CHAPTER

2

Professional Midwifery Today

DEANNE R. WILLIAMS
SUSANNA R. COHEN
CELESTE THOMAS

Introduction

Midwifery in the twenty-first century is a profession that is deeply rooted in service to both women who are vulnerable to poor pregnancy outcomes and the preservation of a childbirth experience that honors the normal process of birth as well as the transformational power of the childbearing experience. While midwives maintain their commitment to provide individualized care responsive to the needs of the woman, they are also increasingly recognized as key players in a global community of healthcare professionals who improve the lives of mothers and babies. This expanded allegiance—from the individual, to the profession, to women wherever they need care—is reflected throughout this text and is the primary focus of this chapter.

Midwifery in the United States, as represented by certified nurse-midwives, certified midwives, and certified professional midwives, is a dynamic profession. The scope of midwifery practice has expanded, as has the core knowledge needed to provide safe care and to participate as members of an interdisciplinary team. Likewise, civil society has expanded its expectations for healthcare professionals, and midwives have responded by adopting new standards for their profession.

The essential characteristics of a profession are measurable, interconnected, and commonly recognized. A profession has the following properties: (1) specialized knowledge typically obtained at the college level (graduation from a nationally accredited education program and earning a degree); (2) legal recognition (federal and state laws); (3) self-organized with a commitment to serve (professional membership organizations); (4) standards of competency (e.g., certification by a nationally recognized certification agency); (5) established standards of practice; and (6) adheres to ethical standards.

Although this chapter will not contribute directly to the clinical competence that students and midwives seek early in their careers, it does put midwifery practice into a societal context via a review of these essential characteristics that make midwifery a profession. This is the environment that graduates enter as they come to understand that being a safe, legal, independent, and successful midwife requires more than clinical competence.

The Professional Paradigm: Midwifery in the Twenty-First Century

Along with the more detailed information about the history of midwifery that was presented in the introductory chapter, **Box 2-1** provides a list of some of the seminal events in the development of modern midwifery in the United States and acknowledges a few of the key individuals, groups, and events that have helped develop midwifery into a profession today.[1,2]

Types of Professional Midwives

Most midwives have been asked the following questions about their profession: What is the difference among a certified nurse-midwife (CNM), a certified midwife (CM), and a certified professional midwife (CPM)? What is a lay midwife?

BOX 2-1 Evolution of the Profession of Midwifery in the United States

1925:	Mary Breckinridge opens the Frontier Nursing Service (FNS) in Hyden, Kentucky—the first nurse-midwifery service.
1929:	FNS nurse-midwives organize the American Association of Nurse-Midwives.
1931:	Lobenstine Midwifery School opens—the first nurse-midwifery education program.
1955:	ACNM incorporated.
1956:	Yale University School of Nursing opens a nurse-midwifery program.
1965:	ACNM accredits education programs.
1960s–1970s:	Counterculture, feminism, and grassroots rejection of over-medicalization of birth and increased conversation about home birth; childbearing women share their very personal experiences comparing traditional medical care with midwifery care.
1970:	First edition of *Our Bodies, Ourselves* published. The ninth edition was published in 2011. This book has been a strong supporter of midwifery since its beginnings and includes many midwives as contributing authors.
1971:	First CNM credential issued based on national examination.
1975:	Publication of *Spiritual Midwifery* by Ina May Gaskin. This book introduced a generation of women to natural childbirth while giving voice to childbirth's spiritual components.
1977:	The Maternity Center of El Paso opens—the first direct-entry education program for lay midwives.
1977:	The first gathering of lay midwives in El Paso, Texas.
1978:	ACNM's *Core Competencies for Basic Nurse-Midwifery Practice* published.
1982:	Founding of MANA.
1989:	MANA establishes the Interim Registry Board to explore a national registry exam; this later becomes NARM.
1990:	ACNM's first *Code of Ethics* published.
1993:	ICM's first *Code of Ethics* published.
1994:	MANA's *Core Competencies for Basic Midwifery Practice* published.
1994:	First CPM credential issued.
1994:	ACNM endorses development of the CM credential.
1998:	First CM credential issued.
1999:	Baccalaureate degree required for CNM.
2000:	NACPM founded.
2010:	Graduate degree required for CNM/CM.

Over time these efforts have been supported by the following parties:

- Community activists who set out to improve the quality of care for special populations, especially those composed of those individuals who because of age, race, ethnicity, or socioeconomic status are considered vulnerable
- Military leaders who identified nurse-midwives as qualified providers who could help make up for difficulty in recruiting physicians
- Birth collectives that wanted to train their own midwives
- Epidemiologists who looked beyond care provided by physicians, discovered midwifery, and published research on midwifery outcomes
- Elected public officials who pushed motivated midwives to get their policies in order, codified those policies, and then resisted attempts by organized medicine to make midwifery illegal

ACNM = American College of Nurse-Midwives; CM = certified midwife; CNM = certified nurse-midwife; CPM = certified professional midwife; ICM = International Confederation of Midwives; MANA = Midwives Alliance of North America; NACPM = National Association of Certified Professional Midwives; NARM = North American Registry of Midwives.

A direct-entry midwife? A licensed midwife? An indigenous midwife? While the answers to these questions are evolving, and they can be both confusing and controversial, an exploration of the similarities and differences between midwives is important to the profession (**Table 2-1**).

Terms such as "lay midwife" and "direct-entry midwife" do not have a common definition. For some, the term "lay midwife" describes an individual who has no formal education as a midwife, while others use this term to refer to a midwife who is not recognized by a government entity. The term "direct-entry midwife" typically refers to a midwife who has entered the profession without first becoming a nurse. In some states, direct-entry and licensed midwife are categories of licensure that are separate from the licensure of CNMs. The terms "traditional midwife," "community midwife," and "indigenous midwife" acknowledge the women or men who follow traditional customs as they attend births in their community. These midwives work in areas that have limited access to the formal education and well-staffed hospitals found in larger cities. Traditional midwives often are elders who are influential and trusted because they practice in concert with local belief systems. Examples include

Table 2-1 Types of Midwives in the United States

	Certified Nurse-Midwife	Certified Midwife (CM does not have to be an RN)	Certified Professional Midwife
Education	Nationally accredited education programs Graduate degree Increase in number of programs that require doctoral degree	Nationally accredited education programs Graduate degree	Nationally accredited education programs
Certification	Nationally recognized certification exam Must graduate from accredited program Graduate degree required	Nationally recognized certification exam Must graduate from accredited program Graduate degree required	Nationally recognized certification exam Minimum requirement: high school diploma or equivalent CNMs and CMs may qualify to take the certification exam
Scope of practice	Obstetrics (hospital and out-of-hospital births), well-woman gynecology, newborn, prescriptive authority	Obstetrics (hospital and out-of-hospital births), well-woman gynecology, newborn, prescriptive authority	Primary maternity care of healthy women experiencing normal pregnancies Specialize in home and out-of-hospital births
Licensure	50 states and 3 territories	3 states	Recognized by licensure in 16 states and by permit or certification in 3 additional states
Challenges	Licensure and scope of practice vary from state to state Some states do not recognize independent practice	Licensure and scope of practice vary from state to state Some states do not recognize independent practice Not recognized in Medicare rules	Illegal in 12 states Licensure and scope of practice vary from state to state Not recognized in Medicare rules
Standard-setting professional organizations	ACNM AMCB ACME	ACNM ACMB ACME	NACPM NARM MEAC MANA

ACNM = American College of Nurse-Midwives; AMCB = American Midwifery Certification Board; ACME = Accreditation Commission on Midwifery Education; NACPM = National Association of Certified Professional Midwives; NARM = North American Registry of Midwives; MEAC = Midwifery Education Accreditation Council;MANA = Midwives Alliance of North America ; RN = registered nurse.

aboriginal midwives in Canada and *comodronas* in Guatemala.

In the United States, the midwifery community was divided for many years between nurse-midwives and lay midwives. Prior to the 1990s, many midwives who were not CNMs resisted becoming nurses to be eligible for midwifery education programs and were opposed to adopting national standards for education and certification. This resistance partially stemmed from concern that the next steps would be a formal education requirement that did not recognize apprenticeship education and state licensure. Concern also arose that national standards would permit non-midwives to define the midwife's scope of practice. Being a "lay midwife" and attending home births was seen by some as the ultimate in independent practice and a source of pride.

The CPM credential, first issued in 1994, was originally developed to provide competency-based certification for midwives who were primarily apprentice trained in out-of-hospital birth. The natural consequences of creating the CPM certification examination were the obligation to ensure that those who take the exam meet common standards for education and practice and the creation of a structure within which to discipline those who do not perform in a manner consistent with the standards. CPMs now have national standards for education, certification, and practice; are seeking licensure in all states; and are pursuing reimbursement from both government and nongovernment insurance companies.

