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Providing certification standards for Certified Professional Midwives

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Midwives Model of Care SUPPORTER

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Justine Clegg receives honor at Miami-Dade

Justine Clegg, MS, LM, CPM, recently received the prestigious honor of "Endowed Teaching Chair" for 2003 at Miami-Dade College. This award represents the highest honor a faculty person can achieve. It affirms that this faculty member has demonstrated that she is an exceptional teacher, making an essential difference in people's lives. Justine Clegg is the Director of the Associate in Science in Midwifery degree program at Miami-Dade College, the only program of its kind in the United States. Justine submitted her portfolio to the College in April to compete for one of the few available Endowed Chair awards. On the cover of her portfolio she put a poster which she had bought at the campus bookstore in 1992 before attending a meeting to discuss the possibility of starting a midwifery program at the College. The poster shows hands cupped together in the shape of a bowl, wrists touching, holding stars which are falling into them. The poster reads, "Keep in touch with your dreams." The theme of Justine's presentation for Endowed Chair was just that - having a dream and working for years to make it come true. In her portfolio she told the following story:

This "herstory" starts in 1979 when a small group of women who were attending births in Florida, most of whom were unlicensed, formed the Midwives Association of Florida in order to pass legislation to enable direct-entry midwives to become licensed. Justine was one of the "founding mothers" of the Association. They dreamed of one day being able to have a degree program for midwives at Miami-Dade Community College, with affordable tuition and community recognition. This small group of women, helped by clients and other community members, wrote legislation and position papers, secured bill sponsors, lobbied and eventually in 1982 passed the Midwifery Practice Act. This law required 3 years of education in midwifery. The "founding mothers" then put together two midwifery schools in Florida. Justine served as Administrative Director of the South Florida School of Midwifery in Miami. The "founding mothers" in Gainesville started its sister school, the North Florida School of Midwifery. This entailed developing curriculum, the Schools' catalogs, admissions policies, obtaining a license from the Florida Department of Education, hiring faculty, finding a location and eventually enrolling the first class of midwifery students, which thanks to a handful of physician legislators turned out to be the only class, as a result of a licensing moratorium that was railroaded through the final days of the 1984 Florida

Justine Clegg Honored!

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.

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legislature. Justine was one of the approximately 35 midwives who became licensed in the 1980s during that brief "window of opportunity."

Discouraged but not undaunted, the "founding mothers" continued to present legislation each year and finally in 1992 were able to pass the revised Midwifery Practice Act, once again opening up midwifery licensing in Florida.

That year Margaret Hebson, former president of the Midwives Association of Florida, attended a political fund raiser where she spoke to Dr. Tessa Tagle, then President of Miami-Dade Community College Medical Center Campus, home of 28 allied health and nursing programs, about starting a midwifery program at the College. Miami-Dade Community College prides itself on being first in the nation - indeed they are now the largest college or university in the country - and on being innovative risk-takers. At Dr. Tagle's initiative, Justine and Sharon Hamilton, then President of the Midwives Association of Florida, met with the Deans of Nursing and Allied Health at the College. Following that meeting, Justine worked for two years writing the Associate in Science in Midwifery degree curriculum, creating an advisory committee of community support people, and preparing a program to present to the Campus' and College's Academic Affairs Committees and then to the College's Board of Trustees, and finally in 1993 to be granted approval to start the Midwifery Program. The first class of midwifery students started in the fall of 1994, and in August of 2003 the tenth class will begin its studies. Justine went on to serve as Chair of the Florida Council of Licensed Midwifery from 1993 to 2002. She was a founder and original Board member of MEAC (the Midwifery Education Accreditation Council), as well as a participant in developing NARM's national certification process, she helped create the Florida State curricular framework for midwifery, and most recently in 2002 was elected to the NACPM Board of Directors. Because the Miami-Dade College tuition is affordable (at approximately $50 per credit for in-state residents, the full 3 year, 90 credit Midwifery Program costs under $5000 plus books and supplies), and financial aid is available, the College's midwifery program attracts people from all over the country and students commute from all over the state. They are joined by the many local residents reflective of the Caribbean and Latin American residents in the Miami area, enabling not only a significant number of women of color to become midwives, but also providing a microcosm of cultural diversity in the classroom to integrate meaningful multi-cultural competency into the midwifery curriculum. With its multilingual rural, migrant, urban, inner city and suburban population, Miami is an ideal community for exposure to a wide variety of clinical experiences reflective of all settings in which midwives may practice. Miami-Dade College is the former Miami-Dade Community College. In the 2003 Florida legislative session, the College's name was changed to reflect that it is one of four community colleges in the state which have been authorized to begin providing baccalaureate degrees.

By awarding an Endowed Chair to Justine Clegg as Midwifery Program Director, the College has recognized her excellence, her contributions to student success, her effective teaching strategies and professional leadership. Through this award, the College has also recognized and honored the value and importance of the midwifery model of care, of women's empowerment through childbirth and of out-of-hospital birthing, all of which are integral to the Midwifery Program Statement of Philosophy. In this spirit, Justine wishes to share this award with every midwife and every midwifery client in the country, who have all in one way or another contributed to making this award possible, and who in turn share in this honor.

Overview of Maternity Care in the US

Carolyn Keefe, MLS — March, 2002

With four million births each year and three-quarters of American women becoming mothers, maternity care affects large numbers of women. It is also big business. The United States has the highest per capita spending on health care in the world, with 20% of all health care dollars going to maternity care, and childbirth is the most common reason for hospitalization in the United States.

Women are subjected to an ever-increasing array of interventions and technologies, many of which are highly invasive, with little or no evidence of their effectiveness. In fact, the medical evidence shows that the routine use of unnecessary interventions put mothers and babies at risk. Medical interventions are also expensive and often used not for the benefit of women and babies, but for the convenience or legal protection of doctors and hospitals.

