

The 2012 American College of Nurse-Midwives Core Competencies for Basic Midwifery Practice: History and Revision

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The American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Practice, approved in 2012, (hereafter referred to as Core Competencies) outline the knowledge, skills, and abilities that can be expected of new certified nurse-midwives (CNMs) and certified midwives (CMs). The Core Competencies are standards for midwifery education, and the document is an important guide for midwifery practice and policy. As a part of the 2012 revision, the Basic Competency Section of the ACNM Division of Education reviewed a variety of national and international documents to ensure that the basic education of CNMs/CMs is consistent with the practice of midwives in the United States and internationally. Few substantive changes were made to the document, but several areas were adjusted and clarified. New graduates continue to be prepared by midwifery education programs to provide safe, evidence-based midwifery care to women across the lifespan, well newborns up to 28 days, and sexual partners of women diagnosed with sexually transmitted infections.

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INTRODUCTION

The American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Practice (hereafter referred to as Core Competencies) outline the knowledge, skills, and abilities expected of new certified nurse-midwives (CNMs) and certified midwives (CMs). The Core Competencies are updated approximately every 5 years by the Basic Competency Section of the ACNM Division of Education. This article describes the history and 2012 revision of the Core Competencies and highlights changes from the 2007 document.

The Core Competencies describe the essential knowledge and abilities required to practice as a safe entry-level practitioner, form the basis of curricula for all education programs accredited by the Accreditation Commission for Midwifery (ACME), and represent the baseline level of knowledge and skills required for entry-level midwifery practice. However, CNMs/CMs may add additional skills and procedures to their practice, as outlined in standard VIII of the Standards for the Practice of Midwifery.¹

The Core Competencies are designed to be congruent with other ACNM documents, including the Philosophy of the ACNM,² Standards for the Practice of Midwifery,¹ and Code of Ethics,³ without replicating their content. In addition, the Core Competencies are consistent with larger international standards for midwifery practice and health care. The ACNM Board of Directors retains final authority over the document to ensure that the college determines the basic education and practice standards for CNMs/CMs in the United States.

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HISTORY OF THE CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

The Core Competencies document provides a history of important changes in US midwifery, as practiced by CNMs/CMs. Initially developed in 1978 by midwifery educators to describe a common set of outcomes expected of nurse-midwifery graduates,^{4,5} the document has undergone 6 revisions.⁶⁻¹¹ Evidence of the development of the midwifery profession is reflected in the documents over time. The transition from simply describing concepts relevant to midwifery practice present in other disciplines to claiming and defining the Hallmarks of Midwifery that are so important to midwifery practice and education programs is a key example.⁴ Midwifery replaced nurse-midwifery in 1997 because the accreditation and certification processes were expanded to include direct-entry midwifery. The transition from naming “phases of the maternity cycle” in describing midwifery practice to identifying “components of midwifery care” is another example of professional growth.

The evolution of scope of practice is further demonstration of growth of the profession. Evident in the document revisions are multiple changes in the defined scope of midwifery practice. Key changes include the provision of care to women beyond the childbearing years, primary care competencies, and defining midwives as primary care providers.⁹ In addition, the inclusion of finance and practice management in professional aspects of the practice demonstrates the evolving competencies required for contemporary practice. Birth as a normal physiologic process has been highlighted recently by ACNM, the Midwives Alliance of North America, and the National Association of Certified Professional Midwives as increasingly important in efforts to improve the current US maternity care situation.¹² Long an important belief among midwives, the concept of normal physiologic birth was first



Quick Points

- ◆ The Core Competencies for Basic Midwifery Practice reflect the knowledge, skills, and abilities expected of graduates of midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME) and form the basis of midwifery curricula in the United States.
- ◆ The Core Competencies were first developed in 1978 and are revised approximately every 5 years by the Basic Competency Section of the American College of Nurse-Midwives (ACNM).
- ◆ The most recent revision of the Core Competencies was approved by the ACNM Board of Directors in December 2012.
- ◆ A variety of national and international documents were reviewed during the revision process to ensure that new graduates are prepared to provide safe, evidence-based midwifery care to women across the lifespan, well newborns up to 28 days, and sexual partners of women diagnosed with sexually transmitted infections.
- ◆ The 2012 Core Competencies were revised to be consistent with the basic skills outlined in the International Confederation of Midwives Essential Competencies for Basic Midwifery Practice and other key documents. While the terminology has been updated, there are no substantive changes to the knowledge, skills, and abilities expected of new graduates.

