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Commentary

The Certified Midwife Credential and the Case for National Implementation

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INTRODUCTION

Midwifery is a distinct profession. The International Confederation of Midwives (ICM) recognizes this.[1] The Association of Women's Health, Obstetric and Neonatal Nurses recognizes this.[2] Historically, in the United States, formal recognition of midwifery's separate professional status came in 1955 through the formation of the American College of Nurse-Midwifery (now the American College of Nurse-Midwives [ACNM]). Full recognition of this status came in 1994. At that time, the ACNM Division of Accreditation (ACNM DOA, now the Accreditation Commission for Midwifery Education [ACME]) developed standards for education programs to prepare midwives who had backgrounds other than nursing, and the ACNM Certification Council (ACC, now the American Midwifery Certification Board [AMCB]) amended its policies to allow persons without nursing backgrounds who completed an ACNM DOA-accredited midwifery education program to sit for the ACC national certification examination.[3,4] Thus, the certified midwife (CM) credential was created by ACNM.

This commentary was written by a geographically diverse group of certified nurse-midwives (CNMs) and CMs, all of whom strongly support recognition of midwifery as its own profession. The commentary argues for national implementation of the CM credential as a vital part of this recognition. It demonstrates the burden of requiring nursing education for midwives; discusses how CMs are educated and work; positions United States midwifery within the global midwifery community, which is not limited to nurse-midwifery; and, finally, shows that arguments posited against implementation of the CM credential are flawed.

THE BURDEN OF REQUIRING NURSING EDUCATION FOR MIDWIVES

To date, only 5 states allow CMs to practice. Why does midwifery remain, in most states, the only profession to require its practitioners to be educated first in another profession? Imagine how valuable it would be if all physicians were required to become nurses before entering medical school. They would clearly see how much nurses know. They would advance an approach that favors wellness over illness. They would develop a better appreciation for the health care team and the role of family and other social supports in health maintenance. They would learn a myriad of technical skills. Think about the many ways this prerequisite education could help such potential nurse-physicians get through medical school.

Of course, this will never happen. The institutional burden would be too great. Coveted and limited spaces in nursing education programs would be filled with students who would not practice as nurses. The personal burden would also be great. Those who did not choose nursing as their undergraduate major could pay from close to $10,000 at a public university in their home state to tens of thousands of dollars at a private university for an accelerated nursing program. While many applicants to medical school must take prerequisite courses, these courses do not include a clinical component, which is often difficult to access and frequently inflexible in terms of student time requirements. The societal burden would be a third limiting factor. For those prospective physicians whose nursing education followed college, a minimum of one additional year would be added before they could enter a profession that sorely needs practitioners. Finally, as medical education today has come to embrace many of the philosophical tenets of nursing, much of this education would be duplicative.

What seems preposterous for medicine is expected of midwifery. The institutional, personal, and societal problematic issues outlined for physicians becoming nurses before attending medical school also apply to requiring nursing education to enter the midwifery profession. While few, if any, would argue that nursing is an inappropriate route to midwifery, why do so many consider it the only route?

CERTIFIED MIDWIVES' EDUCATION AND WORK

For close to 20 years, prospective CMs in the United States have been educated at the State University of New York (SUNY) at Downstate Medical Center in a program in which their education is integrated almost entirely with the education of prospective CNMs. Early studies attested to the success of this education model.[5,6] Since 2010, the Midwifery Institute at Philadelphia University has also offered its midwifery education program to individuals with backgrounds in nursing or other fields.

All applicants to ACME-accredited midwifery education programs must hold a bachelor's degree. All students bring a wealth of information from diverse fields and professions such as nursing, medical imaging, physician assistant, medicine, and public health; the arts, sciences, and social sciences; and the childbirth community including doulas, lactation consultants, childbirth educators, traditional midwives, and parents.

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Each of these students can become an excellent midwife, and together they enrich the education experience for all.

Both the SUNY Downstate and Philadelphia University programs offer one to 3 courses that cover material essential to midwifery practice that is not covered in the basic midwifery curriculum. These courses teach content such as basic health assessment and procedure skills (eg, vital signs, urinary catheterizations, injections, wound care). The pathway for registered nurses (RNs) who wish to become midwives honors their prior knowledge by bypassing these prerequisite courses.[7] Basic midwifery courses, however, are not segregated by student background. Analysis of data from the first 10 years of the SUNY Downstate program shows no differences between CM and CNM graduates in 4 domains: job attainment, job/career satisfaction, job performance, and role identity (Ronnie Lichtman, unpublished data, September 2015).

