

Midwifery in Kansas

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Introduction

“A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title “midwife;” and who demonstrates competency in the practice of midwifery.

Scope of Practice

The term “midwife” means “with woman”¹ and reflects the midwife’s role as the responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may

extend to women’s health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.”²

Introduction

Birth is a natural part of life. For the majority of women, it is not associated with a medical condition or disease.³⁻¹¹ Thus, for a well population, birth needs to take place in a context that humanizes care, is safe and comfortable, minimizes interruptions, and promotes the bonding, touch, and grooming that occur naturally between a mother and her infant. Such a context facilitates breastfeeding and has the potential to empower mothers and increase their confidence in their new role. For many women, the optimal context for birth is the home. A planned home birth with skilled midwifery care for women experiencing low-risk pregnancies focuses on vigilant assessment, shared decision-making and timely referrals, when needed.

Low-risk pregnancies are those that are considered to be problem-free, based on a detailed assessment of a woman’s past medical, gynecological, and obstetric history, and planned home birth by women with low-risk pregnancies is making a comeback in the United States.^{8,11-15} In two recent reports, MacDorman and colleagues^{14,15} noted that the slow but steady decline seen in home births in the United States from 1989 to 2009 has been reversed. Although the majority of women continue to receive care from obstetrician-gynecologists

or family practice physicians,¹⁶ data from 2004 to 2009 document a substantial 29% increase in home births. In 2009, of 4.2 million U.S. births, 29,650 occurred at home. White women led the increase, with 1 in 90 having babies at home, compared to 1 in 357 Black women and 1 in 500 Hispanic women. Twenty-seven states had statistically significant increases in the percentage of home births from 2004 to 2008; only four states had declines. In 2009, 62% of home births were attended by midwives (as opposed to other practitioners); the vast majority with favorable outcomes.

This developing body of evidence shows that women with low-risk pregnancies who had prepared and planned for a homebirth or given birth at a freestanding birth center, have as good or better birth outcomes than women who give birth at a hospital. Despite such data and support by maternal and public health organizations, including the American College of Nurse-Midwives (ACNM) and the American Public Health Association (APHA), the issue of planned home births remains controversial. Medical associations such as the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatricians (AAP) remain skeptical about the value and safety of planned home births and care by skilled birth attendants, including midwives.⁵ Wax and colleagues¹⁷ recently published a meta-analysis of outcomes from planned home births compared to planned hospital births. These investigators concluded that the neonatal mortality rate was significantly greater in planned home births and they attributed this to less medical intervention. While an influential study, the investigators have been criticized for possible bias in their selection of studies for the analysis and for not differentiating between planned and unplanned home births, as planning is a critical predictive factor of a successful outcome.^{18,19}

Other important organizations such as the American Academy of Family Physicians (AAFP) have yet to state an opinion on planned home births. The concerns expressed by physicians regarding the paramount safety of mother and baby and the legal constraints placed on them that hinder collaborative and supportive care certainly are important and are shared by those advocating safe home birth. As Declercq²⁰ wrote, "*The fact remains that the debate over home birth will not be resolved by any study, no matter how well designed. At its core, the home birth debate is ideological, centering on two diametrically opposed perspectives on birth held by groups that generally do not communicate with each other and unfortunately often hold each other in disdain. Perhaps the question we should be asking is not what is right or wrong about any study on this topic. Rather, why are increasing numbers of US women who are experienced in birth (80% with parity 2 or higher) choosing to reject hospital-centered systems of maternity care that so many well-meaning clinicians want to make better?*"^(p. 6)

The purpose of this paper is to describe briefly the status of midwifery in Kansas, clarify the credentials of midwives, and highlight their positive role in the care of women with low-risk pregnancies who desire to give birth at home. In so doing, this paper may contribute to the discussions that need to continue between home- and hospital-based birth professionals, legislators, and insurers. The outcome of these discussions must be to establish a system that advances effective communication in the facilitation of spontaneous, unmedicated vaginal births for women with low-risk pregnancies in as natural a context as possible.

The Ebb and Flow of Midwifery

Throughout history, the process of

having a child, including pregnancy, labor, and birth, has been a family experience. Until the beginning of the last century, almost all births were attended by midwives and took place at home.^{1,14} Frequently the entire, extended family was involved. Doctors were called only when there were complications which necessitated surgery.²¹

With medical advances, greater knowledge about hygiene, and standardized licensure and documented competencies for physicians, mothers in the United States were encouraged to give birth at a hospital.^{5,22} New practices and routines included pain management and physician-assisted labor and delivery. Formula feeding was promoted to counteract possible disease and infection. However, instead of being recognized as a naturally occurring process, birth was viewed from a medical perspective, given the potential for illness or dysfunction in the mother and/or newborn that would require care from physicians. As the medical specialty of obstetrics became established, by the 1940s half of all deliveries occurred in hospitals and by 1969, the percentage of hospital births had increased to 99%.^{9,14,21} As hospital births increased, family involvement declined. Family members were not present at the delivery and neonates were kept separate from their mothers in newborn nurseries.