When all nurse-midwives were required to be experienced nurses prior to entering midwifery education, it was difficult for CNMs to consider other routes to midwifery as equivalent to their own. In 1991, the board of directors of the American College of Nurse-Midwives (ACNM) endorsed the development of an alternative educational path to midwifery that did not require a nursing degree, leading to the CM credential. Over the next 7 years, the requirements to accredit education programs and certify graduates who were not registered nurses were designed and tested to ensure that after graduation and certification, one could not distinguish between the knowledge and skills of a CNM and a CM. The first CM credential, which required passing the same certification examination that is offered to nurse-midwives, was issued in 1998.

Although significant variations between CPMs, CNMs, and CMs still exist (as summarized in Table 2-1), the interaction between the three professional membership organizations for midwives—the ACNM, the Midwives Alliance of North America (MANA), and the National Association of Certified Professional Midwives (NACPM)—now focuses more on common values and goals than on differences. It is increasingly clear that in the United States, where the consumer is unlikely to understand the difference between midwives with different credentials, each individual who uses the title "midwife" assumes responsibility for the image of the entire profession.

Evolution of the Profession of Midwifery

> I found…that wherever a city, a country, a region, or a nation had developed a system of maternal care which was firmly based on a body of trained, licensed, regulated and respected midwives (especially when the midwives worked in close and cordial co-operation with doctors), the standard of maternal care was at its highest and maternal mortality was at its lowest. I cannot think of an exception to that rule…[3]

The Early Years: The Trailblazers

The scope of practice of CNMs and CMs as defined by the ACNM and recognized in federal and state laws has changed over the years. The early nurse-midwifery "trailblazers" (1930s to 1950s)[2] who predated the 1955 incorporation of the American College of Nurse-Midwifery (changed to Midwives in 1969) would probably be surprised to learn that today's CNMs and CMs provide more than just maternity care to women and are working in very specialized women's healthcare clinics. The small number of home births attended by CNMs/CMs might also surprise the trailblazers. They might also wonder why today's CNMs/CMs sometimes have to fight to be recognized as primary care providers, given that primary care was an essential component of the public health nursing practiced by those who added midwifery training to become nurse-midwives.

Building the Profession: The Fence Builders

Lessons learned from the successes and failures of the CNM trailblazers served as guideposts for the "fence builders."[4] The fence builders wrote ACNM standards for the education, certification, and practice of midwives, launched a peer-reviewed journal (*Journal of Midwifery*, whose name was changed to *Journal of Midwifery & Women's Health* in 1999), created a network of midwives supporting midwifery-owned

businesses and offered their services to help save women's lives and educate midwives in low-resource countries. More recent accomplishments that depended upon the work of the early fence builders include legislation that (1) protects the right of women to choose midwifery care (1997); (2) ensures Medicare payment for maternity care provided by nurse-midwives (1988); (3) expands this coverage to full-scope nurse-midwifery care (1993); and (4) now provides for Medicare payments to CNMs that are equal to payments made to physicians (2011).

CPMs have also evolved over time. There are now three standard-setting professional organizations that work to move the CPM profession forward: MANA, founded in 1982; the North American Registry of Midwives (NARM), founded in 1994; and NACPM, founded in 2000. One unique aspect of these organizations is that they represent midwives from very diverse clinical and educational experiences and, therefore, it is not easy to summarize their evolution over time. Judith P. Rooks, in her landmark book, *Midwifery and Childbirth in America,* stated that these midwives "developed as part of the social and cultural ferment of the late 1960s" and "invented themselves in rural communes, religious communities, and the nooks and crannies of urban counterculture enclaves."[2]

After the late 1960s, these midwives faced a number of challenges: (1) their lack of credentials and illegal status in some states; (2) different educational processes, which range from pure apprenticeship to private 3-year schools; (3) negative publicity accompanying bad outcomes at home births that may have been attended by midwives with insufficient training who have not undergone recognized educational processes for direct-entry midwives; and (4) the negative stereotype that midwives in general are less competent than physicians.[1]

Members of MANA realized that the only way to convince the public and the government of their professionalism and avoid legal persecution was to create a standardized national certification process. In response, the NARM certification exam and CPM credential were created. The CPM credential is "open to midwives educated through all possible routes, including apprenticeship, self-study, formal vocational programs, university training, and all combinations thereof."[1]

Midwifery Now: The Tower Builders

Midwives in the twenty-first century must fill the role of "tower builders"[4] by continuing to help the profession, in all of its diversity, meet the growing demand for midwifery care in a digital world. These midwives will carry the profession, and its low-technology, high-touch roots into a high-technology world characterized by more integrated healthcare delivery systems. Like the midwifery trailblazers and fence builders, today's midwives must also be "protectors." They must continue to distinguish the midwifery profession from the professions of nursing and medicine and expand the evidence base that defines the best practices in midwifery.

Few of these labor-intensive accomplishments would have ever moved from internal ideals to cultural norms without consumer support. From the Maternity Center Association (now Childbirth Connection) to Citizens for Midwifery, consumers have provided inspiration, influence, and financial resources to promote and protect access to midwifery care.[5,6] The list of individuals who created a public demand and stood beside midwifery during some very difficult times is long.

Characteristics of the Midwifery Profession

To protect the profession from those who resist increasing access to midwifery care by suggesting that midwives are undereducated, outdated, or unprofessional, it is important for midwives to be able to answer a critical question: What makes one a professional? According to Ament, "in the United States, the overall objective of protecting the public welfare…is accomplished through three interdependent mechanisms: 1) a prescribed, accredited course of study; 2) national certification; and 3) governmental, usually state or other jurisdiction, licensure."[7] Thus a professional must show evidence of attending an accredited education program, attaining national certification, and becoming licensed by all the appropriate legal jurisdictions. Midwifery leaders and healthcare researchers have also described additional "characteristics of professionalism" that are less easily measured, but considered to be integral to the specific profession of midwifery.

Core Competencies

Core competencies delineate the fundamental knowledge, skills, and behaviors expected of members of the profession. They serve as the reference point for standardization of the curricula for otherwise diverse education programs, the criteria for accrediting education programs that are not all within colleges of nursing, and the development of the certification examination. These competencies inform regulatory agencies, consumers, and employers of what, at a

minimum, can be expected from those who meet the criteria to use the professional credential.

The first ACNM Core Competencies for Basic Midwifery Practice were published in 1978, although some concepts could be found in earlier midwifery documents.[8] The core competencies have been updated regularly to reflect changes in the profession, including the decision to educate and certify midwives who do not have a nursing education, previously mentioned as the CM.

First published in 1994, the MANA Core Competencies for Basic Midwifery Practice are referenced for the CPM certification exam and the Midwifery Education Accreditation Council (MEAC) accreditation process.[9]

Using core competencies as a measurement of a student's success enables education programs to recognize that many individuals enter midwifery programs with preexisting skills and enables the students to focus their studies on new areas, rather than repeating already learned information. In addition, clear, meaningful competencies reassure the public as well as the midwifery community that all accredited programs graduate well-prepared individuals.

Accreditation

Earning a college degree is a significant measure of success in the United States. It represents knowledge obtained in an institution that adheres to national standards that are established to ensure preparation of students who are well educated, by qualified faculty in their chosen field. Students, employers, and consumers want to know that a degree reflects mastery of a prescribed set of knowledge and skills.

To increase the value of formal education and to protect students from fraud, the federal government and professional organizations have established standards for institutions of higher education that address the learning environment, content of the curriculum, and qualifications of faculty. In the case of midwifery, the Accreditation Commission for Midwifery Education (ACME) has been recognized by the U.S. Department of Education as a programmatic accrediting agency since 1982 for nurse-midwifery education programs and since 1994 for direct-entry midwifery programs. Maintaining midwifery accreditation standards that are separate from those required for nursing education has allowed the CNM/CM profession to self-regulate, maintain a strong public voice for improving access to midwifery care, and influence public policy that affects the health of women and families.

The U.S. Secretary of Education recognizes the MEAC, established in 1991, as a national accrediting agency for direct-entry midwifery education programs. MEAC-accredited programs, which may or may not be affiliated with an institution of higher education, prepare students to take the CPM examination.

Certification

For CNMs and CMs, certification—passing an examination that measures mastery of fundamental knowledge needed for safe practice that is obtained through a recognized program of study—is required to obtain a state license to practice, to obtain hospital staff privileges, and to qualify for reimbursement from government and private health insurance plans. The criteria for taking the exam, the content of the exam, and the requirements for maintaining certification are developed under the auspices of organizations that do not serve as advocates for the profession. While members of the profession can serve as expert advisors, certification organizations work to protect the recipients of care and follow the standards established by the National Commission for Certifying Agencies. CNMs have been certified by examination since 1971, CPMs since 1994, and CMs since 1998.

