North American
Registry of Midwives news

Providing certification standards for Certified Professional Midwives

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Midwives Model of Care SUPPORTER

Inside This Issue

Interview with Kristie White: The 1000th CPM!

by Robbie Davis-Floyd

Kristie, why did you decide to become a midwife?

Well, I have always been very passionate about women's issues, especially surrounding women and their children. It always seemed so natural to have children, breastfeed them, and love them. I decided to become a midwife after the birth of my third child. I had had hospital births with my first two children. The second birth was very traumatic for me because I was treated very badly by hospital staff. When I became pregnant again, I was completely devastated at the idea of having another hospital birth so I began looking for options. I found out about midwives and began prenatal care with a wonderful midwife in California. I had a beautiful home birth.

During that pregnancy I had to really fight to get insurance coverage for the birth. I even went to an administrative hearing over the matter. I realized how unfair it is for women that we cannot choose out-of-hospital birth without paying out-of-pocket. After the delivery, I knew this was what I wanted to do and a year later I moved to Miami to go to midwifery school.

What educational routes did you choose into midwifery, and why?

I had looked into nurse-midwifery as an option because I wanted to start my Master's degree and I also knew that employment options would be more readily available. I chose to become a Licensed Midwife instead because the concept behind the program was down-to-earth and back-to-basics. That's really how I am on the inside and I appreciated that philosophy of midwifery care.

After many conversations with Justine Clegg, director of the Miami-Dade program, I decided to make the move to Florida. Upon arrival I was embraced by many wonderful and experienced licensed midwives—Leticia Juan, Corina Fitch, Deborah Stein, Sharon Hamilton, Janis Heller, and Joni McCann, as well as Diann Gregory, CNM.

What is important to you about becoming a CPM? What do you see as the significance of the CPM for you and in a larger sense?

I became a CPM with the hope that one day it would be our nationwide certification, equating to state licensure to practice midwifery as for CNMs today. I think midwives are under-utilized in this country. The medicalization of birth has

CPM News

CPM News is a newsletter of the North American Registry of Midwives (NARM) published twice a year, Winter and Summer. We welcome submissions of questions, answers, news tips, tidbits, birth art, photographs, letters to the editor, etc.

Deadlines for submissions are December 1 and June 1. Send all newsletter material to: Joanne Gottschall, 200 N. Jasper Avenue, Margate, NJ 08402 or *cpmnews@narm.org*

The views and opinions expressed by individual writers do not necessarily represent the views and opinions of NARM.

Contact Information

NARM General Information
(or to order How to Become a CPM)
888-842-4784
Fax: 404-521-4052

Applications & Recertification:
NARM Applications Department:
P.O. Box 420
Summertown, TN 38483

NARM Board
Debbie Pulley, CPM
5257 Rosestone Drive
Lilburn, GA 30047
888-842-4784
info@narm.org

Test Department information:
Ida Darragh, CPM
PO Box 7703
Little Rock, AR 72217-7703
888-353-7089
testing@narm.org

CPM News Editor:
Abby J. Kinne, CPM
58 South Center Street
West Jefferson, OH 43162
614-879-9835
editor@narm.org

served our patriarchal nation well as it keeps women unfamiliar with their bodies and their strength. By oppressing midwives, the country oppresses those who can and always have acted as agents of empowerment to women. Nationwide acceptance of CPM licensing along with federal laws that guarantee provider status to licensed CPMs would give midwives the muscle we need to start making changes and getting the message out that there are options when it comes to pregnancy and childbirth.

Now that you are a CPM, how and where do you plan to practice?

For now, I plan to stay in Miami. I am at the beginning stages of my own practice. I also will soon begin working on my PhD in International Relations. I am also very interested in promoting midwifery and would like to work on increasing and protecting our rights to practice in the United States.

Tribute to Carrie Abbott

On Sunday February 20, Carrie Abbott passed away from cancer. Carrie served for many years and in various capacities in MANA and NARM, and as a midwife in Utah. She dedicated her life to her children and her momma's, and had friends all over the country. Carrie will be sorely missed by the midwifery community, however she spoke often of how she missed her husband (who passed a way a few years ago), and how she couldn't wait to be with him again.

If you would like to send a note, her daughter Randa's address is 1160 Sego Lilly Dr. Sandy, UT 84094.

CPM News Alerts

NARM now offers you the option of receiving the newsletter via the internet to save financial and environmental resources. If you would like to try this out, go to www.narm.org/cpmnews.html and open the pdf file. You can print it or save it.

If you would like to receive an email notifying you that a new issue of the CPM News is now available online in lieu of a paper copy, send your name, mailing address and email address to cpmnews@narm.org.

Maggie Bennett Sage Femme

Heeding Women's Call: An Interview With Maggie Bennett, CPM

by Robbie Davis-Floyd

When, how, where, and why did you become a midwife?

Like many of my contemporaries, I became a midwife through my experiences as a pregnant woman. My husband and I planned a homebirth with novice birth attendants. We belonged to an organization called Birthcenter, which met to share experiences and give advice to folks who were planning to birth at home without professional help. The first time I attended a Birthcenter meeting I had a cosmic experience. My recollection is of incredibly beautiful women in flowing dresses, backlit by the sunset pervading the room. I knew I would do anything to be with these and other women. I was impassioned to be with them in birth. I became a midwife because of this pivotal experience in my life. These women, whose names I no longer know, but whose image is indelible in my memory, were my calling to midwifery.

I stepped onto the birthwork path in 1975. During the next four years, I worked with a number of women and men of the Birthcenter as we recreated safe and sensible ways to manage to birth at home. We created a study path for ourselves and later trained other women. We did not call ourselves midwives for a few years, nor did we charge money at first. We were part of the do-it-yourself, power-to-the-people movement and were pretty anti-professional anything. The basis of our community effort was primarily education. For many years parents who came to our classes and ultimately invited us to their births learned really basic midwifery skills such as how to deliver a breech baby, how to resuscitate a baby, and how to stop a hemorrhage. We always emphasized that homebirth was do-able and that our history was grounded in parents being able to birth on their own.

It was only after years of going to births that I taught a class in which three couples planned to birth alone. I was very concerned for them all. It was then that I realized that I had crossed some invisible line and had become a professional midwife. I knew that my presence at birth made success and harmony more likely. I realized that great parent education and sense of responsibility needed to be matched by the presence of a wise and experienced midwife.

Did you support legalization and licensure for midwives in California? If so, why?

At first I did not, because I realized that licensure meant government control. However, I am a fairly smart cookie and realized I would be getting left behind. I saw that the train was pulling out of the station and going faster and faster down the track. So, I jumped on board at the last minute and passed the California Certification. I was the Chairwoman of the California Association of Midwives during the development of the Certification Process and years leading up to the passage of our licensing legislation in 1993. I have great respect for midwives who refuse to get licensed for political reasons. But I loved achieving my Birthcenter Certificate, I felt recognized by my peers when I got my California Certification, and I have grown to love my license to practice midwifery in this state. Being able to participate in the activism that led to the writing and passage of our law was a great gift in my life. The truth is, a relatively small group of women wrote a certification process, created a model of legislation that was adopted by a senator, rallied a consumer group, and managed to negotiate with the government of a really big, conservative state and get a law passed that has made it better for women and families in our state. It is corny, I know, but I learned from some amazing women that participation in our form of government can sometimes work!

What forms has your midwifery activism taken, and why did you become an activist instead of just focusing on practice?

At a certain time, we needed to have a person who didn't offend anyone too much and who could get people to see a common vision and pull our organization together. I was the one. Just as I was called to be a midwife in my community, I was called by my midwifery community to play a certain role. There are brilliant women who organized CAM and designed the original certification model. Word-mistresses wrote our law and communication pros negotiated with the medical board and the legislature. The job I got

was to be present with all of them representing the vision we all shared.

You have been observed doing art at MANA meetings. Also, many of us own copies of your work. What does art mean to you?

I was born an artist. It is my gift. I have a Degree in Fine Arts from the University of Illinois and did postgraduate work in printmaking at Long Beach Sate. I taught art for nearly fifteen years and had overlapping careers for about seven years before I gave up teaching for a total midwifery practice in 1987.

