Regulation and Licensure of Certified Professional Midwives: Beneficial for North Carolina?

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Abstract

The primary caregiver to women who choose the home setting for birth in the United States is the certified professional midwife. Credentialing is awarded by the North American Registry of Midwives, which is accredited by the National Commission for Certifying Agencies. Certified professional midwives are legally authorized to practice, licensed, and regulated in twenty-six states, including North Carolina's neighbor states of Virginia, Tennessee and South Carolina.

North Carolina stands out in the Southeastern region of the United States as having limited access to licensed and credentialed midwives to serve women who choose midwifery care during the antepartum period, and the home setting for birth. This restricted access has negative implications for both safety and quality care for women who choose this option. The Centers for Disease Control and Prevention (CDC) recently reported accelerating rates of planned home birth in the U.S., with North Carolina experiencing one of the largest relative increases. In a hallmark prospective cohort study done in 2000, it was concluded that planned home birth for low risk women in North America, using certified professional midwives, was associated with lower rates of medical intervention, and very similar intrapartum and neonatal mortality rates (1.7 per 1000) to that of low risk women who delivered in hospitals in the United States (Johnson, K.C. & Daviss, B., 2005).

This issue can be viewed as two-fold: problem-solving and benefit providing. From the problem solving perspective, by licensing and regulating certified professional

midwives, North Carolina can address the access to care issue for women who choose home birth. This will minimize the rates of planned unattended home birth, help manage intrapartum transports in emergency cases, and assure that midwives maintain standards of care. From the benefit providing perspective, licensing certified professional midwives in North Carolina can cultivate a lower cost / high quality option for women that is proven to dramatically reduce rates of cesarean section, minimize planned unattended home births and improve access to maternity care in rural areas (North Carolina Friends of Midwives, 2010). Additionally, home-birth families will have the benefit of knowing that their birth attendant is practicing within guidelines and standards that are regulated, while still allowing for a successful, empowering experience.

In this paper the action steps necessary for North Carolina to adopt the licensure of certified professional midwives will be outlined. These recommendations are based on a review of the literature, an analysis of the licensing barriers that were overcome by neighboring states,, an assessment of the current licensing and practice guidelines, and finally, an examination of the history of midwifery-including the foundation and development of the current NC midwifery classifications,

Introduction

Back in American colonial times, most medical care was provided by women in the home. Women were considered prominent as lay practitioners, and in fact, some say that they dominated medical practice as late as 1818 (Starr, 1982). The 1700s saw the decline of midwives, as women no longer held as prominent a position in medical care as they had previously. Prior to the movement of medicine into healthcare and childbirth in the United States, midwives, neighbors, friends or relatives were largely responsible for birthing the babies (Rooks, 1997).

In 1763, when Dr. William Shippen became the first physician to take up obstetric practice, skills for using forceps to shorten labor were developing (Starr, 1982). This view of birth as a dangerous process needing medical intervention in order to be "safe" began the shift from midwives to doctors for childbirth among the urban middle class. While the proportion of births attended by physicians, who promised safety, drastically increased, the location of birth was also shifting from the home into the hospital, where midwives were largely unwelcome. In the 1930s, hospitals were the location for 37% of all births, and by the 1960s the proportion of births in hospitals had reached 97% (Boucher, Bennett, McFarlin & Freeze, 2009).

Midwifery remained relatively dormant during the 1930s, 40s and 50s, until a revitalization began in the 1960s, continuing through the 1970s and 80s. This has been largely attributed to the increased workload of obstetricians resulting from the "baby boom" and their subsequent need for assistance, as well as to the growing consumer

demand of women who opposed the medicalization of childbirth (Lynch 2005, Rooks 1997).

The profession and concept of midwifery has continued to gain legitimacy since the 1960s. There are currently several designations of midwives, including certified nurse-midwives (CNM) and certified professional midwives (CPM). CNMs are registered nurses who have advanced-practice degrees in nurse midwifery. In North Carolina, CNMs are licensed by the North Carolina Board of Nursing. They are also regulated by the Midwifery Joint Committee, although no further licensing is required. CNMs can practice legally in North Carolina, as well as all other U.S. jurisdictions, and are required to work in collaboration with a physician (American College of Nurse-Midwives, 2011).

