midwifery education at FNS. Great Britain had been both the source of British nurse-midwives working in the Frontier Nursing Service and the provider of midwifery education for U.S. registered nurses, who were sent to Great Britain for their education and returned to work at FNS. With the advent of war, the British nurse-midwives wanted to return to their homeland to be of service to their country. It became evident that a long-deferred plan for an educational program in nurse-midwifery in the United States had to be instituted immediately.

The Frontier Graduate School of Midwifery started with a class of two students in November

Figure 1-1 A nurse-midwife of the Frontier Nursing Service in a home in Kentucky, circa 1950.
Source: Reproduced by permission from Frontier Nursing Service, Hyden, Kentucky.

1939.[37(p324)] In 1970, the school changed its name to the Frontier School of Midwifery and Family Nursing (FSMFN) when a Family Nurse Practitioner Program was begun. This program closed in 1991 and then was resurrected in 1999 as the Community-Based Family Nursing Education Program (CFNP), and in 2011 the institution was renamed Frontier Nursing University. In the meantime, midwifery education at FNS continued without pause, and in 1989 became the Community-Based Nurse-Midwifery Education Program (CNEP). In 2004, FSMFN was accredited as an independent graduate school by the Southern Association of Colleges and Schools. This was followed in 2005 by institutional accreditation for the school and continuing programmatic accreditation for the nurse-midwifery program by the American College of Nurse-Midwives and programmatic accreditation by the National League for Nursing for the nurse practitioner programs.

Although FNS started the first nurse-midwifery service in the United States, it did not have the first nurse-midwifery education program in the United States.

The Early Nurse-Midwifery Education Programs

The Manhattan Midwifery School

The first school established specifically to educate graduate nurses to be midwives was the Manhattan Midwifery School, which opened in New York City in 1925. This institution was affiliated with the Manhattan Maternity and Dispensary, a hospital specializing in maternity care. The midwifery course was initiated by Emily A. Porter who was a registered nurse and superintendent of the hospital. The program was placed under the jurisdiction of the hospital's School of Nursing. Plans for this program were formulated during 1924, and there were three graduates from the 4-month course in 1925. The 1927 Annual Report of the Manhattan Maternity and Dispensary states that "this is the only school in the country offering such a course at present."

In 1928, Mary M. Richardson, RN, BS, a public health nurse who was a graduate of St. Luke's Hospital in New York City and of Columbia University Teachers' College, and who had studied midwifery at the Hospital for Mothers and Babies in London, became the Directress of the School of Nursing and the course in midwifery. Two of the program's 1928 graduates went to work with the Frontier Nursing Service. By 1929, the course was 6 months in length. The 1931 annual report, however, noted that Mary Richardson had left as Directress of Nursing to return to public health work and that the course had ended:

> The Midwifery Course for graduate nurses started in 1925 has been discontinued during the last year as it was becoming more and more difficult to get enough District cases to take care of the needs of Medical Students…. It was the first and only Midwifery School for graduate nurses in the country. We are glad to hear that a similar one has recently been opened in New York City—The Lobenstine Midwifery Clinic to which we may refer our many applicants.[41]

There were at least 18 graduates of the Manhattan Midwifery School.[41]

The Lobenstine Midwifery School

The School of the Association for the Promotion and Standardization of Midwifery was more commonly known as the Lobenstine Midwifery School, named for one of the charter members, Dr. Ralph Waldo Lobenstine. The Association for the Promotion and Standardization of Midwifery was the creation of Maternity Center Association, which was convinced of the need for nurse-midwives whose preparation would combine U.S. education in obstetric nursing with the education received by the professional European midwife. [42]

By the 1930s, much had happened to create a more favorable atmosphere since the abortive attempt by MCA in the early 1920s to establish a nurse-midwifery education program. There was growing recognition of how obstetric conditions in the United States compared poorly with those in other countries, which had much lower mortality rates and well-organized systems of educated and supervised midwives. Publicity spread about the conclusive proof gathered by the Frontier Nursing Service of the value of a system utilizing nurse-midwives, the work of MCA in parent education, and its demonstration with the Henry Street Visiting Nurse Association of the value of specialized maternity nursing care.

The Association for the Promotion and Standardization of Midwifery was incorporated in early 1931 by three members of the medical board of the Maternity Center Association and its general director, Hazel Corbin, RN. Ralph Waldo Lobenstine, MD, chairman of the medical board of MCA since 1918, was one of the charter members, as was Mary

Breckinridge, director of the Frontier Nursing Service. Lobenstine worked tirelessly until his death in 1931 to bring about the establishment of nurse-midwifery services and education. The determination of the members of the Association for the Promotion and Standardization of Midwifery and the financial support of a group of 60 former patients and friends of Lobenstine led to the establishment of the Lobenstine Midwifery Clinic, Inc., in November 1931.[42]

The nurse-midwifery services provided through the clinic consisted of prenatal care and patient education at the clinic, intrapartum and postpartum care in the woman's home except when hospitalization was required for medical reasons, and postpartum checkups at 14 days and 6 weeks in the clinic. Four attending obstetricians provided their services at medical clinics and round-the-clock consultation and, if necessary, were present in the woman's home for delivery. During the 26 years the Lobenstine Clinic provided clinical services (1932–1958), a total of 7099 births were attended, of which 6116 took place in women's homes. The maternal mortality rate of the clinic was 0.9 per 1000 live births, as contrasted to a maternal death rate of 10.4 per 1000 live births for the same geographic district as a whole and 1.2 per 1000 live births for a leading hospital in New York City at that time.[42]

Organizational and administrative details of the clinic were worked out and a curriculum was designed for the school. The latter was guided by British curricula but modified to meet the needs, cultural patterns, and healthcare systems in the United States. Hattie Hemschemeyer, RN, BS, MA, a public health nurse educator, was named director of the Lobenstine Midwifery Clinic and School. Rose McNaught, RN, CM, a public health nurse who had obtained her midwifery preparation in London and then returned to work at the Frontier Nursing Service, was loaned to Lobenstine by FNS to help develop the program. She joined the Lobenstine staff as a clinician and faculty member. The school opened in September 1932 and had six graduates in 1933, including Hattie Hemschemeyer.

By 1934, the memorial funds that had been pledged to establish and maintain the school and clinic for 3 years were exhausted. Therefore, in 1934, MCA and the Lobenstine Midwifery Clinic consolidated under the name and auspices of Maternity Center Association, which also assumed administrative and financial responsibility for the School of the Association for the Promotion and Standardization of Midwifery.[42] Thus MCA traces the history of its school of nurse-midwifery back to 1932.

The Maternity Center Association School of Nurse-Midwifery (**Figure 1-2**) graduated 320 students between 1933 and 1959, utilizing the services provided by the Lobenstine Clinic for educational purposes. In 1958, it moved inside a major medical and educational institution, and was established in the Downstate Medical Center, State University of New York in Brooklyn, New York; students used Kings County Hospital for clinical experience. This move was facilitated by Hazel Corbin, RN, executive director of MCA; Marion Strachan, CNM, BS, MA, director of the nurse-midwifery program; and Louis Hellman, MD, chairman and professor of obstetrics and gynecology at Downstate Medical Center and Kings County Hospital.