I am sorry to say I was such a fanatic about midwifery that I put my art work on hold for many years, only making an occasional painting when something inside of me erupted and couldn't be denied. I had a turning-point conversation with an artist friend who also makes quilts. She mentioned that she had made 300 quilts of different sizes at a time when I had been to about 300 births. I realized that if I had painted as many paintings as I had been to births, I would be a pretty good artist. So I decided it was time to tie the threads of my life together—that my midwifery should inform my art and my art should reflect what I believe about women and birth. So, I am on a mission to create at least 300 paintings. I want to be a really good artist by the time I am done and a really good midwife also. I love that lots of people actually collect my work—that is very inspirational. I rarely sell the originals, because I love the idea of multiple images being displayed all around the country. (My printmaking background!)

What draws you on year after year?

In the beginning, I just wanted to find out what made birth work, to understand the physiology behind the miracle. Then I wanted to understand what went wrong in my own birth experience. My first birth, in a hospital, was a beautiful, orgasmic experience, in spite of the fact that I was alone, surrounded by cold personnel and strapped down on a delivery table. My second birth at home, with a partner who loved me, friends who supported me and a serious vision should have been amazing. Instead, I had a planned cesarean because my doctor said my baby was too big to be born. I was made vulnerable by motherhood and disempowered by his fear of my having a homebirth. I spent years understanding cesarean birth in all its political and private permutations. My first goal as a fledgling midwife was to be sure that no woman in my care would ever have an unnecessary c-section. I love it still when I know I helped a woman beat the knife. I love turning babies, catching twins, or helping women have VBACS. There has always been a new thing to learn, a new skill to acquire and a new fear to be faced. These challenges keep me interested. Mostly though, it is the women themselves. I worship women still. I love their growing bodies, their growing sense of self, and the privilege of being present with them as they find their way through the unique challenge that labor and birth present to each mother.

Catch the vision of...The Future of Birth

- **Michel Odent, MD, OB, author of "Birth Reborn" & "Water Babies"**
- **Ina May Gaskin, CPM, Author of "Guide to Childbirth"**
- **Heidi Reinhart, MD, OB and Rudi Fedrizzi, MD, OB former birth center physicians**
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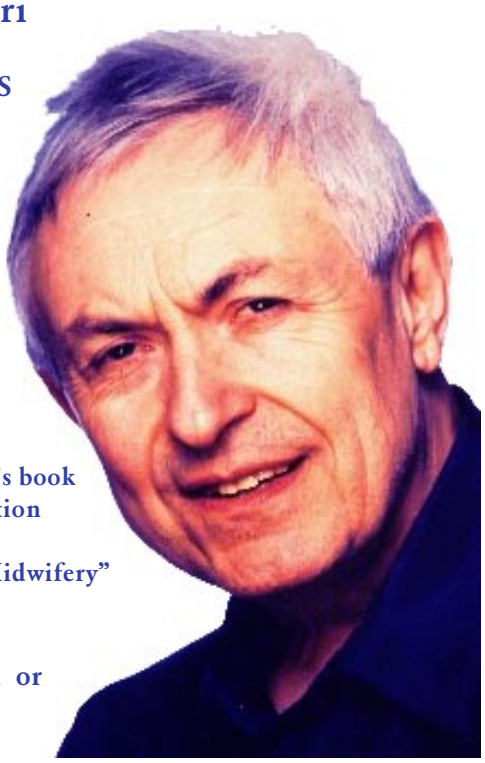

Results of National Study of Vaginal Birth After Cesarean in Birth Centers

Ellice Lieberman, MD, DrPH[1], Eunice K. Ernst, CNM, MPH[2,3], Judith P. Rooks, CNM, MPH[4], Susan Stapleton, CNM, MS[5] and Bruce Flamm, MD[6]

From the [1]Department of Obstetrics and Gynecology, Brigham and Women's Hospital, Boston, Massachusetts; [2]National Association of Childbearing Centers, Perkiomenville, Pennsylvania; [3]Frontier School of Midwifery and Family Nursing, Hyden, Kentucky; [4]University of South Florida College of Public Health, Tampa, Florida; [5]Reading Birth and Women's Center, Reading, Pennsylvania; and [6]Department of Obstetrics and Gynecology, University of California, Irvine, California.

Address reprint requests to: Ellice Lieberman, MD, DrPH, Department of Obstetrics and Gynecology, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115; e-mail: elieberman@partners.org

OBJECTIVE: Some women wish to avoid a repeat cesarean delivery and believe that a midwife-supported vaginal birth after cesarean (VBAC) in a non-hospital setting represents their best chance to do so; there is a small, persistent demand for out-of-hospital VBACs. We conducted a study to obtain the data necessary to formulate an evidence-based policy on this practice.

METHODS.: We prospectively collected data on pregnancy outcomes of 1,913 women intending to attempt VBACs in 41 participating birth centers between 1990 and 2000.

RESULTS: A total of 1,453 of the 1,913 women presented to the birth center in labor. Twenty-four percent of them were transferred to hospitals during labor; 87% of these had vaginal births. There were 6 uterine ruptures (0.4%), 1 hysterectomy (0.1%), 15 infants with 5-minute Apgar scores less than 7 (1.0%), and 7 fetal/neonatal deaths (0.5%). Most fetal deaths (5/7) occurred in women who did not have uterine ruptures. Half of uterine ruptures and 57% of perinatal deaths involved the 10% of women with more than 1 previous cesarean delivery or who had reached a gestational age of 42 weeks. Rates of uterine rupture and fetal/neonatal death were 0.2% each in women with neither of these risks.

CONCLUSION: Despite a high rate of vaginal births and few uterine ruptures among women attempting VBACs in birth centers, a cesarean-scarred uterus was associated with increases in complications that require hospital management. Therefore, birth centers should refer women who have undergone previous cesarean deliveries to hospitals for delivery. Hospitals should increase access to in-hospital care provided by midwife/obstetrician teams during VBACs.

LEVEL OF EVIDENCE: III

For more information go to www.greenjournal.org: VOL. 104, NO. 5, Part 1, November 2004

Please monitor the Green Journal website for editorial responses from Susan Hodges (CfM), and Ken Johnson and Betty-Anne Daviss.

A Critique of the NACC VBAC Study

By Susan Hodges

The recently published "VBAC in Birth Centers," (Lieberman et al, Ob & Gyn. Vol. 104, No. 5, Nov. 2004) has provided some good information about the safety of VBACs. In my opinion, however, the data did not at all support the authors' conclusion that "out-of-hospital birth is not safe for womenwith prior cesarean deliveries" or the recommendation that no VBACs take place outside the hospital.

The results of the study actually showed that birth centers work really well for VBACs. The success rate was high, transports were made appropriately, and the data strongly suggested that "large babies" do not appear to pose added risk for uterine rupture. The data did strongly suggest that VBACs after more than one cesarean, and after 42 weeks, were associated with increased risks to the baby compared with VBACs after only one cesarean section or less than 42 weeks gestation. This is important new information that should be made available to both mothers and caregivers. The Conclusion section also pointed out that first cesarean sections should be avoided, although this was not mentioned in the abstract.

The paper should have just reported the findings of the study, noted that further research is needed for verification and to determine the causes behind the observed results, and suggested that women be advised of the findings as part of informed consent.

Unfortunately, the paper did more than just report the findings. Of greatest concern is the strong statement that "out-of-hospital birth is not a safe choice for women with prior cesarean deliveries," and the strongly stated recommendation that no VBACs should take place in birth centers. I have read and reread the paper, and I just do not see how the data presented support, justify or make a case for this conclusion and recommendation.

The comparison of birth center (BC) VBACs and hospital VBACs in the studies cited did not demonstrate that hospitals overall are safer for all women with a prior cesarean or even for their babies. The primary basis for the conclusion that BC VBACs are "not safe" was the comparison of BC VBACs with several selected hospital VBAC studies that were somewhat similar to birth centers in their VBAC management practices. Data were not provided addressing whether or not the

differences in perinatal mortality were statistically significant. What was found was a possible increased risk only for perinatal death for VBACs in birth centers compared ONLY to hospitals that offer VBAC, and, in the studies cited, have one or more of the following: extensive midwifery program,VBAC policy of no induction, no augmentation and/or no restrictions on gestational age. We know that such policies are rare in hospitals today, and that many hospitals do not "allow" VBACs at all in which case all prior cesarean section mothers are sectioned. It would seem to me that before any one can declare that no VBACs are "safe" in birth centers, one must compare VBAC outcomes in birth centers with outcomes for women with prior cesarean sections in hospitals in general including those that induce, augment, restrict by gestational age, don't have midwives, or don't allow VBACs at all, since these are the conditions women with prior cesareans will find as the alternative to a birth center.