All of this would be acceptable if we had better outcomes to show for it. Unfortunately, our outcomes are not nearly as good as those of developed countries that rely more heavily on midwifery care. Some of the clear problems with our maternity care system include:

- A high infant mortality rate compared to other developed countries — 25th in the world. Infant mortality rates are higher for African American, Latina and Native American babies — with the rate for African American babies twice that of white babies.
- A maternal mortality rate that has not improved in 20 years — 13th in the world. Maternal mortality is higher for women of color than for white women, nearly 4 times higher for African American women.
- A cesarean birth rate of 23.8% — among the highest in the world. Cesarean birth rates are highest for African American women, followed by white women, Latina women, Asian women, and Native American women.
- An induction rate that has doubled in the last decade.
- Many mothers traumatized by their treatment during birth, with as many as 30% exhibiting some signs of posttraumatic stress disorder and 50% with postpartum depression (the highest such rate in the world).

Moreover:

- Of the eight most common surgical procedures in the US, four are obstetric in nature — episiotomy, repair of obstetric laceration, cesarean birth, artificial rupture of membranes. These are in also the top four surgeries performed on women in the US.
- Obstetric procedures are the most common type of surgical procedures performed in the US (6,174,000), slightly higher than cardiac procedures (6,133,000). Consider the following:
  - — obstetric procedures are only performed on women
  - — more obstetric procedures are performed on women than the next two categories (cardiac and digestive) combined;
  - — there are over 6 million obstetric procedures, but just under 4 million births;
  - — these procedures are primarily performed on healthy bodies during a normal physiological process.

Photograph by Terri Moore

apprentice midwife in Conyers, GA.

The problem has steadily gotten worse over the last two decades. All obstetric procedures combined nearly doubled between 1980 and 1999, while certain procedures, such as medical induction of labor, vacuum extraction, and manually assisted delivery increased eleven-fold in that time. Each procedure carries with it risks to mothers and babies, and less invasive techniques exist for most of them. Furthermore, they are usually not medically necessary and are avoidable for the majority of women.

The Midwives Model of Care and the evidence-based Mother-Friendly Childbirth Initiative recognize birth as a normal, natural process and support the use of less invasive techniques, such as position changes, waiting, hydrotherapy, and perineal support, that carry fewer risks to mothers and babies and are usually more effective.

Research shows that midwives are the safest birth attendants for most women, with lower infant and maternal mortality rates and fewer invasive interventions such as episiotomies and surgical births (cesareans). In developed countries where midwives are the primary care providers for pregnant women, mortality and surgical birth rates are much lower than in the United States. However, legal, regulatory, and financial barriers to the practicing the midwifery model of care and mother-friendly care make it difficult for consumers to access either in the US.

NARM Applications Department Report -- June 2003

Sharon Evans, Anchorage, AK

Applicants

From January 1 to June 6, 2003, the Applications Department received a total of 29 applications. Comparisons have been made as follows:

Year	Application Packets Sent	Applications Received/Processed During the Year
2003 (1/1 - 6/6)	79	29
2002	179	97
2001	154	90
2000	220	59

The Applications Department generates random audits from applicants and CPMs. Items required are Practice Guidelines, an Informed Consent document, forms and handouts relating to midwifery practice and an emergency care plan. To date, 5 applicants have been audited in 2003.

CPMs

10 new CPM certificates have been issued so far in 2003 with several more anticipated by the years end.

Year	Total CPMs
2003 (1/1 to 6/6)	845
2002	804
2001	724
2000	624

To date, 5 CPMs have been audited this year.

Recertification

As expected, recertifications are increasing steadily each year. The Applications Department now has a new 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.

Year	Recertifications Issued
2003 (1/1 to 6/6)	77
2002	143
2001	148
2000	72

Finances

The Applications Department receives fees for application packets, CPM applications and recertifications.

Year	Total Fees Received
2003 (1/1 to 6/6)	$ 27,562.40
2002	$ 122,099.00
2001	$ 133,597.00
2000	$ 128,983.28

Preceptors

In the last issue 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 questionnaire. 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 Midwifery 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 births.

In addition preceptors are asked to affirm the length of time (fill in 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 an 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 our grandchildren and for their children.

Sincerely,

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
PO Box 420
Summertown, TN 38483

The Art and Science of Midwifery

Ida Darragh, NARM Test Department

How can a test, especially a written, multiple-choice test, be a true indicator of competence in midwifery practice? The two concepts seem miles apart. How can you test wisdom, judgment, and intuition? These are components of the ART of midwifery. Most midwives agree that midwifery is both an art and a science. Without science, the art of midwifery is freeform and spiritual, sort of a faith-based practice; but without the "evidence-based" background to guide the intuition. Without art, the science of midwifery would be a mere shell of the medical model, lacking the soul of true midwifery. The art of midwifery is the heart, but the science of midwifery is the brain. Both parts are needed to practice the true midwifery model of care. It is the science that sits unspoken in the intellect as the eyes and ears take in the signs and clues from the mother; it is the words spoken, the touch given, that communicate back to her in a way that strengthens her own understanding of her body and her labor. It is the knowledge that is the basis for wisdom; that guides the intuition.

People may doubt how a multiple-choice test can measure the art of midwifery. Those CPMs who have participated in the writing of test questions can verify how difficult it is to write questions that reflect the true spirit of midwifery. The science of midwifery is, however, well documented in the literature. Much of the knowledge that is tested on the NARM exam is based on facts from the midwifery textbooks. The writers then try to frame their questions in a scenario based on true practice experiences. This allows both the art and the science to be reflected in the question. Still, many "truths" that are testable are based on science rather than art. I've written before in the

CPM News about the frustration that many candidates express after taking the NARM Exam, especially about a perceived ambiguity among the answers. That is because all incorrect answers must contain a degree of plausibility. They are still wrong based on the specific information in that question and answer. A test question must make the candidate THINK. In that THINKING process, each answer is evaluated and if the "right" answer doesn't jump right out immediately, it usually slides to the surface soon. It may feel like an educated guess, when it is really the result of letting knowledge simmer under the surface. The candidate may not be "sure" of the right answer, but it is the intuition, judgment, and wisdom that will lead from the facts to the correct answer. It is the science that stays in the background that lets the art move toward intuition, judgment, and wisdom.

This, after all, is the way knowledge works in the real world. A midwife at a birth may sometimes have time to review some books that she carries in her birth bag, or to call another midwife for advice, but more often the decisions are based on what feels right, on what the intuition, judgment, and wisdom are saying. Without the science, without the facts and the book learning, and the evidence-based research, there is nothing feeding that intuition, nothing sustaining the wisdom, no perspectives in the judgment. Without the background of knowledge, the intuition has no soil to nourish its roots.