Table 1. Basic Competency Section Members During the 2012 Revision of ACNM Core Competencies for Basic Midwifery Practice

Julia C. Phillippi, CNM, PhD, FACNM, Chair
Jessica Brumley, CNM, PhD
Lily Dalke, CM, MS
Barbara Hackley, CNM, MS
Kate McHugh, CNM, MSN, FACNM
Kara Myers, CNM, MS
Sharon Ryan, CNM, DNP
Catherine Salam, CNM, MS, FACNM
Jennifer Woo, CNM, WHNP, MSN

Abbreviation: ACNM, American College of Nurse-Midwives.

introduced into the Core Competencies document in 1985, nearly 30 years ago.⁴

2012 REVISION OF THE CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

The Basic Competency Section is a permanent ACNM section; its primary purpose is to revise the Core Competencies every 5 years. Formerly known as the Basic Education Section, the section is part of the ACNM Division of Education. Members receive no financial compensation or gifts for their time, volunteering as a service to the profession. While the Basic Competency Section members revise the Core Competencies, the ACNM Board of Directors has authority for the approval of the final document.

Section Composition

During the active portion of the 2012 document revision, the Basic Competency Section was composed of 9 members (one CM and 8 CNMs), including the chair. Section members are listed in Table 1. Members were recruited to represent the diversity of CNMs/CMs with an eye toward representation from a wide range of geographic areas, practice types, and experiences with midwifery education. Members were from across the United States—including the East and West Coasts, the

Midwest, and the South—and were in full-time practice and full-time education, including a program director, or employed with a range of education, practice, and administrative responsibilities. A new graduate just beginning her first midwifery position also joined the committee. Section members were employed by midwifery programs from across the country, including on-site, distance, and hybrid programs, and also had been educated in them.

Influential Documents

Since the Core Competencies are used as a template for midwifery curricula for ACME-accredited programs, their content must remain consistent with larger national and international priorities for midwifery. The content of the Core Competencies is developed with information from a variety of sources. A list of important sources can be found in Table 2. Some of these sources served to inform the section members of the larger impact and history of the Core Competencies; others guided document changes. Avery's articles on the history of the Core Competencies were read by members to understand the original purpose of the document and its evolution through revision.^{4,5,13} The ACNM Standard Setting Documents, including the Philosophy of the ACNM,² Standards for the Practice of Midwifery,¹ and Code of Ethics,³ were reviewed by section members to ensure that the revision of the Core Competencies would remain congruent with these broader national documents.

The 2012 American Midwifery Certification Board (AMCB) Task Analysis was a high-impact document for the revision process.¹⁴ The Task Analysis is a comprehensive survey of recently certified CNMs and CMs that is conducted by AMCB approximately every 5 years; it provides a comprehensive list of the current skills used and conditions managed by midwives who practice in the United States and have graduated within the past 5 years. The AMCB Task Analysis is the basis of the AMCB certification examination and provides concrete data documenting the skills that graduates use in the workplace. Students need to be prepared by their education programs to enter the workplace as safe practitioners; all skills that are frequently used by new graduates were included in the

Table 2. Influential Documents for the 2012 Revision of the ACNM Core Competencies for Basic Midwifery Practice