The primary criterion for "safe" in this study appears to be focused only on the issue of perinatal mortality. However, "safety" involves more than this one outcome and more than just the outcome for the baby. The paper did point out that the VBAC success rate is considerably higher for BCs than for hospitals. The paper did not address the short- and long-term risks of adverse outcomes for mothers and babies resulting from additional cesarean sections that would occur in hospitals with their lower VBAC success rate (or no VBACs at all). The increased risks of death, infection, injury, etc. for both mother and baby, in this birth and in future pregnancies, must be included in any consideration of overall "safety." So, the conclusion that VBACs are not safe in birth centers must at the very least be qualified as possibly "less safe" for the baby, while lack of "safety" for the mother was not demonstrated.

Based on this assertion that "out-of-hospital birth is not a safe choice for women with prior cesarean deliveries," the paper "advises" that no VBACs should take place in birth centers. For this advice to be valid two additional assertions must be true, assertions that are very significant but not stated. One assertion is the conclusion: For babies of mothers with prior cesarean sections, any hospital in the country is safer than any birth center. The data reported in the study clearly do not support this statement, since the data from only a few selected hospitals that offered and supported VBACs was used. The second assertion is the value judgement: ANY risk to the fetus or baby is always more important than any risk to the mother. This is neither acknowledged as a value judgement nor supported in any way by the data presented in the paper, nor is it legally valid. Furthermore, it essentially reduces the mother to a baby-container whose present and future health and well-being are not valued. The serious problems with these two assertions undermine the validity of the paper's conclusion and recommendation.

For me, this paper raises the question: what is "safe" enough? In the VBAC study, there were seven perinatal deaths, two of which clearly were not caused by having a scarred uterus. The fact that these two babies died possibly was related to the births taking place in a birth center, but this risk also would be experienced by all non-VBAC births in birth centers with the circumstances of these two births, so these two should not reasonably be included as part of an added risk due to prior cesarean. Looking only at perinatal deaths that are or might be associated with the scarred uterus, we find five in 1453, or 3/1000, a rate the same as the average national risk of fetal demise for amniocentesis (eOb.Gyn.News. July 1 2002 • Volume 37 • Number 13), a rate that is considered so acceptable that women are expected to make their own choices regarding this test. Going back to the VBAC study data, of the five perinatal deaths that are or might be associated with the scarred uterus, two were more than 42 weeks, and of the remaining three, two had more than one prior cesarean section. Therefore, among the reported 1271 women who were both less than 42 weeks and had had only one cesarean section, there was, in fact, only one death likely attributable to the cesarean scar, for a perinatal mortality rate of 0.7/1000. We cannot tell from the paper if this is statistically significantly different from the rates reported in the hospital studies, an essential question for events occurring at such a low frequency. There is a good chance that the risks, very low to begin with, are the same. The data from this one study simply do not support the authors' assertion that NO VBACs at all should be in birth centers on the basis of the risk regarding perinatal mortality. Even including women with 2 prior cesareans and women past 42 weeks, the risk for the baby is the same as the reported and accepted risk of fetal loss due to amniocentesis. Many women deciding to undergo amniocentesis are balancing the risk to the fetus with other risks and their own fears. What is different about women who have had a prior cesarean section, especially when they fall into the lower risk group reported on in this paper? Should these women not have the opportunity to weigh the risks and benefits of birth center vs. hospital and make their own decision?

The authors did not demonstrate that there was any statistically significant difference between VBAC outcomes in birth centers and VBAC outcomes in hospitals that support VBACs. They certainly did not demonstrate that any hospital is safer for VBAC than any birth center. Strong recommendations that limit women's choices regarding maternity care and virtually condemn them to serious abdominal surgery should never be made on the basis of a single study, especially one that does not even have good evidence to support its recommendation. Birthing women deserve better.

Legislative News

Moving the CPM Credential Forward through Midwifery Legislation

Nineteen states license direct-entry midwives using all or part of the NARM process. Thirteen states with licensure programs that predate the CPM have adopted the NARM written examination as the state licensure exam. Six states that have passed recent legislation have adopted the CPM credential as the eligibility criteria for licensure. Each year, more states work toward passing legislation to permit or license direct-entry midwifery using the CPM as the basis for eligibility. The NARM Board stays in communication with all of these states to offer advice and to insure that the CPM is represented accurately in any proposed legislation.

This has been a very active year for legislative activity related to the CPM and midwifery. Midwives in thirteen states have been discussing licensure legislation, and many have taken definitive steps toward seeking licensure for direct-entry midwives using the CPM credential as the basis for licensure. The most progress has been seen in Virginia and Utah, the states that came quite close to passing licensure legislation last year. Updates come on a daily basis, and this information is correct at the time we go to press. By the time the newsletter is in your mailbox, the outcomes in Virginia and Utah, and possibly other states, will be known. Check NARM's website for final details.

Virginia legislation has passed the House and Senate committees and floor. As of this writing, it is sitting on the Governor's desk for final confirmation. Eight years of hard labor have finally paid off in Virginia!

Utah legislation will offer voluntary licensure for midwives who want to carry specific medications but will exempt all direct-entry midwifery from the Medical Practices Act. This bill has also passed the House and Senate and is on the Governor's desk for final confirmation. Congratulations go out to the Utah midwives!

Wyoming has submitted a bill to exempt direct entry midwifery from the Medical Practices Act and provide for registration with apparently no regulation as long as midwife clients are seen by a physician at least twice. The bill has passed the House and is being reviewed by the Senate where it is considered "controversial."

Wisconsin has a bill in the hands of a sponsor who is getting ready to take it into the legislative process. After a scurry of activity in the fall, the momentum has slowed a bit at the request of the sponsor. Unlike many states, the Wisconsin legislature meets year round, so there is no particular hurry about the progress of the bill. Supporters of the bill feel optimistic about their chances this year, but are ready to work on it next year if necessary.

Massachusetts has submitted a bill to create a board to license both CNMs and CPMs. The bill is stalled over issues of funding, as are many bills in MA this session. It is the only live bill this year that will establish a joint board for both CNMs and CPMs and is supported by both groups of midwives. It would have a good chance of passing if not for budget constraints.

Nebraska submitted bills to permit CNMs to attend home births and to license CPMs. Both bills have stalled in committee and probably will not move further this year.

South Dakota submitted a licensure bill but it was rejected by the senate committee.

Missouri submitted a bill intended to exempt direct entry midwifery from the Medical Practices Act. The bill would remove the specific language that states that midwifery is the practice of medicine and replace it with a statement that the POM law will not prohibit a mother from giving birth in the setting and with the caregiver of her choice. We have no updates on the status of this bill.

Midwives in **Alabama, Illinois, Georgia, Ohio**, and **Connecticut** are drafting legislation this year, which may or may not progress toward submission to their respective legislatures. Their plans will continue to move the legislation forward into next year's sessions. Illinois is also working on getting a resolution in support of direct-entry midwifery.

Midwives in **Kansas**, and **Indiana** have been working on the legislative process but have not drafted or submitted recent legislation. Successful legislation usually takes several years to pass, and it takes a lot of work from midwives and consumers before a bill is actually proposed. Hopefully, these states will continue to work on the process in 2005.

Legislative News

Texas News

Beth Overton, CPM
President, Association of Texas Midwives

The Texas Sunset Commission meetings were held in Austin on Dec 14th and 15th, 2004.

The Sunset Commission voted *unanimously* to present a bill at the next legislative session which will include the following:

- **Change the title of all Texas' midwives to "Licensed Midwives" (currently "Documented" midwives) and remove any references to "Documented Midwives" from our Act.**
- **Remove the current language in our Act that says only one midwife board member may be a "licensed health care professional".**
- **Change the Midwifery Board membership to consist of 5 Licensed Midwives, 1 OB/Gyn, 1 pediatrician or family practice doctor with knowledge of pediatrics, and 2 public members (one of which must be a midwifery consumer). This configuration will give our board a majority representation of its licensees (midwives). [Note for those not familiar with the Texas Midwifery Board: The current configuration of our board is 3 documented midwives (only one of which may be a licensed health care professional), 1 OB/Gyn, 1 pediatrician or family practice doctor with knowledge of pediatrics, one Certified Nurse Midwife (CNMs are not regulated by this board) and 3 public members (one of which must be a midwifery consumer).]**

We should all work diligently to support this bill because it addresses the issue of licensure of midwives and because it gives us a majority representation on our board (something we have never had before)! Roland Leal (our legislative consultant and lobbyist) told me that (judging by the reactions on the faces of the TMA members present at these meetings) they were caught completely off guard by all of this news. I am sure we can expect opposition during the legislative session to this new bill. However, it will be interesting to see exactly how TMA chooses to oppose us in light of the support we currently have from these legislators. They are also less likely to fight us as much since the medical members of the board were left in place with this proposed configuration of board membership.

