

## **Addendum I**

### **About the American College of Nurse-Midwives**

**The American College of Nurse-Midwives (ACNM)** is the oldest women's health organization in the United States, with roots dating back to 1929. In all but six states in the nation, Certified Nurse-Midwives (CNMs) are licensed independent practitioners. They have prescriptive authority in all 50 states, the District of Columbia, American Samoa and Guam. CNMs provide primary healthcare to women of all ages, including prenatal care, labor and delivery care, post-partum care, gynecological exams, newborn care, family planning services, preconception care, menopausal management and counseling in health promotion and disease prevention.

ACNM developed the Certified Midwife (CM) credential in 1997 as a pathway for entry into the midwifery profession for individuals who are not nurses. Like CNMs, CMs are educated in the discipline of midwifery; they have the same scope of practice, take the same certification exam and are certified by the same certification board (the American Midwifery Certification Board).

In 2005, the most recent year for which data are available, the National Center for Health Statistics reports that CNMs attended 306,377 births in the US. Nearly 97% of CNM-attended births occurred in hospitals, 2% occurred in freestanding birth centers and 1.3% (4,034) at home. Of the total 24,468 home births occurring in the US in 2005, 10,643 (43.5%) were attended by other midwives.<sup>3</sup>

CNMs and CMs practice autonomously within a health care system that provides for consultation, collaborative management or referral to specialists and acute care as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the ACNM. These standards are available on the ACNM website.<sup>4</sup>

## **Addendum II**

### **Ensuring a Qualified Midwifery Workforce**

ACNM shares ACOG and AMA's concern that the individuals providing care to women be formally educated and appropriately qualified and licensed to practice. However, Resolutions 204 and 205 make the mistake of confusing the issue of midwifery qualifications with that of appropriate birth site. Investigators have defined the phrase "planned home birth" as *the care of selected pregnant women by qualified providers within a system that provides for hospitalization when necessary.*<sup>5</sup>

ACNM's 2008 Issue Brief entitled "Midwifery Certification in the United States"<sup>6</sup> (attached) clarifies ACNM's position on midwifery credentials and appropriate qualifications for midwifery practice. ACNM's Issue Brief is consistent with the internationally defined criteria for the professional midwife accepted by the International Confederation of Midwives,<sup>7</sup> the International Federation of Gynaecology and Obstetricians (FIGO) and the World Health Organization.

The ACNM Issue Brief states our position that "a professional midwife in the United States is a person who has graduated from a formal education program in midwifery accredited by an agency recognized by the U.S. Department of Education. The professional midwife has evidence of meeting established midwifery competencies that accord with a defined scope of practice corresponding to the components and extent of coursework and supervised clinical education completed. In addition, this person has successfully completed a national certification examination in midwifery and is legally authorized to practice midwifery or nurse-midwifery in one of the 50 states, District of Columbia, or U.S. jurisdictions."

ACNM supports laws and regulations that include:

1. Successful completion of a formal education program in midwifery accredited by an agency recognized by the U.S. Department of Education.
2. Successful completion of a national certification examination in midwifery.
3. Successful completion of regular recertification/continuing education.
4. A scope of autonomous practice that is consistent with the content of the education process and certification exam.
5. Support for seamless access to, and consultation and collaboration with, qualified health care professionals and institutions, as needed, within the healthcare system.

It should be noted that Resolution 205 erroneously states that ACNM has defined Certified Professional Midwives (CPMs) as "traditional, independent (of the health care system), non-formally trained and community-based providers of care during pregnancy, childbirth and the post-natal period." **ACNM does not define CPMs in this or any other manner, and will not do so. CPMs have their own professional organizations to represent them and standards which address their education, certification and scope of practice.** ACNM is in dialogue with these organizations with the goal of working toward the highest quality midwifery care for women and families in all settings.

- ❖ *ACNM urges AMA and ACOG to support ACNM's definition of a professional midwife and state legislation that meets the criteria ACNM has outlined above.*

### **Addendum III**

#### **Home Birth is a Rational, Personal Choice**

The language of Resolution 204 and 205 suggests that women who choose home birth are participating in a fad rather than making a rational choice. The implicit underlying assumption is that state bans on home birth and restrictions on the providers of home birth services will put an end to the practice. The Resolutions do nothing to address the fundamental factors that influence the choice of home birth.