State Regulation

The assumption of responsibility for the life and health of another individual—or individuals, in the case of the maternal–fetal dyad—comprises a legal and social contract with multiple contingency clauses. State legislators have responsibility for protecting citizens from unsafe healthcare practitioners and do so by establishing, via state laws, the rules that govern practice. State agencies are charged with adopting regulations that further clarify the rules. A typical state midwifery practice act will establish (1) qualifications for initial and renewed licensure, (2) scope of practice, (3) relationship with physicians, (4) prescriptive authority with special requirements related to prescribing controlled substances, and (5) definitions of unlawful or unprofessional conduct. Because the laws governing licensure must be handled through the legislative process, they are subject to the influence of multiple stakeholders; moreover, the process of getting a bill passed can be unpredictable. As a result, there is variation in midwifery scopes of practice and requirements for licensure or authorization to practice from state to state. Some state practice acts are not entirely consistent with the standards of practice endorsed by professional midwifery organizations and taught in accredited midwifery education programs. Despite this discrepancy, the licensed

midwife is expected to follow the rules and regulations for whatever method of authorization he or she is granted by the state. The practice of midwifery can also be subject to state and federal laws governing Medicare and Medicaid payment, prescriptive authority, controlled substances, and licensing of freestanding birth centers.

Midwifery Scope of Practice

An individual's scope of practice is determined by several factors, including legal jurisdictions, institutional policy, and individual education and training. Most laws governing midwifery practice define the clinical or professional relationship between midwives and consulting physicians. At their best, the laws support midwifery independent practice and collaborative management; at their worst, they require direct physician supervision of midwives. The rules and regulations governing midwifery practice usually are available on state-sponsored websites. Professional organizations such as ACNM and MANA provide online summaries of all the state midwifery laws. A recent review by Osborne summarized current state regulations regarding prescriptive authority for midwives.[10]

Midwives who attend births in a hospital and some birth centers are required to be credentialed and privileged by the healthcare facility prior to caring for women in that setting. Bylaws, as established by the healthcare facility, define the requirements for obtaining privileges, the responsibilities of those who are granted privileges, specific procedures that may be performed by the individual providers, protections offered to those who are privileged, and grounds for removal of privileges. These bylaws may also specify the role and responsibilities of the midwife in relation to consulting physician(s) and the responsibilities of the physician in relationship to collaborating midwives. All privileged providers are expected to adhere to institution bylaws, even when they are more restrictive than the state law.

The Professional: The Exemplary Midwife

Professions also assume responsibility for setting their own standards of performance. As is often noted, there is a difference between being a member of a profession and being a "professional." As Kennedy has stated, the "midwife's professionalism is a key factor in empowering women during the childbearing process."[11] Thus, to be a professional, one must know how professionalism is defined and measured.

Kennedy identified three dimensions of midwifery professionalism:

1. The *dimension of therapeutics*, which illustrates how and why the midwife chooses and uses specific therapies when providing care
2. The *dimension of caring*, which reflects how the midwife demonstrates that she cares for, and about, the woman
3. The *dimension of the profession*, which examines how midwifery might be enhanced and accepted by "exemplary" practice[11]

Kennedy divided the dimension of therapeutics into two qualities that must be held in balance: supporting the normalcy of birth, while simultaneously maintaining vigilance and attention to detail, intervening only when necessary. "This process of supporting normalcy could aptly be described as the art of doing 'nothing' well."[11]

The dimension of caring is demonstrated by "1) respecting the uniqueness of the woman and family; and 2) creation of a setting that is respectful and reflects the woman's needs."[11] Midwives explore and honor each individual woman's personal history and cultural context. They work in partnership with women with the goal of providing emotional support and strengthening self-confidence.

Some qualities identified by Kennedy as linked to the dimension of caring include "an unwavering integrity and honesty, compassion and understanding, the ability to communicate effectively, and flexibility."[11] Midwives are emotion-workers. They support the emotional journey of women through health care. For example, midwives support the birthing woman while also identifying and managing their own emotions in order to best meet the needs of the woman, including situations in which the woman may be fearful. The professional midwife then works to minimize her fear. In addition to creating an emotional setting that meets the woman's needs, exemplary midwives are experts at creating safe emotional settings. Midwives who care for women in labor are experts in protecting the sacred physical birth space. Using skills that make midwifery a unique profession, they help to create a peaceful environment that is the most conducive to the birth process, maternal satisfaction, and mother–child bonding in the immediate postpartum period.

The dimension of the profession focuses on "the delineation, promotion, and sustenance of midwifery as a professional role."[11] Midwives demonstrate this dimension through evidence-based practice, quality and peer review, continuing education, commitment

to and passion for the profession, and nurturing and caring for themselves. The exemplary midwife's focus is not just on the individual woman or birth; in addition, the midwife is driven to foster the profession and advocate for improving women's health care locally and globally.

Midwifery Within the U.S. Healthcare System

The quintessential midwifery role is provider of direct care to women. The other chapters in this text detail how that role is fulfilled. Additional roles inherent in midwifery include researcher, educator, policymaker, and business manager, among others. Thus the practice of midwifery is not solely devoted to direct patient care, but rather encompasses a variety of other activities.

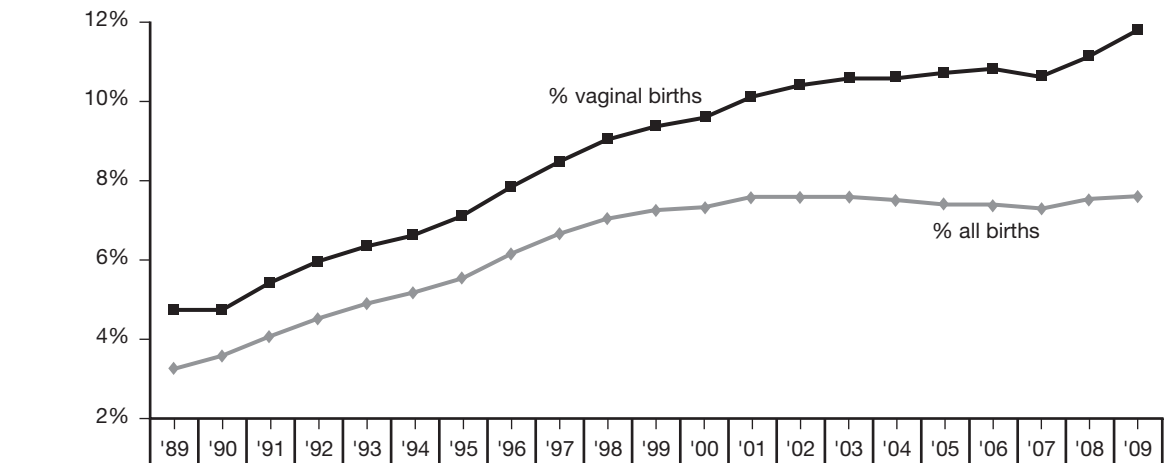
Improving the health of women is a personal, communal, and political responsibility, and midwives work wherever women need them. While many midwives attend births and provide women's health services, they may also work as entrepreneurs, educators, and researchers. In all of these settings, midwives collaborate with a variety of team members.

In clinical practice, midwives may work for large hospitals or healthcare systems in metropolitan areas, in small private practices in rural communities, and anywhere in between. Midwives may attend births in homes, freestanding birth centers, or hospitals. They may be self-employed in a private business, or they may be employees of physicians or healthcare organizations. They may provide care to women from vulnerable populations or to women with extensive social and financial resources. Midwives can limit their practice to women with needs that are age or disease specific, such as family planning, infertility, obstetric triage, menopause, incontinence, or pelvic pain, or they can provide a general range of services.