Subsequent Early Education Programs

Today, almost all of the nurse-midwifery and midwifery education programs that are accredited by the Accreditation Commission of Midwifery Education of the American College of Nurse-Midwives can trace their beginnings to the Maternity Center Association's School of Nurse-Midwifery because they were started by either graduates or students of graduates of the MCA program. The exception is the FNS Frontier Graduate School of Midwifery and a handful of programs started by Frontier Nursing Service graduates.[43]

Figure 1-2 A new nurse-midwifery student (Margaret Thomas) in the 1930s being greeted by faculty member Rose McNaught at the Maternity Center Association Lobenstine Clinic and School.
Source: Reproduced by permission from Maternity Center Association, New York, New York.

By the end of the 1950s, seven nurse-midwifery education programs were in operation in the United States. They are listed here with their starting dates, names, and locations as of 1960:

- 1932: School of the Association for the Promotion and Standardization of Midwifery (became the Maternity Center Association School of Nurse-Midwifery in 1934; affiliated with Downstate Medical Center, State University of New York, and Kings County Hospital, Brooklyn, New York, in 1958; also includes an early affiliation of MCA and Kings County Hospital with Johns Hopkins University during 1958–1960)
- 1939: Frontier Graduate School of Midwifery of the Frontier Nursing Service, Hyden, Kentucky
- 1945: Catholic Maternity Institute School of Nurse-Midwifery, Santa Fe, New Mexico
- 1947: Catholic University of America, Washington, DC (affiliated with Catholic Maternity Institute)
- 1955: Columbia University Graduate Program in Maternity Nursing, New York City, New York
- 1956: The Johns Hopkins University Nurse-Midwifery Program, Baltimore, Maryland
- 1956: Yale University Graduate Maternal and Newborn Health Nursing Program, New Haven, Connecticut

Three of these programs subsequently closed: Catholic Maternity Institute (1968); Catholic University of America (1968), which has the distinction of being the first nurse-midwifery education program to be part of a master's degree program; and the Johns Hopkins University Nurse-Midwifery Program (1981). In addition to the closure of the Manhattan Midwifery School in 1931 and the Preston Retreat School of Midwifery in 1960, two other schools opened and closed during the 1940s:

- 1941–1946: The Tuskegee School of Nurse-Midwifery in Tuskegee, Alabama; a joint project of the Macon County Health Department, the Children's Bureau, the Julius Rosenwald Fund, Tuskegee University (although not officially part of Tuskegee University), and the Alabama State Department of Health. Graduated 31 students.[44]
- 1942–1943: The Flint-Goodridge School of Nurse-Midwifery in New Orleans, Louisiana; in connection with Flint-Goodridge Hospital and Dillard University.

The Flint-Goodridge School of Nurse Midwifery graduated two students[45] and has the distinction of being the first nurse-midwifery program to be affiliated with a university.

The 1940s and 1950s

The early graduates from MCA went into a variety of positions, with their only common denominator being their goal of improving maternity care. The majority of graduates either practiced or taught clinical nurse-midwifery in MCA or FNS programs or became involved with various aspects of public health. A number of nurse-midwives in public health went to work in state health departments in positions designed for the supervision and teaching of indigenous midwives. These positions were in keeping with one of the original purposes of the Sheppard Towner Act—that public health nurses be employed for the instruction of untrained midwives. As many of the early MCA graduates were also public health nurses, they were ideally prepared for working in rural maternity care, where the majority of indigenous midwives practiced.

Other graduates held positions as maternal–child health consultants for state boards of health or within the federal bureaucracy. Still other graduates became involved in the nurse-midwifery education programs at Tuskegee Institute in Alabama and the Flint-Goodridge School in Louisiana.

In 1944, members of the Medical Mission Sisters (a Roman Catholic order) who were graduates of the MCA program started the Catholic Maternity Institute (CMI) in Santa Fe, New Mexico. Births took place in the home or in La Casita, the first nurse-midwifery birth center. In 1947 Catholic University of America affiliated with CMI in order for nurses to study nurse-midwifery as a specialty in their master's degree program, thus becoming the first university-based nurse-midwifery program.

In the middle and late 1940s, graduates of MCA at Yale University were central figures in developing the concept and practice of rooming-in and in studying the effects of natural (prepared) childbirth and family-centered supportive care on a woman's prenatal, intrapartum, and postpartum experience.

The 1950s saw the development of three more educational programs by MCA graduates, at Columbia University, Johns Hopkins University, and Yale University. Maternity Center Association was directly involved in initiating two of these programs (Columbia and Johns Hopkins) by sending nurse-midwives to start them. The 1950s also saw

the founding of the American College of Nurse-Midwifery. The history of this professional organization is detailed later in this chapter.

In the 1940s and 1950s, there was considerable demand for nurse-midwives to serve as nursing educators in maternity nursing; to fill nursing service staff, supervisory, and consultant positions in hospital obstetrics departments; and to act as consultants in federal and international health organizations. These employment possibilities, combined with a lack of opportunities for clinical nurse-midwifery practice, created the situation in which a large percentage of the early graduate nurse-midwives did not actually practice clinical nurse-midwifery. In a 1954 survey, 147 nurse-midwives identified 426 job positions they had held since graduation. Of these 426 job positions, 27% involved being a staff nurse-midwife.[46]

The 1960s

Opportunities to practice clinical nurse-midwifery were severely limited for a nurse-midwife graduating in the early 1960s. Only two states and one city legally recognized the practice of nurse-midwifery at that time: New Mexico, Kentucky, and New York City. Another state, Maryland, had nurse-midwives practicing under an old granny midwife law.

In brief, a graduate could join the faculty of one of the existing nurse-midwifery education programs; practice at Catholic Maternity Institute in Santa Fe, Frontier Nursing Service in Kentucky, Baltimore City Hospital and Johns Hopkins University in Baltimore, or Kings County Hospital or Cumberland Hospital in New York City; or go to an overseas mission field. A few other isolated service positions or projects existed but generally were not well known or, as in the case of the Madera County project in California, offered only short-term employment by virtue of being demonstration projects. Therefore, the majority of graduates of that era went into teaching, supervisory, administrative, or consultative positions in related fields. This situation led to the need for refresher programs for nurse-midwives wanting to return to the practice of clinical nurse-midwifery when, less than a decade later, service sites in which to practice expanded rapidly.

In the late 1950s and the 1960s, nurse-midwives made a deliberate and concerted effort to get into hospitals, as that was where the majority of births (approximately 70% at that time) now took place. The movement of nurse-midwives into hospitals brought concepts of family-centered maternity care and a consumer advocate to childbearing women who gave birth in hospitals. During this era, nurse-midwives began working in both in-hospital and out-of-hospital settings.

By 1967, approximately 23% of 468 employed nurse-midwives who responded to a questionnaire[47] were actually practicing clinical nurse-midwifery. This number represented a substantial increase from the 11% practicing in 1963. Of the 468 employed nurse-midwives who responded to the 1967 survey, 103 (22%) worked in foreign countries, mostly through church missions or international health organizations. Fifty-six percent of the employed nurse-midwives were in service areas related to maternity care but were not working clinically as nurse-midwives; 75% held positions above the staff level. Of the 23% who actually practiced nurse-midwifery, 35% were also on the faculties of schools of nurse-midwifery; 53% provided nurse-midwifery services throughout the maternity cycle; and the remaining 12% functioned as nurse-midwives in one or more—but not all—phases of the maternity cycle.