Researchers have described the factors affecting women's choice of planned home birth, and satisfaction with home birth, as the perceived differences in their ability to control the environment and process of care. Specifically, women note that planned home births increase their privacy, comfort and convenience; decrease the rates of medical interventions and exposure to infectious agents; provide greater cultural and spiritual congruency; change the provider-patient power dynamics; and facilitate family involvement and a relaxed peaceful atmosphere. Women consistently report that these factors increase their sense of safety and allow them the self-determination and empowerment necessary to fully participate in decision-making around aspects of their care.<sup>8- 15</sup>

Women want and have a right to expect unbiased information based on current scientific evidence and to share in decisions regarding their childbirth. Global communication has made international research and evidence-based maternity care options increasingly available to the public. Women and their families are aware that recent cohort studies in national and international settings indicate that planned home births are associated with similar perinatal outcomes and fewer obstetric interventions compared to hospital births.<sup>16- 27</sup>

Expert advisory panels in several nations, including the US, recommend that a woman's informed choice of place of birth be respected and that appropriate home birth maternity services be made available.<sup>28- 35</sup> In 2003, the Society of Obstetricians and Gynecologists of Canada issued a policy statement on midwifery that advocates for the further integration of midwives into maternity services and "recognizes and stresses the importance of choice for women and their families in the birthing process."<sup>36</sup>

Another factor in the desire for home birth in the US is the plummeting availability of vaginal birth after cesarean (VBAC) despite current research demonstrating that successful VBAC results in significant benefits and fewer risks for women and infants than repeat cesarean delivery. Key elements of a successful VBAC include unbiased appropriate informed consent, heightened surveillance of fetal heart rate patterns, and appropriate arrangements for medical consultation and emergency care. In many hospitals, VBACs are simply unavailable, forcing women to make the often difficult choice between a repeat cesarean and laboring at home—where appropriate surveillance and medical consultation are less likely to be available.

With so many factors influencing the choice of birth site, it is unlikely that even this small number of home births can be legislated away. If AMA is truly concerned with the safety of the birthing mother and infant, greater attention should be paid to ensuring continuity of care for women regardless of choice of birth site or birth attendant. By improving the conditions and communication around transfer of care from one birth setting to another, or one care provider to another, even the small

risks to mothers and infants of electing out-of-hospital birth could be greatly reduced.

- ❖ *ACNM urges AMA and ACOG to respect women's choices and work collaboratively and strategically with all maternity care providers to ensure continuity of care and appropriate linkages when women need a higher level of care in any birth setting.*
- ❖ *ACNM recommends that our maternity care system be aligned with the international community of scientific investigators and clinicians in order to better serve American families.*
- ❖ *ACNM urges AMA and ACOG to work strategically to increase the availability of VBAC.*

## **Addendum IV Planned Home Birth Using Established Selection Criteria is a Safe Alternative to Hospital Birth**

In Resolution 205, the AMA joins with ACOG to state that “the safest setting for labor, delivery, and the immediate post-partum period” is the hospital, a hospital-based birthing center, or an accredited freestanding birthing center, and resolves to support legislation promoting this concept.

In essence, it would appear that AMA and ACOG are on a path to embark upon a state-by-state campaign to prevent women from being able to freely choose their birth site. Three reasons are cited for bringing forth the resolution: the fact that 21 states now license midwives to attend home births; the recent flurry of media attention on celebrity home births; and the “unsafe” nature of home birth.

ACNM agrees with the AMA and ACOG that the safety of birth in any setting is of utmost priority. While the majority of births are uncomplicated, there is a risk of adverse outcome in any setting. However, the alarmist rhetoric on home birth by AMA and ACOG is not supported by the scientific evidence.

A primary question is whether the research is truly evaluating “planned home birth.” Many of the studies that have been used to discredit all home birth have not differentiated between planned and unplanned home birth or attendance by qualified versus unqualified attendants, and/or do not clearly define appropriate inclusion criteria. The evidence indicates that appropriate client selection, attendance by a qualified provider and seamless transfer to a receptive hospital care environment, when necessary, promote safe outcomes.

In recent years, high-quality prospective controlled cohort studies and descriptive studies have established that planned home births achieve excellent perinatal outcomes.<sup>37- 47</sup> Home birth is also credited with the reduced use of medical interventions that are associated with perinatal morbidity, including narcotic or epidural analgesia, augmentation or induction of labor, and assisted vaginal births or cesarean section.<sup>48-51</sup> While a large randomized controlled study (RCT) would constitute the gold standard, to date sufficient number of women have not consented to be randomized according to birth site.<sup>52</sup> Fortunately, recent data from a large North American prospective study compare outcomes of planned home births and planned home births when attended by midwives who apply consistent selection criteria, and function within an infrastructure that provides support and consultation as requested.<sup>53,54</sup> If we are to insist upon RCTs to prove the safety of home birth, we should consistently apply that standard to all birth settings and all routine obstetrical interventions applied to healthy childbearing women in the acute care setting—including elective cesarean section.