It may be true that a multiple-choice test cannot adequately measure the art of midwifery, but it can measure the science. The science is the cornerstone; the art is the communication, the style, and the faith, that express what we know to be true.

Applications Department on the Move

The North American Registry of Midwives (NARM) is moving its Applications Department. The Applications Department has been housed in Alaska for most of the Certified Professional Midwife (CPM) history, which began with our first applications in 1994.

Sharon Evans, NARM Board member, Anna Sippey and Dianne Osborne have done the majority of work in the Applications Department. We appreciate all the hard work they have done through the years to make NARM's Applications Department the state of the art department that it is.

Board member, Carol Nelson, will now oversee the Applications Department. The move is in process and after September 1, 2003 all applications, reference letters, recertifications, and application requests should go to the new address listed below. If you have any questions please feel free to call 888-842-4784. The new address is:

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

NARM is exploring the possibility of bringing this newsletter to you 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 email address to *cpmnews@narm.org*.

HIPAA Administrative Simplification: Tool Kit for Small Group and Safety-Net Providers

Prepared by the Pacific Health Policy Group

This document will help small group health care providers and safety-net health care providers gain a basic understanding of HIPAA requirements. It describes the key elements of each rule, suggestions for implementation, security guidelines, timelines, and further resources.

Section One: Background and Provisions provides specific implementation recommendations for each key HIPAA provision. The most important step an organization can take to organize its HIPAA compliance effort is the establishment of a HIPAA steering committee. An entire organization is responsible for HIPAA compliance. Therefore, the understanding, commitment, and involvement of representatives from key clinical and administrative areas are essential to a well-structured compliance program.

The appendices include selected implementation and reference materials, such as the make up of a steering committee, timeline for HIPAA compliance, resources on the Internet, and security compliance, procedures, and checklists, as well as a glossary.

Section Two: Overview Presentation provides a training tool for clinicians and senior managers to use in educating themselves and their staff. It provides an overview of the key HIPAA provisions, as well as a general description of the planning and implementation efforts necessary for the organization to achieve HIPAA compliance.

For the complete document go to *www.chcf.org* and click on HIPAA

Position Paper on the Practice of Midwifery

What is the North American Registry of Midwives?

The North American Registry of Midwives (NARM) is the leading certification agency for direct-entry midwifery in the United States. The NARM Certification credential and/or the NARM Written Examination are required for licensure in most of the states that license direct-entry midwives, and in all the states that license midwives specifically for out-of-hospital birth. NARM's midwifery certification is a state-of-the-art, legally defensible certification program. Since 1994, NARM has certified over 800 direct-entry midwives who practice midwifery primarily in out-of-hospital settings. Midwives credentialed by NARM are called Certified Professional Midwives (CPMs). NARM has defined the practice of midwifery as it applies to CPMs by a Job Analysis, or task survey, which was done in 1995 and in 2001. Demonstration of knowledge and skills on these tasks is required for certification.

Statement on the practice of midwifery:

The practice of midwifery is a distinctly separate profession from the practice of medicine or nursing. Certified Professional Midwives (CPMs) provide the Midwives Model of Care. They have demonstrated the knowledge and skills to provide full prenatal, birth, and postpartum care to low-risk women, to recognize deviations from normal, and to refer, consult, or transfer care if appropriate. The North American Registry of Midwives (NARM) affirms the autonomy of independent midwives, the critical importance of their role as guardians of normal birth, and the value of their compassionate, skilled, and woman-centered care.

Statement on the Regulation of direct-entry midwives:

The state regulation of direct-entry midwifery assures that credentialed midwives meet standard criteria for practicing, follow sanctioned protocols, and are accountable for their actions. Certified Professional Midwives (CPMs) are competent to practice midwifery. If a state chooses to regulate direct-entry midwives, NARM encourages the requirement of the CPM credential as the standard for eligibility. Supervision by any other health care provider is not required, though collaborative relationships are encouraged.

Adopted: April 6, 2003

In the following cases, the courts ruled that midwifery does not constitute the practice of medicine or nursing for purposes of statutes regulating the practice of medicine.

- In the Supreme Court Of The State Of Kansas, No. 73,851, the State Board Of Nursing and State Of Kansas ex rel. State Board Of Healing Arts, Appellants, v. e. Michelle Ruebke, Appellee. March, 1996

  The practice of midwifery is separate and distinct from the practice of medicine. The practice of midwifery is not incident to the practice of medicine or surgery so that it becomes part of the healing arts by the application of K.S.A. 65-2869.

  Assistance in childbirth rendered by one whose practical experience with birthing provides comfort to the mother is not nursing under the Kansas Nursing Act, such that licensure is required.

- Peckmann v. Thompson, 745 P. Supp. 1388 (C.D. Ill. 1990), is particularly informative on the question of whether the "practice of medicine" in its ordinary sense could be applied to midwifery. The Illinois court found that it could not, stating:

  "As noted, paragraph 4400-50 prohibits the 'practice of medicine in all of its branches.' Because the Act fails to define this term, and because its common understanding generally does not encompass assisting the normal delivery of a healthy child, the plaintiffs reasonably may have concluded that their conduct was not proscribed by that portion of the Act. Similarly, paragraph 4400~49 prohibits, among other things, the unlicensed treatment of any 'ailments, or supposed ailments.' Again, because that term is nowhere defined, and because its common understanding generally does not describe the condition of a pregnant woman without complications, the plaintiffs reasonably may have concluded that their conduct was not proscribed by that portion of the Act." 745 F. Supp. at 1393.

- State of California, In the Matter of the Accusation Against: Case# 1M-98-83794 Alison Osborn, LM. OAH # N-1999040052.

  Findings of Fact: "Midwives employ a midwifery model of practice distinct from the medical model of practice."

  Legal Conclusions: "Unlike physicians, physician assistants, physician assistant midwives, registered nurses, or certified nurse midwives who practice within the context of a medical model, licensed midwives practice within the context of a midwifery model."