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

In 1989, the Centers for Disease Control and Prevention (CDC) began collecting data on nurse-midwife–attended births. Since then, there has been a steady increase in the number of women having vaginal births attended by CNMs and CMs, and in 39 states an overall increase in the proportion of births attended by midwives (**Figure 2-1**).[12,13]

Historically, the percentage of out-of-hospital births (including birth center and home births) declined from 44% in 1940 to 1% in 1969, and



	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09
All	3.3	3.6	4.1	4.6	4.9	5.2	5.6	6.2	6.7	7.1	7.3	7.3	7.6	7.7	7.6	7.5	7.4	7.4	7.3	7.5	7.6
Vaginal	4.8	4.8	5.4	6.0	6.3	6.7	7.1	7.8	8.5	9.0	9.4	9.6	10.1	10.4	10.6	10.6	10.7	10.8	10.6	11.1	11.4

Figure 2-1 Percentage of live births attended by certified nurse-midwives, 1989-2009.
Source: Martin JA, Hamilton BE, Ventura SJ, et al. Births: Final Data for 2010. *National Vital Statistics Reports,* Vol. 61, No. 1. Hyattsville, MD: National Center for Health Statistics; 2012.

remained stable until recently. The majority of out-of-hospital births occur at home. According to the National Center for Health Statistics (NCHS), from 2004 to 2009, U.S. home births increased from 0.56% to 0.72%—a 29% increase.[14]

The Employee

With so many opportunities, the typical midwife seeking a job searches for a position that is a good match to his or her experience, personality, skill set, and lifestyle. When evaluating the positives and negatives of any job, it is important to review several other aspects of the business that may contribute to success or frustration. These aspects may include availability of and relationship with collaborative physicians, ancillary support (e.g., billing, patient flow), retirement benefits, reimbursement for professional expenses (e.g., licenses, certification, continuing education), and payment for malpractice premiums. It is important to determine whether the malpractice coverage is an occurrence policy or a claims-made policy. An occurrence policy covers claims that *occur* during the life of the policy, whereas a claims-made policy covers only claims that are *made* during the life of the policy. A claims-made policy requires the insured to purchase extended coverage, termed a tail or prior acts policy, if employment changes. Who pays the cost of the extension—which may be 1.5 times the annual premium—is an important consideration, especially when the midwife is an employee. Ament provides a post-job-interview rating tool that facilitates an objective measure of the match between the midwife's expectations and the practice characteristics (**Table 2-2**).[7]

Whether or not a prospective employer offers a formal contract, asking for confirmation in writing of offered remuneration and job specifics is a wise request. If asked to sign a contract, it may be important for the professional to consult with an attorney. Even if a contract is considered non-negotiable, the midwife should thoroughly understand the content prior to signing. **Box 2-2** provides a list of topics that should be discussed prior to accepting a position.

Table 2-2 Postinterview Evaluation for a Midwife

Rate your responses to the following questions:
1 = acceptable 2 = unsure 3 = unacceptable

Practice philosophy	1	2	3
Patient volume	1	2	3
Patient demographics	1	2	3
Patient outcomes	1	2	3
Productivity requirements	1	2	3
Clinical hours	1	2	3
Practice partners	1	2	3
Support staff	1	2	3
Practice facilities	1	2	3
Birth facilities	1	2	3
Nonclinical responsibilities	1	2	3
Availability of resources	1	2	3
Orientation	1	2	3

The Entrepreneur

Most midwives consider midwifery to be a vocation. Thus it can be challenging to think of midwifery as "a business"—yet all midwives need to understand the basic principles of running a successful business. There is a growing need for midwives to become accomplished administrators and business managers. Even job hunting is a business skill.

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

Business Advice from Experts

It is unwise to open a business without seeking the expertise of, at a minimum, an attorney and an accountant. The legal structure of a midwifery business (e.g., sole proprietorship, partnership, or limited liability company) will have short- and long-term personal and financial consequences. Midwife business owners should be experts on the laws and regulations that govern midwifery practice, but must also know how the laws governing medical practice, the corporate practice of medicine, and pharmacy regulations impact their plans. Midwives providing care during out-of-hospital births must comply with health department regulations, birth center requirements, building codes, and a variety of business regulations.

BOX 2-2 Contract Negotiations

1. *Type of Position: salary, hourly?*
2. *Benefits*
   a. Salary
   b. Health, dental, optical insurance
   c. Paid vacation (#)
   d. Paid sick leave (#)
   e. Paid holidays (#)
   f. Life insurance, retirement annuity
3. *Other Professional Benefits*
   a. Tuition reimbursement
   b. Expense account/continuing education costs and paid time off
   c. Professional membership dues
   d. Professional journal subscriptions
   e. Professional licenses
   f. Pager/cell phone
   g. Mileage
   h. Bonuses
      i. Productivity by volume or
      ii. Productivity by effectiveness
   i. Malpractice insurance
      i. Amount of coverage
      ii. Personal policy or rider
      iii. Tail
4. *Other*
   a. Work hours: office, call, administrative time, committee or other responsibilities
   b. Paid for overtime?
   c. Scheduling of appointments: how many per day, time per visit
   d. Productivity data
   e. Length of orientation
   f. Employee handbook

Contract

1. Position description
2. Work hours/expectations
3. How evaluated? When? By whom?
4. Salary (and benefits)
5. Duration of contract
6. Amendment and modification agreement
7. Restrictive clause?
8. Termination of contract conditions
   a. Of the person
   b. Of the position
   c. Length of notice
   d. Compensation

Midwives who employ others must determine how they will compensate those employees and follow the relevant employment tax codes and antidiscrimination policies. Beyond malpractice coverage, new business owners are often surprised to learn how many insurance policies need to be purchased and how many business contracts need to be finalized. In all of these areas, good advice can save money, protect investments, and enable midwives to provide care for women.

Preparing a business plan and seeking guidance from an accountant on the costs of doing business provide clarity for all involved and are requirements when seeking loans to help establish a business. Elements in a business plan are listed in **Box 2-3**. The time spent attending to details and establishing a reporting system that provides regular feedback on revenues versus expenses provides a way to measure success for the entire team and relieves pressure when the unexpected happens.

In a country that places a high value on independent business ownership, many types of support exist

BOX 2-3 Business Planning

Benefits of a Business Plan

- Makes you think about many aspects you might not have considered
- Helps to solidify ideas into an organized format
- Clarifies the role of others: collaborating physicians, other health professionals
- Serves as a benchmark for actual performance

Business Plans Help You To

- Quantify resources
- Evaluate finances
- Prioritize objectives

Elements of a Business Plan

- Cover page
- Executive summary
- Practice organization
- Market analysis
- Market plan
- Regulatory issues
- Facility and space requirements
- Equipment requirements
- Accounting, taxes
- Financial data
- Time lines

for small business owners, including information on how to formulate business plans and where to apply for small business loans. Midwives who are business owners often agree to mentor the next entrepreneur. The Midwifery Business Network is an organization of midwives who are committed to sharing information, providing support to midwives interested in the business aspects of midwifery practice, and increasing the number of midwife-owned services.[15] The Midwifery Business Network sponsors an annual fall conference and has published an *Administrative Manual for Midwifery Practices*.[16] Other business guides also exist in areas outside of midwifery, which may provide additional useful information.[17]

Midwifery services that are not independent businesses still have business or administrative aspects of importance. Even a two-person service has to reach an agreement on scheduling, compensation, records management, monitoring of financial statements, negotiation of collaborative agreements with physicians, peer review, and strategies to handle personal and professional adversity. Services that reside in large corporations may inherit many of these decisions and struggle to have a voice in changes that directly influence their practices. While responsibilities for the success of the service are shared, there must be a designated leader or service director who serves as the primary contact with the corporation, assumes responsibility for participating on department- or corporate-level committees, is able to describe the success of the service in corporate terms, and knows how to move an agenda within the organization. Midwives place a high value on building relationships with women and on positive feedback from the individuals for whom they provide care. Those skills can be extrapolated into the business arena and will serve the midwives well.

Marketing

Many advisors encourage early attention to a marketing plan. Without a coherent, consumer-friendly message about the services offered and an identified medium for reaching the target population, the business may not be able to sustain itself. Not every service can cover the cost of a logo and four-color brochures, but all midwives can develop marketing skills. For example, the organized, scientific, lecture approach may intimidate some women, while others may look for messages that midwifery practice is evidence based and provides adequate safeguards in the event of major complications.

Professional organizations may be a ready source of marketing advice and materials. Indeed, many are involved in national marketing campaigns that can be adapted to local settings. Both ACNM and MANA, for example, have marketing campaigns that can be adapted for local audiences.

Billing for Services

No matter what size the business, every employee should be able to describe the source of revenue that covers employee salaries and know how to support that revenue stream. When the services provided by a midwife are billable, then the midwife must clearly document the services provided and complete a form to initiate the billing process. The midwife also is responsible for fulfilling the requirements for documentation that support the billing codes. For example, the amount paid for an exam will vary based on the intensity of the exam as measured by the number of systems included in the physical assessment, the types of problems identified, and the amount of time spent providing and coordinating care. If this content is not thoroughly documented in the healthcare record, payment may be reduced or even denied.

However the billing gets done, service directors are usually responsible for establishing a system of checks and balances that monitors the accuracy and timeliness of the billing process and limits the opportunity for embezzlement or insurance fraud. The time and money spent establishing a viable medical record and billing system are necessary outlays to ensure the ongoing success of the business.