All ACNM Standard Setting Documents ¹⁻³
Previous revisions of the ACNM Core Competencies ⁶⁻¹¹
<i>Journal of Midwifery & Women's Health</i> articles on the history of the ACNM Core Competencies ^{4,5}
AMCB 2012 Task Analysis ¹⁴
ICM Essential Competencies for Basic Midwifery Practice ¹⁵
Essential Genetic and Genomic Competencies for Nurses with Graduate Degrees ¹⁸
WHO Sexual and Reproductive Health Competencies ¹⁹
AACN Essentials for Master's Education in Nursing ²⁰

Abbreviations: AACN, American Association of Colleges of Nursing; ACNM, American College of Nurse-Midwives; AMCB, American Midwifery Certification Board; ICM, International Confederation of Midwives; WHO, World Health Organization.

Core Competencies. However, the Core Competencies are not limited to high-frequency skills in the Task Analysis. ACNM can decide to expand the scope of practice for CNMs/CMs by adding new competencies. Examples of previous expansions include the care of menopausal women and the primary care of women.⁹

Other documents were used to ensure consistency of the Core Competencies with broader national and international priorities. The International Confederation of Midwives (ICM) Essential Competencies for Midwives is an example of a similar document with a focus on midwifery practice around the globe.¹⁵ This document was developed through collaboration of representatives from midwifery organizations worldwide; it details the professional knowledge, skills, abilities, and behaviors required for safe midwifery practice. Like the Core Competencies, the ICM Essential Competencies present a list of core skills required for safe midwifery practice. However, unlike the Core Competencies that focus solely on the entry-level skills needed by newly certified midwives, the ICM Essential Competencies provide 2 sets of skills. These include basic skills expected of all midwives and additional skills that are within the scope of practice of some midwives, which may not reflect entry-level practice for all midwives. Examples of additional skills include the insertion of intrauterine devices, the repair of third-degree lacerations, and taking leadership roles in health care policy. Some skills that are denoted as additional may not be within the midwifery scope of practice in all countries or locales. The additional skills may require advanced training that may or may not be included in a midwifery curriculum.

The section members ensured that all basic skills in the ICM Essential Competencies were included in the Core Competencies. However, the Core Competencies have historically been concise, not providing detailed lists of curriculum content but instead allowing midwifery education program directors the latitude to develop their curricula to meet current practice needs. For instance, the Core Competencies state that students must be educated about all available contraceptive methods, but they do not stipulate each potential method. This approach allows educators to be nimble in preparing their graduates for practice because guidelines and methods

change quickly. Reflecting on the history of the Core Competencies, the section did not adopt the ICM Essential Competencies document as a whole but instead ensured that ICM basic skills were included in the broad categories within the Core Competencies. For example, the ICM Essential Competencies specifically identify deworming as a competency. The Core Competencies do not specifically mention deworming; this would be one of many possible deviations from normal that midwives should be prepared to treat while providing primary care.

The inclusion of both basic skills and additional skills in the ICM Essential Competencies resulted in some controversy because the provision of induced abortion is included as an additional skill. The *Journal of Midwifery & Women's Health* published 2 letters to the editor addressing induced abortion becoming an ACNM Core Competency because it was listed in the ICM Essential Competencies.^{16,17} Performance of induced abortion is not an ICM basic skill and is not an ACNM Core Competency.

Other influential sources helped inform the content of the Core Competencies, ensuring that components viewed as important by other major health-related organizations were included or considered. The Essential Genetic and Genomic Competencies for Nurses with Graduate Degrees¹⁸ were reviewed, and competencies related to genomics and appropriate for midwifery practice were added. The World Health Organization (WHO) Sexual and Reproductive Health Competencies in Primary Care were reviewed to ensure that CNMs/CMs would be qualified as sexual and reproductive health providers for women.¹⁹ In addition, the American Association of Colleges of Nursing (AACN) Essentials of Master's Education in Nursing, Informatics Essentials, was used to inform the addition of informatics competencies.²⁰ Other national and international sources were consulted as needed so that the Core Competencies were consistent with national trends. For instance, the report of the Interprofessional Education Expert Panel,²¹ endorsed by a wide range of education organizations, stated that the term *interprofessional* was preferable to *interdisciplinary* when describing collaboration.