The final Sunset report should be published at the following web link (although last I checked it was not yet published).
http://www.sunset.state.tx.us/79.htm

We owe a BIG thank you to Roland Leal for a really great job at talking to these legislators on our behalf over the past few months. He is doing a really good job on our behalf. We also owe thanks to various ATM and TfM members who have volunteered time in Austin and in other ways to help educate the Sunset Commission about our issues and concerns. We still have a lot of work ahead of us but we can at least go into the 2005 legislative session on more a positive note.

Roland tells me that when/if these changes are made law, the earliest we could expect them to be put into effect is in September of 2005. But first we must get through the upcoming legislative session.

Please check the ATM website http://texasmidwives.com/legislative_info.htm for ongoing updates. We will try to update the site on a regular basis for your benefit and also send out emails when there is breaking news.

Association of Texas Midwives:
www.texasmidwives.com

Pennsylvania News

In August of 2003, Karen Carr (a CPM from Maryland) transported a mom (in PA) who was attempting a VBAC to the hospital because the mom elected to go.

In August of 2004, Karen was summoned by the Commonwealth of Pennsylvania Bureau of Professional and Occupational Affairs to a hearing to show cause of practicing midwifery without a nurse midwifery license. Karen acted as her own attorney and even brought a witness to testify who cited the 1990 Fornelli ruling in the Lucille Sykes case.

In December of 2004, Karen received a notice of withdrawal to show cause. The notice stated, "The practice of midwifery is not limited to individuals holding a nurse midwife license. "

For more details contact Karen Carr @ (410) 467-4586.

Utah News

Suzanne Smith, CPM

After an intense battle, the Direct-Entry Midwife Act finally passed the Utah legislature and is awaiting the signature of the governor. It was four years in the making, and it all came down to a single vote. A hostile senator tried and temporarily succeeded in substituting his own gutted version of the bill, but our sponsor managed to get it reversed the next day and the original bill passed 15-14 during the last three hours of the session on March 2, 2005. We are so grateful to all the legislators, midwives, students, friends, relatives, everyone who contributed to achieving this monumental feat.

So what does this mean for the midwives of Utah? All midwives, as of May 2, 2005 when the bill takes effect, will be able to legally provide prenatal, intrapartum, postpartum, newborn, and limited well-woman care (including pap smears and diaphragms). We will be able to order lab work and ultrasounds, recommend herbs, homeopathics, foods, etc., resuscitate a newborn with oxygen, in short, do the things midwives need or want to do,

all without a license and without regulation.

If a midwife wants to legally use medications besides oxygen, however, she must license. Requirements for licensure are the CPM plus an approved pharmacology course. Medications all licensed midwives can use are: oxytocin (protocol written into the bill), Rhogam, vitamins, eye ointment, vitamin K, sterile water, and oxygen. Licensed midwives may obtain and administer any other drug as long as a licensed health care provider who can legally prescribe that drug approves it. If an unlicensed direct-entry midwife uses medications, the crime has been reduced from a 3rd degree felony to a class B misdemeanor.

The midwifery board is independent (not under the Medical Board), consisting of four licensed direct-entry midwives and a member of the public. There is no physician supervision of midwives, licensed or not, under the Utah law.

We estimate the licensure portion of the bill will take a year to 18 months to implement. If you want to read the bill, you can find it at: http://www.le.state.ut.us/~2005/htmdoc/hbillhtm/hb0025.htm

Legislative Conference Calls

Is your state working on legislation? Never drafted a bill before? Are you considering legislation? Do you know where to start? Do you have questions on how to proceed? We might have some answers for you.

The Joint Boards of MANA, MEAC, NARM, and CfM invite all midwives and midwifery activists in states considering or pursuing legislation to a conference call. Representatives of the Joint Boards will join a call to discuss midwifery legislative issues with two or three midwives and activists from a state working on legislation. They can discuss their current progress (or lack thereof) or any other issues surrounding the development of a bill and/or the process of obtaining support within the midwifery community, the consumer community, and the legislative community. Local midwives will share information about what is happening in their state and receive constructive feedback and new ideas from people who have been involved with midwifery legislation on state and national levels. This will be a good starting point for those considering legislation in the next year or two or be a strategy session for those who have a bill currently in the legislative process.

If midwives and/or midwifery advocates in your state are considering legislation and would like to talk with members of the above boards (and other key people this group feels may be able to provide helpful contributions to the conversation), please call Debbie Pulley, MANA Legislative Chair, at 888-842-4784. Please be prepared with the names and phone numbers of two or three midwives (or activists) on your legislative committee and a few possible dates for the phone call. The legislative calls are usually on Sunday night, but other arrangements may be possible. It would also help the committee if you could email or fax your draft bill if you have one, to legislation@mana.org or 404-521-4052.

Midwife Needed in Virginia

Hello! I'm writing you from Floyd County, Virginia. Floyd is a very beautiful area nestled in the Blue Ridge Mountains. It is a very scenic and rural area with easy access to Roanoke, Blacksburg, Christainsburg, and Radford. Our community is very friendly and conscious. It is an area filled with arts, craftspeople, lots of music and liberal minded folks. There is a lot of access to organic foods and alternative healthcare. Our community lately is at a great loss for our beloved midwife has retired. Floyd County is bursting with many young families and pregnant couples. It is even joked that the pure clean water of our area is bound to get you pregnant. Many couples in the area are wanting to have homebirths. There is only one other CNM servicing our county, who also services eight other counties, and is completely booked. She can't service all those in need. Many couples feel discouraged from having the homebirths they were hoping for and feel that hospital care may be their only option.

We are calling out to all midwives who might be interested in opening a practice within our area. There would be plenty of work for you. The rate for services in the area is about $2500 per birth. There are three hospitals in the area for back up assistance. CNMs are legal in VA, and legislature is now making progress to legalize CPMs. The state legislature voted on January 25. In the past we have had lay midwives service the area with an undercover profile. As of January 15, two OBs have closed up their practices, a third seems to also be leaving. Women are receiving care through the Health Department, with no prospect at this time for a homebirth. I know of sixteen pregnant moms currently in this situation. We are welcoming anyone with midwifery training that would feel comfortable attending births in the area.

Our community is so longing for such care that we would be willing to help with relocation expenses and help find appropriate housing (which ranges from $300-$500 per month for a nice rental.)

If you are interested, please feel free to respond. Thank you for your time!

Happy Birthing,

Meredith Klein
PO Box 249
Floyd, VA 24091

phone 540-789-2013
email: mamabearmer@yahoo.com

Committee Reports

NARM Applications Year End 2004 Report

Carol Nelson, LM, CPM-TN, Director of Applications, Summertown, TN

In the year 2004 the NARM Applications Department received a total of 131 applications. In 2003 we had received 72 applications.

There were 235 applications sent out to people requesting application packets.

There were 57 candidates who took the February written exam, 11 were retaking the exam and 7 candidates waiting to take their skills exam.

There are 8 application files waiting for some piece of information, i.e. reference letters, current CPR cards, transcript or diploma etc. to complete their CPM application.

There are 40 files where we have received information (reference letters, transcript or diploma etc), but so far have not received the CPM application.

There are 7 applicants who have passed their written exam and are waiting for their graduation from a MEAC accredited school.

CPMs

105 New CPM certificates were issued in 2004.

TABLE OF COMPARISON Total number of CPM's	
2004	996
2003	893
2002	804
2001	724
2000	624

Recertification

The Applications Department now has a Recert Table to keep track of incoming and outgoing recertifications. It became necessary to create the additional database table for the Certification and Applications Departments to check recertification information sent and received between the two departments. Additionally, Debbie Pulley, Public Education and Advocacy Department, can look in the recertification Table, should a CPM want to know their status, or if the recertification information has been sent to the Certification Department for processing. A notice letter is sent to all CPMs to remind them that their CPM Credential is coming up for recertification.

TABLE OF COMPARISON	
2004	173
2003	126
2002	143
2001	148
2000	72

Inactive Status

As of January 1, 2005 we had 28 people take advantage of the new inactive status.