Development of opportunities to practice clinical nurse-midwifery remained slow into the late 1960s. It was not until 1968, when nurse-midwives were employed in the Maternal–Infant Care (MIC) nurse-midwifery program in New York City to practice in community clinics linked with hospitals, that previously unheard-of employment opportunities for nurse-midwives to practice midwifery began to become available.[48] The first nurse-midwife to practice within the Indian Health Service started her job in 1969.[49]

Five nurse-midwifery education programs opened in the 1960s, four of which subsequently closed (the second date is the closing date):

- 1960–1981: University of Puerto Rico/Caparra Heights District Hospital, San Juan, Puerto Rico
- 1963–1972: New York Medical College Graduate School of Nursing Nurse-Midwifery Program, New York City
- 1965: University of Utah Graduate Maternal-Infant Nursing Program, Salt Lake City, Utah
- 1966–1975: Ponce District Hospital, Ponce, Puerto Rico
- 1969–1985: University of Mississippi Medical Center Nurse-Midwifery Program, Jackson, Mississippi

A number of obstacles contributed to this slow development in practice and education. Paramount among

these were misconceptions and stereotypes regarding nurse-midwives. These misconceptions led to outright hostility by some, even as some other professionals supported nurse-midwifery. Both hostility and support emanated from the professional groups with whom nurse-midwives most closely work: physicians and nurses.

Following are some of the stereotypes and misconceptions often heard during that period of time that hindered the development of nurse-midwifery in the 1960s, as well as the factual rebuttals given at that time:

- ***Stereotype:*** Midwives are untrained and unskilled. Frequently, when only the "midwife" part of the term "nurse-midwife" is used, a negative image of the good-hearted, loving, but untrained midwife of past history is engendered. It leads to the irrational conclusion that nurse-midwives are an uneducated menace representing a backward step into illiteracy in the provision of maternal–infant health care.
- ***Fact:*** The term "nurse-midwife" actually specifies exactly who and what a nurse-midwife is. Either part of the name alone does not fully describe the unique profession of the nurse-midwife in the United States. The nurse part recognizes the prerequisite education in nursing, differentiates the nurse-midwife from the historical or contemporary lay midwife, and assures a continuing emphasis on patient education, support, and counseling. All certified nurse-midwives are registered nurses. Half of the nurse-midwifery education programs are offered in schools granting a master's degree. The midwife part of the name recognizes the additional specialized preparation and functioning of the nurse-midwife, tempers the medical focus in normal obstetrics, and identifies the nurse-midwife with professional midwife counterparts the world over.

- ***Misconception:*** Nurse-midwives are trying to be "little doctors." In general, physicians think that nurse-midwives do not know "their place," while nurses think that nurse-midwives have "sold out" to physicians and are, therefore, "traitors to nursing."
- ***Fact:*** Nurse-midwifery is a clearly defined profession that includes a scope of practice, which overlaps with both nursing and medicine. Nurse-midwives believe fervently in who they are, what they have to offer, and what they can do. Nurse-midwives are experts in the normal childbearing cycle. They wish to be precisely who they are and to do precisely what they do—that is, to encourage and facilitate natural, normal childbearing processes with a minimum of intervention; to educate, support, and instigate personal and family growth; to foster self-confidence and independence; to dispel fear; and to provide a calm atmosphere of acceptance and caring. Nurse-midwives are neither sell-outs nor traitors to either nursing or medicine. Instead, they realistically recognize the need for having the support of both the nursing and the medical professions for real growth in nurse-midwifery to take place. For the benefit of mothers and babies, nurse-midwives continue to seek accord with both.

The 1970s

In the late 1960s and early 1970s, everything changed. Suddenly nurse-midwifery was not only acceptable but inundated with requests for practitioners and berated for the lack of nurse-midwives to meet the demand. Thus the late 1960s and early 1970s were a time of rapid development in nurse-midwifery, with widespread proliferation of nurse-midwifery services and educational programs that continued through the decade.

By the end of the 1970s, there were 22 basic nurse-midwifery education programs in the United States; in 10 years, the number of programs was double the number developed during the preceding 37 years. Fifteen new programs opened during this period of time, of which seven subsequently closed (the second date is the closing date):

1972: University of Illinois at Chicago Nurse-Midwifery Program

1971–1975: Loma Linda University Nurse-Midwifery Program, California

1973: University of Minnesota Nurse-Midwifery Program, Minneapolis

1973: Medical University of South Carolina Nurse-Midwifery Program, Charleston

1973: Georgetown University Nurse-Midwifery Program, Washington, DC

1973–1984: St. Louis University Graduate Program in Nurse-Midwifery, Missouri

1973–1985: Meharry Medical College Nurse-Midwifery Program, Nashville, Tennessee

1974–1998: University of Kentucky Nurse-Midwifery Program, Lexington

1975: University of Medicine and Dentistry of New Jersey Nurse-Midwifery Program, Newark

1975–1995: University of California, San Diego Nurse-Midwifery Program

1974–1997: U.S. Air Force Nurse-Midwifery Program, Andrews Air Force Base, Maryland

1976: Emory University Nurse-Midwifery Program, Atlanta, Georgia

1977–1985: University of Arizona Nurse-Midwifery Program, Tucson

1978: University of Miami Nurse-Midwifery Program, Florida

1978: San Francisco General Hospital/University of California San Francisco Interdepartmental Nurse-Midwifery Education Program

The proliferation of educational programs overextended the existing resources for clinical experience for students. A workshop of nurse-midwifery education and service directors focusing on their interdependence was held in 1973. The group divided into task forces to make recommendations for solutions to the serious lack of clinical experience available to students. These recommendations were forwarded from the workshop to the ACNM Board of Directors.[50] Nurse-midwives cooperated with one another in the provision of clinical facilities and clinical faculty for educational purposes. This effort meant sacrifice for the preservation of the profession on the part of those midwives for whom their own direct care of women, babies, and families is their greatest satisfaction.

A number of factors contributed to this unprecedented growth in nurse-midwifery education and practice sites:

- Official recognition by organized obstetrics. A joint statement in 1971 by the American College of Obstetricians and Gynecologists, the Nurses Association of the American College of Obstetricians and Gynecologists, and the American College of Nurse-Midwives recognized and supported the development and utilization of nurse-midwives. Recognition was for the practice of nurse-midwifery within "teams of physicians, nurse-midwives, obstetric registered nurses and other health personnel…directed by a qualified obstetrician-gynecologist…for the complete care and management of *uncomplicated maternity* patients."[51]
- Increased visibility and involvement of the women's movement and feminism. Women's increased feelings of self-worth and self-confidence led to a natural alliance between women, who wanted to participate in and be responsible for their childbearing experience, and nurse-midwives, who facilitate the natural and normal processes, provide family-centered care, and promote parental self-determination.
- Recognition by the consumer. An increasing number of articles about the "new midwife" were published in major magazines such as *Redbook, Newsweek, Life*, and *McCall's*; in Sunday news magazines; and in newspapers such as the *New York Times* and the *Wall Street Journal*. Greater consumer awareness and the satisfaction of those experiencing nurse-midwifery care and writing about it led to consumer demand for nurse-midwifery services.
- Use of nurse-midwives in federally funded projects such as Maternal–Infant Care (MIC), Family Planning monies (314E), the Agency for International Development (AID), and demonstration projects geared toward improving maternal–infant health care and providing family planning services. Through these projects, other healthcare professionals became familiar with nurse-midwifery. This familiarity dispelled misconceptions, and many physicians and nurses subsequently became ardent supporters of nurse-midwifery.
- Childbearing by the children of the post–World War II baby boomers during the mid-1960s and 1970s. There was not a sufficient supply of obstetricians to care for all of the childbearing women in the country during this second baby boom. This shortage, combined with the small number of general practitioners doing obstetrics, led to policy analyses on how best to use the optimal capabilities of each healthcare worker and promoted the obstetric interdisciplinary team concept as articulated in the 1971 joint statement mentioned earlier.
- Demonstration of the efficacy of the obstetric interdisciplinary team concept. The effectiveness of nurse-midwives had been statistically proven many times since the first studies of the Frontier Nursing Service,[37, 39, 40] by the Madera County Demonstration Program in California in the 1960s,[52] and in every service where nurse-midwives had worked. The team concept was demonstrated in Mississippi,