Revision Process

The revision process began in 2009 when the Basic Competency Section and the ACNM Board of Directors worked in concert with AMCB to adjust the timing of both the Task Analysis and the Core Competencies revision. In 2006, the revision of the Core Competencies was begun on time, despite a delay with the release of the next Task Analysis. Thus, the 2007 Core Competencies were informed by the 2000 Task Analysis, while the AMCB certification examination from 2007 until 2012 was based on the 2007 Task Analysis. Although the 2000 and 2007 Task Analyses had very similar content, there was potential for a disconnect between program curricula and certification examination content with future revisions if the Core Competencies and the examination did not reference the same version of the Task Analysis. To correct this problem, the AMCB Board moved up the next Task Analysis and the ACNM Board of Directors delayed the Core Competencies revision by 18 months. This ensured that for the next 5 years

the AMCB certification examination would be based on and the Core Competencies would be informed by the same Task Analysis.

The bulk of the work of the Basic Competency Section began following the release of the 2012 Task Analysis.¹⁴ Prior to beginning the revision, section members reviewed all influential documents listed in Table 2 and met via telephone to orient to the process. To ensure that the revision included all possible important information, feedback on the Core Competencies was solicited from many sources. The chair met in person or via phone with the chair of the Directors of Midwifery Education (DOME), the president of AMCB, and the primary investigator for the Task Analysis. The section also solicited comments from the larger ACNM membership through an announcement distributed using various electronic sources, including ACNM Quick eNews,²² the ACNM Student Facebook page, and the DOME electronic mailing list.

Following solicitation of feedback, section members drafted revisions by area of clinical care, such as gynecologic, antenatal, and newborn, each reviewing one or 2 sections of the Core Competencies as a first reader. All changes required a citation within the key documents or a nationally recognized source. The section members reviewed the Core Competencies for consistency with the ICM Essential Competencies and all areas of practice, as described by the Task Analysis, and compatibility with the other national and international documents. Google Docs facilitated section members' access to documents. Following the initial revision, a second reader on the section reviewed each section of the Core Competencies and justified all revisions with a reference.

Following the 2 reviews, the full section met using distance technologies to review the proposed revisions. The hallmarks of midwifery, professional responsibilities, midwifery management process, and fundamentals were reviewed and adjusted by the full section. The clinical care sections were then reviewed again and adjusted if needed. The revised competencies were reviewed by all members several times prior to approval by the section as a whole.

The final draft document was then circulated to key stakeholders for input. Stakeholders included the following: ACNM president, ACNM executive director, ACNM senior education policy advisor, current and immediate past chairs of DOME, AMCB president, Midwifery Business Network president, chair of the ACNM Division of Education, *Journal of Midwifery & Women's Health* editor-in-chief, student member of the ACNM Board of Directors, and an author of 2 articles on the history of the Core Competencies. Only minor edits were suggested. Once their suggestions were incorporated, the Basic Competency Section members approved the final revision and submitted it to the ACNM Board of Directors for review. The revised document was approved without revision by the ACNM Board of Directors in December 2012.

THE 2012 CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

The Core Competencies are displayed in Appendix 1 and also can be obtained from the ACNM Web site. Several revisions were made to the Core Competencies, but the overall content has changed little from the 2007 Core Competencies. Changes

in wording or content from the 2007 competencies are italicized in Appendix 1. Word deletions that simply eliminate extraneous words and clauses are not italicized.