Inactive CPMs will continue to receive the CPM News and may recertify within a six year period. Inactive status must be established within 90 days of the CPM expiration, and is maintained annually for up to six years. Inactive status in renewed each year by filing an intent to be inactive and a fee of $35.00. During this period, inactive CPMs will receive the CPM News and all NARM mailings, but may not use the CPM designation or refer to themselves publicly as a CPM or as certified by NARM. During the six year period, an inactive midwife may renew the certification by submitting the recertification form and fees ($150.00, 25 continuing education hours, five hours of peer review, plus the recertification form documentation). A letter will be sent to all inactive CPM's to remind them of their inactive status coming up for renewal.

Expired CPMs

CPMs whose certification has been expired for more than 90 days, or who have not declared inactive status, will be given expired status and will be required to follow the new policy on reactivation in order to be recertified. All of NARM's policies regarding recertification, certification status, or reactivation are available on the web at www.narm.org

Finances

The Applications Department receives fees for application packets, CPM applications, and recertifications. In 2004 a total of $124,130.00 was processed through the Applications Department.

Audits

The Applications Department generates random audits from applicants and CPM's recertifying. Items required are Practice Guidelines, an Informed Consent document, forms and handouts relating to midwifery practice and an Emergency Care Plan.

Change in Policy for MEAC Graduates

MEAC graduates must apply for NARM certification within three years of graduation. If application for certification is made after this time NARM will require documentation of ten births, twenty-five hours of continuing education, and five hours of peer review within the three years prior to application submission.

NARM Updates

Did you know you can find NARM updates on the webpage?

Anytime there are any changes or announcements, the information is immediately posted to the web. Be sure to check it regularly.

Test Department Year End 2004 Report

Ida Darragh, Director of Testing

Major Tasks of the Test Department in 2004 included:

1. Maintaining yearly renewal of NARM's accreditation by the National Commission of Credentialing Agencies (NCCA), the accrediting arm of the National Organization for Competency Assurance (NOCA).
2. Presenting Item Writing Workshops at the MANA Conference in Portland, and in Wisconsin in November. Thirteen new Item Writers were trained in 2004, bringing our current total (since 2002) to 40 and representing 18 states. Questions are now being written and reviewed for Form I of the exam, which will probably debut in August of 2005.
3. Working with the CPM in states considering licensure. Representatives from the NARM board spoke with the regulatory board in Rhode Island in January in support of the CPM as an avenue for licensure, and met with consumers and midwives in Wisconsin in November in preparation for their legislative work. NARM board members regularly participate in e-mail and telephone discussion with midwives in states seeking licensure.
4. Training and recertifying NARM's Qualified Evaluators, who administer the NARM Skills Assessment to the PEP candidates. Fourteen new QEs were trained, bringing our total of active QEs to 66.
5. Administering the NARM Skills Assessment to 33 PEP candidates (more than twice as many as in 2003), and the NARM Written Examination to 135 candidates.
6. Attending the annual NOCA and CLEAR conferences, and participating on the NOCA Program Committee and the CLEAR Program Committee and Credentialing and Exam Resources Committee.

NARM Testing

The NARM Skills Assessment was administered to 33 PEP candidates in 2004. The assessment was taken by candidates from 13 states, Canada, and one from Ireland who traveled to the US to complete the NARM certification process.

The NARM Written Examination was given to 135 candidates in 2004. Eighty-two candidates were taking the exam to complete the CPM certification process and fifty-three candidates were taking the exam for state licensure, though many who receive the CPM apply for licensure and many who receive licensure then apply for the CPM. Eleven states currently administer the NARM Written Exam as a state licensure exam. These states are Alaska, Arkansas, Arizona, California, Colorado, Louisiana, Montana, New Mexico, South Carolina, Texas, and Washington. An additional eight states require the CPM or the Exam portion of the CPM for licensure: Delaware, Florida, Minnesota, New Hampshire, New Jersey, Oregon, Tennessee, and Vermont. NARM currently offers the Written Examination at the eleven state agencies and at ten University Testing Centers in Florida, Idaho, Iowa, Massachusetts, Maryland, Ohio, Oregon, Tennessee, Utah, and Vermont.

Test Development

Two item writing workshops were given as part of the ongoing process of test development. Five CPMs attended the workshop at the MANA conference in October, and eight CPMS attended the workshop in Wisconsin in November. This brings to 40 the number of CPMs who have been trained to write test questions since 2002. Test questions are written by teams during the workshop and many writers continue to submit questions throughout the year. All questions are reviewed again by two teams of item writers. Final reviews are done by the NARM Board.

NARM Participation in NOCA and CLEAR

The NARM Test Department and Board of Directors participates in the national conferences of both the National Organization for Competency Assurance and the Council for Licensure, Enforcement, and Regulation. In 2004, Director of Testing Ida Darragh attended the NOCA conference in Miami in November, and the CLEAR conference in Kansas City in September and business meeting in New Orleans in January. In addition, Ida served on the NOCA Program Committee, and on CLEAR's Exam Resources and Advisory Committee and Credentialing and Examination Issues Committee.

Goals for 2005

Test Department goals for 2005 include:

Training and working with more Item Writers to create a larger databank of test questions.

Continue working with NOCA and CLEAR, and maintaining our certification with NOCA.

Revision of the Qualified Evaluators training manual and the Item Writer's training manual. Presentation of Item Writer workshops and Qualified Evaluator workshops.

Participation on the weekly NARM Board phone calls and annual meetings.

Scheduling of NARM Skills Assessments as needed, and of the NARM Written Examination on the third Wednesdays of February and August at regional sites and again at the annual MANA conference.

Arranging translation of Form H in Spanish.

Committee Reports

NARM Treasurer Year End 2004 Report

Carol Nelson, Treasurer

The year 2004 was a good year for NARM from a fiscal standpoint. We ended the year with money in the bank and all expenses paid. The certification process has taken a lot of financial resources and continues to take more as we grow in numbers. By the time this newsletter comes out we will be over 1000 CPMs! NARM was incorporated in 1992 and to date we have spent over $1,360,000.00 on the Certified Professional Midwife process. Our total income for 2004 was $173,788.00.

NARM's main sources of income are from Test Sales and Applications. Applications include requests for applications, certifications, and recertifications. Our income from the Applications Department last year was $124,130.00. Test Sales are from the states that use the NARM written exam in their Licensures/Certification process. Income from the Test Department in 2004 was $41,145.00. Occasionally we will get a grant for a specific project such as the 1995 and 2001 Job Analysis. A Job Analysis every five years or so is necessary to remain state of the art in testing. We also have income from brochure sales, frames and retained income in 2003 that came to $8,513.00.

As the Treasurer for NARM, I believe a balanced budget is the only fiscally responsible way to run our organization. We need to not only be balanced but we must think ahead to projects of the future and be saving money for those projects. Another Job Analysis in a few years is one such project. To remain state of the art in testing, this is a must. Other projects include continued work on our test such as Item Writing and Cut Score workshops, recertification work with the Qualified Evaluators and the Skills Assessment for a few examples.

Our expenses closely run the same as our income. A few of our main expenses are: Consultants for our Applications Office and our Testing Company. Legal Fees to be sure we stay legally defensible, Printing, Postage, Telephone, Conference and Exhibit fees (educational booths at midwifery and other related organizations conferences to promote CPMs and the Midwives Model of Care), Dues/Membership in organizations such as the National Organization for Competency Assurance (NOCA), Insurance, Office Expenses and Supplies.

We are looking forward to NARM's continued growth and a balanced budget in 2005.

With the growth of our certification process and more Certified Professional Midwives each year, we feel honored to be doing our part to move midwifery forward and to promote the Midwives Model of Care.

Meet the NARM Board of Directors

Left to right: Robbie Davis-Floyd (Public Member), Shannon Anton (Accountability), Joanne Gottschall (Special Projects), Ida Darragh (Testing Department), Carol Nelson (Applications), Debbie Pulley (Public Education and Advocacy), Sharon Evans (Policy Management)

Who are the NARM Board of Directors?

Ida Darragh, CPM, LM
Board Chairperson
Testing Department

Carol Nelson, CPM, LM
Treasurer
Applications

Debbie Pulley, CPM
Public Education & Advocacy
Secretary
1-888-84BIRTH

Shannon Anton, CPM
Vice-Chairperson
Accountability

Joanne Gottschall, CPM
Special Projects

Sharon K. Evans, CPM, CDM
Policy Management

Robbie Davis-Floyd, Ph.D.
Anthropologist/Writer/Editor
Public Member

NARM Board Remains Receptive

The NARM CPM credential was created during the Certification Task Force meetings. These meetings were conducted over a three year period and participation remained open to all midwives. Policies and guidelines for the future of the CPM credential were made by strict consensus process and continue to guide the actions of the NARM Board today.