CPMs, on the other hand, cannot practice legally in North Carolina; however, they are currently licensed and practicing in twenty-six U.S. states, including those states contiguous to North Carolina (South Carolina, Tennessee and Virginia). The CPM is a skilled, independent midwifery practitioner that has met the standards for certification set by the North American Registry of Midwives (NARM) (National Association of Certified Professional Midwives, 2001). For the last several years, North Carolina has been embroiled in the controversy surrounding legislation which would legalize the practice of midwifery by CPMs. It is important to appreciate the different groups of practicing midwives and perhaps more importantly, to understand why these different groups can enhance the healthcare delivery system for women in North Carolina, especially those women who desire to choose a home birth option. In 2006,

there were 38,568 out-of-hospital births in the United States, which included 24,970 home births and 10,781 births in freestanding birth centers (U.S. Department of Health and Human Services, 2010). Of the home births, 61% were delivered by midwives, and of this 61%, nearly three-fourths (73%) were delivered by midwives other than CNMs (U.S. Department of Health and Human Services, 2010). In order to meet the demand of North Carolina families desiring home birth, licensure and regulation of CPMs seems to be a logical step to pursue.

I have explored the impact of licensure of CPMs in North Carolina for women who desire midwifery care and delivery services. With this in mind, I researched midwifery, concentrating on two models– the certified nurse midwife and the certified professional midwife. I collected data to perform a SWOT (strengths, weaknesses, opportunities, and threats) analysis on the concept of legalizing licensure of CPMs in North Carolina. Lastly, I read stories and watched videos from women and families who have had births with CPM care, and shared their experiences, in order to grasp their passion for this issue. I will conclude by presenting the benefits of legalizing the licensure and practice of CPMs in North Carolina, and discuss the impact such licensure might have on the healthcare delivery system for women.

An Examination of Popular Midwifery Practice

Throughout the late 1700s, there were no medical schools or educational standards, and the general healthcare of a family was often the responsibility of the woman. Midwives during this time did not have formal training either, but often learned

their skills through apprenticeship, as most craftsmen of that day did. Midwifery was not highly regarded, as birth was believed to be a natural process that required little knowledge to attend; therefore, midwifery was not thought to be a profession.

The early 1800s saw the establishment of formal medical schools, and the late 1800s saw a brief resurgence of midwifery education and practice (Rooks, 1997). Midwifery courses were taught at the Boston Female Medical College, and a growing number of formally trained midwives were emigrating from Europe to the U.S. Concurrently, physicians who had previously worked with these midwives in Europe were also emigrating, creating an aroused interest in educating midwives. Several midwifery schools were opened during this time period, but most had little staying power, due to financial instability, limited access to clinical experience for students, and lack of sound theoretical base for the profession (Rooks, 1997) The exceptions were the midwifery schools established around Salt Lake City by pioneering Mormons, who needed to be able to rely on members of their own community for the care of their pregnant women, because of society's opposition to polygamy. In 1948, obstetrics was recognized as a medical specialty, eventually leading to minimal government interest in regulating midwives. Midwives began to be seen as caregivers only for those who could not afford a doctor, while physicians were attending to middle and upper class women (Rooks, 1997).

At the turn of the 20th century, midwives attended nearly half of all births in the U.S., but physicians wanted to end the practice of midwifery and move childbirth to the hospitals (Rooks, 1997). Additionally, a growing middle class was now able to choose

physician care, further stigmatizing midwifery as almost exclusively for the lower class. Midwives struggled to defend themselves against these campaigns of negativity, but again, many of them lacked formal training, and many were immigrants who did not speak fluent English. Also, because of their relative geographic isolation from one another, it was difficult to unite and organize (Rooks, 1997).

Despite the challenges to their services in the early half of the century, midwives continued to practice primarily in rural areas and inner cities, where they were the only available birth attendants. During this same period, the government recognized the need to lower the infant mortality rates. Because of the relative disinterest of physicians to serve rural areas, they realized they could train nurse-midwives under their supervision in maternity and childbirth services, and fulfill their obligation to improve care (Rooks, 1997; Stone, 2000). A few publicly funded training programs for nurses to become qualified to attend uncomplicated deliveries emerged from hospitals, and thus, the American concept of the nurse-midwife was born. These early programs were specifically designed to meet the needs of nurse-midwives who would be serving underserved populations – women in rural areas, poor women, and/or those of different races or cultures than “mainstream America” (Stone, 2000).

The first successful nurse-midwifery education program, Frontier Nursing Service, was founded in 1939 by Mary Breckenridge in southeastern Kentucky (Rooks, 1997). Nurse-midwives were somewhat considered public health nurses; they had an interest in family centered maternity care, and were acutely aware of cultural and environmental effects on health (Certified Professional Midwives in the United States,

2008). Nurse-midwives claimed their legitimacy through education and training, and in general, positioned themselves as legitimate in contrast to non-nurse midwives who were considered illegitimate, perhaps helping to create a chasm that has underpinned the debate we are facing today. Although nurse-midwives increasingly improved the health of mothers and their babies, their service was detached from mainstream American healthcare; they were restricted from private practice, and most were unable to work in hospitals (Rooks, 1997).