where infant mortality was cut in half in Holmes County in the early 1970s.[53]

- The involvement of nurse-midwives in interconception health care (i.e., family planning, human sexuality, and gynecologic screening) and in neonatal care including promotion of parenting. The ability of nurse-midwives to provide care throughout the childbearing cycle facilitates the provision of continuity of care to new families.

The two different credentialing mechanisms for national certification as a certified nurse-midwife (credentialing of the individual) and for the accreditation of nurse-midwifery education programs (credentialing of the education program) were well established by the early 1970s. A decade later, ACNM certification was recognized by the National Commission of Health Certifying Agencies. The ACNM Division of Accreditation (DOA) was first recognized by the U.S. Department of Education (USDOE) as a national accrediting body in 1982. Recognition has been renewed as proscribed by the USDOE ever since.

The first private practice with nurse-midwives began in the early 1970s.[54] With the consumer "discovery" of the nurse-midwife came a burgeoning of private practice nurse-midwives, and another inhibiting misconception was laid to rest:

- ***Misconception:*** Nurse-midwives are less expensive than physicians and their care is not as good as the care offered by physicians. This is why nurse-midwives are hired to care for the indigent and those persons who cannot pay for healthcare services.
- ***Fact:*** This misconception arose from the fact that in prior decades, nurse-midwifery practices were mainly situated in large medical centers and city hospitals serving the medically indigent or in remote rural areas with few physicians. This initial concentration of nurse-midwives in settings serving women from lower socioeconomic groups occurred because the nurse-midwife's professional services were welcomed first in areas where help was most desperately needed. By the mid-1970s, nurse-midwives were in practice with physicians all over the country, taking care of families from all socioeconomic brackets. According to a 1976–1977 survey by the American College of Nurse-Midwives,[55] approximately 26% of all nurse-midwives practicing nurse-midwifery worked in some form of private practice arrangement. Nurse-midwives were well accepted by women, who often preferred to have a nurse-midwife in attendance at their birth as long as their condition did not require the physician member of the team. This preference is largely a result of the time the nurse-midwife spends explaining and teaching during the office visits, the commitment of the nurse-midwife to the woman throughout labor, and the practical application of the beliefs of the nurse-midwife in promoting a family-centered, normal childbearing experience.

During the 1970s, nurse-midwifery had become not only acceptable but also desirable and demanded. After years of struggling for existence, nurse-midwives now faced the problem of a severe shortage of supply to meet the demand both from within the established healthcare system and from a small but growing number of consumers who were dissatisfied with the health care provided by the "official" system. These consumers desired care outside of the system, and looked to nurse-midwives for support and services. Inability by the small total number of nurse-midwives to respond to both demands and provide a sufficient number of childbirth alternatives (e.g., hospital birthing rooms, childbirth centers, or carefully selected home births) led to further dissatisfaction on the part of the consumer with professional health care and fostered the development of often untrained lay midwives or birth attendants, along with a do-it-yourself movement.

Lay midwifery developed in the 1970s in response to disenchanted childbirth consumers who wanted to give birth to their babies outside of the hospital. The term *lay midwifery* in the 1970s and 1980s referred to all non-nurse-midwives, whose preparation in midwifery was highly variable. Lay midwifery struggled with its early identity as these providers disagreed sharply among themselves regarding the desirability of formal education, standards, credentialing, and regulation.

A number of groups and organizations supportive of lay midwifery and home birth sprang up during the 1970s: the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), Home Oriented Maternity Experience (HOME), Association of Childbirth at Home International (ACHI), and the National Midwives Association (NMA). Existing organizations such as the International Childbirth Education Association (ICEA) and La Leche League added their support. The first national meeting of lay midwives took place in 1977 in El Paso, Texas.

The 1980s

By the 1980s, nurse-midwives were practicing in the full range of possible arenas—from clinics and federally funded programs to health maintenance organizations (HMOs) and hospitals, from being employed by physicians to employing the physicians—and providing a full range of services, from in-hospital birth services to out-of-hospital birth services or a mix of both, to provide continuity of care between settings. By this time, nurse-midwives were perceived to be competitors of physicians for the obstetric healthcare dollar. Supportive physicians continued to enable nurse-midwifery practice by providing necessary physician consultation, collaboration, and referral systems. Opposing physicians tried to restrict the growth of nurse-midwifery through state legislative battles over statutory recognition of nurse-midwives, mandated third-party reimbursement, and prescriptive authority; denial of hospital practice privileges; and pressure on supportive physicians vis-à-vis their malpractice insurance. The entire situation was exacerbated by an overabundance of physicians—a trend that would continue for the foreseeable future. In the view of many physicians, nurse-midwives were no longer needed.

An investigative congressional hearing into the problems faced by nurse-midwives was held in 1980,[56] and the Federal Trade Commission became actively concerned about possible and real restraint-of-trade issues.[57] At the same time, healthcare costs had become unacceptably high and some nurse-midwifery services were demonstrating that they were cost-effective.[58]

A survey of nurse-midwives in 1971 showed that 37% of the respondents were in the direct practice of nurse-midwifery, compared with 23% in 1967 and 18% of those nurse-midwives practicing in the United States in 1963. By 1976–1977, 51% of 1218 respondents living in the United States and replying to a questionnaire[55] were practicing clinical nurse-midwifery. In the 15 years from 1963 to 1978, active nurse-midwifery services increased from six services in 3 states and New York City to multiple services in 35 states, with more in planning stages. By 1982, 67% of 1584 survey participants living in the United States stated they were practicing clinical nurse-midwifery.[59] In 1984, nurse-midwives were practicing in all 50 states; by 1988, nearly 80% of the respondents to an ACNM survey were in nurse-midwifery practice and education.[60] The legal recognition of nurse-midwifery had spread from 3 states and New York City in 1963 with its legal status in the other states largely unknown, to a very clear legal status in all 50 states and 4 jurisdictions (District of Columbia, Guam, Puerto Rico, and the Virgin Islands) as a result of extensive and intensive work by the legislation committee of the American College of Nurse-Midwives.

