Exchanging the Merits of OB Collaboration with Certified Nurse-Midwives

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Introduction: A Growing Shortage of OB/GYNs

As the number of working OB/GYN physicians slowly declines, the female population is projected to increase 36% by 2050. Almost half of all U.S. counties do not have a single OB/GYN provider. Without question, the United States faces a gap in perinatal care services. In fact, the American College of Obstetricians and Gynecologists (ACOG) estimates there will be an 18% shortage of (up to 22,000) OB/GYNs by 2030.¹ There are a number of reasons for the decline. Many physicians are retiring without new OB/GYN medical students in line to replace them. However, the risk of malpractice litigation factors heavily in the count as well. More than 9,000 OB/GYNs responding to the 2015 ACOG Survey on Professional Liability expressed concerns about litigation and a culture increasingly unfriendly toward OB/GYNs.

5.1% of survey respondents left the field of obstetrics altogether out of “risk or fear of professional liability claims or litigation.” However, losing the number of OB/GYNs is only part of the problem. There’s also the loss of access to OB services that occurs when physicians change their scope of practice to avoid risky outcomes. For example, 23.8% of OB/GYNs said they decreased the number of high-risk patients they would accept; 17% increased the number of precautionary, or planned, cesarean deliveries they do, and 13.4% stopped performing VBACs (Vaginal Birth After Cesarean). Overall, 9.3% deliberately reduced the overall number of deliveries they performed. As it turns out, their litigation concerns were valid. 73.6% of respondents had been sued at some point during their career. Researchers documented an average of 2.6 claims per OB/GYN.²

Without question, the advancing gap in OB workforce and perinatal care access must be addressed. And part of the solution dates back centuries — nurse-midwifery.

A Brief History of Midwifery

The practice of midwifery has existed for thousands of years. Prior to the 20th century, midwifery carried an enduring women-only mystique that completely excluded men from the birth process. In the United States, midwifery became prevalent in the antebellum South, with slave-midwives assisting plantation mistresses and others in childbirth. The most experienced slave-midwives became well-respected, and the scope of their expertise expanded beyond childbirth into general healthcare. They often were referred to as “root doctors” or “doctor women.”³

By the 1920s, midwifery care had become fragmented by socioeconomic class. Prejudice against women, people of color, and immigrants who practiced midwifery set the practice back. Upper and middle-class women preferred male doctors to the “lowly” nurse-midwife who mostly served the poor community. (Many medical schools of the period would not accept women. Ironically, a study in 1910 revealed that 90% of physicians did not have a college education and had attended substandard medical schools⁴; therefore, many experienced midwives of that time actually may have been better-qualified to deliver babies.) Period physicians widely believed that medical interventions during labor and delivery were necessary to prevent childbirth complications, and they in fact became routine.
The trend toward physician-attended births continued, and the number of midwife-attended births dropped from 40% in 1915 to 10.7% by 1935. In 1933, the White House Conference on Child Health observed that maternal mortality had not decreased despite the rising number of physician-attended hospital births. In fact, the panel found that childbirth-related infant deaths increased from 40% to 50% between 1915 and 1929.

The practice of hospital nurse-midwifery increased during World War II to fill the void left by physician shortages. In addition, some teaching hospitals added midwifery services as the post-war baby boom led to an unusually high need for maternity care.

By 1950, 80% of all births occurred in hospitals, where it was common practice, and even expected, that women would enjoy a medication-induced “twilight sleep” throughout labor and delivery and wake up with a swaddled bundle of joy and no recollection of the childbirth experience.

The American College of Nurse-Midwives (ACNM) was formed in 1955, and New York’s Columbia-Presbyterian-Sloane Hospital became the first mainstream medical institution to welcome nurse-midwives as practitioners. By 1960, 97% of births occurred in hospitals.