- Summary of Cases from the American Law Reports 4th, © (1988) The Lawyers Co-operative Publishing Company © 2002 West Group, Annotation Midwifery: State Regulation, Noralyn O. Harlow, J.D:

  While holding that a state nursing registration board had the power to discipline a nurse on the basis that she violated a statute governing nursing and its accompanying regulations by engaging in the practice of mid-

wifery without certification, the court in *Leigh v Board of Registration in Nursing (1985) 395 Mass 670, 481 NE2d 1347,* later app *399 Mass 558, 506 NE2d 91,* nevertheless found that the mere practice of midwifery itself was not grounds for discipline because it did not constitute the unauthorized practice of medicine. The court observed that there was no statutory prohibition against the practice of midwifery by lay persons, noting that the legislature regulated midwifery only with respect to nurses. In addition, the court found that since case law indicated that ordinary assistance in the normal cases of childbirth would not be considered the practice of medicine, it therefore could not prohibit the practice of midwifery as the unauthorized practice of medicine.

- Overturning a nursing board's revocation of a nurse's license to practice, the court in *Leggett v Tennessee Bd. of Nursing (1980, Tenn App) 612 SW2d 476,* held that while the nurse was acting as a lay midwife, she was not performing as a nurse and therefore was not subject to nursing regulations or statutes. Since state statutes and regulations specifically excluded midwifery from the practice of medicine and from the practice of nursing, and since the nurse did not perform as a nurse in her role as a midwife, the court ruled that she should not have her nursing license revoked, especially where there was no showing that performing the services of midwife independently of the profession of nursing in any way adversely affected her skill or ability as a registered nurse.

  In *Leggett v Tennessee Bd. of Nursing (1980, Tenn App) 612 SW2d 476,* the facts of which are set out in § 14c, the court noted that midwifery was specifically excluded from the practice of medicine by state statutes and regulations, and thus a midwife was not subject to provisions regulating the practice of medicine.

- Holding that the statutory provision for licensing individuals who wished to practice "medicine, surgery, and midwifery" applied only to those wishing to practice medicine, and did not extend to individuals who practiced only midwifery, the court in *People v Hildy (1939) 289 Mich 536, 286 NW 819,* reversed a conviction of a midwife for practicing medicine without a license. The court reasoned that since the practice of midwifery was recognized in other statutes separate from the practice of medicine and surgery, individuals who wished to practice only midwifery were not regulated by the statute which covered individuals who wished to practice medicine, surgery, and midwifery, inclusive.

- Holding that the practice of midwifery did not constitute the unauthorized practice of medicine, the court in *Banti v State (1956) 163 Tex Crim 89, 289 SW2d 244,* overturned a midwife's conviction for the misdemeanor offense of unlawfully practicing medicine. The court found that the legislature had not included the act of assisting women in childbirth within the practice of medicine for the purposes of the statute making the unlicensed practice of medicine a punishable offense, observing that the legislature had in a number of statutes recognized midwifery as outside the realm of the medical practice act.

- In holding that midwifery did not constitute the unauthorized practice of medicine, the court overruled *Sachs v Board of Registration in Medicine (1938) 300 Mass 426, 15 NE2d 473,* a case involving the issue of whether the practice of medicine included optometry, where the court stated that the practice of medicine included midwifery.

NARM Establishes New Categories of Inactive and Expired Certification

The designation Certified Professional Midwife (CPM) indicates that a midwife has documented the clinical experience and demonstrated the knowledge, skills, and abilities that are required for certification. The NARM process is considered valid and reliable because it meets or exceeds the national standards for certification in setting the criteria for certification and for determining that all CPMs have met those criteria. The purpose of recertification is to verify that all CPMs continue to meet those standards. Although current experience as a primary midwife is necessary for the initial certification, it is not a requirement for recertification. CPMs may take a sabbatical from attending births, or may retire completely, and still maintain certification. Many CPMs who retire from active practice want to maintain their credential as a way to identify their status as a CPM as they continue in fields peripheral to midwifery practice, such as teaching or political activism. In order to keep a credential, a certificant must demonstrate continued competency in some manner that satisfies the original intent of the certification. NARM has chosen to meet that intent by requiring continuing education in the field of midwifery.

Maintaining the credibility of the CPM certification credential is an ongoing process. New candidates for certification are aware of the intricate applications process and of the challenging testing process. It is easy to think that's all there is! However, those processes must be continually revised and updated. Application materials are revised and reprinted regularly. Our major publications, the Candidate Information Bulletin and the How to Become a CPM, must be reviewed for currency and new information added.

The Job Analysis that determines the content of the testing programs must be reviewed every five years, and new forms of the written examination must be developed every two years. NARM makes every effort to involve all CPMs in these processes, which utilize both human and financial resources. In addition to the tasks of primary certification, NARM promotes midwifery through the CPM credential at several national conventions each year, such as the American Public Health Association, the National Conference of State Legislators, the American College of Nurse Midwives, the Midwives Alliance of North American; and at national conferences of certification and regulatory agencies such as the National Organization for Competency Assurance and the Council of Licensure, Enforcement and Regulation. When the midwives in an unlicensed state are seeking licensure options through legislation, NARM acts as a resource for those involved in the state process and may send representatives to educate the state boards or legislators about the importance of legal recognition for midwives. All of these activities beyond basic certification services are services that NARM provides to promote midwifery and support midwives. These services are necessary to maintain the value of the CPM credential to each and every CPM, and they are services that require time, effort, and money. To best maintain this credential NARM needs for every CPM to stay recertified beyond her initial three-year certification period, whether actively practicing or not. NARM depends on the $150 recertification fee (that's $50 per year) to continue the work that keeps the certification valid and valuable for all CPMs.

It is NARM's hope that all CPMs will maintain their certification, becoming recertified when their certification period ends. However, NARM also realizes that some CPMs will retire and may not maintain their priority of continuing midwifery education and recertification. Without keeping the credential current, the midwife may not claim to meet the certification standards by using the CPM designation. The midwife may consider the retirement as temporary and may intend to recertify in the future. NARM recognizes that within a specific time frame, a midwife whose certification has expired should be allowed to recertify by documenting continuing education and reapplying for certification status. NARM is answering this need by creating an "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 is renewed each year by filing an intent to be inactive and a fee of $35. 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 that six-year period, an inactive midwife may renew the certification by submitting the Recertification form and fees ($150, 25 continuing education hours, five hours of peer review, plus the recertification form documentation).