With the post-World War II baby boom and increased medical efficiency, the time mothers and their well newborns spent at the hospital gradually decreased from two weeks to a few days.^{9,11,22,23} From the 1950s to the 1970s, important factors encouraged many women to consider different options in the birthing process. These influential factors centered on the growing women's movement, the related increased interest in natural childbirth, and substantial research findings showing the negative effects of mother-infant separation following birth. Consequently, in the 1980s and 1990s,

hospital-based labor and delivery facilities began to focus on providing more family-centered maternity care and to promote the relationships between childbearing women, their families, and care providers.

Women's increased understanding of the importance of giving birth in as natural a context as possible also was associated with a return to planned home births and midwifery services.²¹ However, increasingly educated women then, and today, needed reassurance that the midwifery services they required were being provided by competent and experienced persons.

Midwives in Kansas: Qualifications, Licensure, and Certification

In Kansas, as in many other states, the profession of midwifery is comprised of both nurse-midwives and direct-entry midwives. In European countries, such as Germany and the United Kingdom, and in Asian-Pacific countries, such as Australia, nurse-midwives and direct-entry midwives have to meet the same qualifications.²⁴ In contrast, the regulatory system in the United States enables individual states to have a key role in determining scope of practice, licensure, and payment guidelines for the two types of midwifery practice. Thus, in the U.S., these practice guidelines can, and do, vary across the country.²¹ Of interest, Kansas remains one of many states that do not yet have a Maternal Mortality Review Board.²⁵

Nurse-midwives in Kansas. Nurse-midwives are registered nurses who have graduated from an accredited midwifery education program at an institution of higher learning and passed a national certification exam given by the American Midwifery Certification Board (AMCB). These certified nurse-midwives (CNMs) have hospital privileges, are able to prescribe medications, be reimbursed through medical insurance, and work in private practices with

obstetricians. In case of emergencies, they also have physician support. They are required to complete regular Continuing Education Units (CEUs) to maintain their certification status.

The programs from which these CNMs graduate are accredited by the American College of Nurse-Midwives (ACNM). The ACNM was established in 1969 and functions primarily to develop and promote the standards and practice of nurse-midwives. It has a Division of Accreditation, recognized by the US Department of Education, which accredits the certificate, baccalaureate, and graduate degree programs in nurse-midwifery. The organization strives to work collaboratively with the American Nurses Association (ANA) and ACOG concerning legislative issues that impact midwifery practice. Certified nurse-midwives are recognized and licensed to practice in all 50 states, the District of Columbia, and US territories. In Kansas, the practice of CNMs is regulated by the State Board of Nursing.^{21,26}

At the present time, there are 43 accredited education programs in the United States that offer post-baccalaureate certificate and Master's degree programs in nurse-midwifery and midwifery, including several programs with long distance (on-line) learning education options. In Kansas, there is one accredited graduate program in nurse-midwifery at the University of Kansas in Kansas City.²⁶

There are 63 licensed CNMs in Kansas. These CNMs practice in a variety of settings including hospitals, freestanding birth centers, homes, and military bases. They are able to prescribe medications, having obtained prescription writing privileges in 1989. There are 28 nurse-midwifery practices located throughout the state. In 2007 (the most recent year for available information), CNMs attended 1,902 births, approximately 4.5% of all births in Kansas

for that year.³

Non-nurse midwives in Kansas. Midwives who are not nurses frequently are referred to as "direct-entry midwives (DEMs)," or "lay," or "traditional" midwives. They are not required to have a college degree or prior nursing experience to start a career in midwifery. Some of these midwives gain practical experience through completing general education and apprenticeship-training requirements, and pass written skills tests prior to receiving a certificate credential from the Midwives Alliance of North America (MANA) and its credentialing unit, the North American Registry of Midwives (NARM). The credential is "Certified Professional Midwife" (CPM). CPMs have legal status in Kansas but, as yet, there is (a) no designated regulatory agency, (b) no state law governing their relationship with physicians, nor (c) any requirement for their continuing education.^{21,26}

Other non-nurse midwives enter an accredited midwifery education program directly without any previous nursing experience. Following their graduation from this accredited program and a passing score on the national certification exam, they receive the same certification as nurse-midwives. This certification reflects the fact that they have demonstrated the same competencies for midwifery practice that are expected of nurse-midwives. They are recognized as "certified midwives" (CMs) but not "certified nurse-midwives" (CNMs). They are licensed to practice in all 50 states, the District of Columbia, and US territories. In Kansas, their practice is regulated by the State Board of Nursing.^{21,26}