The demographics of modern women desiring midwifery care in general, and planned home births specifically, have begun to be studied. In 2007, Boucher, Bennett, McFarlin and Freeze studied 160 women who had experienced planned home births. The following demographics were gleaned from their convenience sample: median age of the women was 35 years of age; 62% had at least a Bachelor's or Master's degree, with another 25% declaring some college or two-year degree; 94% were married or partnered; 33% of the women described themselves as homemakers, and 65% were employed as professional, managerial, sales, or service personnel; and, 87% were self-described as white, 6% Hispanic and 1% Asian.

Additionally, when asked why they had chosen home birth, the primary themes identified were: safety and better outcomes; desire for an intervention-free delivery; previous negative hospital experience; control of the birthing process; and privacy (Boucher, Bennett, McFarlin and Freeze, 2009). This number may be only a small percentage of the approximately 25,000 women who chose home birth in 2006; however, national data collected from birth certificates for that same year show that

81% of home births were to non-Hispanic white women, home birth was lowest for women aged 15-19, and was 2.7 times higher for married women than for unmarried women (MacDorman, M.F., Menacker, F. & Declercq, E., 2010). Of the 130,886 total births in North Carolina in 2007, 13,900 (10.6%) were attended by CNMs in home, hospital or birthing centers, and 1,089 (.8%) were overseen by other attendants (North Carolina Friends of Midwives, 2010). Although the percentage of home births may be comparatively small, the women and families who choose this option are passionate about it. Stories such as these are commonplace in the literature:

> Eleven weeks ago I gave birth to my fourth child... at home. My 10 lbs., 21 inches, 16-days-late baby girl was born safely into the hands of my Certified Professional Midwife (CPM). I was also attended by a midwife apprentice, and lovingly supported and encouraged by my husband and my three other young children. This was my second homebirth, and I have also had two hospital births. As an educated woman with the financial means to determine the birth of my choice, I chose homebirth with a CPM as the safest and most natural option. My care team was skilled, knowledgeable, supportive, and competent. The state of NC must seriously consider the licensing of CPM's as the next logical step in providing quality maternity care for all eligible women. A woman experiencing a low-risk pregnancy and labor is served better by a caring, consistent CPM, who can attend her in the security and comfort of her home, rather than receive the care of an obstetrician who is trained in the care of high risk pregnancies. Further, many women do not have maternity benefits, and the cost of an OB and

a hospital birth can be quite costly. Birthing women in other countries are routinely cared for by midwives, many in their own homes, with excellent outcomes. Let us move forward to give NC women and all women the freedom of choice that is their right in this country. *Jennifer, Wilmington, NC March, 2008*

Homebirth is a childbirth option that should be preserved and protected by allowing the only skilled professional trained specifically to attend out-of-hospital birth in the home: the Certified Professional Midwife.

I am a registered nurse as well as a student nurse midwife and I have chosen to give birth at home four times with a CPM because I know first-hand the cascade of unnecessary medical intervention often seen in the average hospital birth. For my family the safest way to welcome our children into the world was at home under the care and skill of a CPM.

I am proud to be a member of the nursing profession and will be equally proud to become a Certified Nurse-Midwife who supports the right of a pregnant patient to give birth where and with the attendant of her choosing. I look forward to one day working with my sister CPMs as we safeguard normal birth for future generations of North Carolina women. *Ashley, Chapel Hill, NC March, 2008*

CPMs provide the personal, individualized care that many women crave in a comfortable, safe, intimate atmosphere. This model of care is the only reasonable choice for some families.

CNMs

The growth of midwifery was slow through the 1950s. Most midwives practiced in maternity clinics and provided home birth care prior to the early 1960s, when their practice switched to providing care almost exclusively in hospitals (Rooks, 1997). This incorporation into hospitals created opportunities for midwives, while at the same time limited their autonomy and altered the care they provided. In the early 1970s, the American College of Obstetricians and Gynecologists (ACOG) officially recognized nurse-midwives as part of the obstetrical team (Stone, 2000). Around the same time, national standards for education and certification were established by the American College of Nurse-Midwives (ACNM) and federal funding was provided for nurse-midwifery training (Certified Professional Midwives in the United States, 2008). Nurse-midwives are now recognized in every state and territory, with the majority employed by physicians, clinics and medical centers. Nurse-midwives may attend births in homes or free-standing centers, but approximately 95% of all births attended by nurse-midwives are in hospitals (Certified Professional Midwives in the United States, 2008).