If a CPM does not recertify or notify NARM of Inactive Status within 90 days of expiration, the certification will be considered expired. Expired CPMs will not receive the newsletter or any NARM mailings, and may not use the designation CPM or Certified Professional Midwife. Expired CPMs who wish to recertify, regardless of the length of the expired period, must purchase a Reactivation Packet ($50), complete all the requirements for recertification, attend at least five births, and retake the NARM Written Examination ($700, or the current examination fee).

CPMs whose certification is due to expire in the remainder of 2003 may choose from these options, and will receive a letter explaining the choices prior to expiration. All CPMs whose certification expired within the past six years will also be offered the opportunity to choose an inactive status, with no penalty, until December 31, 2003.

As of January 1, 2004, all 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 and forms regarding recertification, certification status, or reactivation are available on the web at *www.narm.org*.

What's on the Website:

Site Sections
• How to Become a CPM
• Candidate Information Bulletin
• CPM Recertification
• Policy and Procedures
• Peer Review
• CPM State Information
• 1995 Job Analysis
• Application Deadlines
• CPM Stat Forms

Related Organizations

CfM Membership News

Citizens for Midwifery has just broken the "500" mark for members! This is great news, since we depend on memberships to support our work. However, if Citizens for Midwifery is to become a truly effective force in changing childbirth in the U.S., our organization must have many, many more members! Growth is needed in order to have credibility, in order to get media attention and access to "the public," and in order to be economically self-sustaining for basic costs (including an increasing need to hire help for some tasks as well as travel to build bridges with other groups, such as ICAN - see below).

Your clients are people who understand first hand the benefits of the Midwives Model of Care, and are therefore especially important. Citizens for Midwifery does not have access to your clients, except through you. We have FREE literature you can include in your new client packets. We have a reduced membership so you and your clients don't have to choose between joining Citizens for Midwifery and your state midwifery or midwifery advocacy organization. We strongly encourage you to talk to your clients about the politics of midwifery and childbirth, and to at least tell them about Citizens for Midwifery.

If you are not a member of Citizens for Midwifery, we invite you to join. (CfM is "consumer-based" but welcomes EVERYONE who loves midwives and wants to see the Midwives Model of Care available to every mother. Visit our website www.cfmidwifery.org , browse the information, join on-line, print out an order form and send for materials for your client packets. Consider including a membership for each client. Add the cost onto your normal charges, explain to your clients that you are willing to put yourself on the line for them, and that joining Citizens for Midwifery is what you are asking of them in return. In this way you are helping Citizens for Midwifery continue to operate. At the same time you are making sure your clients are informed about the politics of childbirth, both through your comments to them and also through the *Citizens for Midwifery News* that all members receive. Can ALL of you do this with ALL of your clients? Of course it won't always be appropriate. However, it is likely that this is both possible and appropriate for almost all of you and for most of your clients.

A huge thanks to a handful of midwifery practices across the country who are now signing up all of their clients with memberships in Citizens for Midwifery. This has contributed significantly to the recent and much needed increase in members!

CfM at ICAN Conference

As the President of Citizens for Midwifery, I attended the International Cesarean Awareness Network (ICAN) Conference in Florida, May 9-11. I was an invited speaker, having been asked to give a presentation about "VBAC Attack and Midwifery." I began with a review of the present trends for cesareans (up) and VBACs (down), and the available research along with the disinformation campaign (per Henci Goer's article). I discussed the different categories of midwives and the advantages of the Midwives Model of Care, along with legal issues facing midwives. A short list of "concerns" that caregivers, including midwives, may have (Type of suture; Placental problems; How long since c-section; Number of c-sections; Embolism risk) elicited a heated and intense response. The list was seen as reasons to deny a VBAC, and these women are really frustrated with the many roadblocks that are used as excuses to deny them a chance at a vaginal birth. I finished up with the idea that women who feel wronged, abused, or otherwise mistreated by the medical system could file formal complaints with their state medical board and others, as well as some ideas for keeping VBAC alive. Overall, I encouraged ICAN members to also join CfM, and for the two organizations to look for ways we might work together on issues or projects of mutual interest.

Meeting with this group of women greatly heightened my awareness of the trauma and terrible emotional and physical costs of unnecessary cesareans and the increasingly difficult situation for women seeking VBACs. As more and more hospitals refuse to allow VBACs, the only option for these women is out-of-hospital birth, with or without a midwife. Even licensed midwives attending home births are not legally allowed to attend VBACs at home in a number of states.

While a number of childbirth educators and doulas attended, almost no midwives were present, and no representatives from MANA or ACNM. Many ICAN members have felt let down or betrayed by midwives or have had negative experiences with midwives (of all kinds). There is a great opportunity to learn from these women and build bridges with this organization and its members.

While preparing for my talk, I found the Vermont/New Hampshire VBAC Project materials at *http://www.vbac.com/hottopic/vbacproject.html.* This project has helped maintain access to VBACs (hospital and home) in these two states. The information for consumers is excellent, including a chart comparing rates of several different complications (including uterine rupture) for VBAC vs. planned repeat cesarean section which puts the very small risk of uterine rupture (however defined) into perspective. The VT/NH project materials probably would be very useful wherever anyone is working to get or maintain access to VBACs.

The data presented in the VT/NH Project, as well as the findings of Lydon-Rochelle (even considering the problems with this study), added to the risks for future pregnancies associated with each additional cesarean section, makes a strong case for VBACs. In particular, it is difficult to see any medical rationale for either the new ACOG guidelines or blanket prohibition of home VBACs with the many supportive advantages of the home setting. Bravo to all of you who have worked hard for state rules allowing licensed midwives to attend home VBACs!