Data Collection

Lessons learned from Mary Breckenridge, who gathered local data prior to opening the Frontier Nursing Service, continue to serve the midwifery profession well. These lessons include the power of local data, including baseline descriptive data before opening a service, descriptive and outcome data from the first day of operation, assistance from researchers, and dissemination of the findings. A number of readily accessible mechanisms for collecting and collating practice-specific and national data exist that describe the care provided by midwives. Members of ACNM can join in the ACNM Benchmarking Project,[18] which allows participants to examine their practices and compare them to other like practices across the United States. The MANA Division of Research, with its MANAStats system, and the American Association of Birth Centers, with its Uniform Data Set, both have developed web-based data collection tools that can be used by individuals and contribute to a national database on the outcomes of midwifery care.[19,20]

The Educator

All midwives are educators. Policymakers, potential employers, and consumers all need to learn what is unique and valuable about the midwifery approach to care. Women need to learn how to care for their own bodies and how to safely prepare for puberty, pregnancy, menopause, and all the points in between. Consumer-oriented materials often are used for this purpose, and may be written by midwives. For example, the *Journal of Midwifery & Women's Health* regularly publishes a patient education handout titled *Share with Women*. This series of copyright-free handouts targeted to women reviews important clinical topics using appropriate language and illustrations for lower health literacy.

Some midwives educate others to be midwives. All midwives in practice are encouraged to clinically teach and precept students. There are approximately 40 midwifery education programs accredited by ACME with numerous midwives on faculty. Directors of these programs meet twice a year through their association, known as Directors of Midwifery Education (DOME). It is by "midwifing" individuals to develop skills in the cognitive, affective, and psychomotor domains that the midwifery profession continues to flourish. The legacy of midwifery also depends on socialization of midwifery students into the role and responsibilities of the midwife.

The Researcher and User of Research

Sackett et al. concisely defined evidence-based practice (EBP) in 2000 as the "integration of the best research evidence with clinical expertise and patient values."[21] Not all midwives need to actively conduct research, but all need to understand relevant research and implement evidence-based care. The systematic use of evidence in the field of obstetrics usually is dated to the 1989 publication of the two-volume book, *Effective Care in Pregnancy and Childbirth* (1989).[22] In this ground-breaking treatise, the authors combed through existing obstetric research articles and identified those clinical practices supported by research as well as those practices that the evidence did not support.

Several databases that summarize the most recent evidence on a multitude of clinical topics are available to women's healthcare providers. One important evidence-based database is the Cochrane Library (named for Archie Cochrane a physician and pioneer in the area of evidence-based medicine). The Cochrane Library contains several databases, including the Cochrane Database of Systematic Reviews.[23] Other sources of research that midwives often use include PubMed, the Up-to-Date Database, and DynaMed. Anderson and Stone, in their textbook, outlined the steps for locating the evidence for a particular clinical scenario (**Box 2-4**).[24] It is of note that these steps are similar to the midwifery management process as discussed in the *Introduction to the Care of Women* chapter.

When gathering information, it is important to remember that "not all evidence is created equal." Once all the research data have been gathered, the findings need to be compared and contrasted. Evidence then is evaluated as to its strength. The clinically applicability of the recommendations are ultimately based on the strength of the evidence (**Figure 2-2**).[25]

The Collaborator: Member of an Interprofessional Healthcare Team

All healthcare providers work within a healthcare system that includes professionals who have different scopes of practice, different professional cultures, and different professional roles. The factors that make interprofessional relationships work well become especially pertinent for midwives when a woman develops complications or conditions that lie beyond the scope of midwifery practice. Although it has long been recognized that interprofessional teams provide better care than single-disciplinary groups for patients with complex medical needs,[26] interprofessional collaboration and communication have only recently been the focus of education, research, and clinical initiatives.[27,28]

BOX 2-4 Methodology for Finding the Evidence

1. Identify the clinical problem.
2. Formulate a focused, answerable question following the PICO format (problem, intervention, comparison, outcomes).
3. Locate relevant and appropriate resources.
4. Critically appraise the information.
5. Implement and integrate the evidence into clinical practice.
6. Communicate the information (to the woman, her family, and to other providers).

Source: Adapted from Anderson BA, Stone SE. *Best Practices in Midwifery*. New York: Springer; 2013.

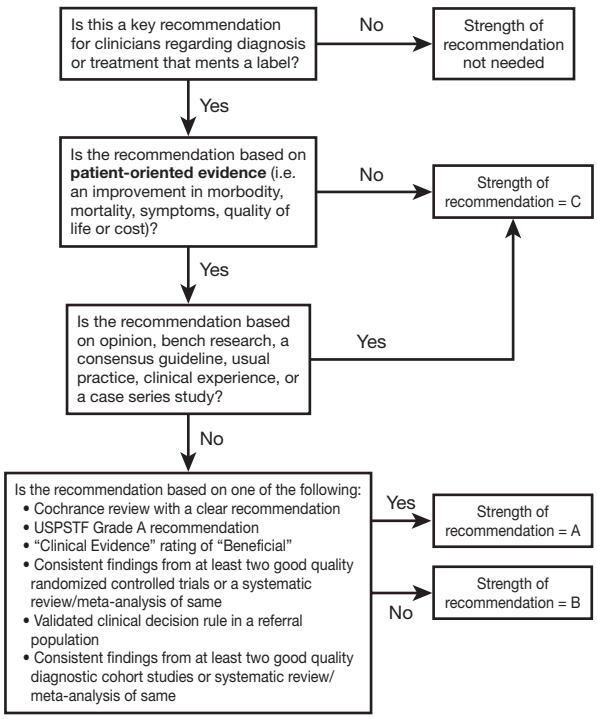


Figure 2-2 Algorithm for evaluation of strength of evidence and determination of recommendation.

Source: Reprinted with permission from Ebell MH, Siwek J, Weiss BD, et al. Strength of recommendation taxonomy (SORT): a patient-centered approach to grading evidence in the medical literature. *J Am Board Fam Pract.* 2004;17(1):59-67.

The patient safety movement has shined a light on the most recent focus on interprofessional collaboration and the need to improve communication between healthcare providers. In the 1999 groundbreaking Institute of Medicine (IOM) report *To Err Is Human*, it was estimated that 45,000 to 98,000 patients die each year in U.S. hospitals due to medical errors.[29] Subsequent medical error and patient safety reports have highlighted poor communication and inadequate team coordination as the source of many of these medical errors. For example, a Joint Commission sentinel event analysis on preventing infant death and injury during birth identified communication problems as the root cause of the healthcare delivery error in 72% of the cases analyzed.[30] Fifty-five percent of the organizations studied cited organizational culture, including "hierarchy and intimidation, failure to function as a team, and failure to follow the chain-of-communication," as commonly encountered barriers to effective communication and teamwork.[30]

In the years following these publications, much work has been done on identifying ways to foster and support teamwork in healthcare delivery. Successful interprofessional collaboration in obstetrics, for example, has been associated with improved patient outcomes, a high degree of patient satisfaction, fewer cesarean sections, and lower costs.[31]

The Definitions of Collaborative Care

According to the International Confederation of Midwives (ICM) Essential Competencies for Basic Midwifery Practice, "The midwife…works collaboratively (teamwork) with other health workers to improve the delivery of services to women and families."[32] Moreover, "[t]he midwife has the skill and/or ability to…identify deviations from normal during the course of pregnancy and initiate the referral process for conditions that require higher levels of intervention."[32]

ACNM recognizes that midwives are independent practitioners who function within a complex medical system, which includes collaboration with multiple healthcare professionals, to ensure the health and safety of women and their newborns.[33] The levels of collaborative management as defined by ACNM include consultation, collaboration, and referral, and the definitions for each of these levels often serve as guidelines for similar language within state laws and hospital bylaws (**Table 2-3**).[34]

The 2011 ACNM and American College of Obstetricians and Gynecologists (ACOG) Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives declares that "health care is most effective when it occurs in a system that facilitates communication across care settings an among providers."[35] MANA, NARM, and NACPM have all published documents that address the relationship between CPMs and physicians.[36] In these documents, midwifery practice is described as autonomous and CPMs are expected to collaborate, refer, and transfer care in critical situations.

Essential Components of Collaboration

Interprofessional collaboration can be a challenging endeavor. In 2011, a group of experts from several professional associations published a white paper that itemized recommended core competencies for interprofessional collaboration within four competency domains: (1) roles and responsibilities for collaborative practice, (2) values and ethics for interprofessional practice, (3) interprofessional communication, and (4) interprofessional teamwork and team-based care.[27, 28,37] In addition, several authors have identified essential components of successful collaboration, which are summarized in **Box 2-5**.[27,28,37–40]

Table 2-3 The Continuum of Collaborative Management in Midwifery Care

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

SBAR = situation, background, assessment, recommendation.