In North Carolina specifically, CNMs can provide prenatal, intrapartum, and postpartum care outside of a clinic or hospital setting; however, only seven CNMs currently avail themselves of this privilege, primarily due to the restriction that they must have constant back- up supervision by an MD. As noted in an interview with Maureen Darcey, CNM and Director of Midwifery Services at Women's Birth and Wellness Center in Chapel Hill, "Even though there is no shortage of women and families who desire safe, natural home births, there is a definite shortage of MDs who are willing and able to

step up and provide medical back-up for the providers. Currently, MD back-up is available in very limited areas, primarily in the mountain areas around Asheville and some smaller, rural areas, as well as in the triangle area." Darcey went on to discuss that a free-standing birth center is opening in Statesville, NC. While this is a positive step toward alternatives to hospital birth, the CNMs who deliver there do not have the required physician backing to perform home births. Darcey feels that this is an illustration that midwives of all educational backgrounds are operating – or not - at the pleasure of physicians (personal communication, October 28, 2011).

CPMs

The Certified Professional Midwife is a knowledgeable, skilled and professional midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the *Midwives Model of Care* (National Association of Certified Professional Midwives [NACPM], 2011). The *Midwives Model of Care* is based on the fact that pregnancy and birth are normal life events, and includes:

- Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle;

- Providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;

- Minimizing technological interventions; and

- Identifying and referring women who require obstetrical attention. (Midwifery Task Force, 1996).

Additionally, the CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings. CPMs practice as autonomous health professionals working within a network of relationships with other maternity care professionals who can provide consultation and collaboration when needed (NACPM, 2011).

The certification process for professional midwives began in 1983, when the Midwives Alliance of North America (MANA) created a credentialing committee to gather information about the status of and processes for credentialing of midwives. By 1985, the Credentialing Committee was working in conjunction with the Standards and Practice Committee and the Education Committee to develop proposals for a voluntary registry for direct-entry midwives (Midwives Alliance of North America [MANA], n.d.). In 1986, MANA established the Interim Registry Board (IRB) tasked with developing a test that would measure midwifery knowledge based on the MANA Core Competencies. In 1991, the first “trial” exam was given to midwives across the country, and later that year, the revised exam was officially administered as the Registry Examination (MANA, n.d).

At the same time, the Interorganizational Workgroup on Midwifery Education (IWG) was formed, made up of CNMs and direct-entry midwife subject matter experts, representing the educational viewpoints of the ACNM, MANA, and public members.

The purpose of this group was to establish guidelines for midwifery education; the outcome of the group was the realization that direct-entry midwives needed to develop their own credentialing and accreditation mechanisms (MANA, n.d.). The IWG began assimilating direct-entry skills lists from a variety of existing educational institutions, and finally produced a skills checklist tailored to aid in measuring competency in entry-level midwives who practice primarily in out-of-hospital settings.

Eventually, the IWG presented the concept of the skills competency and a certification process to the MANA board (MANA, n.d.). In 1992, the IRB incorporated as a non-profit corporation named the North American Registry of Midwives (NARM), and from 1993-1995, co-sponsored with MANA certification task force meetings. The purpose of the meetings was to gather input from midwives and midwifery educators from diverse areas, practices and cultures to guide the development of a common certification process (North American Registry of Midwives [NARM], Midwifery Education Accreditation Council [MEAC] & Midwives Alliance of North America [MANA] Issue Brief, 2008). As a result, it was determined that a certification process would have two components – education and certification. The education portion would consist of documentation of clinical skills with preceptor verification and a hands-on skills assessment by a trained “Qualified Evaluator.” The certification verification would be comprised of an extensive written exam, based on essential bodies of knowledge and skills necessary for safe and competent entry-level, out-of-hospital midwifery practice (NARM, MEAC, MANA Issue Brief, 2008).

Over the next several years, this process was tested, developed and re-tested. NARM contracted with a commercial testing company to assure validity along the way. One drawback that was realized at the outset of the certification program was that there were many midwives who had been practicing for years, and were obviously not working under supervision. This recognition led to the creation of the "Experienced Midwife" category, which carried very explicit qualifications. However, all midwives would be required to pass the NARM written exam (MANA, n.d.). In the late 90s, NARM created the Midwifery Education Accreditation Council (MEAC) as a certification mechanism. MEAC established requirements for the accreditation of midwifery schools, and became recognized by the U.S. Department of Education as a national accrediting organization for direct-entry midwifery education programs and institutions (NARM, MEAC, MANA Issue Brief, 2008). By the early 1990s, several states actively regulated the practice of non-nurse midwifery, and many more were interested in licensing laws. There was growing consensus among midwives themselves that uniform, national standards for the education and certification of direct-entry midwives would be useful in defining their expertise for the public, thereby increasing women's access to their services (NARM, MEAC, MANA Issue Brief, 2008). In 2001, the National Association of Certified Professional Midwives (NACPM) was created to communicate the principles of midwifery practice, as well as to establish standards of care specific to CPMs.