From the Vermont/New Hampshire VBAC Project

http://www.vbac.com/hottopic/vbacproject.html

Complications occurring in women trying vaginal birth after cesarean section versus planned cesarean birth.
(This table is from the Vermont/New Hampshire VBAC Project document "Birth Choices after Cesarean" which can be found on the website *www.vbac.com*)

Complication	VBAC Attempt	Planned Cesarean Birth
Uterine Rupture (a)	5/1000	2/1000
Hysterectomy (a)	2/1000	4/1000
Blood Transfusion (a)	11/1000	17/1000
Maternal Infection (a)	43/1000	59/1000
Infant Infection (b)	50/1000	20/1000
Infant Breathing Problem (c)	13/1000	41/1000
Serious Infant Breathing Problem (c)	1/1000	4/1000
Overall Risk infant death (a)	6/10,000	3/10,000

(a) Mozurkewich, D.L. and E. Hutton, *Elective repeat cesarean delivery versus trial of labor: A meta-analysis of the literature from 1989-1999*. Am J Obstet Gynecol, 2000. **183**: p. 1187-97.
(b) Hook, B., *et al.*, *Neonatal morbidity after elective repeat cesarean section and trial of labor*. Pediatrics, 1997. **100**: p. 348-53.
(c) Levine, E., *et al.*, *Mode of delivery and risk of respiratory diseases in newborns*. Obstet Gynecol, 2001. **97**: p. 439-42.

Data* for women who had a first (single) baby by c-section from 1987-1996, and subsequently gave birth to a second live single infant during the same period of time (20,095 women, based on Washington State records for hospital births), were analyzed in this study. The study found:

For women with one prior c-section: Rate of uterine rupture in second birth (Per 1000)

Repeat c-section without labor 1.6 (11 of 6,980 women)
Spontaneous onset of labor 5.2 (56 of 10,789 women)
Labor induced without prostaglandins 7.7 (15 of 1,960 women)
Labor induced with prostaglandins 24.5 (9 of 366 women)

* *Mona Lydon-Rochelle, Holt, Victoria L., Easterling, Thomas R., Martin, Diane P. "Risk of Uterine Rupture during Labor among Women with a Prior Cesarean Delivery" New England Journal of Medicine, Vl 345, No. 1, July 5, 2001.*

MANA CPM Survey is Complete!

A special thanks to those of you who completed and returned the survey postcard which was enclosed in the last CPM News. The information you provided for us will be very helpful in guiding MANA in the future to best meet the needs of our midwives!

The most common reasons why CPMs are members of MANA was: "Because MANA honors diversity, unity and serves as an umbrella for all midwives.", "To receive support and leadership from a professional organization" and "Because MANA supports the CPM, solidarity and unity."

The most common reason why CPMs are not members of MANA was for financial reasons. They felt membership was cost prohibitive.

Reduced fee membership

Did you know that MANA offers a payment plan and a reduced fee membership to members who are unable to pay the full fee? We do! Simply write a statement of need to our Membership Chair, Nina McIndoe, explaining the circumstances which prevent you from paying the full fee.

Nina McIndoe
MANA Membership Chair
2471 Waterfall Lane
Columbus, OH 43209
membership@mana.org

MANA CPM Section E-Group

As a MANA Member, you can join the new CPM Section of MANA! This group has an E-Group that is currently discussing their meeting agenda for the Fall Conference in Austin, TX and identifying issues of concern to MANA's CPM members.

To join MANA's CPM E-Group, you must be a MANA member and a CPM. To join the E-Group, send an email to *manacpm-subscribe@yahoogroups.com* and join the excitement!.

Notices & Announcements

Revocation of CPM Credential

The North American Registry of Midwives (NARM) recognizes that each Certified Professional Midwife (CPM) will practice according to her/his own conscience, practice guidelines and skill level. Certified Professional Midwives shall not be prevented from providing individualized care.

When a midwife acts beyond Guidelines for Practice, the midwife must be prepared to give evidence of informed choice. The midwife must also be able to document the process that led the midwife to be able to show that the client was fully informed of the potential negative consequences, as well as the benefits of proceeding outside of practice guidelines.

NARM recognizes its responsibility to protect the integrity and the value of the certification process. This is accomplished through the availability of a grievance mechanism. All Certified Professional Midwives have the opportunity to speak to any written complaints against them before any action is taken against their certificate.

Sherrill Malone's CPM certification was revoked for failure to comply with the jointly agreed upon stipulations that resulted from a Peer Review.

Veterans Administration Approval

Veterans and their eligible dependents may now be reimbursed for the cost of taking the Written Examination of the North American Registry of Midwives. The Veterans Administration has approved the NARM Exam in a category called "Licensing and Certification Tests." The approval is retroactive to March 1, 2001. The reimbursement covers only the cost of taking the test ($700) and not for any other fees such as the application fee or the PEP fee.

NARM Item Writing Workshops

One of the most important aspects of the CPM certification process is that it is designed by midwives. The criteria for certification was set by the Certification Task Force, composed of many midwives from across the country who met multiple times to discuss the specifics of certification; the content of the Skills Assessment and the Written Examination are determined by the Job Analysis survey which was sent in 1995 to 3000 identified practicing midwives and in 2001 to 678 CPMs; and the questions for the Written Examination are written and reviewed by CPMs who are trained as Item Writers. Item writer training is a course in the design of a multiple-choice exam: the elements of a good question, the criteria for correct and incorrect answers, and the consistency of structure and language. Ideas for exam questions can come from many sources, but these ideas must be crafted into questions and answers (items) by those with an understanding of the design elements.

NARM has prepared a workshop for CPMs who want to write questions for the NARM Written Examination. This workshop was presented at the MANA conference in Boston last October. Many CPMs expressed an interest in Item Writing, but were unable to attend the conference workshop. NARM would like to train more item writers this year, especially teams of writers from various parts of the country and from varying practice environments. NARM is offering to repeat the Item Writing workshop for groups of six or more CPMs. Participants need to commit to a two-day time frame. There needs to be a host, or someone who will coordinate all local arrangements, including a place for the workshop and lodging for the trainer and any overnight participants (a home will be fine). There is no cost for the Item Writing Workshop, but participants will be responsible for their own travel arrangements. Please contact NARM if you are willing to be a host of an Item Writing Workshop, or if you want to be notified of any planned workshops in your region. Call the test department at 1-888-353-7089, or email *testing@narm.org*.

Qualified Evaluator Workshops

If a region will host an Item Writing Workshop with at least 5-6 participants, NARM will also offer QE training with no minimum number of participants. QEs must be CPMs with at least three years experience and 50 births beyond the number required for certification. There is a cost of $100 for the QE Workshop, but this fee includes a copy of the Practical Skills Guide for Midwives (a $60 value). QEs are also paid by NARM for administering the Skills Assessment ($75 per candidate). The QE workshop is a full day workshop and can be held the day after the Item Writing workshop. The QE workshop fee will be waived for anyone who hosts the Item Writing workshop. Please contact NARM as indicated above if you are interested in a QE workshop.