The wording of the hallmarks of midwifery was adjusted only slightly. Menarche was added to the list of physiologic developmental processes in hallmark A. The word *woman* was added to hallmark D because not all women seeking midwifery care wish to involve their family. The need for cultural competence in hallmark L was replaced with the integration of cultural humility because educators had difficulty ensuring that graduates were prepared for all possible cultures and instead wanted graduates to be prepared to understand the role of culture (both of the midwife and the woman) in the provision of care. The term *evidence-based* was added to the hallmark M about complementary and alternative therapies; and evaluation was eliminated from this hallmark because the evaluation of research was already in the section about professional responsibilities.

The professional responsibilities of CNMs/CMs (Appendix 1, Section II) were expanded to include technologies and information systems, commonly known as informatics, used in improving care.²³ The midwifery management process was adjusted slightly to better reflect current trends in practice. The management step evaluating the need for immediate intervention was reworded to use the term *health care team members* instead of *physician* because midwives work with a diversity of health care professionals. Referral was added as an option in addition to consultation and collaboration. The terminology surrounding the provision of therapeutics in the midwifery management process was increased, consistent with the current scope of practice of CNMs/CMs; this includes the independent prescription of pharmaceuticals.

Section IV on the fundamentals of midwifery care was expanded to include psychosocial, sexual, and behavioral development, consistent with the WHO Sexual and Reproductive Health Competencies.¹⁹ In addition, the term *genomics* was added in response to the growing value of this information in clinical practice and graduate-level education.¹⁸

The overall organization of sections involving provision of clinical care was revised to bring primary, preconception, gynecologic, antepartum, intrapartum, and postpregnancy sections under the heading of Components of Midwifery Care of Women (Appendix 1, Section V). This was done to reflect the flow of the woman's life and to avoid segregating primary care as distinct from the care of women during and after pregnancy. Primary care of women was expanded to include the care for chronic conditions, consistent with the AMCB Task Analysis.¹⁴ Preconception care was expanded to reflect the differentiation of modifiable and nonmodifiable risks to health^{18,19}; and fertility awareness, cycle charting, symptoms of pregnancy, and pregnancy spacing were added for consistency with international documents.^{15,19}

Gynecologic care was revised to expand the competency about human sexuality to include biologic sex, gender identity and role, sexual orientation, intimacy, and eroticism, congruent with the WHO Sexual and Reproductive Health Competencies.¹⁹ Counseling for gender concerns was also included for the same reason. Text in this section that discussed management and therapeutics was eliminated because it is now included in the midwifery management process. Text

concerning the provision of contraception was edited to include all available contraceptive methods.

The Core Competencies include the evaluation, treatment, and/or referral of sexual partners for sexually transmitted infections (STIs). This is not a change from the previous Core Competencies and reflects the Centers for Disease Control and Prevention's recommendation for clinicians to provide expedited partner therapy to the sexual partners of women with STIs.²⁴ This competency does not imply that new graduates are expected to provide comprehensive sexual health care to men who are not sexual partners of female clients. The provision of care solely to men would be outside of the CNM/CM scope of practice outlined by ACNM,²⁵ unless the midwife had additional training.¹

Midwifery care during the antepartum period was revised to include knowledge of the epidemiology of maternal and perinatal morbidity and mortality, consistent with international requirements for midwives and sexual health providers.¹⁵ Promotion of normal pregnancy was also included as a reflection of the current evidence and support for the physiologic management of the normal childbearing processes.¹² Two new competencies for the intrapartum period were added to clarify the role of the midwife in assisting mothers with pain and coping during the intrapartum period.

The area of competency focusing on postpartum care was expanded to include involution following a pregnancy of any gestation, to be consistent with the ICM Essential Competencies and to denote that new graduates should be expected to safely manage involution following a preterm birth or a spontaneous or induced abortion—referring for complications as indicated as part of the midwifery management process. Some additional competencies for postpregnancy care were also added to be consistent with the ICM Essential Competencies.¹⁵

The newborn section was expanded to be consistent with the ICM Essential Competencies, although the overall scope of midwifery care of the newborn as encompassing well care up to 28 days remained unchanged. The components of facilitation of adaptation to extrauterine life have been expanded to reflect the ICM Essential Competencies and current research. While midwives should be prepared to perform initial physical and behavioral assessment of term and preterm newborns, consistent with the ICM Essential Competencies, they are only expected to manage the ongoing care of well newborns up to 28 days of life.