In order to further validate their practice, in 2000, all CPMs participated in a required year-long prospective study. This was undertaken by independent researchers designed to evaluate the practice of CPMs. Over 5,400 planned home births involving

CPMs were analyzed and compared with low risk hospital births. The results showed lower rates of expensive medical interventions, as well as outcomes that were comparable to their hospital counterparts. The study was published in the *British Medical Journal* in 2005 (NARM, MEAC, MANA Issue Brief, 2008).

In 2001, the American Public Health Association (APHA) issued a policy statement which addresses the issue of access to out-of-hospital maternity services through regulated, certified direct-entry midwives (APHA Policy Statement 20013, January 2001). APHA directly supports efforts to increase this access by encouraging development and implementation of guidance for licensing, regulation and practice of direct-entry midwives. Further, APHA endorses, in the case of CPMs, a didactic certification program, consisting of comprehensive written examination and extensive clinical experience (APHA Policy Statement 20013, January 2001).

This table illustrates the clinical requirements necessary for different disciplines to acquire certification to deliver babies:

	Certified Professional Midwives	Certified Nurse Midwives	Family Practice Physicians
Births as Assistant	20	-	-
Birth as Primary Attendant	20	20	40 (>30 vaginal)
Out-of-Hospital Births	10	-	-
Continuity of Care	3	-	10

Prenatal Exams	75 (20 initial)	85 (15 initial)	-
Newborn Exams	20	20	-
Postpartum Exams	40	35	-

(North Carolina Home Birth, 2008).

As demonstrated, CPM certification through NARM requires the most rigorous of clinical experiences. CPMs follow the practice standards of the NACPM, which include the development of collaborative relationships with other healthcare practitioners who can provide care outside the scope of midwifery practice when necessary. The NACPM standards limit the CPM scope of practice to primary maternity care of healthy women experiencing normal pregnancies. This focused practice requirement affords the CPM expertise in this area, while other disciplines must develop expertise for a much wider scope of practice. Additionally, uncomplicated vaginal birth at home with CPM care costs, on average less than 1/3 what it does in a hospital, with virtually identical outcomes (North Carolina Friends of Midwives, 2010).

The Road to Legalization and Licensing of CPMs

Unlike our neighboring states of South Carolina, Tennessee and Virginia, North Carolina denies women legal access to CPMs. Despite the fact that CPMs are expressly trained as experts in the field of home-based maternity care, they are open to criminal prosecution for “unlicensed health care practice” in North Carolina, which remains one of only a handful of states that explicitly prohibits the practice of professional midwives (North Carolina Friends of Midwives, 2011). Table 1 illustrates

the different categories of regulation, licensure and legal status for CPMs and Certified Midwives (CM).

The current restrictions on midwives in North Carolina began in 1983, with the Act to Regulate the Practice of Midwifery. The statute, G.S. 90-178.3, reads:

§ 90-178.3. Regulation of midwifery.

(a) No person shall practice or offer to practice or hold oneself out to practice midwifery unless approved pursuant to this Article.

(b) A person approved pursuant to this Article may practice midwifery in a hospital or non-hospital setting and shall practice under the supervision of a physician licensed to practice medicine who is actively engaged in the practice of obstetrics. A registered nurse approved pursuant to this Article is authorized to write prescriptions for drugs in accordance with the same conditions applicable to a nurse practitioner under G.S. 90-18.2(b).

(c) Graduate nurse midwife applicant status may be granted by the joint subcommittee in accordance with G.S. 90-178.4. (1983, c. 897, s. 1; 2000-140, s. 60).

The Act requires midwifery practice to be regulated through the Midwifery Joint Committee, an autonomous joint subcommittee which includes two nurse-midwives (North Carolina Board of Nursing representatives) and two ob-gyn physicians (North Carolina Board of Medicine representatives). This committee originally met frequently to develop rules for operationalizing the new law.

Additionally, the committee was charged with approving privileges to nurse-midwives, and in some instances, did so under regulations that were already in place. For example, prescriptive privileges were granted according to the North Carolina Nurse

Practitioner Regulations (North Carolina Homebirth, 2010). The rules for the Midwifery Joint Committee were initially adopted on February 1, 1984, and were amended several times until the last revision on March 1, 1994. Standardized practice guidelines were adopted in 1986, outlining procedures for individual practices where CNMs are employed. CNMs are currently responsible for maintaining their scope of practice (written and onsite) within their individual practice, and keeping their supervising physician apprised of any changes in the practice guidelines. The rules of supervision and practice of CNMs are enforced according to G.S.90-178.3 (Legal Status of North Carolina Midwives, 2010).