The late 1970s and early 1980s also saw the rapid development of out-of-hospital childbirth centers, with Maternity Center Association spearheading this movement. Twelve nurse-midwifery education programs opened during the 1980s, 7 of which subsequently closed (the second date is the closing date):

- 1980: University of Colorado, Denver
- 1980: University of Pennsylvania, Philadelphia
- 1981: Oregon Health Sciences Center, Portland
- 1981–2003: University of Southern California, Los Angeles
- 1982–1988: Rush University/St. Luke's Medical Center, Chicago, Illinois
- 1982–1987: Stanford University, Stanford, California
- 1982: University of Florida, Gainesville
- 1983: Case Western Reserve University, Frances Payne Bolton School of Nursing, Cleveland, Ohio
- 1983–1999: University of California, San Francisco/University of California, San Diego Intercampus Nurse-Midwifery Program
- 1984–2003: Baylor College of Medicine, Houston, Texas
- 1987–1998: Education Program Associates, San Jose, California
- 1989–2006: Parkland Hospital/Texas Women's University, Dallas, Texas

In 1982, Midwives Alliance of North America (MANA) was organized for representation of lay midwives including those in Canada and Mexico as well as the United States. The midwifery membership in MANA is diverse; it includes anyone who chooses to call herself, or rarely himself, a midwife and reflects a complete range of educational preparation and experience. MANA established an Interim Registry Board (IRB) in 1986 to create an examination and maintain a registry of midwives who passed the examination. Taking the examination was voluntary.

The 1990s

The 1990s witnessed another growth spurt in nurse-midwifery education programs, with an unprecedented 26 programs opening. This growth spurt was

in part a result of states' recognizing the quality and cost-effectiveness of nurse-midwifery care and funding local programs. During the 1980s and 1990s, the number of programs again doubled, so that by the end of the twentieth century 45 ACNM-accredited basic nurse-midwifery education programs existed, one of which was also an accredited basic midwifery education program. A listing of all the current education programs accredited by the ACNM Division of Accreditation can be obtained from the ACNM website (www.midwife.org).[61] Ten of the 26 programs that opened during the 1990s subsequently closed.

The ACNM set the goal of having 10,000 certified nurse-midwives by 2001. In 1995, slightly more than 5000 had been certified. With the increased number of new programs, the growing number of students in existing programs, and the advent of community-based distance-learning programs, the trajectory to reach the 2001 goal was on target; in mid-2001, the total number of persons ever certified as nurse-midwives was 9327. Distance learning came into its own in the late 1980s and 1990s. The idea was first envisioned for nurse-midwifery education in the 1970s but took a quantum leap forward when combined with web-based technologies in the late 1980s.[62,63]

The healthcare system started to move in the direction of managed care in the early 1990s. As this movement gathered steam, nurse-midwives once again found themselves struggling to be recognized and "at the table" both nationally and locally for far-reaching decisions affecting the healthcare system and nurse-midwifery practice. Practical preparation for establishing nurse-midwifery practices and services increasingly focused on business aspects of a practice, including marketing, budgets, financial concerns and policy issues, methods of determining productivity, billing and coding, and effective business practices. Responding to the needs for practical guidance, the Nurse-Midwifery Service Directors Network published *An Administrative Manual for Nurse-Midwifery Services*. For its part, in addition to offering its long-existing *Guidelines for Establishing a Nurse-Midwifery Practice*, the ACNM put together a marketing packet for CNMs and handbooks on managed care and managed care contracting. In 1996, the Midwifery Business Institute was started by nurse-midwives at the University of Michigan School of Nursing and the University of Michigan Health System; both institutions co-sponsor this periodic conference.

In 1989, the ACNM board of directors stated that "The ACNM will actively explore, through the DOA [Division of Accreditation], the testing of non-nurse professional midwifery educational routes." In 1990, the DOA determined that to address the charge from the board of directors, it was necessary to first identify those nurse competencies that were assumed to be brought by a registered nurse to a nurse-midwifery education program. The DOA completed this task in 1994. These competencies were then combined with specified prerequisite courses into an ACNM DOA document entitled *Skills, Knowledge, Competencies, and Health Sciences Prerequisite to Midwifery Practice*.[64]

In 1994, the ACNM, in response to requests from state regulatory agencies, took a leadership role in setting the standards for the credentialing of non-nurse professional midwives. The immediate impetus for this effort was the growing use of licensed healthcare professionals—most often physician assistants—to practice midwifery without educational preparation or credentialing for this role. Using, at a minimum, the same criteria specified for nurse-midwifery education programs, the ACNM DOA developed criteria for basic midwifery education programs for non-nurse midwives, and the ACNM Certification Council committed itself to the testing and certification of graduates from ACNM DOA-accredited midwifery programs who would receive the credential of Certified Midwife (CM).[64] These midwives meet the same endpoint academic and clinical objectives as nurse-midwives. The first education program for non-nurse (direct-entry) midwives preaccredited by the ACNM DOA was established in 1996. The program launched its first graduates in 1997, and in 1999 it was fully accredited. Three other direct-entry midwifery programs have since been preaccredited by the ACNM DOA.

In 1991, the National Coalition of Midwifery Educators, an organization separate from MANA and the MANA Education Committee, formed the Midwifery Education and Accreditation Council (MEAC). MEAC organized and defined itself in terms of accrediting education of direct-entry midwives in the maternity cycle and out-of-hospital—especially home birth—practice. It developed standards and criteria that reflect the core competencies and guiding principles set by the Midwives Alliance of North America.

The examination of the Interim Registry Board (IRB) of MANA was first administered in 1991. In 1992, the IRB separated from MANA and incorporated as the North American Registry of Midwives (NARM). Midwives credentialed by NARM are Certified Professional Midwives (CPM).

Credentialed midwifery at the beginning of the millennium now encompassed both nurse-midwives

and two types of non-nurse (direct-entry) midwives, leading to three sets of initials: certified nurse-midwives and certified midwives, who were credentialed by ACNM, and certified professional midwives, who are credentialed by NARM. The two types of direct-entry midwives (CMs and CPMs) have different educational processes and two very different scopes of practice. Both are well defined and distinguishable from the noncredentialed lay midwife.

The 2000s

By 2011, the number of CNMs and CMs ever certified had more than doubled during the previous 15 years, to reach 11,546 CNMs and CMs.[65] The proliferation of education programs slowed, however, as 12 programs closed during the 2000s (9 of which were part of the 26 that had opened during the 1990s); another 5 new programs opened, however, bringing the total number of ACNM-accredited programs to 39 in 2011.

The National Center for Health Statistics first began collecting data on midwifery-attended births in 1975; in 1989, it revised the birth certificate data collection form to distinguish CNM-attended births from births attended by other midwives. CMs are now included with CNMs in birth certificate data.[66] The number of CNM-attended births has risen from 132,286 births in 1989 to 313,516 births in 2009, representing 7.6% of all births.[65–67] The proportion of vaginal births attended by CNMs/CMs, however, is 11.8%.[66] This discrepancy in proportions is thought to be due, at least in part, to the rapid growth in cesarean deliveries[68] and means that now CNMs/CMs attend 1 in 9 vaginal births.[66] In 2009, 96.1% of CNM/CM-attended births occurred in the hospital, 2% in freestanding birth centers, and 1.8% in the home.[65]

Legislative issues continued to be of highest priority for nurse-midwives in the 2000s. By midyear 2008, nurse-midwives had prescription writing authority in all 50 states.[68] Other state-level legislation focused on removal of supervisory verbiage in licensure laws, reimbursement, liability insurance, and removal of barriers to practice and access. The Committee for the Advancement of Midwifery Practice (CAMP) was created in New York state in 2000 to expand licensure of CMs with full-scope practice, equivalent to CNMs, to all 50 states. Top federal legislative issues throughout the decade included obtaining an equitable Medicare reimbursement rate to improve access by CNMs/CMs to vulnerable populations, federal funding of ACNM-accredited education programs, and support of improving quality and reducing disparities in access to women's healthcare services.