ACNM has established clear guidelines for home birth and publishes a handbook that addresses selection criteria for home birth clients, mechanisms for medical consultation and transfer and the establishment of quality management systems.<sup>55</sup> The informed consent process for home birth includes the delineation of potential risks and benefits of each available birth site and provision for transport if conditions require personnel and/or equipment available only in the hospital setting.

We do need more research regarding obstetric practices in general and site of birth. In its policy statement on home birth, ACOG has stated that “The development

of well-designed research studies of sufficient size, prepared in consultation with obstetrical departments and approved by institutional review boards, might clarify the comparative safety of births in different settings.” It is difficult to imagine how this goal could be realized if home births were legislatively prohibited. To date, most US obstetric departments have not engaged in the evaluation of alternative settings for maternity care; on the contrary, most have demurred from even entering into collaborative agreements with home birth providers. IRBs have approved all of the well-recognized international and Canadian studies, but are unlikely to do so in the US if the feasibility of the study or the safety of the option are in question.

- ❖ *ACNM urges AMA, ACOG, other stakeholders (including payers, policymakers and consumers) and other experts in the delivery of health care services to women and childbearing families to participate in an independent, university-based multi-disciplinary consensus conference on interprofessional strategies to increase safety and access to qualified providers across all birth settings.*

## **Addendum V Disaster Preparedness Planning Must Include Provisions for Birthing in Place**

The September 11th terrorist attacks, Hurricane Katrina, flooding in various regions of the country and other natural and manmade disasters have increased our attention on preparedness in our health care systems. In this context, increased attention must be directed to the childbirth choices that pregnant women and their families will face in these situations.

Pregnant women might find themselves isolated from health care facilities and providers in a disaster (as we saw in the aftermath of Hurricane Katrina). Hospitals overwhelmed by pandemic flu or biologic or chemical attack may not be available or suitable for healthy mothers and infants. **Homes and businesses need to be prepared for a woman to give birth in place.**

ACNM has published a how-to guide entitled Giving Birth in Place. This document is available at [http://www.midwife.org/siteFiles/education/giving\\_birth\\_in\\_place.pdf](http://www.midwife.org/siteFiles/education/giving_birth_in_place.pdf), and can be modified to address a variety of situations.

- ❖ *ACNM urges AMA, ACOG and other stakeholders to work with ACNM to strategically plan for the issues facing childbearing women and their families in disaster and emergency situations.*

## Addendum VI

### Is Home Birth a Significant Problem in the US Maternity Care System?

While home birth has received considerable media spotlight this year as a result of high-profile documentary films, books and Internet blogs, we do not know if there is or will continue to be a rise in the number of home births in recent years as a result of this attention to the delivery of maternity care services.

Even a 100% increase in the numbers of home births would barely push this phenomenon beyond 1% of all births. In 2005, the National Center for Health Statistics reports that more than 4,138,349 babies were born in the U.S. Of these, only 37,402 (0.9%) occurred outside of the hospital and only 24,468 (0.59%) were home births.<sup>56</sup>

Consider instead the following significant trends that are affecting literally millions of American families this year:

- ❖ The US maternal mortality rate is rising for the first time in decades.
- ❖ The U.S. ranks 27th among developed countries in terms of infant mortality rates, according to Save the Children's "Mother's Index"—behind such nations as Slovenia, Estonia, Portugal, and Hungary. According to the report, "infant and child mortality rates in the United States are higher than in any other industrialized country, the only exceptions being Latvia, Lithuania and Slovakia."<sup>57</sup>
- ❖ In 2006, the U.S. recorded its highest cesarean section rate at 31.1% of all births, far higher than the 10-15% rate recommended by the World Health Organization.<sup>58,59</sup> Naturally, these occur in hospitals. C-sections are sometimes a lifesaving procedure for mothers and infants, but this climbing rate suggests that far more are being done without evidence-based rationale. While some claim that consumer demand for cesareans is the primary driver behind this, research has not supported this assertion.<sup>60</sup> Research is beginning to reveal that this rising cesarean rate is increasing the incidence of stillbirth in subsequent pregnancies, infertility, stroke and other long-term complications. Not only have primary cesareans increased, but the old adage "once a cesarean, always a cesarean" that we said goodbye to in the 1980s has returned.
- ❖ Large disparities by race and Hispanic origin in the receipt of appropriate health care during pregnancy persist.
- ❖ The rising incidence of nosocomial infections, including methicillin-resistant *staphylococcus aureus*, and other hospital-related causes of morbidity.
- ❖ The US has no national plan to address the declining obstetrical workforce and the fact that greater numbers of obstetricians and midwives will be needed in the near future.

