



Professional Midwifery in the United States: The American College of Nurse-Midwives Turns 50

The year 2005 marks the 50th Anniversary of the incorporation of the American College of Nurse-Midwives (ACNM). From a tenacious group of 16 founding members, ACNM has multiplied and diversified. The organization now represents more than 7000 certified nurse-midwives and certified midwives who are attending more than 10% of the vaginal births in the United States and providing primary health care services to millions of women each year.

Throughout the year, the *Journal of Midwifery & Women's Health* (JMWH) will publish a wonderful collection of articles and photographs that will remind us of where we have been and challenge us to think of new places to go. Thanks to Katy Dawley, CNM, PhD, and Helen Varney Burst, CNM, MSN, DHL (Hon.), we no longer have to search through volumes of journals to nail down noteworthy historical dates.¹ The March/April issue of JMWH will feature a series of articles on the history of ACNM. More than a review of history, these articles also analyze data trends and provide clarity as we weigh the value of our accomplishments.^{2,3} Likewise, a review of 78 years of research on midwifery care of the poor will provide powerful confirmation of the contribution our profession has made to improve the lives of women and their families.⁴ Articles that capture significant events in the evolution of our professional journal, standards for education, and challenges of leadership will be trail markers for our incredible journey as a profession.^{5,6}

As we pause for this momentous occasion and prepare for the years ahead, it is important to explore the professional policy debates that have, and will continue to, accompany our commitment to each other, our profession, and the women we serve. Some of our more serious debates have been captured in JMWH editorials, others are found in *Quickenings*, and some are permanently etched in the memories of past presidents.²

The decision to establish a profession and a professional organization, separate from nursing, was controversial 50 years ago, and our relationship with nursing continues to evolve. Few would deny that we have successfully established a credible, national voice for the profession. But, with nurse-midwives licensed under Boards of Nursing/Advanced Practice Nursing in 38 states, the District of Columbia, and 3 territories, our professional status is often under or inappropriately recognized. Some say times have changed and we are not that different from our nurse

practitioner colleagues; others warn that we are in danger of losing our identity and our ability to practice independently under the guise of the title "advanced practice nurse." Although ACNM has made a strong commitment to assist state by state efforts to establish boards of midwifery, this has been a difficult goal to actualize.

It may seem incomprehensible to some that ACNM members once strongly opposed the expansion of our scope of practice to include family planning services and sexual health counseling. Now we question the impact of midwives working as first assistants at cesarean sections and wonder what responsibilities we will be asked to assume as the human genome project and stem cell research unfold. Our position on informed decision making must be reevaluated as the Centers for Disease Control and Prevention calls for opt-out rather than opt-in screening for HIV/AIDS. We have barely begun to talk about the new ethic statements that are needed as we deal with the increasingly complex business aspects of health care.

Our early adherence to core competency-based education set an example that many wish to emulate; yet, we adopted the bachelor's degree as a minimum standard just as the nursing community was adopting the master's degree as the requirement for entry into advanced practice. Then, in October 2004, the American Association of Colleges of Nursing (AACN) endorsed a position that supports a Doctor of Nursing Practice degree as the highest level of preparation for clinical practice. In a move that is either visionary or preposterous, AACN is also recommending that, by the year 2015, a doctorate be required for all advanced nursing practice roles.

Almost 10 years ago, ACNM adopted a common standard for the education, certification, and practice of nurse (CNMs) and direct entry (CMs) midwives; yet, to this date, only 2 states offer a license to a certified midwife that is equivalent to the license offered to a certified nurse-midwife. And before we have this problem resolved, we may be compelled by world trade agreements to recognize midwife credentials that are endorsed by countries whose education system may not be equivalent to our own.

Our rather remarkable rate of growth has blessed us with a diverse set of value systems, and our capacity to impact women's health policy has never been stronger. More women have access to midwifery care. More physicians have learned to respect our contribution to women's health. We have demonstrated our capacity to work collaboratively

and take responsibility for our own actions. The 2002 ACNM-American College of Obstetricians and Gynecologists Joint Statement of Practice Relations between obstetricians and gynecologists and CNMs/CMs is a significant milestone. Time will undoubtedly reveal that the positive impact of this statement is both in what it says and what it does not say.

We have become accustomed to reading nothing but the best about our profession. At the same time, we are not exempt from being sued, and we are being held responsible for our omissions and commissions. As we face increased demands from the public to be accountable for errors, unprofessional conduct, and malpractice, we will need to be part of a larger community to solve these problems. As a voluntary membership organization, ACNM can take the lead in establishing a code of ethics and standards of practice and education that reflect well on the profession. We can work with other agencies and organizations to address system problems that contribute to or exacerbate errors. We can set an example for individual midwives, group practices, and state regulatory bodies.

Clearly, our work as a profession is not done, and our family ties will be tested in the future. I believe our strengths lie not only in what we have done but how we have done it. We have created a wide variety of mechanisms whereby members can participate in our decision-making process. In fact, lack of membership has not been an impediment to being heard by this organization. Our volunteer network is now supported by professional staff. Our most far-reaching decisions have been grounded in time-consuming data collection, extensive education, and the opportunity for respectful dissent. Willing to stand firm

on our commitment to build a profession, we have also been willing to change with the times. Even more important, we understand that our profession is judged by the actions of individuals and the actions of the organization. We have not forgotten the high price that has been paid to earn our reputation as health care professionals who can be trusted with the lives of women and their families. Individually and collectively, we will not, must not, break that trust.

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