AMERICAN COLLEGE of NURSE-MIDWIVES

POSITION STATEMENT

Principles for Credentialing and Privileging Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs)

The American College of Nurse-Midwives (ACNM) recommends that the following principles be incorporated when developing language related to the credentialing and privileging of CNMs and CMs.

The bylaws and guidelines of hospitals and other health care organizations should reflect the scope of practice of CNMs/CMs as defined by national standards and state laws.

Explanation: State law determines whether a CNM/CM is a licensed independent practitioner as defined by the Joint Commission,[1] yet health systems often impose conditions of physician supervision or contractual collaboration for midwives to be able to practice in a hospital. This requirement risks the appearance of restraint of trade[2] because it requires one independent provider to agree to supervise another and grants physicians' gatekeeping authority to control the practice of midwives. The American College of Obstetricians and Gynecologists (ACOG) advocates for a team-based approach to care,[3] in which each provider has a clear and autonomous role and practices to the full extent of their accredited education, clinical training, and national certification. In addition, the ACOG in a joint statement with the ACNM supports CNMs/CMs as independent providers.[4] The ACNM strongly supports institutional bylaws and guidelines that foster cooperation among licensed independent practitioners and facilitate consultation, collaboration, and referral, as indicated by the condition/status of the patient.

Health care institutions should adopt a broad definition of medical or professional staff that does not designate categories of providers. In so doing, a CNM/CM's authority to practice is not dependent on a relationship with or the permission of another provider.

Explanation: The quality of the medical staff reflects the degree to which all of its members are committed to supporting quality management activities and can work effectively as a health care team. Midwives should be included in the same categories of the voting medical staff as physicians, not a separate category of providers, such as "Allied Health Staff" or "Associates to Medical Staff," because these categories imply a dependent relationship when none may exist by law.

The requirements for credentialing, privileging, and re-privileging of physicians and midwives as documented in the bylaws and guidelines of hospitals and other health care organizations should be equivalent. These should include:

- A reliable, consistent, and timely mechanism to process applications and verify credentials for physicians and midwives.
- Full active medical staff membership, privileges, rights, and responsibilities, including, but not limited to, voting rights, due process, committee membership, and eligibility for any related medical staff and committee leadership positions.
- Comparable risk management policies that address credentialing and granting of privileges, including critical performance indicators, mechanisms for peer review by members of the

midwifery profession, notification of disciplinary action, and a fair hearing and appeal process.
- Performance monitoring guidelines that reference all licensed independent practitioners equally, including CNMs and/or CMs, as applicable.
- The expectation of equal involvement of physicians and midwives in the development, implementation, and evaluation of mechanisms for continuous professional practice evaluation.

The bylaws and guidelines of hospitals and other health care organizations should be written so as to ensure that midwives are accountable for the care they provide, and the bylaws and guidelines should avoid requirements that create vicarious liability for other health care professionals.

Explanation: Where state laws and regulations permit CNMs/CMs to practice as independent practitioners, hospital bylaws should support them in so doing, resulting in them individually being held responsible for their actions. Professional liability policies are available to CNMs/CMs to support this practice.

The bylaws and guidelines of hospitals and other health care organizations should not require routine physician co-signatures on CNM/CM notes or orders in the medical record.

Explanation: Routine requirements for co-signature create unnecessary paperwork, inaccuracies in outcome data collection,[5,6] and barriers to care which can discourage physicians from choosing to work with CNMs/CMs. A co-signature can also be misinterpreted to mean that a physician has assumed responsibility for a plan of care.

The delineation of privileges for CNMs/CMs should clearly state that they can admit and discharge patients and manage their care to the full extent of a CNM/CM's education, training, and licensure, and should provide a mechanism for recognizing expanded practices that are distinguished from the standard privileges granted to midwives.

Explanation: Standard privileges reflect the clinical skills and judgments described in the ACNM *Core Competencies for Basic Midwifery Practice*,[7] which all CNMs/CMs are expected to perform without any additional training safely and competently. Some midwives may choose to expand their practice by acquiring additional clinical skills or procedures, for example, vacuum-assisted birth or circumcision.[8] CNM/CMs who wish to obtain privileges for such expanded-practice procedures should do so in a manner consistent with Standard VIII of the ACNM *Standards for the Practice of Midwifery*[9] and the ACNM Position Statement titled *Expansion of Midwifery Skills and Practice Beyond Basic Core Competencies*.[8]

Requirements for continuous professional practice evaluation should be consistent for the procedures that CNMs/CMs and physicians perform in common, and midwives should be included in the development of such guidelines.

Explanation: There is a recent trend for health care organizations to develop requirements for a minimum number of proctored or evaluated procedures as a measure of competence and as a requirement for recredentialing and continued privileges. CNM/CM requirements for these proctored procedures should be consistent with the requirements for physicians at that same facility for procedures that both CNMs/CMs and physicians perform. In addition, it is appropriate for CNMs/CMs to proctor other CNMs/CMs and to determine/assess their competency. When demonstration of a minimum number of procedures is required, those procedures should be performed only when indicated for safety or quality of care.

References

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