By 2002, the *Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives* had evolved through the 1980s and 1990s to now emphasize mutual respect, equivalency, and a collaborative relationship.[69,70] The most recent *Joint Statement* in 2011 builds on the 2002 *Joint Statement* to highlight the promotion of evidence-based practice, acknowledge that CNMs/CMs are licensed independent providers, and states that obstetrician/gynecologists and CNMs/CMs should receive equivalent third-party reimbursement.[71,72]

Throughout the decades, the work of nurse-midwives has been documented and facilitated by what was first the ACNM Research and Statistics Committee and eventually became the Division of Research in 1988.[73,74] This work and the studies done form a body of knowledge, provide evidence for midwifery care, guide policy, inform legislative efforts and legislators, and facilitate national and international networking.

The 2000s was another time of media coverage not only in newspapers and magazines, but also documentaries promoting midwifery.[75] In addition, a number of nurse-midwives authored books, including both novels and memoirs.[76] The ACNM published *Every Baby Magazine;* established Midwives PAC and publishes a monthly on-line newsletter, *The Advocate,* on federal and state advocacy; and joined with other organizations in an advocacy such as the Coalition for Patient's Rights. Childbirth Connection (formerly known as Maternity Center Association) continues to provide leadership in improving the quality of maternity care through research, education, advocacy, and work with other organizations in producing influential reports, such as *Evidence-Based Maternity Care: What It Is and What It Can Achieve* in 2008.[77] Childbirth Connection was also the catalyst for the creation of the Transforming Maternity Care Project, which convened a Vision Team in 2008 to produce a document titled *2020 Vision for a High-Quality, High-Value Maternity Care System.* This document formed the basis for the development of a blueprint of strategies during a 2009 symposium. Opportunities for action to bring about transformation in maternity care have been identified, and there is ongoing monitoring of progress. Access to the project and details can be found at the following website: www.transform.childbirthconnection.org.

In May 2001, the U.S. Department of Education renewed its recognition of the ACNM Division of Accreditation for preaccreditation and accreditation of nurse-midwifery education programs, and also recognized the expansion of the scope of its activities to include preaccreditation and accreditation of direct-entry midwifery education for the non-nurse. In addition, the DOA was recognized as an institutional accreditor in 2006.[78] In 2008, the name of the DOA changed to the Accreditation Commission for Midwifery Education (ACME).

The Midwifery Education and Accreditation Council (MEAC) also applied for and received recognition from the U.S. Department of Education as an accrediting body in January 2001. MEAC-accredited programs prepare graduates for the examination of the North American Registry of Midwives (NARM) and recognition as a CPM. In 2005, MEAC initiated the Outreach to Educators Project, which evolved into the Association of Midwifery Educators (AME) in 2006.

In 2001, the National Association of Certified Professional Midwives was formed with the purpose of establishing a professional organization and setting national practice standards for CPMs.

The American College of Nurse-Midwives

The American College of Nurse-Midwives is the national professional organization for CNMs and CMs. Its mission is "to establish midwifery as the standard of care for women. We lead the profession through education, clinical practice, research, and advocacy."[79] Incorporated in 1955, the ACNM was founded as the outgrowth of a series of circumstances that rendered its creation necessary.

Early efforts to organize nurse-midwives met with difficulties. An organizational meeting in 1940, chaired by Hattie Hemschemeyer, Director of the Maternity Center Association School of Nurse-Midwifery, resulted in the formation of the National Association of Certified Nurse Midwives (NACNM). Bylaws were written, but the organization never evolved. A 1944 meeting of nurse-midwives, again called by Hattie Hemschemeyer to discuss formation of a national organization, led the group to reject the option of establishing a new organization as financially and time/effort prohibitive. The group also rejected the option of working to make the FNS-related American Association of Nurse-Midwives (AANM) become the national organization they envisioned because the AANM "did not admit colored nurse-midwives."[80] Instead, the group accepted an offer from the integrated National Organization of Public Health Nurses (NOPHN) to establish a section within NOPHN for nurse-midwives.[80]

As a section of NOPHN, nurse-midwives could define themselves, share information and knowledge, and start the process of setting education and practice standards for the profession. In 1949, the nurse-midwifery section published the first national descriptive data gathered about nurse-midwives.[81] NOPHN was dissolved in 1952 following a general reorganization of U.S. national nursing organizations. While NOPHN was absorbed into the American Nurses Association (ANA) and the National League for Nursing (NLN), these organizations did not make any provision for a recognizable entity of nurse-midwives. Instead, the nurse-midwives were assigned to the ANA's Maternal and Child Health Council and the NLN's Interdivisional Council, which encompassed the areas of obstetrics, pediatrics, orthopedics, crippled children, and school nursing. The membership and concerns of the NLN council were simply too broad to serve as a forum or voice for nurse-midwifery. Moreover, being part of the ANA's Council would have meant that nurses who were not midwives would be making decisions about nurse-midwifery practice and education. Ironically, even though nurse-midwives were in positions of leadership in maternal–child nursing in educational, professional, and federal organizations pertaining to health care, they were rarely recognized as specifically being nurse-midwives.

The Committee on Organization

As the identity of nurse-midwives could not be maintained in either the ANA or the NLN, the nurse-midwives present at an ANA convention in the spring of 1954 agreed to establish the Committee on Organization. Sister M. Theophane Shoemaker, the director of the Catholic Maternity Center in Santa Fe, New Mexico, was chair of the committee.

The Committee on Organization, though claiming its progress was slow and tedious, had within 2 months identified reasons for organizing; discussed ways in which organization could be accomplished; written a definition of a nurse-midwife; identified the functions of a new organization if one was to be established; set educational standards for nurse-midwifery schools, including a statement of purpose and basic admission requirements; designed and mailed a questionnaire to locate nurse-midwives and ascertain their desire to organize; written and mailed two of the eventual six *Organization Bulletins of The*

Committee on Organization;[82] and organized a meeting of nurse-midwives for December 1954. Forty-six nurse-midwives attended that meeting, during which they reviewed the work done thus far, discussed the results of the questionnaire (to which 147 nurse-midwives had replied), and approved the definition of a nurse-midwife and a statement of purpose of a nurse-midwifery organization. The major issue, however, was how organization could be accomplished. Four possible options had been identified:

1. Organization within the American Nurses Association as a conference group
2. Organization within the National League for Nursing as a council
3. Reorganization of the American Association of Nurse-Midwives into a national organization
4. Formation of an entirely new organization of nurse-midwives to be known as the American College of Nurse-Midwifery

The American Association of Nurse-Midwives had been started in 1929 as the Kentucky State Association of Midwives, incorporated by nurse-midwives working with the Frontier Nursing Service. Mary Breckinridge, then director of the FNS, was the continuing president of AANM during her lifetime. At that time, the organization's function was akin to that of an alumnae association, although membership was not limited to alumnae. Efforts to reach out to the AANM to persuade its members to reorganize were made by Sr. Theophane Shoemaker and Hattie Hemschemeyer. Mary Breckinridge, however, stood firm in her belief that nurse-midwives should be part of the nursing organizations and that the structure of the AANM would not change.[80] The AANM, therefore, was eliminated as a possible option based on its members' analysis and statement of preference not to be considered.