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

Source: Definitions adapted from American College of Nurse-Midwives. *Collaborative Management in Midwifery Practice for Medical, Gynecological and Obstetrical Conditions.* Silver Spring, MD: American College of Nurse-Midwives; 1997.

BOX 2-5 Essential Components of Successful Collaboration and Teamwork[a]

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

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

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

Teamwork

Teamwork and communication are skills that can be learned.[41–43] Although patient outcomes following simulation training have not yet fully been determined, it appears that simulation training improves teamwork, team coordination, and interprofessional communication.[41,43]

The U.S. Agency for Healthcare Research and Quality (AHRQ) has developed a series of materials and training curricula, collectively titled TeamSTEPPS, which can be used in healthcare settings to help foster successful teamwork.[39,44,45] The TeamSTEPPs curricula emphasize the development of four core competencies: communication, mutual support, situation monitoring, and leadership.

Communication Techniques for Successful Collaboration

Direct and deliberate communication techniques include the *SBAR, closed-loop communication*, and *the handoff*.

The SBAR—an acronym for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation—is structured communication tool that has been shown to significantly improve the quality of communication between healthcare providers and to reduce medical errors.[46] The SBAR approach omits the nonessential elements of a woman's history, distills the most pertinent information, and clarifies what is needed. The midwife can use the SBAR approach to obtain a consultation from a specialist (**Box 2-6**) or to communicate during an emergency (**Box 2-7**).

In closed-loop communication, the midwife directs the message to a particular team member, the team member repeats the order or request aloud, and the midwife confirms that the team member heard correctly. This communication allows the whole team to hear the orders and correct any errors before the orders are executed. Closed-loop communication tools such as the *call-out* and the *check-back* can be used to communicate critical information to all members of the team, thereby allowing them to anticipate what will be needed next, but use of such tools also requires that team members communicate what they intend to do with the information.

When transferring care from one provider to another, an official handoff includes the transfer of information along with primary care responsibility; this step provides an opportunity to clarify information, confirm understanding, and discuss the management plan. The handoff can occur between two midwives or between the midwife and the referral physician when a transfer of care is indicated. The goal of the handoff is to give the new primary provider all of the information needed to safely care for the woman and her family. **Figure 2-3** provides an example of a handoff form.

Communication skills such as the SBAR, closed-loop communication, and the handoff are like any clinical skill—they must be practiced and adapted to individual settings.

BOX 2-6 SBAR Used for a Consultation

The midwife at a clinic is caring for a woman at 33 weeks' gestation who was previously diagnosed with gestational diabetes type 1A. When reading the woman's blood glucose log, the midwife observes that more than 20% of her values are high. She calls the consulting maternal–fetal medicine physician and gives this consult SBAR.

S: I want to consult with you about a woman with uncontrolled gestational diabetes.

B: Maria Gonzalez is a 24-year-old G1P0 at 33 weeks by LMP consistent by 19-week ultrasound. Her 1-hour GTT was 150 and her 3-hour GLT had 2 elevated values. She was sent to the diabetes education center and received diet and glucose monitoring education. Over the last 2 weeks, 20% of her values are out of range, with five fasting levels between 100 and 110 and five 2-hour postprandial levels higher than 150, the highest being 180. She had a reactive NST today, the fetus is size equal to dates, and her urinalysis was negative for glucose.

A: Diabetes diet is inadequate to control glucose levels and I believe she needs medication.

R: I would like your recommendation for medication therapy and schedule her to see you for a consultation in the next few days.

BOX 2-7 SBAR Used in an Emergency Situation

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

S: This woman is having a postpartum hemorrhage.

B: Marta gave birth to her fifth child 15 minutes ago over an intact perineum. Her total EBL is 800 mL. She has received 40 IU of oxytocin (Pitocin), 0.2 mg of ergonovine (Methergine), and 800 mcg of misoprostol per rectum (Cytotec). The placenta appeared intact, and there are no clots in the lower uterine segment.

A: She has severe uterine atony, and I think I feel some placental tissue in the anterior portion of the fundus.

R: Can you please put on some gloves and assist me?

The Policymaker

The building blocks of the midwifery profession (standards for education, certification, and practice) open many doors for midwives to contribute to the development of public and private policy. For the profession as a whole to thrive, each midwife must walk through these doors. Federal, state, and institutional policies determine which healthcare services and birth settings are available to women as well as who will be reimbursed and at what rate. Which education programs receive government funding to support faculty and students is also a matter of policy. Hospitals, clinics, and employers all write policies that influence access to midwifery care.

Members of the midwifery profession, primarily serving in a volunteer capacity, wrote the vast majority of the original policies that define the profession of midwifery. Even today, professional organizations remain dependent upon a high level of volunteer effort to keep these policies relevant. Meeting the policy needs of the profession primarily represents a labor of love and a dogged determination to turn a vision into reality.

Many of the successful midwifery policymakers will confess to initially not seeing the need for this work, doubting their own abilities, or hoping someone else would do it.[47] It was discovered that becoming a policymaker is a learned behavior; thus the midwifery profession is now filled with successful midwife role models, and guidance on how to make this transition is readily available (**Box 2-8**).

In spite of many past successes, much policy work remains to be done. Some physician associations are opposed to laws that recognize advanced practice clinicians as independent providers, instead advocating for required physician supervision. Many state laws governing the practice of nurse-midwifery need to be changed to permit independent practice.

BOX 2-8 How to Become a Midwife-Policymaker

- Write policies for your midwifery practice or local midwifery group.
  - What do you need to write good policy?
- Volunteer to observe legislative policy in action.
  - Who seems most effective and why?
  - What is common etiquette and the standard for appearance?
  - Was the speaker effective? How did you know?
- Identify a mentor.
- Know your strengths.
  - Offer a lived experience.
  - Be the voice of a midwife or support a client who agrees to speak.
  - If you can't do policy, support your colleagues who can.
- Come prepared and speak a language the audience can understand.
  - No bluffing.
- Know your opposition.
- Never go alone.
  - Get help preparing statements.
  - Make friends in the room.
  - Defer to other experts.
- Learn a new language.

Source: Adapted from Williams DR. We need to say in unison: We are midwives and we do policy! Editorial. *J Midwifery Women's Health*. 2008;53(2):101-102.

As of 2012, CPMs could not be licensed to practice in more than 30 states, and CMs could not be licensed in 47 states. Major decisions are also looming: should CNMs seek more midwifery practice acts that are separate from nursing and include their CM colleagues or stay under the advanced practice registered nurse (APRN) umbrella; can CNMs/CMs and CPMs be licensed under the same practice act; should CPMs be required to earn a college degree; should CNMs/CMs be required to earn a doctoral degree; and will the U.S. Congress pass healthcare legislation that moves the profession forward or backward—either outcome is always a possibility.

Professional Ethics in Midwifery

Midwives must be well versed in the ethics involved in all healthcare interactions.[48,49] The subject of professional ethics in health care is complex, and the introduction presented here is not a comprehensive review of this important topic. Additional resources that address health literacy, health numeracy, values clarification, options counseling, the interface between legal and ethical issues, and ways to communicate risk are listed at the end of this chapter.

An ethical framework for practice, beginning with the concept of accountability, is critical to the continuation of midwifery as an independent and respected profession.[7,50] Ethical guidelines encourage self-regulation, foster professional identity, protect midwives and clients, and serve as a measure of professional maturity.[51]

Ethics is defined as a guiding set of principles that inform actions.[51] The ACNM Code of Ethics was first published in 1990, and the ICM ethical code was introduced in 1993. These documents, as well as the MANA Statement of Values, provide guidance for the ethical behavior of midwives in various roles, including caring for women and their families, education, research, public policy, business management, and financial organization of health services.[52,53] A number of other organizations have published statements on "the rights" of individuals who receive health care—a concept that is inherent in most statements on ethical principles. In 2004, the Childbirth Connection (formerly the Maternity Association) revised *The Rights of Childbearing Women*; this document applies widely accepted principles of human rights to maternity care.[54]

Bioethical Principles

Four broad ethical principles define modern bioethics—the ethics of working with or caring for human beings. They include respect for autonomy, nonmaleficence (do no harm), beneficence (do good), and justice (**Table 2-4**).[55, 56]

Respecting an individual's privacy, ensuring confidentiality, encouraging shared decision making, and providing for informed decision making are all extensions of these bioethical principles. Research has shown that when healthcare providers do not respect these rights, their behavior may be seen as a form of abuse and could lead to psychological trauma for the woman.[57] Healthcare professionals can also experience ethical dilemmas when the application of one ethical principle appears to contradict a second principle.