In the 1970s, the feminist movement drove efforts to revitalize the practice of nurse-midwifery and suppress the “medicalization” of childbirth. Midwifery proponents argued that pregnancy and childbirth were not diseases and that normal deliveries could be performed at home by midwives and without the supervision or involvement of a medical doctor. ACOG vigorously discouraged home births, and a deep divide between OB medicine and midwifery was forged.

During the 1980s, nurse-midwives experienced difficulty obtaining liability coverage, and physicians who affiliated with them were threatened with increased premiums or a complete loss of coverage as well. Primary care associations such as the American Academy of Family Physicians (AAFP) officially stated that nurse-midwives should not be allowed to operate independently, and all payments for OB services should be funneled through supervising physicians. Pursuing its own solutions, the ACNM in 1993 established a stable, long-term professional liability program. They also developed national standards of practice and a national certifying examination.

Although laws regulating the practice of nurse-midwifery vary from state to state, the federal government in the 1990s required state Medicaid programs to pay for the care provided by certified nurse-midwives (CNMs). The Affordable Care Act of 2010 further legitimized payment for CNM services, and obstetric practices began welcoming CNMs. That same year, ACNM and ACOG established a formal partnership to explore ways the professions could work together to improve patient care. And in 2011, the two organizations issued a Joint Statement affirming their shared goals and emphasizing the importance of collaboration in the quality delivery of maternity care.
Types of Midwives

The term “midwife” is derived from Old English, meaning “with woman.” Midwives not only have special expertise in pregnancy and childbirth, they also counsel their clients on reproductive issues and, in many cases, provide primary care throughout a woman’s life.

The majority of nurse-midwives are Certified Nurse-Midwives (CNMs). CNMs are registered nurses with bachelor’s degrees who have completed an accredited course of study in midwifery and passed a national certification exam. They are legally authorized to practice and can write prescriptions in every state and U.S. territory. CNMs deliver babies almost exclusively in hospitals or birthing centers.

Certified Midwives (CMs) aren’t registered nurses, but they must have a bachelor’s degree and coursework in specific health and science subjects to qualify. Like CNMs, CMs must successfully complete an accredited course of study in midwifery and pass the same national certification exam. CMs are licensed to practice in New Jersey, New York, Rhode Island, and Delaware. They are able to prescribe in New York only.

Certified Professional Midwives (CPMs) must have a high school diploma or its equivalent. Their training is less formal and more apprenticeship-based. They are regulated in 28 states with varying forms of license. They cannot write prescriptions. The majority of CPMs attend out-of-hospital births.

Barriers and Benefits to Nurse-Midwifery

Even though the practice of independent nurse-midwifery is gradually gaining acceptance, six states still require that nurse-midwives practice under the supervision of a physician. They are California, Nebraska, Virginia, North Carolina, South Carolina, and Florida. A few other states require some form of midwife-physician collaboration for such things as prescribing medicine.

In a move that may seem contrary to the spirit of the 2011 Joint Statement embracing collaboration with nurse-midwives, ACOG’s Committee on Obstetric Practice issued a Committee Opinion on Planned Home Birth in August 2016 that asserts women who choose to give birth at home face double the risk for perinatal death as opposed to delivering in a hospital or birthing center. Acknowledging that choosing a childbirth method is a woman’s prerogative, the panel emphasized that it should be an informed decision that carefully considers the fitness of the candidate for home birth — a healthy woman with much lower risk for complications.

The Opinion lists “fetal malpresentation, multiple gestation, or prior cesarean delivery” as absolute contraindications to a planned home birth. The availability of a certified nurse-midwife to attend the home birth and ready access to medical consultation and transportation to a nearby hospital also were noted as important considerations in the home birth decision. According to ACOG, there are an estimated 35,000 home births annually in the United States, 25% of which are unplanned or unattended. Research suggests that the farther a woman must travel to receive OB/GYN care increases her risk for a pregnancy complication and an adverse outcome.
Study after study has demonstrated that healthy women with normal pregnancies who deliver with a nurse-midwife tend to have outcomes comparable to those of OB/GYNs. CNMs perform fewer medical interventions. Nurse-midwife-attended deliveries on average carry a 13% lower probability for C-section. In addition, those who choose a hospital birth attended by a CNM generally have a shorter hospital stay and a more personally satisfying experience.