The remaining options were either to organize within one of the national nursing organizations or to create a new organization. This decision was deferred until letters requesting a conference group and a council, respectively, were submitted to, and replies were received from, the ANA and NLN. The letters were approved during the meeting.

The NLN expressed interest and concern but pointed out that its bylaws for organization of a council would not meet the needs of the nurse-midwives. The reply from the ANA was not encouraging. This organization was interested in a plan to establish an interdisciplinary committee of the ANA and the NLN, with additional representatives from the public, to study the improvement of the care of mothers and children. The nurse-midwives could be a part of this committee. Sister Theophane Shoemaker identified the basic issue of being part of a larger nursing organization in a letter to Hattie Hemschemeyer: "We still would not have autonomy in setting up standards of education and practice. And the definition of ourselves would depend upon ANA's decision."[83]

This information was published in the fourth *Organization Bulletin*, along with the plans for the next meeting of the Committee on Organization and a request for comments regarding what was emerging as the obvious direction for organization. At its meeting in May 1955, the Committee on Organization voted unanimously to proceed with the formation of the American College of Nurse-Midwifery. Those present based their action on the facts that all the other options had essentially been ruled out, that 133 of the 147 nurse-midwives answering the questionnaire had responded positively to the idea of belonging to a new organization of nurse-midwives, that formation of a separate organization obviously seemed to be the only way that nurse-midwives could work together and accomplish the goals that had been delineated in the statement of purposes, and that only one response had been received to the request for comments regarding this direction. The Committee on Organization had done such a splendid job of keeping all the nurse-midwives informed and involved that there was nothing further to be said.

The Committee on Organization then began working to incorporate and establish the new organization. The incorporation of the American College of Nurse-Midwifery took place on November 7, 1955, in the state of New Mexico. New Mexico was chosen because it was one of the few states in which nurse-midwives were practicing and incorporation there involved the least amount of red tape, time, and expense.

The ACNM as an Organization

The first annual meeting of the American College of Nurse-Midwifery was held November 12 and 13, 1955, in Kansas City, Missouri. Hattie Hemschemeyer, Director of the Maternity Center Association School of Nurse-Midwifery, was elected the first president of the ACNM. In her first message to members in the *Bulletin of the American College of Nurse-Midwifery,* she wrote about the driving force and movement of nurse-midwifery in terms that remain equally valid today:

> The College must select carefully the work it undertakes and then do well the work it has undertaken. We need to work with dedication and conviction….
>
> We have a pioneer job to do, and if we work as well and as constructively in a group as we have in the past as individuals, we can help to improve professional competence, provide better service and educational programs, and make fuller use of resources. The future looks bright.[84]

On the ACNM's 10th anniversary, Hemschemeyer stated, "Our identity as a College gives us fundamental rights and grave responsibilities."[85]

In 1956, both the American College of Nurse-Midwifery and the American Association of Nurse-Midwives were accepted into the International Confederation of Midwives (ICM) upon the recommendation of England and Scotland and the unanimous vote of the executive council of the ICM. In 1969, the American Association of Nurse-Midwives merged with the American College of Nurse-Midwifery to form the American College of Nurse-Midwives. In October 1972, the American College of Nurse-Midwives hosted the triennial congress of the ICM in Washington, DC, when Lucille Woodville, then nursing consultant to the Bureau of Indian Health Affairs and past president of the ACNM (1969–1971), was president of the ICM (1969–1972).

The objectives of the American College of Nurse-Midwives, first expressed in the Articles of Incorporation in 1955, and approved as "specific purposes" in the Articles of Incorporation and Bylaws in the May 2008 revision of the Bylaws, reflect both nurse-midwifery's concern for quality health care for women and infants and the assumption of the "grave responsibilities" alluded to by Hattie Hemschemeyer:

> Article II. Purposes and Limitations. Section C. Specific Purposes:
>
> Consistent with the ACNM Articles of Incorporation and these Bylaws, ACNM is empowered to:
>
> 1. foster and promote excellence in the practice of midwifery and the education of midwives;
> 2. facilitate the advancement and awareness of excellence in midwifery practice and education, including care of women through the life span and practices which foster public safety;
> 3. support midwives, other women's health professionals, and students through educational activities, professional conferences, written publications, and other means;
> 4. engage in and support research activities relating to the profession of midwifery and women's health;
> 5. develop and disseminate standards for midwifery practice as provided by CNMs and CMs;
> 6. disseminate a comprehensive body of knowledge concerning women's health and the practice of midwifery, through continuing education activities, professional conferences, written publications, and other means;
> 7. foster the development and support of midwives, midwifery practice and education, and midwifery professional organizations internationally, and to promote improved access to quality maternal and newborn care in all countries;
> 8. support quality services to members concerning business and clinical issues, and provide guidance on credentialing, legislative and regulatory issues;
> 9. establish and support accreditation of CNM/CM educational programs, and facilitate the continuing education of midwives;
> 10. provide a recognized forum for the free exchange of ideas and information related to the midwifery profession and women's health issues;
> 11. serve as a source of information to the public and to government agencies concerning excellence in midwifery and women's health care practices and services;
> 12. support the development and recognition of qualified individuals involved in midwifery practice, education, scholarship, and policy;
> 13. support and foster cooperation among midwives and other women's health care clinicians, educators, students, and organizations, including research organizations, government bodies, educational institutions, and other organizations in the United States and internationally;
> 14. foster consensus for professional policies and practices related to midwifery practice and education;

15. support and foster appropriate professional licensure regulations and legislation related to midwifery and women's health issues;
16. speak for the profession of midwifery in relation to issues affecting the professional affairs of CNMs and CMs; and
17. engage in all other corporate activities permitted by law.[86]

The seal of the ACNM (**Figure 1-3**) reflects basic philosophical beliefs of nurse-midwifery. Rita Kroska, CNM, PhD, who designed the seal in 1955, interprets its symbols as follows:

> The large shield is comprised of four symbols: a small shield of stars and stripes exemplify the United States of America; three intertwined circles exemplify the family with the lower circle containing crosshatching to illustrate the crib containing the child; a tripod with flames rising exemplifies continuance and warmth in dedication to the American family; and, lastly, the large shield contains an undulating band above the tripod but beneath the smaller shield and circles. The undulation portrays movement, persistence, steadiness, and steadfastness to the word written within. That word is VIVANT, an expletive in French, which means Let Them Live! It is there to fill out the sentence of the symbols, to give emphasis short of exclamatory oath, that of unremitting dedication to safeguarding and promoting the health and wellbeing of family life, particularly the mother and infant.
>
> The large shield is encircled by a ribboned band containing the inscription, "AMERICAN COLLEGE OF NURSE-MIDWIVES, NEW MEXICO, Nov. 7, 1955."
>
> Originally, between 1955 and 1969, the word "nurse-midwives" was "nurse-midwifery," and without the year 1929 included within the inscription. The two changes took place in 1969 when the American Association of Nurse-Midwives with headquarters at the Frontier Nursing Service in Wendover, Kentucky, and the American College of Nurse-Midwifery joined and became the American College of Nurse-Midwives. The year 1929 was the founding of the American Association of Nurse-Midwives.[87]

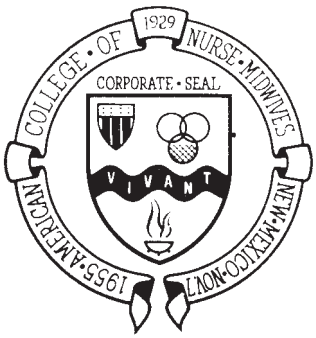

Figure 1-3 The seal of the American College of Nurse-Midwives. *Source:* Reproduced by permission of the American College of Nurse-Midwives.