Table 2-4 Bioethical Principles

Bioethical Principle	Definition	Midwifery Application
Autonomy	Self-determination	The midwife respects the right of the woman to make decisions regarding her care.
Beneficence	Do good	The midwife acts in a way that promotes the woman's best interests and well-being.
Nonmaleficence	Do no harm	The midwife avoids any actions that cause harm to the woman or her infant.
Justice	Fairness	The midwife accords the woman her due rights and treats all women equally.

Source: Adapted from Mighty HE, Fahey J. Clinical ethics in obstetrics and gynecology. In *Obstetrics and Gynecology: The Essentials of Clinical Care*. Stuttgart, Germany: Thieme Publishers; 2010:517-526.

Privacy and Confidentiality

Protection of a woman's privacy is not simply ethical; in most cases it is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When working in collaboration with other healthcare providers, only those parts of the health information that are immediately pertinent to the individual's care should be disclosed, and the woman should be personally notified if the midwife desires to contact a consultant about the woman's health.

Family members, partners, or friends are often present during office visits or in a birthing site. It is important to confirm that the woman has given permission before information is shared when others are present. A midwife must also be careful to not discuss client information in places where third parties might overhear. Emails, faxes, digital records, the Internet, and social media can all be sources that lead to inadvertent but serious breaches in confidentiality. Family members should not automatically be used as translators when a woman does not speak the same language as the midwife.

Informed Consent and Informed Decision Making

The concept of informed decision making or informed consent (as it is often referred to legally) evolved through a number of court decisions and government regulations. In the 1950s and 1960s, U.S. courts began to mandate that consent be obtained before surgery. The 1970s saw an explosion of court rulings provided legal guidance regarding informed decision making.[58]

The ethical concept underlying informed consent includes client understanding of the recommended treatment and her free consent to that treatment.[59] The minimum required components of informed consent are sixfold: (1) diagnosis or assessment, (2) purpose of the proposed treatment or procedure, (3) possible risks of the treatment, (4) possible benefits of the treatment, (5) alternative treatments and the risks and benefits of those alternatives, and (6) possible benefits and risks of not receiving the treatment or procedure. The assumption underlying informed consent is that the individual is capable of understanding the content of the discussion so that self-determination may be protected and supported.

The legal interpretation of informed consent centers on disclosure and liability—did the individual receive enough information to consent to a procedure to protect the provider from being sued? This legal interpretation has been the cited as one reason for the creation of consent forms.

Some midwives and others prefer to use the term "informed decision making" for this process, as it encompasses both informed consent and informed refusal. Foster identified three essential components of informed decision making: (1) *knowing* or understanding, (2) *competency*, and (3) *voluntary* permission.[51] The ethical/moral interpretation of informed decision making centers on autonomous choice—was the woman able to exercise her right to decide what happens to her body? The ethical obligation is often a higher standard than what is mandated by the law.

Facilitating informed or shared decision making is a process that may take place over several visits and conversations. Women need time to process information and ask questions. Healthcare consumers may not always be familiar with complicated language and may need concrete explanations to understand

the information well enough to make a decision. A woman's cognitive ability or the presence of physical, medical, intellectual, or developmental disabilities must be taken into consideration as well. If a woman is deemed incapable or incompetent, then a responsible individual must decide for her.

Women may also experience personal circumstances that curtail their ability to make a decision voluntarily. The ACNM Code of Ethics identifies some of these circumstances: pressure from family members, the midwife, or other care providers; aspects of the environment such as lack of privacy; lack of funding; restriction of healthcare access; or an abusive relationship.[57] The midwife must assess these factors and also take into account the cultural context when determining whether the woman is able to make a decision on her own volition at any given time.[58,60] **Box 2-9** identifies some practical considerations for addressing a potential ethical issue.

Ethical Dilemmas

The ACNM Code of Ethics states:

> The conflict of two or more moral obligations in a particular situation necessitates deliberate ethical analysis and decision making, including weighing and balancing principles and preferably involving and achieving consensus among all affected parties.[52]

For example, one healthcare provider's attempt to "do good," such as performing a cesarean section birth for a diagnosis of failure to progress, might be interpreted by the recipient of care as "doing harm"—in this case, performing surgery without adequate time waiting for a vaginal birth. Equally challenging is the fact that obstetrics is a field in which the professional attending birth has two patients, the mother and the fetus, whose interests may not be in equipoise.[56] However, a woman's right to autonomy does not change because she is pregnant. The consensus of modern medical ethics is that the duty owed to the fetus may be different from that owed to the mother, and the duty to both change depending on the gestational age and maternal condition(s).[61] A few example ethical scenarios are presented in **Box 2-10**.

BOX 2-9 Ethics: A Midwife's Quick Checklist

- Are the woman's wishes clear?
- Does the woman have the capacity to consent to, or refuse, treatment?
- Are there disagreements involving family members or partners?
- Is the woman's current plan of care appropriate?
- Is her health information being protected?
- Can you identify resource or fairness issues?

Source: Adapted from Sokol DK. Ethics man: rethinking ward rounds. *BMJ.* 2009;338:571.

BOX 2-10 Ethical Scenarios

Ethical Scenario 1

A woman with a low-risk pregnancy is "miserable" and requests an induction at 37 weeks' gestation. She and is adamant that she will go elsewhere for her care if the midwife will not induce her. The midwife validates the woman's feelings and explains the risks of elective induction but supports the position that induction at 37 weeks is not recommended.

The midwife knows that the benefits to the woman and fetus are maximized (**beneficence**) and harm is minimized (**nonmaleficence**) when labor begins on its own. This professional must weigh this information with the principle of **autonomy**, the woman's right to make an informed decision about her body and fetus.

Ethical Scenario 2

A woman presents for her first visit of the pregnancy and tells the midwife that she is uninsured and does not have many financial resources. Normally the midwife counsels women extensively about their genetic options in pregnancy at the first visit. It becomes clear to the midwife in the course of their conversation that the woman would never be able to afford any of the costly genetic testing and wonders if counseling should be performed. The midwife decides to counsel this woman in the same manner as any other woman.

The midwife's decision to counsel this woman regardless of her ability to afford genetic testing illustrates the principle of **justice**.

Evidence for Midwifery Care

Recent systematic reviews have demonstrated that not only is midwifery-led care (care in which the primary provider is the midwife) equivalent to the care provided by physicians, but on many outcome measures it has proved to be superior. A 2008 Cochrane meta-analysis reviewed 11 trials including 12,276 women, and found several statistically significant differences in outcomes for those women who received midwife-led care (**Table 2-5**).[62] All of the studies included in this systematic review were randomized, controlled trials; in addition, the studies were not limited to one country. The findings noted that midwife-led care included less prenatal hospitalization, less regional analgesia, fewer episiotomies, and fewer instrument deliveries. In addition, women who were cared for in a system of midwife-led care were more likely to experience no intrapartum analgesia/anaesthesia, a spontaneous vaginal birth, feeling in control during childbirth, attendance at birth by a known midwife, and initiation of breastfeeding. Finally, the newborns of women who had midwife-led care were more likely to have a shorter length of hospital stay. The authors concluded that "most women should be offered midwife-led models of care

Table 2-5 Systematic Review of Midwife-Led Care, 2008

Outcome or Subgroup Title	Number of Studies	Number of Participants	Statistical Measure with 95% Confidence Interval
Significant Risk Reductions Found			
Duration of postnatal hospital stay (days)	2	1944	Mean difference = –0.14 [–0.33, 0.04]
Mean labor length (hours)	2	1614	Mean difference = –0.27 [–0.18, 0.72]
Mean length of neonatal hospital stay (days)	2	259	Mean difference = –2.00 [–2.15, –1.85]
Antenatal hospitalization	5	4337	RR = 0.90 [0.81, 0.99]
Fetal loss/neonatal death before 24 weeks	8	9890	RR = 0.79 [0.65, 0.97]
Overall fetal loss and neonatal death	10	11806	RR = 0.83 [0.70, 1.00]
Instrumental vaginal birth (forceps/vacuum)	10	11724	RR = 0.86 [0.78, 0.96]
Episiotomy	11	11872	RR = 0.82 [0.77, 0.88]
Admission to special care nursery/neonatal intensive care unit	10	11782	RR = 0.92 [0.81, 1.05]
Neonatal convulsions (as defined by trial authors)	1	1216	RR = 0.33 [0.01, 8.03]
Regional analgesia (epidural/spinal)	11	11892	RR = 0.81 [0.73, 0.91]
Opiate analgesia	9	10197	RR = 0.88 [0.78, 1.00]
Significant Increases Found			
Attendance at birth by known midwife	6	5225	RR = 7.84 [4.15, 14.81]
High perceptions of control during labor and childbirth	1	471	RR = 1.74 [1.32, 2.30]
No intrapartum analgesia/anaesthesia	5	7039	RR = 1.16 [1.05, 1.29]
Breastfeeding initiation	1	405	RR = 1.35 [1.03, 1.76]

RR = relative risk.