Continuing the spirit of open accountability, observers may attend NARM Board meetings. The NARM Board usually meets in person twice a year. The Board will meet for several days prior to the MANA Conference in Boulder, CO this fall. If you would like to attend, contact NARM for details.

Individuals wishing to submit proposals or suggestions to the NARM Board are encouraged to contact NARM in writing. Proposals may be made at any time. Attendance at a NARM Board meeting is not required.

If you would like to serve on the NARM Board or a committee, please contact us directly. The NARM Board welcomes your participation!

North American Registry of Midwives
5257 Rosestone Dr.
Lilburn, GA 30047
phone toll free 1-888-842-4784
e-mail: info@narm.org

NARM Accountability Committee Year End 2004 Report

Shannon Anton, Director of Accountability

NARM Accountability Committee follows Peer Review and Grievance Mechanism policies and addresses complaints against CPMs. Legal advice is sought when appropriate. NARM Board receives regular updates regarding the activities of Accountability Committee.

NARM accountability processes work to address concerns regarding competent midwifery practice. The NARM Board reserves the right to evaluate, at its sole discretion, the appropriate application of NARM's Peer Review and the Grievance Mechanism. Complaints received by the NARM Board that do not involve issues relating to competent midwifery practice will not be addressed through the Peer Review and the Grievance Mechanism that NARM has established.

In 2004 NARM received three complaints against a midwife who had previously received Peer Review recommendations in response to a 2002 complaint. The NARM Board reviewed the complaints using NARM's Grievance Mechanism, and the midwife's CPM was revoked.

One complaint originating in 2003 was potentially resolved in 2004 through local peer review. The midwife was given four recommendations for improving her practice.

Since the beginning of the CPM credential in 1995, this committee has received eighteen formal (written) complaints appropriate for NARM accountability processes. Three CPM credentials have been revoked; each of the midwives faced at least three separate complaints.

Two complaints remain on file and must be cleared before those midwives may apply for recertification.

The outcome of two complaints heard in Peer Review found no fault with the CPM; in one of these instances the consumer was dissatisfied with that outcome and filed a second complaint to initiate the Grievance Mechanism. The outcome of the Grievance Mechanism proceedings reached the same conclusion.

Four midwives have had complaints that proceeded to the Grievance Mechanism. Of those, three had their CPM credentials revoked.

NARM has revoked three CPM credentials, one in 2000, one in 2003 and one in 2004.

What's on the Website:

Site Sections

- Contact NARM
- About NARM
- How to Become a CPM
- Candidate Information Bulletin
- CPM Recertification
- CPM Inactive Status
- Policy and Procedures
- Professional Accountability
- Peer Review
- CPM State Information
- OSU Testimony
- 1995 Job Analysis
- Application Deadlines
- CPM Stat Forms
- CPM Newsletters Online

www.narm.org

Notices & Announcements

NARM Workshops

NARM can offer a variety of workshops to be presented at state midwifery association meetings or regional conferences. If a minimum of 9 CPMs will attend the Test Writing workshop, there will be no fees charged for any workshops except the Qualified Evaluator workshop which has a $100 fee. Without the Test Writing workshop, there may be fees necessary to cover travel and lodging expenses. Continuing Education credits will be awarded for all workshops. For more information, call 1-888-353-7089 or write testing@narm.org.

The Test Writing Workshop can be done as a 7-hour (full day) or 10-hour (evening and full day) workshop.

The test writing workshop brings together groups of CPMs to discuss the midwifery knowledge and skills that are essential components of the practice of midwifery. Based on real-life experiences, teams of midwives craft scenarios related to problems they have encountered in prenatal, birth, or postpartum situations, research these scenarios in the reference texts, identify the knowledge necessary to solve the problem, and develop multiple choice answers to evaluate that knowledge. Discussions are lively and stimulating, and participants find the process to be rewarding on a personal and professional level. Additionally, participation by CPMs in the development of test questions is integral to the reliability and validity of the Certified Professional Midwife credential. NARM Certification was created by midwives, for midwives, and is administered by midwives on the NARM Board. The NARM exam is written by midwives, with focus on the practical aspects of midwifery care and knowledge. Your participation makes a better exam! Participants must be CPMs.

Qualified Evaluator Training: (4 hours) This workshop trains CPMs to administer the NARM Skills Assessment. This workshop is open only to CPMs with at least 2 years and 30 births additional experience beyond the CPM. There is a $100 fee for the QE workshop, but participants receive a copy of the new edition of the Practical Skills Guide for Midwives (a $60 value) and become eligible to administer the Skills Assessment, for which they are paid $75.

The following 2-hour workshops are open to anyone:

Midwifery Ethics: In today's maternity services ethical issues are everywhere, and yet there is often a poor understanding of how practitioners deal with them. Many qualified midwives, while believing that they are ethical in their work and lives, might find it difficult to define what this means in practice. We all have to make decisions everyday with clients, other health care providers and our own families. While ethics is seen by some as a theoretical issue, to be debated in classrooms and at conferences, the everyday import of ethical decision-making means that the theory-practice gap needs to be bridged. Our exploration of ethical midwifery is a critical reflection of moral issues as they pertain to maternal/child health on every level. This workshop explores the ethical issues that face midwives in today's world, as well as strategies for resolving these issues. Participants will discuss the ethical issues relating to accountability, autonomy, confidentiality, informed consent, and the use of technology.

Preceptor-Apprentice Relationships: This session is designed to meet the needs of both preceptors and apprentices and to help avoid common problems in the preceptor-apprentice relationship. Discussion includes the role and responsibility of the preceptor and apprentice, advantages and disadvantages to the apprenticeship model of education, avoiding common misunderstandings between preceptors and apprentices, and documenting the apprenticeship for the NARM application process.

NARM and the CPM Process: This workshop explains the development of the NARM process and the requirements for CPM certification. The session is designed for apprentices who intend to apply for CPM certification and for the preceptors who will train them to meet these requirements. It is also a very valuable workshop for anyone who is interested in seeking legislation to license midwives using the CPM process as a basis for licensure. Participants will become familiar with all routes of entry into the CPM process, how the criteria for certification were determined, and how each element of the process contributes to the reliability and validity of the credential.

Charting: One of Your Most Critical Skills and Your Legal Defense

Midwives often view documentation as a necessary chore, but one that is not as important as providing hands-on care. Yet documentation is one of the most critical skills that a midwife will perform. Although we tend to approach documentation casually, our entire career could depend on the accuracy and completeness of our charting. How much should be charted and why? In documenting, we need to keep in mind the possible legal and ethical complications, and the legal relevance of malpractice. Failure to document appropriately has been a pivotal issue in many malpractice cases.

Preparing for Legislation: available as both a 2-hour workshop and a full day workshop. This workshop is for midwives and consumers who are preparing to lobby for legislation to license midwives in their state. The 2-hour workshop is an overview of the legislative process and lobbying strategies. The full day workshop goes into more depth and includes actual training for lobbying, including writing fact sheets, giving interviews, making the best use of the 15-minute or 2-minute opportunities for speaking with legislators, giving testimony at public hearings and legislative committee sessions, and answering tough questions spontaneously.

MANA Statistics – Web Based Data Entry: (2 hours) This workshop explains the new MANA Statistics Collection Project, including the web based data entry system, so that all midwives can enter their personal statistics into the MANA database for use in analyzing and publishing research on direct-entry midwifery. Participants will learn how to enter their data on the web (and options for not entering on the web), how this information may be used, and how to retrieve their own personal or group statistics.

Looking for Opportunities to Obtain CEU's?

Don't miss a great opportunity to earn CEU's and have a great time doing it! Plan on attending MANA 2005 in Boulder, CO September 30th through October 2nd.

Last year at MANA 2004 in Portland, OR, there were opportunities to earn contact hours during the regular conference plus additional contact hours if you attended a pre-conference workshop.

For more information, watch for announcements about the conference on MANA's website at www.mana.org.

The Quality Vital Statistics Alliance (QVS Alliance)

Sharon K. Evans, CDM, CPM

The NARM Board received a letter dated April 12, 2004, from the State Registrar and Director of the Colorado Office of Vital Statistics. NARM was invited to participate in the planning process for a national advisory group called the Data Providers Certification Project Team (DPCPT). The purpose of the group is to improve the quality of birth data collection as well as educating midwives and doctors on the correct data entry on birth certificates. As of November 2004 the DPCPT was given another name: Quality Vital Statistics Alliance or the QVS Alliance.

