To Whom It May Concern:
I am writing to express my support for an independent governing board for direct-entry midwifery.
Midwives and their clients are best served by a governing body well-versed in the specifics of midwifery care, rather than by a general body of well-intentioned persons.
In addition to being a midwife I am also a chiropractic physician and a PhD researcher of health and health care.
Although the dominant model of midwifery training in the United States is that of becoming a nurse first and then a midwife, in Europe this is not the case.
Direct-entry midwives in the United States follow the European model of training for midwifery, which is a midwifery specific curriculum.
I am attaching a paper that I published comparing the education of nurse midwives with the education of US direct-entry midwives.
In the article you will see that the training programs for the two types of midwives is the United States is largely parallel.
My understanding is that nurse midwives are governed by the nursing board.
Since nurse-midwives are goverened by their own board in Oregon, direct entry midwives should also be goverened by their own board.
As part of the professionalization process of midwifery in the United States, acquiring our own board is the next step.
Sincerely,
Caroline PEterson, DC, PhD, CPM, LDM, MPH

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Midwifery and the Crowning of Health Care Reform

Caroline Peterson, CPM, DC, PhD, MPH

BACKGROUND

In July 2009, the American College of Nurse-Midwives (ACNM) sent a letter to members of Congress opposing the federal recognition of certified professional midwives (CPMs) under the Social Security Act.[1] The Social Security Act is the piece of legislation that provides for national health care coverage, such as Medicare and Medicaid, for elders, the socioeconomically disadvantaged, military personnel, and persons with disabilities. Although the Social Security Act was signed by President Roosevelt in 1935, certified nurse-midwives (CNMs) were not included in coverage by this act until 1988. Only in the past 10 years was the act expanded to include coverage for the full scope of care provided by CNMs and certified midwives (CMs). CNMs/CMs have struggled valiantly to create a recognized, fairly reimbursed, autonomous profession in the face of political and economic opposition from nurses and physicians. Part of their success in forging the CNM/CM profession is attributable to the academic model they developed to train midwives.[2]

In the letter to members of Congress, ACNM contended that midwifery services provided by CPMs should not be covered under the Social Security Act because graduation from an accredited program is not a requirement for national CPM certification by the North American Registry of Midwives (NARM). To be eligible to sit for the NARM written examination, individuals may complete their education through an apprenticeship, a Midwifery Education Accreditation Council (MEAC)-accredited education program, or an ACNM Accreditation Commission for Midwifery Education (ACME)-accredited education program.[3] If a midwife passes the NARM examination, no distinction is made in her CPM credential based upon her route of education. The concern ACNM expressed to Congress members is only with midwives who are not trained through an accredited program. However, it is difficult to substantiate ACNM's concern because CPMs are not differentiated based upon educational route.

While graduation from an accredited education program is the standard preparation for health care providers in the United States and other countries, the question remains: Is midwifery preparation through an accredited education program inherently better than midwifery preparation through an unaccredited apprenticeship process? Unfortunately, no data are available to answer this question. Therefore, a less exact question must be asked: Is there a difference in the quality of preparation and health care provided by a CPM and a CNM/CM?

This commentary will review the apprenticeship pedagogic model and the role of core competencies in assessing skills and knowledge. It will also compare the core competencies of ACNM with the Midwives Alliance of North America (MANA) core competencies, and the national certification examination prerequisites and content for CNMs/CMs and CPMs. Practice outcomes are also discussed. Relevant abbreviations and their descriptions are presented in Table 1.

THE APPRENTICESHIP PEDAGOGIC MODEL

Throughout the world, all health care practitioners were historically trained by the apprenticeship model. At the turn of the 20th century, medical education in the United States was presented with two competing pedagogic models. William Osler advocated that education should continue to be individually tailored and apprenticeship-based. Abraham Flexner countered that education should be standardized and based on a didactic scientific model of training.[9] Although the medical school curriculum was redesigned along the lines of Flexner's vision, many surgical training programs retained the apprenticeship model. Today, the apprenticeship model continues to be the gold standard for surgical training.[10]

Within the past decade, rural medical education programs have returned to the apprenticeship model of education. From New York to Washington state, these programs consistently produce physicians who have national examination scores equal to or better than physicians who are educated in the traditional manner.[11,12] Furthermore, studies have found that apprenticeship-trained students are happier with their education process, have much more experience with continuity of care, and do not have to deal with the competing needs of multiple mentors.[11,12]

An apprenticeship-trained CPM must spend at least 1 year—and typically 3 to 5 years—in clinical training with a midwife who is a CPM, CNM, CM, or other legally recognized midwife, or a midwife who has attended at least 50 births as the primary midwife and has at least 3 years experience. In addition, the apprenticeship-trained midwife must engage in didactic education. The didactic component of education may be acquired through distance-learning midwifery courses, self-directed learning, or by attending a MEAC- or ACME-accredited program. NARM guides the didactic content by providing reading lists, core competencies, and an overview of specific

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Table 1. Midwifery Certification and Education Abbreviations