In 2007, a legislative study was recommended to assess the needs of women who desire and choose home birth. The House Select Committee on Licensing Midwives was conducted during three meetings in 2008, and while the North Carolina Medical Society remained opposed to every aspect of home birth, arguments for licensing and regulation were overwhelmingly positive and it was recommended that stakeholders form a working group to propose a licensing methodology (North Carolina Friends of Midwives, 2011).

This recommendation was included in the 2009 Study Act, and from fall 2009 until May, 2010, the study group– comprised of representatives from the key stakeholder groups of the North Carolina Medical Society, the North Carolina Hospital Association, North Carolina Friends of Midwives, the Midwifery Joint Committee, the North Carolina Nurse's Association, the North Carolina Affiliate of American College of Nurse-Midwives and lobbyists– met for three sessions. These sessions were facilitated

by a neutral party, and while there was open dialogue between all parties, no common ground was agreed upon.

According to Russ Fawcett, the vice-president of NC Friends of Midwives, the primary sticking point remained the NC Medical Society's refusal to recognize the adequacy of training and education of CPMs. Additionally, the fact remained that midwives of any background would still be required to work with MD back-up. Since there is always the minute possibility of a less-than-optimal outcome with any birth, including home birth, physicians in general are wary of providing the back-up that is required for any midwife This leaves physicians in control of the home birth issue. The physician's groups acknowledged that unregulated midwives are practicing in North Carolina nearly every day; however, physicians are not responsible for them or their outcomes, and at this point, do not acknowledge that licensure and regulation is a safer option for all involved (personal communication, November 3, 2011). Representative Winkie Wilkins (D-Durham, Person) agrees, stating that choice is the reason he sponsored H.B. 522. Wilkins sat on the midwife licensure study committee in 2008 and for him it all came down to one question – "If we don't license them, what are they going to do? They will keep practicing, so that women have choices, options. I'd rather we know who and where they are. This will be accomplished with licensing" (Burrows, 2011).

In February, 2011, the "CPM Bill" was sent to drafting, and on March 29, 2011, House Bill 522 (HB522), an *Act to License Certified Professional Midwives in North Carolina*, was filed by Representative Pat Hurley (R – Randolph), Representative Becky

Carney (D - Mecklenburg), Representative William Current (R – Gaston) and Representative Winkie Wilkins (D – Durham, Person). The bill made it through the House and was referred to the Committee on Health and Human Services. On April 19, 2011, the bill became SB622 and was introduced to the Senate by Senators Davis Rouzer (R – Johnston, Wayne) and Brent Jackson (R – Duplin, Lenoir, Sampson). The bill was referred to the committee on Agriculture/Environment/Natural Resources.

However, while the bill was assigned to the House Health and Human Services Committee, it was determined that it had to first go through the Legislative Committee on New Licensing Boards first (as CPMs are not yet licensed in North Carolina). The bill successfully made it through this committee, and the next stop is back with the Committee on Health and Human Services, when the session starts in May, 2012 (North Carolina General Assembly, 2011).

There are differences between CPMs and CNMs, and their practices may be very similar in some instances while starkly different in others. Ultimately, the core of their practice is serving and supporting women and babies through pregnancy and birth. The differences in licensure and regulation, both between CPMs and CNMs - as well as within each profession – can also be very different. As noted earlier, CNMs are licensed to practice in all U.S. jurisdictions. However, there is no one uniform method of licensing and oversight, with the only commonality from state-to-state being the requirement for collaboration with an MD. CPMs have varied licensure and regulatory paths, as well as variances in scopes of practice.

Virginia has licensed CPMs since July 2005, when their general assembly passed a credentialing bill with a wide majority. Throughout history, direct-entry midwives were "permitted" by the Department of Health to practice in Virginia. Despite having little formal training, outcomes overall were good, with only two complaints filed between 1918 and 1976 (Commonwealth Midwives Alliance, 2007). However, in 1977, the general assembly passed legislation that limited the practice of non-nurse midwifery to those who were permitted prior to January 1, 1977, and no new permits were to be issued after that time. At this same time, CNMs became licensed (Commonwealth Midwives Alliance, 2007).