Continuing Education Credits

CEUs have been granted by MEAC for both the Item Writing Workshop and the QE Workshop. Participation as an Item Writer or QE also qualifies the CPM for credit in category five of the recertification packet.

Send your ideas for test questions to *testing@narm.org*

(See page 13)

NARM Needs Your Ideas for Test Questions

While NARM Test questions must be written by those trained in Item Writing, ideas for the questions can come from any midwife. The purpose of the exam is to differentiate between those midwives who are competent to practice independent midwifery and those who are not quite ready for independent practice. We are looking for situations that are common to midwifery practice as identified by those who are currently in practice. NARM welcomes submissions of ideas for test questions from all CPMs. Please send us a problem or scenario in 3-5 sentences. These situations can come from prenatal care, birth, or postpartum. Include, if you will, your idea for the correct answer and any ideas for incorrect answers. Incorrect answers should be plausible to an inexperienced apprentice, but lacking some understanding of the situation. NARM seeks LOTS of ideas. The Item Writers will likely revise the scenario and answers, but IDEAS are what we need to start with. Test Specifications for the Written Exam can be found in the Candidate Information Bulletin, or on the web at www.narm.org. Send any ideas by email to *testing@narm.org,* or to the NARM Test Dept, P.O. Box 7703, Little Rock, AR 72217-7703.

NARM Thanks These CPMs Who Have trained as Item Writers and Qualified Evaluators

We say this over and over again, but it bears repeating: NARM is created by and for the midwives who believe in credentialing direct-entry midwives as a way to insure the continuation of home birth (out-of-hospital birth) for families in every state. The NARM Board members are volunteers who are, or have been, practicing direct-entry midwives, plus at least one consumer with a home birth background. Every part of the credentialing program has been crafted by the very people it supports and represents. From the early MANA committees to the Certification Task Force meetings, from the first and second Job Analyses to the test question writing teams and the cut score workshop, every significant aspect of the NARM certification program has been designed and implemented by direct-entry midwives. That is why NARM is the leading certification agency for direct-entry midwifery in the United States. NARM is grateful to all the CPMs who have committed their time and energy to making this process work for all of us.

There are over 100 Qualified Evaluators who have been trained to administer the NARM Skills Assessment as part of the Portfolio Evaluation Process. In 2003, NARM has thus far given the Qualified Evaluator workshop in Boston, MA., Lakeland, FL., and Nashville, TN.

New Qualified Evaluators on the NARM list include:

Karen Brock, Alabama
Pamela Crowl, Colorado
Marianne Power, Florida
Jeanne Madrid, Florida
Madrona Bourdeau, Oregon
Linda Schutt, New York
Kathy Williams, Tennessee
Cynthia Taylor, Tennessee
Mary Anne Richardson, Tennessee
Jane Hitch, Tennessee

NARM has also held three workshops in 2003 to train CPMs to write questions for the NARM Exam. This training includes the issues of reliability and validity, components of the multiple-choice question, relevancy of knowledge and skills, and grammar and structure of test questions.

These participants will join the other NARM Item Writers in submitting questions for the NARM exam. All questions are then reviewed by several teams of experienced midwives before being placed in the item bank of potential test questions.

NARM greatly appreciates the work done by these CPMs in helping to create a reliable and valid midwifery examination.

Karen Brock, Alabama
Karen Erlich, California
Marianne Power, Florida
Jeanne Madrid, Florida
Sue LaLeike-Olson, Florida
Gwen Johnson, Florida
Jennie Joseph, Florida
Claudia Conn, Georgia
Rebecca Hensley, Kansas
Karen Carr, Maryland
Adrian Feldhusen, New Hampshire
Linda McHale New Jersey
Joanne Gottschall, New Jersey
Kathy Williams, Tennessee
Debi Church, Tennessee
Cynthia Taylor, Tennessee
Carol Nelson, Tennessee
Sandy Tinnin, Tennessee
Susie Meeks, Tennessee
Heather Wilson, Tennessee
Mary Anne Richardson, Tennessee
Angie Neis, Tennessee
Jane Hitch, Tennessee
Sharon Wells, Tennessee
Ann Crowl, Texas
Shannon Anton, Vermont

Notices & Announcements

Cesarean Rates Hit All-Time High, Midwives Sound Alarm

Increase Fueled by Rise in Elective Cesareans

Washington, DC-The American College of Nurse-Midwives (ACNM) released a response to recent data released by the National Center for Healthcare Statistics (NCHS) showing a national cesarean section rate of 24.4% - an all-time high. In its statement, ACNM calls upon all obstetric providers to provide thorough information on the impact of all birth options to the mother during prenatal consultations. The current trend suggests that some obstetric providers are abandoning the most cautious approach under the guise of questionable science, convenience, and fear of lawsuits.

"As we move forward into the 21st century, the national cesarean section rate is rising fast enough to get the attention of the American health care system and ignite a furor over the move toward an assembly line model of childbirth," remarked ACNM Executive Director Deanne Williams, CNM, MS. "Despite the NCHS figures showing that one of every four women will have major abdominal surgery to deliver her child-some people are alarmed and, inexplicably, some are not."

Stories of cesarean sections performed for motivations other than maternal or fetal well-being have been making headlines in recent years. They reflect a rise in elective cesareans for reasons such as avoidance of labor pain, patient or provider convenience, legal concerns of the provider or questionable assumptions about the origin of incontinence in women. There is no question that lives can be saved by the judicious use of cesarean section; but, in a nation with seemingly endless resources, easy access to information and multiple sites for clinical training as can be found in the United States, a national cesarean rate of 24% is not a sign of progress, but rather misplaced priorities.

"The list of reasons women must not think that surgical birth is safer than vaginal birth is long and ranges from the increased incidence of drug resistant infections, to the potential for life threatening complications from blood transfusions," according to ACNM President Mary Ann Shah, CNM, MS, FACNM. "Women risk permanent damage to abdominal and urinary tract organs, longer recovery times, little-to-no chance for a subsequent vaginal birth and a premature end to their ability to safely bear children. Technology is an alluring panacea for ills, but blind devotion without critical evaluation, places women at great risk"

The ACNM Statement can be viewed at www.midwife.org. For more information, or to speak with an ACNM spokesperson, contact Eric A. Dyson at 202-728-9876, or email *edyson@acnm.org*.