The QVS Alliance is also responsible for making sure that accurate information is placed on the birth certificate. The National Association for Public Health Statistics (NAPHSIS) and the National Center for Health Statistics have given the QVS Alliance formal endorsements for the creation of a certificate program. So far, several forms have been created; the Birth Registrar Training Survey, the Birth Registrar and Midwife Training Survey, the State/Local Vital Records Training Survey, and Sample Prenatal and Delivery Data Collection forms. A sixteen-page instruction manual called Recommendations, Collection, Registration and Data Integrity for the Certificate of Birth has been compiled as an instruction guide for the various survey forms.

The first step in the process has begun. Four areas were chosen for the first of a two-part project. They are California, Colorado, New York City and Utah. They have been chosen to fill out the survey(s) and provide feedback to the QVS Alliance. Once received and analyzed, the survey will go out to all the states. Each state in the pilot project is required to handle the survey tool and to offer it to others in their state.

The QVS Alliance is seeking to improve communication and cooperation between midwives, hospital staff members, Obstetricians, MD's, labor & delivery departments, medical records and vital statistics. Recently the QVS Alliance requested Pam Crowl, CPM, and myself to help seek a term/terms for out-of-hospital birth attendants. The following has been suggested:

A line that says "title." Following that, circle all that apply or underline the title: CPM, CDM, LM, RM, CNM, MD, Other

NARM is very interested in your feedback on the title issue. We need to be ever cautious about revealing the privacy of midwives living in illegal and/or unfriendly jurisdictions. I know we all have been frustrated by the limited information on birth certificate data sheets. People need to know that out-of-hospital birth is safe. Please feel free to e-mail your comments to me at: sevans@narm.org. Suggestions will be sent to the QVS Alliance.

Future goals include a more national scope in the correct collections of birth data. After the Pilot Project, survey forms will be sent to all hospitals, doctors and midwives. It is our desire that documentation regarding birth will be correctly applied to each state's statistics. I believe we will prove that midwives' statistics will reveal the low-risk status in out-of-hospital births that we all know is true.

Midwifery Statistics

For more than ten years, MANA midwives have voluntarily turned in their birth statistics for research and analysis by Ken Johnson and Betty Anne Daviss. Most of these have been retrospective, meaning they are turned in after the births occurred. While this data is helpful in our own understanding of birth and of our own practice styles, that information is not as valuable for research purposes because of the possibility that only the good outcomes are being reported. For research purposes, data must be collected prospectively, meaning that the births are listed as the clients come into the midwife's care (or at least before the birth) and all births logged are reported after the birth. This assures that all outcomes are included in the statistics. This is the only kind of data that will be accepted as serious medical research. For this reason, NARM CPMs participated in a one-year mandatory statistics collection project in the year 2000. All CPMs logged their births prospectively and turned in dataforms after the birth. That data was entered into computer programs and analyzed by Johnson and Daviss, who presented reports on their work at yearly MANA conferences and also at yearly conferences of the American Public Health Association. That research has now been written and submitted to professional journals. The process of writing and submitting is different for each journal, and each application takes several months before it is accepted or rejected, and then the process starts all over again. We fully expect that the CPM 2000 statistics results will be published in a reputable public health or medical journal in the year 2005.

Many midwives continued to submit statistics after the year 2000. The research work of Johnson and Daviss continued to focus on the CPM 2000 project as the highest priority. Meanwhile, MANA created the Division of Research (DOR) composed of five divisions: research and publication, education, administration, data collection, and web based database development. The data that has been collected since the year 2000 on paper forms is being entered into the computer by the data collection division. The most exciting part of the DOR is the web based system of data entry that will allow midwives to enter their information directly by computer into a web based data collection system. This will allow midwives to see instantly what they have submitted and what still needs to be entered, and it can be done throughout the pregnancy with the final information entered after the birth. This will also be a faster system of data collection, thus allowing research to be carried out with a minimum of delay.

The data that has been submitted previously on paper forms will be entered into the same system, but only prospective data will be offered for certain kinds of research. Retrospective data will be valuable for a midwife's own statistics summary or for more general analysis of midwife styles and skills. All the older data will eventually be a part of the master database for these purposes. The important factor for future data collection is to get as much data as possible about midwife-attended births entered prospectively on the new web based system. Midwives who do not have access to the web, or who prefer the paper dataforms, can still submit their data by mail and the DOR division of data collection will enter the data into the database. Eventually, all data that has been submitted will be combined with all the newer data, and we will have a huge database of valuable information that will provide the kind of statistics we need to demonstrate the outcomes of midwife care.

For this to be a successful venture, WE NEED FOR ALL MIDWIVES TO SUBMIT THEIR STATISTICS. All personal data will be kept confidential and the identity of the midwife will not be released except to the midwife herself and to whichever group practices she agrees to join. Statistics can be compiled and reported back to the midwife for her own practice, and also for any group practices or associations that she identifies for her statistics reports. Researchers will have access, with permission of the DOR, to the data relevant to their research project, and will not know the identity of the midwives or the clients. Clients will be identified only to the midwife, and even then only by the client code chosen by the midwife.

To contribute to the statistics project, each midwife must ENROLL into the system. Even if you participated in the previous data collection, you must enroll into the new one. To enroll, go to www.manastats.org. At this web site, you can read about the data collection system and download an enrollment form. The form must be filled out and mailed in, and then the midwife will be assigned a Midwife Code. At that point, clients may be listed on the prospective log on the web or by mail. Data cannot be entered until the midwife is enrolled, so ENROLL TODAY. If you do not have access to the web, you may receive all necessary information from:

MANA Statistics
P.O. Box 6310
Charlottesville, VA 22906

It is very important that all CPMs participate in the collection of statistics. Please get started as soon as possible. It is easy and very rewarding! CPMs can also get Continuing Education credit towards recertification for submitting their birth data to the statistics project (see the recertification forms on www.narm.org).

CHECK IT OUT!
GO TO THE WEB TODAY!

DOWNLOAD YOUR ENROLLMENT FORM!

www.manastats.org

Report from Citizens for Midwifery

Susan Hodges, President

Congratulations to all who participated in the development of the recently adopted Essential Documents of the NACPM! They are outstanding and will prove invaluable wherever efforts are underway for legal recognition of CPMs.

Your Clients and Citizens for Midwifery

CfM Board members Carolyn Keefe and I saw many of you at the MANA conference in the fall. At the conference more midwives expressed their desire to have their clients become members of CfM, a good way to help your clients be more informed and more ready to take action for midwifery when needed. There are a number of ways to "sign up" your clients, including a special price break if you are signing up your clients and paying for their first year of membership – you can do this at the "special" rate of $20 instead of the suggested rate of $30. Please do not hesitate to e-mail or phone CfM if you need information or suggestions on ways to do this. And if you think of anything CfM can do to make this easier for you, or a handout that you would find especially helpful for your clients, please let us know! We really appreciate your work and your efforts to inform your clients and introduce them to Citizens for Midwifery.

CfM Development

At our annual in-person board meeting this fall, the CfM Board realized that we need more midwifery advocates to be more involved with the work of CfM for our organization to continue growing and making an impact for birthing women and midwives. We are developing a Strategic Plan, and know already that we need to further develop the Board and have clearly defined volunteer opportunities to make it easy and inviting for more advocates to get involved. As midwives, we would appreciate any help you can give us to identify people who are potential active participants.

Do you have clients that like to surf the internet? Who like to write or edit? Can you think of a client who enjoys calling people up to get information? Perhaps you've kept in touch with some clients from a few years ago who might have more time now than when they had a newborn? The CfM Board has already identified a number of straightforward tasks that any number of people could do to help CfM and be more involved, with the newsletter and with our website. For example, a good website needs regular systematic checking to catch out-of-date information and dead links, and then follow up to obtain new information and current web site addresses; in particular, many of our State pages are either undeveloped or have out-of-date information. For the CfM News, we could use reporters for the state by state section, and we welcome thoughtful articles on birth- and midwifery-relevant topics, as well as reviews of books, articles, useful websites, etc. Please contact me (susan@cfmidwifery.org) if some good people come to mind, or if you have any questions about these opportunities.

Born in the USA

Through a special arrangement with Fanlight Distribution members of Citizens for Midwifery can now obtain the made-for-public-TV documentary "Born in the USA" for only $89.00. This is a tremendous savings over the list price of $200.00. The special price offer originally was available only through December 2004; while this deadline has been extended, the offer is likely to be time-limited, so get your order in now!