CONCLUSION

The creation of the Core Competencies for Basic Midwifery Practice was visionary in its time. The establishment of competency-based standards helped to establish professional skills and have influenced other health-related competency documents. The Core Competencies for Basic Midwifery Practice continue to be a foundational ACNM document that not only describes the competencies for graduates of midwifery programs but also represents the ever-evolving scope of midwifery practice in the United States for educators, midwifery employers, and policy makers.

AUTHORS

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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Appendix 1: 2012 Core Competencies for Basic Midwifery Practice new text in italics

I. Hallmarks of Midwifery

The art and science of midwifery are characterized by the following hallmarks:

- A. Recognition of *menarche*, pregnancy, birth, and menopause as normal physiologic and developmental processes
- B. Advocacy of non-intervention in normal processes in the absence of complications
- C. Incorporation of scientific evidence into clinical practice
- D. Promotion of *woman* and family-centered care
- E. Empowerment of women as partners in health care
- F. Facilitation of healthy family and interpersonal relationships
- G. Promotion of continuity of care
- H. Health promotion, disease prevention, and health education
 - I. Promotion of a public health care perspective
 - J. Care to vulnerable populations
- K. Advocacy for informed choice, shared decision making, and the right to self-determination
- L. *Integration of cultural humility*
- M. Incorporation of *evidence-based* complementary and alternative therapies in education and practice
- N. Skillful communication, guidance, and counseling
- O. Therapeutic value of human presence
- P. Collaboration with other members of the interprofessional healthcare team

II. Components of Midwifery Care: Professional Responsibilities of CNMs and CMs

The professional responsibilities of CNMs and CMs include, but are not limited to, the following components:

- A. Promotion of the hallmarks of midwifery
- B. Knowledge of the history of midwifery
- C. Knowledge of the legal basis for practice
- D. Knowledge of national and international issues and trends in women's health and maternal/newborn care
- E. Support of legislation and policy initiatives that promote quality health care

- F. Knowledge of issues and trends in health care policy and systems
- G. *Knowledge of information systems and other technologies to improve the quality and safety of health care*
- H. Broad understanding of the bioethics related to the care of women, newborns, and families
 - I. Practice in accordance with the ACNM Philosophy, Standards, and Code of Ethics
 - J. Ability to evaluate, apply, interpret, and collaborate in research
 - K. Participation in self-evaluation, peer review, lifelong learning, and other activities that ensure and validate quality practice
 - L. Development of leadership skills
- M. Knowledge of licensure, clinical privileges, and credentialing
- N. Knowledge of practice management and finances
- O. Promotion of the profession of midwifery, including participation in the professional organization at the local and national level
- P. Support of the profession's growth through participation in midwifery education
- Q. Knowledge of the structure and function of ACNM

III. Components of Midwifery Care: Midwifery Management Process

The midwifery management process is used in all areas of clinical care and consists of the following steps:

- A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
- B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
- C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
- D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or *referral with other health care team members*, as dictated by the condition of the woman, fetus, or newborn.
- E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and *includes therapeutics as indicated*.

- F. Assume responsibility for the safe and efficient implementation of a plan of care *that includes the provision of treatments and interventions as indicated.*
- G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

IV. Components of Midwifery Care: Fundamentals

- A. Anatomy and physiology, including pathophysiology
- B. Normal growth and development
- C. *Psychosocial, sexual, and behavioral development*
- D. Basic epidemiology
- E. Nutrition
- F. Pharmacokinetics and pharmacotherapeutics
- G. Principles of individual and group health education
- H. Bioethics related to the care of women, newborns, and families
- I. Clinical genetics and *genomics*