With roots dating back to 1929, the American College of Nurse-Midwives is the oldest women's health care association in the U.S. ACNM's mission is to promote the health and well-being of women and infants within their families and communities through the development and support of the profession of midwifery as practiced by certified nurse-midwives and certified midwives. Midwives believe every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations.

Eric A. Dyson
Communications Manager
American College of Nurse-Midwives (ACNM)

202-728-9876 (phone)
202-728-9897 (fax)

Become a NARM Qualified Evaluator

The NARM Qualified Evaluator workshop will train CPMs to administer the NARM Skills Assessment to candidates coming to certification though the Portfolio Evaluation Process. QE candidates must have the following experience in addition to the minimum required for the CPM certification: two additional years of midwifery practice, 30 additional out-of-hospital births, 300 additional prenatal exams, and 30 additional postpartum exams. These additional experiences may have occurred before or after certification, but must be in addition to the numbers required for entry-level certification. QEs must also maintain certification as a Certified Professional Midwife. Participants will receive the QE Handbook and the Practical Skills Guide for Midwives. There are many states where QEs are desperately needed. If you qualify, please consider becoming a QE. If you are a new CPM who had to travel a distance to take the Skills Assessment, encourage the experienced midwives in your area to become Qualified Evaluators.

Registration and fees are required for the Qualified Evaluator workshop. The NARM workshops are listed in the MANA conference brochure, but you must register for these workshops through the NARM Test Department. For more information, call the NARM Test Department at 1-888-353-7089. For more information about the MANA conference, check the web page at *www.mana.org* .

Don't let your CPM certification expire!
(See new policy on page 8).

NARM Qualified Evaluators!

If you are a NARM Qualified Evaluator who became qualified before 1997, you must recertify as a QE by the end of 2003. You can recertify by taking the video exam or by attending the QE Workshop in Austin at the MANA conference. There is a $25 fee for either method of recertification as a QE. In addition, you must be currently certified as a CPM, so don't let your certification expire!

If you are a QE and have not recertified by video or workshop, please let us know if you intend to maintain your QE status, and how you intend to recertify. If you want the video for recertification, please let us know NOW so we can send it to you. You will have two weeks to watch the video, fill out the booklet, and return it to NARM.

Name_____

Address_____

City _____

St_____ Zip_____

Email address_____

Please send me a registration form for:

- ❑ The NARM Cut Score Workshop, Setting the Passing Standard, Oct 30, Austin
- ❑ The NARM Qualified Evaluator Workshop, Oct 30, Austin, fee $100
- ❑ Recertify as a QE at the MANA conference, Oct 30, Austin, fee $25
- ❑ Recertify as a QE, send me the video exam, fee $25

Send with fee to NARM Test Dept, P.O. Box 7703, Little Rock, AR 72217-7703

NARM Board participates in related organizations

Following are upcoming conferences that members of the NARM Board will be attending:

Council on Licensure, Enforcement and Regulation (CLEAR)
Toronto, Canada
September 11th-September 14th

Midwives Alliance of North America (MANA)
Austin, TX
October 31st- November 2nd

Amer. Public Health Assn (APHA)
San Francisco, CA
November 14th - November 20th

National Organization for Competency Assurance (NOCA)
Orlando, FL
November 21st-November 23rd

Midwifery Today
Philadelphia, PA
March 18-20, 2004

NARM's Pre-Conference Workshops at MANA, October, 30, 2003, Austin, Texas

Evaluating Midwifery Education: Setting the Passing Standard for the NARM Exam

One of the significant features of the NARM certification program is the participation by CPMs in every aspect of the program. Last year at the MANA conference, NARM had a workshop to train CPMs to write questions for the NARM Exam, a workshop that was repeated several times during the year. These questions are added to our Item Bank, a database of questions from all versions of the exam. From that Item Bank, a new version of the exam is developed every 2-3 years. When a new version is prepared, it must be evaluated by Subject Matter Experts (CPMs with training in the process) to set the passing score (cut score) for that version of the exam. The training for this process requires education in the evaluation of knowledge as it applies to a midwife who is just competent enough to practice independently. These criteria must then be applied to every question on the examination. A mathematical process will result in the setting of the passing score. NARM needs a group of volunteer CPMs who will participate in this workshop on October 30 at the MANA Conference in Austin, Texas.

We really need CPMs to participate in this process. It is important that real midwives write the test questions, review the test questions, and set the passing score for the exam. Although all the people on the NARM Board are "real" midwives and participate in both writing and reviewing questions, it is not the function of the board to do these things isolated from the rest of the midwife community. We need for several CPMs outside of the Board and outside of formal educational venues, to participate in this process.

NARM does not provide transportation to the conference or any expenses for the actual MANA conference, but will provide a shared room for one night prior to the workshop and lunch during the day. CEUs have been applied for. All participants must sign a confidentiality agreement and must also agree not to participate in a test preparation course for at least three years after the workshop.

To register for the workshop, or for more information, please contact Ida Darragh at 1-888-353-7089 or *testing@narm.org*.

Information Requests

Can NARM Give Your Name to Those Who Request Information?

NARM often receives requests from people who want to find a CPM in their area. Because of the volatile legal situations in some states, NARM has a policy of not releasing names of CPMs unless permission has been received from the midwife. If you wish to give permission for the release of your name, you must notify NARM's public education office. You may do this by sending the statement below to *info@narm.org*, or by mailing it to Debbie Pulley, CPM, NARM Public Education, 5257 Rosestone Drive, Lilburn, GA 30047.

Release Form

I, (print/type name)_____ give permission for NARM to release my name as a CPM. This becomes effective on (date)_____. I understand that to revoke this permission, I must send notice in writing to the same address.

Current address:_____

Current city, state, zip:_____

Current phone:_____Current e-mail (if available):_____

Current status: ___ legally recognized (licensed, registered) by state, or___ no legal recognition by state

CPM News

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Anchorage, AK 99514

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