Source: Adapted from Hatem M, Sandall J, Devane D, et al. Midwife-led versus other models of care for childbearing women. *Cochrane Database Syst Rev.* 2008;4(CD004667). doi: 10.1002/14651858.CD004667.pub2.

and women should be encouraged to ask for this option although caution should be exercised in applying this advice to women with substantial medical or obstetric complications."[62]

Similar results were highlighted in a 2011 systematic review that examined outcomes for APRNs in the United States. For the purposes of this study, the authors defined certified nurse-midwives as APRNs, and their birth outcomes from 1990 to 2008 were examined separately from those of other groups of providers.[63] This review summarized the results from all levels of studies, including observational studies, and studies were limited to the United States. A high level of evidence was found that certified nurse-midwives, when compared to physicians, had lower rates of cesarean section birth, episiotomy, operative delivery, labor analgesia, and perineal lacerations, and equivalent rates of labor augmentation, low Apgar scores, and low-birth-weight infants. The systematic review also demonstrated a moderate level of evidence that nurse-midwives have lower rates of epidural use and induction of labor, comparable or higher rates of vaginal births, comparable or lower rates of newborn intensive care unit admissions, and higher rates of breastfeeding among women who received care from these professionals (**Table 2-6**).[63]

In addition to these two large reviews, numerous other published research studies have focused on specific practices of midwives that may account for these differing maternal and neonatal outcomes. In 2012, ACNM updated a PowerPoint slide set titled "The Pearls of Midwifery," which translates the latest evidence in a manner that can be easily communicated to other providers, or to women and their families (**Box 2-11**).[64]

Traditional Practices and New Evidence

Many of the practices promoted by midwives have a "tradition of use" but no modern research evidence to determine either their risks or their benefits. International meetings of midwives often reveal indigenous or population-specific common birth practices that have not been systematically evaluated. These situations, where the evidence for best practice is not available, provide the midwife with the opportunity to describe, without endorsing, local practices and the customs that surround them; identify potential risks and benefits, particularly if adopted in different locations; promote critical thinking about the wisdom of adopting the new approach; and develop a research project to study the practice.

Midwifery has a long tradition that includes learning by watchful waiting; sharing empirical knowledge via oral traditions; defining and protecting the normal, nonmedicalized birth process; and actively challenging "the evidence." These characteristics have served women well, especially when research is conducted to evaluate the midwifery approach. Examples where midwives have had a strong influence in the evolution of best practices include elimination of routine episiotomies,[65] redefinition of the Friedman labor curve,[66] promotion of early and prolonged breastfeeding for neonatal and maternal health,[67] delayed cord clamping,[68] immediate skin-to-skin contact between mother and newborn,[69] water immersion during labor,[70] and nonpharmacologic methods of pain control.[71]

Midwife scholars and researchers can be the link between women and the evidence. Many care practices have already been studied and either validated or refuted, while many others need motivated, informed midwives to conduct systematic reviews.

Conclusion

This chapter describes the midwifery profession now. Midwifery is an evolving profession with a strong, inspirational foundation; a mature infrastructure to promote policies that improve access to high-quality midwifery care; highly educated individuals who are defining best practice; and plenty of unfulfilled potential. Midwives have demonstrated their capacity to do the hard work of profession building, critically evaluate traditional models of care, challenge policies based on flawed research, and pursue a more just healthcare delivery system. How the profession changes and grows will reflect who the new midwives are, what brings them to the profession, who educates them, and how much they are willing to give to individual women, to the profession of midwifery, and to the process of creating a world where all women receive the best care possible.

> I think of midwifery as a seed full of potential—a seed that will grow into a lush blossoming tree with green branches and plenty of ripe fruit for nurturing women, babies and families. (Marina Alzugaray, MS, LM, CNM)

Table 2-6 A Systematic Review of Outcomes Provided by Certified Nurse-Midwives, 1990–2008, United States

Outcome	Number of Studies	Comments	Grade of Evidence	Summary
Breastfeeding	3 studies (0 RCT)	All favored CNMs	Moderate	Higher breastfeeding rates among women cared for by CNMs compared to other providers
Cesarean section births	15 studies (1 RCT)	Only the RCT did not have significant difference, but it was a 1992 study with rates less than 10%; 13 of 15 other studies favored CNMs and the others showed equivalency	High	Lower rates of cesarean section births for women cared for by CNMs than physician providers
Epidural anesthesia	10 studies (0 RCT)	Nine of 10 observational studies noted CNMs used less epidural anesthesia than physicians	Moderate	Less epidural use by women cared for by CNMs than other providers
Episiotomy	8 studies (1 RCT)	Consistency among studies	High	Episiotomy rates lower for women cared for by CNMs than other providers in all studies
Labor analgesia	6 studies (1 RCT)	All women had access, but less analgesia was used by women under CNM care	High	Less analgesia use by women cared by CNMs than other providers
Labor augmentation	9 studies (1 RCT)	Only one observational study did not favor CNMs; it was from single institution Otherwise, findings were consistent, especially with the RCT	High	Lower or comparable use of labor augmentation for women cared for by CNMs and other providers
Labor induction	9 studies (0 RCT)	No RCT; 7 of 9 studies favored CNMs (similar to labor augmentation)	Moderate	Comparable or lower rates of labor induction for women cared for by CNMs compared to other providers
Low Apgar births	11 studies (1 RCT)	Most studies define a low Apgar score as < 7 Studies included some focusing only on low-risk births; others included high-risk births and inconsistent use of statistical control	High	Comparable Apgar scores among newborns of women cared for by CNMs than physician providers
Low birth weight (< 2500 g)	8 studies (1 RCT)	Six studies reported no difference; the other two favored CNMs	High	Comparable rates of low-birth-weight neonates of women care for by CNMs and other providers
NICU admission	5 studies (0 RCT)	Lack of RCT and inconsistent statistics; no study found a higher rate of admission and two reported lower rates for CNMs	Moderate	Comparable or lower rates of NICU admission for newborns of women cared for by CNMs compared to other providers
Perineal lacerations	6 studies (1 RCT)	All studies favored CNMs	High	Rates of third- and fourth-degree perineal lacerations lower for women cared for by CNMs than other providers
Vaginal birth after cesarean birth (VBAC)	5 studies (0 RCT)	Four of 5 studies favored CNMs; the other showed no difference	Moderate	Comparable or higher rates of VBAC for women cared for by CNMs compared to other providers
Vaginal operative births (forceps, vacuum, or both)	8 studies (1 RCT)	RCT similar for forceps; lower for CNMs with vacuum Five of 6 studies favored CNMs	High	Lower or comparable rates of vaginal operative births for women cared for by CNMs and other providers

CNM = certified nurse-midwife; NICU = neonatal intensive care unit; RCT = randomized controlled trial; VBAC = vaginal birth afte cesarean.

Source: Adapted from Newhouse RP, Stanik-Hutt J, White KM, et al. Advanced practice nurse outcomes 1990-2008: a systematic review. *Nurs Econ*. 2011;29(5):230-250.

BOX 2-11 Midwifery Pearls

- Oral nutrition in labor is safe and optimizes outcomes
- Ambulation and freedom of movement in labor are safe, are more satisfying for women, and facilitate the process of labor
- Hydrotherapy is safe and effective in decreasing pain during active labor
- Continuous labor support should be the standard of care for all laboring women
- Intermittent auscultation should be the standard of care for low-risk women
- Do not routinely artificially rupture the membranes
- Second stage management should be individualized and support an initial period of passive descent and self-directed open-glottis pushing
- There is no evidence to support routine episiotomy or aggressive perineal massage at birth
- Delayed cord clamping improves neonatal outcomes
- Immediate skin-to-skin contact after birth promotes thermoregulation, improves initial breastfeeding, and facilitates early maternal-infant bonding
- Out-of-hospital birth is safe for low-risk women

Source: Adapted from American College of Nurse-Midwives. Evidence-based practice: pearls of midwifery: a presentation by the American College of Nurse-Midwives, Washington, DC, 2010. Available at: http://www.midwife.org/Pearls. Accessed December 11, 2012.

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Additional Resources

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