These trends—appropriately highlighted by the media, films and others—suggest that maternity care in this country is in crisis, or very nearly so.

- ❖ *ACNM invites ACOG and AMA to partner with ACNM and other stakeholders to develop strategic approaches to address these troubling trends in maternity care.*

## **Addendum VII**

### **AMA's Call for More Physician Oversight and Regulation of Midwifery is Unwarranted**

Resolution 204 calls for increased physician and regulatory oversight over midwifery practice. Our disagreement on this matter could not be stronger, and we are shocked that AMA and ACOG raise this call in light of the abundant evidence on the effectiveness of autonomous, professional midwifery care.<sup>61- 70</sup> No evidence has been presented in the resolutions or elsewhere that CNMs and CMs are in need of greater supervision and oversight.

As with the practice of medicine, the education and practice of modern professional midwifery has been developed over decades by ACNM and other organizations and governments throughout the world. Exemplary competence-based standards, accreditation of educational programs, and certification and licensure standards that provide for oversight of education, practice, and continuing competency in the profession are all well established. Professional midwives have adopted evidence-based knowledge, procedures and technologies for practice and facilitated continuity of care by advocating for and participating in seamless systems of care for all women and childbearing families. Midwifery researchers continue to contribute to the development of this evidence base for practice. Standards for consultation, collaboration and referral to other health professionals, when indicated, are inherent in our model of care.

Barriers to practice for professional midwives still exist in the US, creating a vacuum of qualified providers and leading some women to seek unqualified, unregulated practitioners. Some women even resort to unattended birth in an effort to gain control over their birth experiences.

Resolution 204 implies that midwifery is subordinate to medicine and not an autonomous profession, which in its own right is capable of resolving issues that evolve relating to the standards for education and practice of the profession.

ACNM considers it vital to ensure proper CNM/CM representation on regulatory boards overseeing our practice to ensure that decision-making on scope of practice and other critical issues is appropriate and well-informed. An appropriately configured board of midwifery would most effectively meet this need.

- ❖ *We strongly urge AMA and ACOG to support the continued autonomy of professional midwifery and ACNM's state policy agenda to ensure a qualified midwifery workforce.*

## **Addendum VIII**

### **ACNM's Policy Agenda to Ensure Qualified Professional Midwives**

ACNM is developing long-range strategic plans to significantly increase the number of professional midwives in order to meet the needs of the maternity care system. Our success will require increased resources devoted to accredited educational programs and to promoting certified nurse-midwifery and certified midwifery as a solid career choice for those wishing to work in women's health. We urge AMA and ACOG to support ACNM's efforts to ensure a high-quality professional midwifery workforce.

In addition to the initiatives recommended by ACNM above, we welcome ACOG and AMA to further demonstrate their support for CNMs and CMs by working strategically with ACNM to address the fundamental issues hampering their success by:

1. Eliminating state laws and regulations requiring physician supervision
2. Eliminating state laws and regulations requiring that CNMs and CMs obtain written collaborative practice agreements with physicians in order to practice
3. Rescinding Medicare and state Medicaid policies that refuse to pay CNMs and CMs equally for the same services provided by physicians
4. The passage of state laws providing for licensure for CMs (currently, CMs are recognized in only 3 states)
5. Constructing a firewall that would reduce the potential for vicarious liability among autonomous health care providers
6. Working with ACNM and other stakeholders to develop comprehensive health care reform and professional liability insurance reform

❖ *ACNM urges AMA and ACOG to work with ACNM to remove the barriers to practice faced by CNMs and CMs.*

❖ *ACNM urges AMA and ACOG to work strategically with ACNM and other stakeholders to identify and address maternity workforce issues that will impact women's future access to qualified care providers, and create a workforce plan that maximizes the talents and specialties of obstetricians, gynecologists, CNMs and CMs.*

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