One CM who subsequently attended nursing school in order to maintain her position as program director of a nurse-midwifery education program states, "Having completed nursing education and licensure, I appreciate and respect nursing as a caring and valuable profession. Nonetheless, it is my nursing education that reaffirmed that nursing need not be a prerequisite to midwifery education" (Julia Lange Kessler, written communication, March 2015). A CM describing a day in her life details a day that is indistinguishable from the day of a CNM (Christiane McCloskey, written communication, March 2015). In New York State, where CMs have practiced for more than 15 years and are a key component in alleviating the shortage of women's health care providers identified by the American Congress of Obstetricians and Gynecologists,[8] CMs work identically to CNMs. They are employers and employees; own small businesses; guide birth in hospital, home, and birth center settings; provide family planning and gynecologic services; diagnose and treat common health conditions of women and their newborns; have leadership roles in national, state, and local midwifery organizations; precept a variety of students; and teach in midwifery, nursing, and medical education programs. Nationally, the Health Care Provider Taxonomy Code linked to National Provider Identifiers, commonly known as NPI numbers, describes midwifery as practiced by CNMs and CMs without differentiation. Both CNMs and CMs use the same title and number: Advanced Practice Midwife 367A00000X.[9]

MIDWIFERY AS A DISTINCT GLOBAL PROFESSION

Globally, midwifery is a distinct profession. ICM represents 116 midwifery associations, including ACNM, from 101 countries.[10] ICM promulgates standards for midwifery education that set quality indicators for global expectations.[11] These standards were based on a Delphi study conducted for ICM by an international research team that included 2 US midwives. Joyce Thompson, former ACNM President, co-chaired the team and Judith Fullerton, an eminent midwifery researcher, participated in the study.[12] Two midwifery education pathways are recognized in these standards: 1) an option for individuals to directly enter the profession of midwifery, and 2) a post registration option for individuals, including nurses, who have related education and professional experience that obviate the need for selected educational elements.[11]

Many developed countries where midwifery is well established offer both pathways to midwifery education that meet the ICM education standards. These nations include the United Kingdom, Australia, and New Zealand. This is important not only to grow the midwifery workforce, but also to grow the art and science of midwifery.

National and international research shows that midwives educated directly in midwifery are safe and effective.[13,14] In countries where midwifery has direct-entry education and sits side-by-side with nursing in name, independence, and recognition, midwifery science is advancing at a rapid pace. As a collaborator with midwives from all countries in contributing to global health, United States midwifery needs to respect, value, and support multiple education pathways to midwifery. To paraphrase the title of the 2014 United Nations Population Fund's landmark report on the state of the world's midwifery,[15] midwifery is a universal pathway to help women achieve their right to optimal health.

A gap analysis conducted by ACME to determine how well ACME education standards compare to the ICM global education standards did not address the dearth of direct-entry, as defined by ICM, midwifery education programs in the United States at the university level.[16] Some US midwifery education programs referred to as direct entry require students to complete nursing education and obtain RN licensure during the midwifery education program; they are not the direct-entry model addressed in the ICM education standards. Such programs impose the burdens of double education for students and use institutional and societal resources for duplicative education. They also mitigate against recognition of midwifery as a separate profession. Finally, they do not meet the expressed needs of a significant number of potential midwifery students. Ulrich found that 21% of applicants to a US graduate nursing education program with a specialty in nurse-midwifery viewed nursing as "a stepping stone" to midwifery.[17] The primary reasons participants in this study reported for choosing nurse-midwifery education programs are many of the same reasons for choosing ACME-accredited midwifery education programs that are separate from nursing.

The components of nursing that are beneficial to midwifery, such as a wellness approach; an appreciation for the emotional, social, and spiritual aspects of health; and a community health perspective, are well taught in midwifery education programs worldwide. In many midwifery education programs in the United States, a significant number of students are RNs who have never practiced as nurses or whose nursing practice experience does not include labor and birth or women's health. The midwifery education program is the great equalizer. Regardless of what knowledge, skills, and experiences students enter with, they exit the program only after meeting the core competencies of knowledge, skills, and professional behaviors for a safe, beginning level of midwifery practice.[18]

RATIONALE AND MECHANISMS FOR NATIONAL IMPLEMENTATION OF THE CERTIFIED MIDWIFE CREDENTIAL

Some might argue that the CM credential is a failed experiment because the numbers of CMs are low. Instead, we

contend that the CM is an opportunity that demands national action. The program chairs of both of the existing midwifery education programs for prospective CMs have observed that when potential applicants who have not yet chosen an education route discover that the CM credential limits geographic mobility, they often choose to attend nursing school prior to applying for the midwifery program when they have the funds and the time to do so (Ronnie Lichtman and Dana Perlman, oral communication, April 2015). How many are lost to the midwifery profession has not been measured, but undoubtedly some never make it to nursing school and others stop after completing nursing education. The lack of national support for the CM credential has thus sustained its low numbers. Despite this, at the SUNY Downstate midwifery education program, students in the CM track have traditionally comprised one-quarter to one-third of the total number of students. In 2014 and 2015, their numbers exceeded half the entering students.