The A.C.N.M. Foundation

The A.C.N.M. Foundation was established in 1967 as a nonprofit, tax-exempt organization that collaborates closely with and complements the goals of the ACNM.

Its mission is to promote excellence in health care for women, infants, and families worldwide through the support of midwifery.[88] The A.C.N.M. Foundation supported critical early developments within the ACNM, such as the first national certifying examination; the first portable exhibit about nurse-midwives; workshops on nurse-midwifery education, clinical practice, and the approval process; and means for publicizing nurse-midwifery and the ACNM. The Foundation has sponsored, published, and disseminated significant reports, studies, surveys, educational materials, and research. It distributes numerous midwifery scholarships and awards.[89] The ACNM would not have been able to accomplish all that it has without the support of the A.C.N.M. Foundation and the dedication of its board of trustees.

Activities of the ACNM

The membership of the American College of Nurse-Midwives has been characterized from the beginning by dedication, commitment, hard work, articulateness, personal sacrifice, vision, and pioneering spirit. The annals of the ACNM's brief history are peopled with creative giants who were also willing to do the necessary detail work while dipping into their own pocketbooks to finance it. Starting with a charter membership of 124, the ACNM had grown to a membership of 860 by its twentieth anniversary in 1975. By 1980 the membership, including students, had increased to more than 1500, by 1984 to 2534, by 1995 to more than 5000, and by the end of 2002

there were more than 7000 CNM, CM, and student members. Seventeen nurse-midwives attended the first annual meeting in Kansas City in 1955; 291 members attended the twentieth annual meeting in Jackson, Mississippi, in 1975. Convention attendance first passed the 1000 mark with 863 members and 138 guests at the 1984 Philadelphia meeting, and more than 2000 people attended the Washington, D.C., meeting in 2000.

The rapid expansion of nurse-midwifery and proliferation of nurse-midwives placed stress on the professional organization. The total number of nurse-midwives and the membership of the ACNM experienced a sevenfold increase during the first 20 years of the organization's existence, tripled during the next 10 years, and tripled again during the next 20 years by the time of the 50th anniversary of the ACNM in 2005.

The organization faced the challenge of having to change from a small, intimate group of hard-working, dedicated nurse-midwives with a relatively simple organizational structure to a large group with an organizational structure and management style that could cope with a rapid increase in membership without losing its dedication and ideals. This was achieved with a major restructuring and revision of the ACNM bylaws in 1974. The organization went from determination of policy by a simple majority vote by the members attending the annual meeting to decision making being placed in the hands of a representative-style board of directors of volunteer nurse-midwives made up of nationally elected officers and six regionally elected representatives. The board of directors was, and continues to be, kept informed by the work of the ACNM membership committees and divisions and the expressed will of those in attendance at the annual meeting.

The second restructuring and revision of the ACNM bylaws occurred in 2008. The membership had again increased (sixfold), and the organization needed a structure that could respond nimbly in the modern era of instant communication, shifting healthcare policy, and changing membership needs while continuing to retain its values. This bylaws revision followed several years of thought about restructuring, identification of strategic priorities, and a values proposition survey. Major changes included the redefinition of associate members as individuals other than a CNM/CM interested in supporting the mission and purposes of ACNM and all CNMs/CMs as active members; the creation of state affiliates, replacing the previous local chapter system, and CNM/CM partner organizations; and the creation of a president-elect and a student representative on the board of directors.

The ACNM continues to be a volunteer membership organization, as CNMs/CMs believe strongly in their right to involvement and participation in the direction, values, and policies of their profession. The membership and the ACNM as a whole are supported by a professional staff. The ACNM has undergirded every aspect of nurse-midwifery and midwifery for CNMs and CMs: education, practice, recognition, legislation, credentialing, insurance, communication, research, and interprofessional and interorganizational relationships.

Recent examples of interprofessional and interorganizational endeavors reflect the organization's vigor. Since 2009, the ACNM has participated in the planning and implementation of a Home Birth Consensus Summit that was held in October 2011 with representatives from other professional stakeholder organizations, including Midwives Alliance of North America, American Congress of Obstetricians and Gynecologists, American Academy of Pediatrics, National Association of Certified Professional Midwives, Association of Women's Health, Obstetric, and Neonatal Nurses, and Childbirth Connection. A follow-up summit was held in April 2013.[90] In addition, in June 2012, the midwifery membership organizations in the United States released a document, *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM*. This document summarizes the evidence for the benefits of normal physiologic childbirth, and identifies factors that facilitate or disrupt physiologic childbirth.

The productivity of the membership of the American College of Nurse-Midwives since its founding in 1955 is inspirational, and the group's history is peopled with visionaries, committed hard-working implementers, and talented contributors. In 1994, the ACNM established the Fellows of the American College of Nurse-Midwives (FACNM). Membership in this group is an honor bestowed upon those midwives whose demonstrated leadership, clinical excellence, outstanding scholarship, and professional achievement have merited special recognition both within and outside of the midwifery profession. The mission of FACNM is to serve the ACNM in a consultative and advisory capacity.

The ACNM has also supported international efforts through its Department of Global Outreach (DGO). Established in 1981, the DGO has implemented projects and provided technical assistance in more than 30 developing countries. A major project

of the DGO has been the writing of the *Life-Saving Skills Manual for Midwives*.[91] Now in its fourth edition (originally published in 2008), it forms the basis for life-saving skills training programs and projects in Ghana, Indonesia, Nigeria, Uganda, and Vietnam. The work of technical editors—an extensive number of external reviewers representing more than 10 countries—and field-testing have made this training effort of healthcare providers truly life-saving. A corollary has been the development of the family-focused, community-based *Home Based Life Saving Skills Guidelines and Manual*[92] to further reduce maternal and neonatal mortality. Field-tested in India, Ethiopia, Vietnam, Gaza, and the West Bank, it forms the foundation for competency-based training of women and men within a community within the context of their culture and the social context of childbirth within that society.

The founding of the ACNM was described as follows: "To support individual efforts the nurse-midwives have banded together.…This provides them with an official mouthpiece for education, a base for common planning and discussion."[93] Almost a century ago, the lack of any national organizations, journals, system of education, legal recognition, or access to the healthcare system led to the "midwife problem and debate." Today the ACNM provides or works for all of these mechanisms of survival and speaks for the profession of nurse-midwifery and midwifery as practiced by CNMs and CMs.

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