In 1998, the Virginia Joint Commission on Health Care (JCHC) began to study the advisability of legalizing the practice of midwifery, and in fact, in 1999, recommended legalization of the practice of midwives who met the competency requirements of NARM (Commonwealth Midwives Alliance, 2007). For the next few years, legislative efforts continued to further determine how to best regulate direct-entry midwives, and in 2003, the law requiring that non-nurse midwives be registered with the Department of Health was repealed. In 2005, the CPM licensing bill passed the general assembly and was signed into law in July of that year, and the first CPM was granted licensure on February 13, 2006 by the Virginia Board of Medicine, who oversees regulation (Commonwealth Midwives Alliance, 2007). Currently, Virginia's CPMs are attempting ratify a dilemma that exists within midwifery care. Although CPMs are trained to carry and administer some medications that may be necessary for safe out-of-hospital births, the current statute specifically prohibits them from doing so. This gap

represents a compromise to optimal safety in rare emergencies, as well as prohibiting easy access to necessary medications for newborns. A workgroup has been convened by the Board of Medicine over the last several months, but has yet to come to agreement on the issue (Commonwealth Midwives Alliance, 2011).

In 2000, Tennessee's legislature adopted a law that allowed for the licensing of CPMs. The bill created a Council under the Board of Osteopathic Examiners to issue licenses, gave the Board the authority to adopt regulations regarding CPMs and to discipline CPMs, required CPMs to form a collaborative care plan with a physician for all clients, required CPMs to include documentation of an initial consultation with a physician in a client's chart, and required that copies of emergency plans be sent to physicians named in clients' charts. The Tennessee Midwives Association implemented practice guidelines and standards, which must be adhered to, along with MANA's Core Competencies (Tennessee Midwives Association, 2010).

The following SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats) (Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support Resource Kit, n.d.). is intended to concisely illustrate aspects of legislative promotion of CPM licensing.

SWOT Analysis for Legislatively Promoting CPMs

Strengths	Established, nationally-recognized certification process through NARM Established (proven) regulatory guidelines available from states currently licensing; can be tailored for requirements of North Carolina, based on needs assessment CPM practice is autonomous, free from external control of competing professions

	Enables NC women who choose out-of-hospital birth to receive care from a licensed, experienced midwife who is backed by an accredited licensing body Would enable continuity of care, prenatal referrals, and effective intrapartum transport (when warranted) Minimizes unplanned, unattended births or care by a non-credentialed attendant Supported by ACNM, a professional organization poised to influence policy initiatives relating to midwifery care, both nationally and locally Supportive "grass roots" groups are typically strong and well-organized
Weaknesses	CPM credentialing standards supporting competency-based education and multiple educational pathways are easily misunderstood (unfamiliar to policy and legislative bodies) While MANA provides national support, state action is undertaken by local, sometimes poorly-resources groups/bodies Professional mechanisms of CPMs are still evolving, and may be seen as confusing or incomplete Conclusive research of efficacy and safety of CPM practice is relatively new and scanty
Opportunities	Increasing momentum of states recognizing CPMs Policy recommendations from the Taskforce on Midwifery gives substantive authority for conclusion of CPMs in the healthcare policy outcomes Strong consumer constituency advocating for legalization of qualified, licensed home birth providers North Carolina Physicians for Midwives North Carolina Friends of Midwives
Threats	Regulatory inclusion of restrictive language for clinical supervision or physician-controlled practice agreements ACOG's latest opinion paper (January 2011) non-supportive of out-of-hospital births (while not specifically mentioning CPMs) North Carolina Medical Society – has been unwavering in their opinion that planned home birth is "not in the best interest of anyone"

Action Steps

In 2011, it is clear that direct-entry midwives have established an accrediting process that is didactic, based in practice and is consistent from state-to-state. There is a credentialing process for licensing midwives that saves individual state jurisdictions the expense and time of developing and implementing their own process of assessing and evaluating midwifery competency. This same credentialing establishes a national

standard for quality assurance within the profession, and helps assure that care is delivered by qualified, prepared midwives. CPM care has been shown to be safe, cost-effective and satisfying to consumers.

In order to provide and cultivate a safe, supportive environment for women who desire midwifery care and choose birth in an out-of-hospital setting, the CPM must be legally recognized in North Carolina. This will be accomplished by enacting HB522/SB662 (the Midwifery Licensure Act) in the short session of the legislature in 2012. In addition to the legislators that introduced the CPM Bill into the House and Senate, there are several other champions for midwifery in North Carolina: Representative Nathan Dollar (R – Wake), who has been a key supporter of the bill since its introduction; Senator Stan Bingham (R – Davidson, Guilford); Senator Eleanor Kinnaird (D - Orange, Person); and Senator Thom Goolsby (R – New Hanover). According to Russ Fawcett, “although leadership in 2012 is not different than 2011, it is dramatically different than 2010, and prior Assemblies. They are starting to understand that North Carolina is much better off with trained and regulated midwives than without them”.