Abbreviation	Expanded Form	Description
ACME	Accreditation Commission for Midwifery Education	Accrediting agency for CNM/CM midwifery education institutions and programs, recognized by the US Department of Education[4]
ACNM	American College of Nurse-Midwives	Professional organization that establishes practice and educational standards for CNMs/CMs[4]
AMCB	American Midwifery Certification Board	Certifies, recertifies, and disciplines CNMs/CMs[4]
CM	Certified midwife	Midwives who complete an ACME-accredited program, pass the AMCB certification examination, and are not registered nurses; CMs are licensed to practice in New York, New Jersey, and Rhode Island[5]
CNM	Certified nurse-midwife	Midwives who complete an ACME-accredited program, pass the AMCB certification examination, and are registered nurses[5]
CPM	Certified professional midwife	Midwives who meet the standards for certification set by NARM[3]
MANA	Midwives Alliance of North America	Professional organization for all midwives in North America[6]
MEAC	Midwifery Education Accreditation Council	Accrediting body that sets educational standards and criteria for CPMs, and is approved by the US Department of Education[7]
NARM	North American Registry of Midwives	Certifies, recertifies, and disciplines CPMs[8]
PEP	Portfolio evaluation process	The means by which NARM evaluates core competencies of apprenticeship-trained midwives[3]

knowledge and skills required to pass the written examination and the hands-on skills assessment examination.[3]

CORE COMPETENCIES

Diverse pedagogic strategies have been shown to be effective in health care education, including problem-based learning,[13] peer training,[14] distance learning,[15] and patient-centered learning.[16] Because there are many effective means of acquiring knowledge and skills, what is of ultimate importance is not the curricular structure but the outcome thereof. Because of this, competency-based examinations have become the standard in health care education for medical residents in the United States.[17] Both ACNM and MANA ascribe to core competencies. Content analysis comparing the core competencies of these organizations shows nearly identical competencies for pregnancy, birth, and postpartum care. The Accreditation Council for Graduate Medical Education (ACGME) has elaborated a toolbox of assessment methods for competency-based curricula. Tools to assess skills and knowledge include portfolios, record review, case logs, standardized patient examination, standardized oral examination, and written examination.[18] All of these are used in the portfolio evaluation process (PEP) to assess the knowledge and skills of apprenticeship-trained midwives who sit for the NARM examination.[19]

MIDWIFERY NATIONAL CERTIFICATION

To be eligible to sit for the NARM certification examination, a student must complete 1350 clinical hours; serve as primary midwife for a minimum of 20 births; attend at least 40 total births; and perform a minimum of 135 outpatient visits, including prenatal, newborn, and postpartum examinations.[19] Before taking the NARM examination, apprenticeship-trained midwives must additionally complete the PEP. To be eligible for the PEP, one must fulfill and document all education and clinical requirements. The candidate's midwifery skills are then tested by a qualified midwife who was not her preceptor. Following the hands-on skills assessment the candidate may sit for the 8-hour NARM examination.[3]

No specific number of clinical hours, births, and/or outpatient visits is required for the American Midwifery Certification Board (AMCB) certification examination. Rather, one must complete a midwifery program accredited or preaccredited by ACME to be eligible to sit for the AMCB examination. A university nurse-midwifery education program in Oregon requires 760 clinical hours, 30 to 50 total births, and 150 outpatient visits to complete the program.[20] A MEAC-accredited midwifery school on the Texas/Mexico border regularly provides approximately 2592 clinical hours, 40 catches, 100 total births, and 450 outpatient visits in their training program.[21] While actual clinical experience in both CPM and CNM/CM education programs may exceed the minimum requirements established by their program, the requirements to sit for the two midwifery certification examinations appear to be fairly similar.

Just as pregnancy, birth, and postpartum core competencies and clinical training requirements are similar for CPMs and CNMs/CMs, so too is the content of their national certification examinations. The NARM examination and the AMCB practice examination with questions from the

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actual examination[22] were compared with content analysis. The questions in each test were nearly identical for content, structure, and depth and breadth of knowledge required.

MIDWIFERY QUALITY OF CARE

If the core competencies, clinical training requirements, and national certification examination content are virtually identical for CPMs and CNMs/CMs, do pregnancy, birth, or postpartum outcomes differ for their clients? Unfortunately, there are no data to answer this question. At this time, the level of comparison is only for low-risk hospital births versus planned homebirths attended by CPMs. The most exhaustive study found there was no increased mortality or morbidity risk for planned homebirths attended by CPMs in the United States and Canada compared with low-risk hospital births.[23] Although not stated in the article, NARM indicates that 99% of the CPMs in the study were certified through NARM, and more than 50% of NARM-certified CPMs complete the apprenticeship training program.[24]

CONCLUSIONS

The profession of midwifery is still marginalized in the United States.[25] The solution is not to create factions amongst different types of midwives but to come together to lift up the profession in all its guises. Already we have similar core competencies, clinical training requirements, and certification examinations. Let us work together to continue improving upon the model of midwifery education and practice.

As a nation we are now given the opportunity to redefine quality health care for all. The poor and underserved must not be punished for the infighting of a profession. Births attended by midwives continue to rise as family medicine physicians and obstetricians face medicolegal and other challenges, forcing them to constrain the provision of prenatal and intrapartum care.[26,27] However, in the face of the increased need for midwives, there is a 50% decrease in the number of newly-certified CNMs/CMs and a 25% decrease in number of CNM/CM education programs.[28] Because of the increased need for midwives and decreased minting of new midwives, those in practice report working up to 80-hour weeks to meet the needs of mothers and babies.[27] That lifestyle is not sustainable.

The midwifery workforce must grow and must be equitably reimbursed to meet the pregnancy- and birth-related health care needs of the nation. Core competencies, clinical requirements, and national certification examinations are nearly identical for CPMs and CNMs/CMs. No evidence exists that apprenticeship-trained midwives are less competent than midwives who completed accredited education programs. Midwives must join together to help elaborate the health care reform agenda and insist upon full coverage for all midwives under the Social Security Act. Let us come together to raise the profession and to respond to the needs of a nation of mothers, babies, and families: ''Yes we can.''

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