An argument frequently made for the midwifery profession to be a part of the nursing profession is that, because there are so few midwives compared to nurses, midwifery has more power if it works within nursing. If numbers were a deciding factor, however, there would likely be no ACNM. According to the first issues of the *Bulletin of the American College of Nurse-Midwifery* (the original name of what is now the *Journal of Midwifery & Women's Health*), only 17 nurse-midwives from 8 states attended the first ACNM Annual Meeting (then called Convention) in 1955.[19] Less than a year later, Hattie Hemschemeyer reported that the College had 124 members.[20] This represents extraordinary growth, but still small numbers. While skeptics might point to New York, the first state to recognize the CM credential, as a state with midwifery political clout due to its many midwives, in reality there were only 400 midwives in the state when New York approved legislation that made midwifery its own profession. With a population of more than 19 million in the census taken shortly after the legislative vote, 400 midwives represented just .00002% of the state's residents. In a state with a population of 3 million, the equivalent number of midwives would be about 60. The very small states of Rhode Island (population 1.055 million) and Delaware (population 935,614) both accept the CM credential. The issue is not about numbers of midwives, it is about political will.

It is amazing what a relative few midwives with knowledge, motivation, persistence, and passion can accomplish. In 1992, New York midwives successfully achieved legislation that created a Board of Midwifery to regulate midwifery as an independent profession; made licensed midwife (LM) the licensure designation for both CNMs and CMs; and gave full prescriptive privileges to all midwives. Later laws granted midwifery status as a profession whose members cannot be denied hospital privileges simply by virtue of class of licensure; added LMs to the list of professionals who could order laboratory tests and order physical therapy evaluation and treatment; and, most recently, eliminated the need for LMs to have a signed written agreement with a physician to practice.

Another argument that has been proposed for midwifery working within nursing involves the financial cost of "going it alone." Using New York State as a model again, costs can be minimal. The secretary of the New York State Board of Midwifery was the secretary of the Board of Pharmacy at the time of his appointment; he continues to maintain both positions. This obviates the need to hire a secretary with full benefits, a separate office, a telephone, a computer, and a staff. Such an arrangement may not be possible in all states, but there are creative ways to deal with costs. In today's world of electronic communication, for instance, the cost of meetings can be negligible. Lobbying for legislative change is an expense, but lobbyists need not work full-time for midwifery. Coalitions can be built to lobby jointly with other professions when agreement exists around a particular legislative need, such as a proposed law that benefits women's health. Each ACNM state affiliate receives dues from its members. This has greatly increased the revenue, for example, of the New York State Association of Licensed Midwives (NYSALM), which started as an independent organization and became the ACNM New York State Affiliate several years ago. Financial issues should not deter midwifery from claiming its rightful place as a distinct profession.

Although some midwives might fear the consequences of having a single regulatory board for midwifery in states that also recognize the certified professional midwife (CPM) credential, this fear is unfounded. Regulatory boards commonly have authority over professions with different levels and scopes of practice. Most states do not have separate boards for RNs, advanced practice RNs, and licensed practical nurses. Generally, one Board of Nursing regulates each of these discrete nursing licensures. Boards that regulate CNMs and CMs with their identical scope of practice are perfectly capable of working with CPMs to include their scope of practice. The state regulatory body could be a Board of Midwifery, as it is in New York, or a board that encompasses a variety of professions.

The current President of NYSALM, who is a CM, reports that CMs are approximately 8% of the state's 976 LMs (Karen Jefferson, written communication, April 2015).[21] In comparison, about 7% of physicians are doctors of osteopathic medicine (DOs) nationally.[22] Yet, the argument that the DO is a failed option is never made. In fact, like CMs in New York State, DOs benefit from statutes, regulations, access to hospital credentialing, and prescriptive authority to support their practice to the full extent of their education in all states.

CONCLUSION

A 2011 ACNM report stated, "The expansion of education programs designed for the preparation of CMs would seem to offer potential relief from the capacity constraints inherent in linking midwifery education to nursing education.[23] In 2013, the organization took a stronger stance, asserting, "ACNM encourages its state affiliates to support licensure of CMs in every state as a key factor in the success of the midwifery profession…"[24] We advocate a more directed strategy: a concerted, state-by-state effort for recognition of the CM credential with personnel and budgetary support from the national organization. Priority states can be identified based on a systematic assessment of interest. This will ensure that our profession grows in numbers, participates fully in the

global midwifery community, maintains its status as a distinct profession, perpetuates a midwifery research agenda, and claims a unique voice in health policy discussions. Slow progress should spur us, not deter us, in the development of diverse university-based educational paths to midwifery. Diversity will strengthen midwifery. We need to remove barriers to midwifery education and practice rather than uphold them. The way forward is clear. We challenge our midwifery colleagues to actively support and promote expansion and national implementation of the CM credential.

AUTHORS

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CONFLICT OF INTEREST

Ronnie Lichtman and Dana Perlman are chairs of the SUNY Downstate Midwifery Education Program and The Midwifery Institute at Philadelphia University, respectively, which are referred to in this article as the 2 existing midwifery education programs for prospective CMs. The views expressed here are those of the authors and not of or on behalf of any organization or institution with which they are affiliated.

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