V. Components of Midwifery Care of Women

Independently manages primary health screening, health promotion, and care of women from the perimenarcheal period *through the lifespan using the midwifery management process. While a woman's life is a continuum, midwifery care of women can be divided into primary, preconception, gynecologic, antepartum, intrapartum, and postpregnancy care.*

- A. Applies knowledge, skills, and abilities in primary care that include, but are not limited to, the following:
 - 1. Nationally defined goals and objectives for health promotion and disease prevention
 - 2. Parameters for assessment of physical, mental, and social health
 - 3. Nationally defined screening and immunization recommendations to promote health and to detect and prevent disease
 - 4. Management strategies and therapeutics to facilitate health and promote healthy behaviors
 - 5. Identification of normal and deviations from normal in the following areas:
 - (a) Cardiovascular and hematologic
 - (b) Dermatologic
 - (c) Endocrine
 - (d) Eye, ear, nose, and throat
 - (e) Gastrointestinal
 - (f) Mental health
 - (g) Musculoskeletal
 - (h) Neurologic
 - (i) Respiratory
 - (j) Renal
 - 6. Management strategies and therapeutics for the treatment of common health problems and deviations from *normal of women, including infections, self-limited conditions, and mild and/or stable presentations of chronic conditions; and utilizing consultation, collaboration, and/or referral to appropriate health care services as indicated.*

- B. Applies knowledge, skills, and abilities in the preconception period that include, but are not limited to, the following:
 - 1. Individual and family readiness for pregnancy, including physical, emotional, psychosocial, and sexual factors that include:
 - (a) *Non-modifiable* factors such as family and *genetic/genomic* risk
 - (b) *Modifiable* factors such as environmental and occupational factors, nutrition, medications, and maternal lifestyle
 - 2. Health and laboratory screening
 - 3. *Fertility awareness, cycle charting, signs and symptoms of pregnancy, and pregnancy spacing*

- C. Applies knowledge, skills, and abilities in gynecologic care that include, but are not limited to, the following:
 - 1. Human sexuality, *including biological sex, gender identities and roles, sexual orientation, eroticism, intimacy, and reproduction*
 - 2. Common screening tools and diagnostic tests
 - 3. Common gynecologic and urogynecologic problems
 - 4. *All available contraceptive methods*
 - 5. Sexually transmitted infections, including indicated partner evaluation, treatment, or referral
 - 6. Counseling for sexual behaviors that promote health and prevent disease
 - 7. Counseling, clinical interventions, and/or referral for unplanned or undesired pregnancies, sexual and *gender* concerns, and infertility
 - 8. Identification of deviations from normal and appropriate interventions, including management of complications and emergencies utilizing consultation, collaboration, and/or referral as indicated

- D. Applies knowledge, skills, and abilities in the perimenopausal and postmenopausal periods that include, but are not limited to, the following:
 - 1. Effects of menopause on physical, mental, and sexual health
 - 2. Identification of deviations from normal
 - 3. Counseling and education for health maintenance and promotion
 - 4. Initiation or referral for age /risk appropriate periodic health screening
 - 5. Management and therapeutics for alleviation of common discomforts

- E. Applies knowledge, skills, and abilities in the antepartum period that include, but are not limited to, the following:
 - 1. Epidemiology of maternal and perinatal morbidity and mortality
 - 2. Confirmation and dating of pregnancy
 - 3. *Promotion of normal pregnancy using management strategies and therapeutics as indicated*
 - 4. Common discomforts of pregnancy
 - 5. Influence of environmental, cultural and occupational factors, health habits, and maternal behaviors on pregnancy outcomes