These varying credentials and certification processes continue to exist for midwives in Kansas, and in other states, as the ACNM and MANA organizations work towards further agreement on the requirements for midwifery education and

practice.²¹

A caveat in Kansas. In Kansas, by law, women have the right to give birth anywhere they choose and to have any attendant they wish. Birth is recognized as a natural, not medical, event. Therefore, a birthing attendant is not required to hold a medical license.^{27,28} While this law empowers women with low-risk pregnancies who wish to plan a home birth, these women need to make sure that they understand the qualifications, or lack of qualifications, of persons who promote themselves as experienced midwives. Davis-Floyd and Johnson²⁹ present the case of “renegade” midwives (p. 456) who view the credentialing process as antithetical to their independence and autonomy and yet who consider themselves well-qualified to practice as a result of their documented skill and experience. In examining the nuances of the arguments regarding credentialing and license to practice, Davis-Floyd and Johnson write that “*all midwives are, to some extent, renegades. Yet there is a spectrum of renegadeness, and those at the further end of it threaten the cultural acceptance of professional midwifery.... Every midwife must keep in mind that protecting the profession is ultimately in the best interests of mothers and babies, because it is the existence of midwifery that keeps the options of safe, non-interventive, and nurturant birth open to all who choose midwifery care.*”²⁹

Reimbursement for Midwifery Practice in Kansas

In 2010, the US Congress noted that “*Midwives serve as faculty at many of the Nation’s most prominent academic health centers; however, the time they spend training medical students, residents, and midwifery students is not reimbursed as it is for physicians. As a result, medical students, residents, and midwifery students often fail to benefit from the practice experience and*

physiologic birth experience of midwives.”¹⁶ (p. 10) In its subsequent 112th session, Congress introduced H.R. 2141: *Maximizing Optimal Maternity Services for the 21st Century*,³⁰ recognized as the “MOMS Act,” accompanied by H.R. 1054: *Access to Certified Professional Midwives Act*,³¹ in the House of Representatives. Both Acts support a systematic plan to promote evidence-based maternity practice and models of care, including appropriate reimbursement of services from certified midwives for planned home births. The establishment of interdisciplinary Centers for Excellence on Optimal Maternity Outcomes is planned and such Centers will include midwifery services. These Centers are essential for the coordinated, rather than fragmented, healthcare services needed by pregnant women, and midwifery services, when appropriate, need to be an integral aspect of this coordinated care.^{9,32}

Currently in Kansas, third-party reimbursement for CNMs is not mandatory. If CNMs receive Medicaid reimbursement, they receive it at 75% of physician rates.³³ This inadequate rate of reimbursement will continue as long as state regulators view midwifery practice as a service that is specifically delegated by a physician.²¹ Thus, a collaborative and supportive relationship between physicians and certified midwives is essential for the effective practice of midwifery and optimal care of women and infants. Physicians who work with CNMs are sued less often than physicians who do not work with CNMs and state attorneys general can play a key role in ensuring that restraint-of-trade practice does not become law.²¹

For Certified Professional Midwives in Kansas, their lack of regulation, or licensure, limits where they may practice, thus, third-party reimbursement. Most CPMs focus their service on home births, for which they receive direct payment.^{17,33,34}

Conclusions

Birth is a natural part of life. When there are no medical complications, it needs to take place in as natural a context as possible to promote the bonding of mother and baby. Medical staff at hospital-based birthing centers strives to accomplish this but increasing numbers of women with low-risk pregnancies are choosing to plan for a birth at home. Although controversial, such planned home births frequently are attended by midwives, working in consultation with physicians.

Certified nurse-midwives, certified midwives, and certified professional midwives are able to practice in Kansas. CNMs and CPMs are regulated by the Kansas Board of Nursing. The practice of CPMs is not regulated. All three types of midwives can assist at a planned home birth. Data show that appropriate use of the midwifery model for planned home births for women with low-risk pregnancies ranks well in terms of reduced labor interventions (although the duration of labor may be longer), increased maternal satisfaction, maternal and infant safety, and cost effectiveness for antenatal and intrapartum periods.^{6,7,11,15} Conversely, results of a recent meta-analysis suggest a higher neonatal mortality rate with births at home.¹⁷

The ACNM envisions that, by 2020, certified midwives will attend 20% of births in the U.S.²⁶ The intent is that these midwives will be able to work collaboratively with physicians to shape women's healthcare systems, increase the diversity of effective healthcare providers, and ensure optimal outcomes for women and infants in both urban and rural areas.^{4,9,29,35,36}

There is much work to be done to accomplish this vision. The national organizations that credential and certify midwives need to develop agreed-upon standards and such standards need to be adopted in Kansas. Well-designed studies with carefully controlled variables need to continue to support or revise midwifery practice for planned home births by women with low-risk pregnancies. When specific outcome measures document the effectiveness of midwifery practice, these practices need to be promoted and followed. Women with low-risk pregnancies who desire to experience a planned home birth need to be empowered to do so and these women need to be supported by a team of healthcare providers, including a qualified and skilled midwife, that is focused on effective communication and evidence-based practice.

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