The legislators who are backing this bill are passionate about the cause. Since North Carolina has been debating this issue, Virginia, Tennessee and South Carolina have all voted to license CPMs. North Carolina champions now have the advantage of using those states’ years of experience with CPMs to call upon. Educated legislators and constituents, as well as the momentum that the NCFOM has been gaining with homebirth families and the public in general, must unite to form a strong voice that will

make a difference in the General Assembly next year. Supporters must maintain a cohesive front, since backing from the North Carolina Medical Society is not likely to occur,

Thousands of women are passionate about birthing their babies outside the hospital setting. Current North Carolina law specifically states that a CNM may only attend births when she has physician back-up, and few are willing to provide it. CPMs and lay midwives attend many home births in North Carolina, which is not currently legal. However, homebirth *is* legal in NC and consumers should have access to qualified, trained, and legal attendants. The best way to preserve the safety of mother and baby during homebirths is to increase access to the medical infrastructure, allowing families to obtain lab tests, ultrasounds, consultations, and referrals when appropriate.

Women in North Carolina deserve options and choices in their healthcare decisions. More importantly, women need the assurance that the provider they choose for healthcare is competent and safe. Licensure is the mechanism that ensures public safety.

Appendix A: Glossary of Terms

1. **ACNM** – American College of Nurse Midwives – the professional association that represents certified nurse-midwives and certified midwives in the U.S.; provides members with research and continuing education programs, and establishes clinical practice standards

2. **ACOG** – American Congress of Obstetricians and Gynecologists – national association of professionals providing health care for women; maintain standards of clinical practice and continuing education for members

3. **CNM** – Certified Nurse Midwife – an advanced practice registered nurse who has specialized education and training in nursing and midwifery

4. **CPM** – Certified Professional Midwife – a knowledgeable, skilled, independent midwifery practitioner who has met the standards of certification set by North American Registry of Midwives

5. **MANA** – Midwives Alliance of North America – professional organization for all midwives, with emphasis on unifying and strengthening midwifery, thereby improving the quality of health care for women, babies and communities

6. **MEAC** – Midwifery Education Accreditation Council – creates standards and criteria for the education of midwives; standards incorporate nationally recognized core competencies and guiding principles set by Midwives Alliance of North America and requirements for national certification of the North American Registry of Midwives

7. **NACPM** – National Association of Certified Professional Midwives – a professional association committed to increasing women's access to quality maternity care by supporting the practice of Certified Professional Midwives

8. **NARM** – North American Registry of Midwives – sets standards for competency-based certification of midwives nationally; supports advocacy efforts for legal recognition at federal and state level

9. **NCFOM** – North Carolina Friends of Midwives – a grassroots organization of midwifery advocates dedicated to promoting, supporting and protecting midwifery in North Carolina

Table 1: Midwifery State-by-State Legal Status (5-11-2011)

	Regulated	Unregulated				CPM	Medicaid Reimburse-ment
	Licensure(L) Certification(C) Registration(R) Permit(P)	Legal by Judicial Interpretation or Statutory Inference	Not legally regulated, but not prohibited	Legal by Statute, but Licensure Unavailable	Prohibited by Statute, Judicial Interpretation, or Stricture of Practice		
AK	L					CPM	X
AL					X		
AR	L					CPM	
AZ	L					CPM	X
CA	L					E	X
CO	R					CPM	
CT			X				
DE	P					CPM	
DC					X		
FL	L					E	X
GA				X			
HI				X			
ID	L					CPM	X
IL					X		
IN					X		
IA					X		
KS		X					
KY					X		
LA	L					CPM	
ME		X					
MD					X		
MA		X					
MI		X					
MN	L					CPM	
MS		X					
MO		X					
MT	L					E	
NE			X				
NV		X					
NH	C					CPM	X
NJ	L					CPM	
NM	L					CPM	X

NY	C					*	
NC					X		
ND		X					
OH			X				
OK		X					
OR	Voluntary-L					CPM	X
PA					X		
RI	C					*	
SC	L					CPM	X
SD					X		
TN	C					CPM	
TX	L					CPM	
UT	Voluntary-L					CPM	
VT	L					CPM	X
VA	L					CPM	
WA	L					E	X
WV			X				
WI	L					CPM	
WY	L					CPM	

Note: Midwives practicing in unregulated states have no legal, regulatory protection.

Information for this chart was provided by the Midwives Alliance of North America (MANA) and the North American Registry of Midwives (NARM).

E	State uses NARM Exam as part of licensure process.
CPM	Reciprocity of CPM credential or CPM plus state specific requirements accepted for licensure, certification, documentation or registration.
*	Certified Midwives (CMs) who are certified by the American Midwifery Certification Board (AMCB) are the only direct-entry midwives permitted to practice in these states.

Licensure/Certification
Inference/unregulated
Illegal

Midwives Alliance of North America, 2011

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