6. Health risks, including but not limited to domestic violence, infections, and substance use/abuse
 7. Emotional, psychosocial, and sexual changes during pregnancy
 8. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation
 9. Deviations from normal and appropriate interventions, including management of complications and emergencies
 10. Placental physiology, embryology, fetal development, and indicators of fetal well-being
- F. Applies knowledge, skills, and abilities in the intrapartum period that include, but are not limited to, the following:
1. Confirmation and assessment of labor and its progress
 2. Maternal and fetal status
 3. Deviations from normal *and appropriate interventions*, including management of complications, abnormal intrapartum events, and emergencies
 4. Facilitation of physiologic labor progress
 5. Measures to support psychosocial needs during labor and *birth*
 6. *Labor pain and coping*
 7. Pharmacologic and non-pharmacologic strategies to facilitate maternal coping
 8. Techniques for
 - (a) Administration of local anesthesia
 - (b) Spontaneous vaginal *birth*
 - (c) Third-stage management
 - (d) Performance of episiotomy and repair of episiotomy and *1st and 2nd degree* lacerations
- G. Applies knowledge, skills, and abilities in the *period following pregnancy* that include, but are not limited to, the following:
1. *Physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth*
 2. Management strategies and therapeutics to facilitate a healthy puerperium
 3. *Discomforts of the puerperium*
 4. *Self-care*
 5. *Psychosocial coping and healing following pregnancy*
 6. *Readjustment of significant relationships and roles*
 7. *Facilitation of the initiation, establishment, and continuation of lactation when indicated*
 8. *Resumption of sexual activity, contraception, and pregnancy spacing*
 9. Deviations from normal and appropriate interventions, including management of complications and emergencies
- A. Applies knowledge, skills, and abilities to the newborn that include, but are not limited to, the following:
1. Effect of maternal and fetal *history and* risk factors on the newborn
 2. *Preparation and planning for birth based on ongoing assessment of maternal and fetal status*
 3. Methods to facilitate physiologic transition to extrauterine life that include, but are not limited to, the following:
 - a. *Establishment of respiration*
 - b. *Cardiac and hematologic stabilization, including cord clamping and cutting*
 - c. *Thermoregulation*
 - d. *Establishment of feeding and maintenance of normoglycemia*
 - e. *Bonding and attachment through prolonged contact with neonate*
 - f. *Identification of deviations from normal and their management*
 - g. *Emergency management, including resuscitation, stabilization, and consultation and referral as needed*
 4. Evaluation of the newborn:
 - a. Initial physical and behavioral assessment for *term and preterm infants*
 - b. Gestational age assessment
 - c. Ongoing assessment and management for term, well newborns during first 28 days
 - d. Identification of deviations from normal and consultation, and/or referral to appropriate health services as indicated
 5. *Develops a plan in conjunction with the woman and family for care of the newborn for the first 28 days of life, including nationally defined goals and objectives for health promotion and disease prevention:*
 - a. *Teaching regarding normal behaviors and development to promote attachment*
 - b. *Feeding and weight gain, including management of common breastfeeding problems*
 - c. *Normal daily care; interaction; and activity, including sleep practice and creating a safe environment*
 - d. *Provision of preventative care that includes, but is not limited to:*
 - (1) *Therapeutics, including eye ointment, vitamin K, and others as appropriate by local or national guidelines*
 - (2) *Testing and screening according to local and national guidelines*
 - (3) *Need for ongoing preventative health care with pediatric care providers*
 - e. *Safe integration of the newborn into the family and cultural unit*
 - f. *Appropriate interventions and referrals for abnormal conditions:*
 - (1) *Minor and severe congenital malformations*
 - (2) *Poor transition to extrauterine life*
 - (3) *Symptoms of infection*

VI. Components of Midwifery Care of the Newborn

Independently manages the care of the newborn immediately after birth and continues to provide care to well newborns up to 28 days of life by utilizing the midwifery management process and consultation, collaboration, and/or referral to appropriate health care services as indicated

- (4) *Infants born to mothers with infections*
- (5) *Postpartum depression and its effect on the newborn*
- (6) *End-of-life care for stillbirth and conditions incompatible with life*

- g. *Health education specific to the infant and woman's needs:*
 - (1) *Care of multiple children, including siblings and multiple births*
 - (2) *Available community resources*