A History-Making Collaboration

For four decades now in the San Francisco (CA) Bay Area, a revolutionary obstetrician-CNM collaboration has quietly grown into a highly successful model for OB/GYN care at San Francisco General Hospital (SFGH). When the University of California San Francisco (UCSF) School of Nursing and the UCSF School of Medicine began an interprofessional education program in the mid-1970s, the medicalized culture of maternity care was beginning to shift in favor of fewer interventions. At the same time, nurse-midwifery was building acceptance with its notion that pregnancy was not a disease to be managed but a normal physical function designed to progress naturally for most healthy women.

SFGH leaders realized that growing numbers of local women wanted midwifery care but did not necessarily want to labor and deliver at home. So they established the city’s first hospital-based midwifery practice in collaboration with obstetricians. It was a huge success; births increased 50% in the first year of the practice’s operation. Soon nurse-midwives and obstetricians became well-acquainted to working together in an environment of respect and collaboration. That was 1975. Today, some 46% of SFGH maternity patients choose midwifery for their care.

Over the years, the midwives and obstetricians learned from and gained perspective from one another. With CNMs on hand to monitor natural labor in progress, the use of medical interventions such as inductions, continuous electronic fetal monitoring, and cesareans diminished significantly. For example, the episiotomies for spontaneous vaginal deliveries at SFGH dropped from 86% to just 10% over an 18-year period. Clinical leaders slowly acknowledged that unnecessary interventions often generate additional interventions that cost more and don’t necessarily improve outcomes.

Without question, the program at SFGH has blazed trails in OB/GYN-CNM collaboration. It has identified a congenial balance between the formerly dueling philosophies of natural childbirth and the preventive, immediate access to advanced, high-tech care when needed. Both professions are equal parts of an integrated practice that is meeting a demand as well as engendering positive patient experiences.
Conclusion

The number of births attended by CNMs and CMs has increased steadily every year since 1989 (the first year such statistics were captured). Today, there are an estimated 13,000 nurse-midwives practicing across the United States. In 2011, they attended 7.6% of all U.S. hospital births and 30.2% of out-of-hospital births. An estimated 26,000 U.S. babies a year are born at home under the care of a midwife. Despite the rising popularity of home births, CNMs and CMs actually deliver 95% of their patients in a hospital setting.

Many developed countries around the world embrace midwifery as the primary provider in cases of uncomplicated pregnancy. They routinely consult with OB/GYNs on higher-risk cases and transfer care to the OB/GYN as warranted. In these countries, there are an estimated 2.5 midwives for every obstetrician. By contrast, the United States has approximately four (4) obstetricians for every nurse-midwife.

By virtue of the Ob Hospitalist Group (OBHG) model, OB hospitalists collaborate with a wide array of women’s healthcare professionals every day, including nurse-midwives. OBHG believes every patient is best served by a team working in tandem to deliver the highest-quality of care possible. OBHG occasionally offers hospital-based opportunities for experienced CNMs. Teamwork drives OBHG programs, and a passion for people is a core value of the organization.
For 10 years, Ob Hospitalist Group (OBHG) has led the nation in elevating the quality and safety of women’s healthcare by providing 24/7 Board Certified physicians who deliver real-time triage and hospital-based obstetric coverage to ensure consistent, timely care for patients as well as affordable, non-competitive support for local OB/GYN physicians.

Headquartered in Greenville, SC, OBHG is the original architect of the Obstetric Emergency Department (OBED), which ensures that every expectant mother presenting to the hospital receives consistent and unconditional medical care by an experienced physician. OBHG’s national network includes more than 450 dedicated OB hospitalists in nearly 100 partner hospitals across 26 states.

For more information, visit www.OBHG.com, contact Programs@OBHG.com, or call 800.967.2289.