Print out an order form from the CfM website http://www.cfmidwifery.org/pdf/orderform.pdf and send it with your check or money order. Remember, you must be a CfM member in order for us to accept your order. If you are not already a member, you may include your membership (form and check) with your order to qualify you for this special.

"Born in the USA" (released in 2000) was created by a home birth couple who are professional documentary film-makers. If you are not familiar with "Born in the USA," read a review at http://www.cfmidwifery.org/resources/cfm/item.asp?ID=6 or more descriptive information at http://www.fanlight.com/catalog/films/297_bitusa.shtml. This film is just as timely and effective now as it was when it first came out. It is a very effective educational tool, for public meetings as well as classroom use.

Quality Assurance for Midwives?

Do you have a system for getting feedback from your clients? How do you assess your practice (both clinical and other aspects, such as emotional support) in terms of how it measures up to the ideals contained in MANA's or the NACPM's Essential Documents, the Mother-Friendly standards, or the Midwives Model of Care? We are all human, and having an effective way to get meaningful feedback from your clients can help anyone to keep "on track".

I am interested in exploring the possible development of a feedback questionnaire, with input from both midwives and consumers. The need for such feedback is clear if you read posts from women who have had less than satisfactory experiences with home birth midwives, many of whom feel betrayed because their midwife did not provide care that lived up to their expectations of the Midwives Model of Care. They may never have had an opportunity to give their midwives meaningful and concrete feedback about their care or how their midwife's actions or behavior impacted them.

Do you have a questionnaire or form you ask your clients to fill out when

care is completed? Do you have any suggestions for or thoughts about such a questionnaire? I hope you will share them by e-mailing to questionnaire@cfmidwifery.org or sending to the CfM PO box, attention "questionnaire".

Reported by Susan Hodges
susan@cfmidwifery.org
www.cfmidwifery.org

ICAN Conference

April 29th - May 1st

San Diego, CA

http://conference.ican-online.org

1-800-686-ICAN

NACPM News

Hello to all CPMs! The Board of Directors of NACPM is pleased to announce that the members of NACPM have voted to adopt the Essential Documents, including Standards of Practice. The final draft is available on the website: www.nacpm.net. This vote was the culmination of a two and one-half year project by the NACPM Standards Committee. The document was drafted by the Standards Committee and was circulated for comments to all CPMs, the Standards Advisory Committee, as well as other interested parties. The final revisions were made at the MANA Conference 2004 in October, with particular help and input from members of the NARM Board. The Standards Committee carefully considered every comment that was received, and the NACPM Board considers the final document to be a strong and powerful articulation of the philosophy and practice of the members of NACPM. Special thanks and appreciation goes to all of the CPMs who contributed, as well as to the members of the Standards and Standards Advisory Committees. The membership of these committees is also available on the website.

As many of you may know, the Standards of Practice are already proving their usefulness. The midwives and consumers from Wisconsin contacted NACPM in the fall to say that this document may just make the difference in the success of the legislative effort to license CPMs in their state. These documents are also considered essential in the groundbreaking effort in Massachusetts to legislate a joint CPM-CNM board of midwifery. The Board has heard from midwives and consumers from other states inquiring about the Standards document.

NACPM members also voted to add to the Essential Documents endorsements of the Midwives Model of Care (© 1996-2004 Midwifery Task Force), the Mother Friendly Childbirth Initiative (© 1996 Coalition for Improving Maternity Services) and the Rights of Childbearing Women (© 1999 Maternity Center Association, Revised 2004).

NACPM Board members were elected in December as well. Mary Lawlor and Dolly Browder each have one year of their terms remaining. Suzy Myers was reelected to the Board, and Marilyn Green of Tennessee, Kathy Acree of Louisiana, and Edie Wells of Wisconsin were newly elected. NACPM welcomes and congratulates these new board members! A late-spring board meeting is being planned to take place in Seattle to develop the agenda for NACPM for the next year.

In preparation for the spring meeting, the Board will be reviewing agenda suggestions that members have contributed over the past couple of years. If you have suggestions you would like to be considered, please send them to Mary Lawlor at lawcing@sover.net or mail them to her at 234 Banning Road, Putney, VT 05346.

We invite any CPM who has not yet done so to join NACPM! As we said in a previous newsletter: The power of NACPM to support the work of CPMs will grow as its membership grows. The power of NACPM to ensure that CPMs are included in the delivery of maternity care in any of the national health care reforms that are being considered, its power to increase communication among midwives, its power to advocate for midwives in issues such as insurance reimbursement, its power to influence national health policy and legislation, and its power to work with other national organizations and groups to ensure that women and families are afforded the opportunity for natural childbirth, will develop and grow as the number of CPM s continues to grow, and as the membership of NACPM grows. Please join now. You will find membership information on the website, www.nacpm.net, including a membership form to download. You may also request a membership form from Mary Lawlor at the above address. We look forward to hearing from you!

Preceptors

In the last several issues of the CPM News, notice was given that preceptors in the NARM Preceptor Table were sent a survey letter requesting information such as address confirmation, numbers of births attended, etc. In an effort to update the vital information in this table, NARM is requesting that all CPMs who are or who anticipate becoming a preceptor in the next year please fill out the enclosed survey ques-

tionnaire. If you have already filled the survey out thank you. You will not have to do it again. If you know of a non CPM midwife who is a preceptor, please encourage that midwife to participate by volunteering, the information. The letter and survey is as follows:

Dear Midwife Preceptor:

Your name is in our database because you are listed as a preceptor for at least one NARM CPM applicant. We are contacting you to obtain necessary additional information for our database of midwifery preceptors.

NARM is dedicated to the preservation of apprenticeship and the Midwives Model of Care. With that goal in mind, a Preceptor Database has been developed for the purpose of research to prove the validity of competency based education.

The purpose of this letter is twofold:

1) To inform you of the requirements for preceptors of NARM PEP applicants.
2) To obtain general information to update the database.

A preceptor for a NARM PEP applicant is required to affirm they are a primary midwife, that the applicant acted as a primary under supervision, and they were physically present in the same room in a supervisory capacity during that care in which the applicant acted as primary under supervision.

On Verification of Birth Experience Form (114), preceptors also affirm the following number of procedures with the applicant:

- Number of births
- Number of initial prenatal exams
- Number of prenatal exams
- Number of newborn exams

Preceptors must affirm they are:

- A nationally certified midwife (CPM, CNM, or CM); or
- Legally recognized in a jurisdiction, province, or state as a practitioner who specializes in maternity care, or
- A midwife practicing as a primary attendant without supervision for a minimum of three (3) years and fifty (50) out-of-hospital.

In addition preceptors are asked to affirm the length of time (fill in the date) they have been a primary midwife and the number of births they have attended as a primary midwife.

NARM may request additional information from preceptors, such as client charts.

Preceptors may also be audited for Practice Guidelines, Informed Consent Documentation, forms and handouts relating to midwifery practice and emergency care plan. Refusal to provide additional information may detain the application process or may be grounds for denial of application approval.

NARM greatly appreciates your cooperation in this matter.

By being a midwifery preceptor, you are part of a growing movement with each one of you making a difference in midwifery and access to midwives across the nation, regardless of the route of entry you have chosen into the profession. Together we can make a difference in midwifery availability for out grandchildren and for their children.

NARM Preceptor Survey

Name: _____ Date _____

Address:_____ Phone: (W) _____

City: _____ State: ____ Zip: _____ (H) _____

I am/am not a credentialed midwife (circle one).
(If applicable) my title is:_____ (Please spell out if different from the list of titles below) _____
Are you interested in becoming a CPM at this time? _____ If not please share your reasons for this decision. _____
_____

I am:
- ❑ A nationally certified midwife (CPM, CNM, or CM); or
- ❑ Legally recognized in a jurisdiction, province, or state as a practitioner who specializes in maternity care, or
- ❑ A midwife practicing as a primary attendant without supervision for a minimum of three (3) years and fifty (50) out-of-hospital births.

I have been a primary midwife since (fill in date):_____
I have been preceptor for (fill in number)_____ of NARM CPM applicants.
I have attended (fill in number)_____births as a primary midwife.

NARM greatly appreciates your time in this matter. Please either send the information to the Applications Department via email *applications@narm.org* or mail it to NARM Applications Department.

MANA Conference 2005

Standing Tall, Growing Together

Join

- the Midwives Alliance of North America
- the Colorado Alliance of Independent Midwives, and
- the American College of Nurse Midwives - Denver Chapter

as they present MANA 2005

Sept. 30 through October 2, 2005

Registration information can be found
on the MANA website at
www.mana.org.
Click the Conference button on the left.

CPM News

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