A National Survey of the Midwifery Director Role in Academic Midwifery Practices Involved in Medical Education in the United States

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A survey to explore the role characteristics and key responsibilities of midwifery directors in academic practices involved in medical education in the United States was undertaken. Six key content areas were investigated: role responsibilities and characteristics, interaction with other medical divisions and committees, budgetary structure, interaction with learners, clinical schedules, and job satisfaction. A mail-based descriptive survey was distributed to 112 midwifery directors with a 56% response rate (N = 63). The results show a composite profile of academic midwifery practice directors involved in medical education that work primarily for departments of obstetrics and gynecology, are championed by the departmental chairperson, and have budgetary placement under this department. Collaboration with the residency director has not been fully realized, thereby limiting midwifery exposure and input regarding medical education, curricula changes, and access to key education committees. National changes in resident work hours had both a positive and negative impact on the director and overall midwifery practices. Job satisfaction documents both positive and challenging aspects to the director position, and most directors felt successfully integrated with physician colleagues.

LITERATURE REVIEW

Literature searches from MEDLINE and PubMed databases from 1996 through 2008 using search terms such as “academic midwifery practices,” “midwifery director role,” and “medical education” revealed a body of literature on midwifery practices involved in medical education but yielded no specific articles on the academic midwifery director’s role in medical education. Before 1998, much of the documentation focused on models of midwifery practice involved in medical education and teaching.6–8

A shift in the relevant literature commences with the 1998 survey of midwifery participation in medical education in the United States.9 This study described both the active role midwives play in teaching medical students and residents and investigated the extent and characteristics of midwifery participation in US medical teaching. It found that approximately 54% of US medical schools formally identified midwives as educators at that time. In that same year, two other publications on midwifery involvement in medical education were noted. One focused on a model for the future exploring midwives replacing resident house staff for selected clinical service needs in hospitals, and the other documented resident reactions to a teaching and collaborative practice model that included midwives.10,11

INTRODUCTION

Twenty years ago, a survey of the leadership role of academic midwifery directors involved in practices that participate in medical education would have yielded few responses. However, in the last 10 to 15 years, there has been a rapid expansion of this type of midwifery practice in both the United States and the United Kingdom.1–4 This paradigm of academic midwifery practice involving medical education has not only become a fast-growing model, but has blossomed in many settings, albeit with varied characteristics. Yet the role of the midwifery director as a pioneer in spearheading and navigating the leadership and management of these practices has never been fully explored. Informal consultation and mentorship, as well as occasional site visits, have often been the primary avenues for new and aspiring directors to communicate role development and responsibilities in this model. In a health care system where leadership and management are often key to survival, it is now critical to formally document the academic midwifery director’s role in midwifery practices involved in medical education.5

The purpose of this survey is to examine the structure and function of the academic midwifery director role in the United States as it relates to departments of obstetrics and gynecology and medical education. Aspects that were assessed include role characteristics, responsibilities, budgetary structure, learner and committee interaction, clinical schedules and job satisfaction. A better understanding of the director role will assist professionals who choose this career path as well as influence leadership direction for these practices in the future.
In 2000, Metheny and Angelini described an interdisciplinary educational model in which midwives had successfully participated in medical obstetric education since the early 1990s. Hanson et al. studied medical students’ knowledge of midwifery practice after didactic and clinical exposure. In this particular study, midwives were recognized for their active teaching role. A study conducted in Wales described an expanded role for midwives involved in medical education and the integration of midwifery within a department of obstetrics and gynecology. The most recent publication described a model in which midwives teach residents and medical students on labor and delivery. This model described the successful involvement of midwives who could teach residents and medical students and provide overall service needs created by reduced resident work hours.

Changes in resident work hours have also affected midwifery practice models involved in medical education. In 2003, the Accreditation Council of Graduate Medical Education (ACGME) changed work hours for all residents to limit them to 80 hours per week. The potential for advanced practice clinicians to compensate for these changes has created new opportunities for midwifery practice.

Times of paradigm shifts in complex organizations demand more of leaders. The last 10 years have brought rapid changes for midwifery practices involved in medical education. As the leader of these practices, the midwifery director has been in a pivotal position to both witness and comment on these changes.

MATERIALS AND METHODS

A mail-based survey of academic midwifery directors involved in medical education in the United States was conducted to explore role characteristics and key responsibilities. Initially, chairpersons in obstetrics and gynecology or residency directors of 162 allopathic medical schools were surveyed to investigate whether there were sufficient numbers of midwives involved in medical education to explore this topic. Thirty-nine (24%) of 162 schools responded that midwives were involved in medical education at their facility. Based on this positive response, participants for this study were then obtained from an exhaustive list of midwifery practices involved in medical education.

Ultimately, through a rigorous process that included multiple sources and cross comparison, a comprehensive list of 156 midwifery practices involved in medical education was compiled using the following sources: (1) direct mailing to residency directors or chairs of obstetrics and gynecology among medical schools listed in the 2007 to 2008 Directory of the Association of Professors of Gynecology and Obstetrics (APGO) and the American Medical Association (AMA); (2) American College of Nurse-Midwives (ACNM) 2006 membership directory; (3) an ACNM listserv database of midwives participating in medical education; (4) member names from the ACNM “Midwives in Medical Education” task force; and (5) consultation with expert nurse-midwives currently involved as medical faculty. Forty-four practices were excluded because of incorrect addresses, multiple midwives from the same practice, no longer being involved in medical education, or no forwarding practice addresses. A final list of potential participants included 112 midwifery practices.

Items for the survey tool used in this study were developed from a review of the literature on aspects of the general midwifery service director’s role along with questions from a 1998 survey of midwifery involvement in medical education. The survey questions were based on six categories: role responsibilities and characteristics, interaction with other medical divisions and committees, budgetary structure, interaction with learners, clinical schedules, and job satisfaction. A multiple choice format was used with space for open-ended comments for each question, which allowed respondents to augment answers with qualitative statements for further clarification and expression. One survey item, job satisfaction, was structured for a completely open-ended response.

A pilot study was initiated involving five directors of US academic midwifery practices, whose expertise was known to the author, to address content validity of the survey questions. This feedback resulted in rewording of 3 questions and the elimination of another question. The final survey tool consisted of 20 items.

Questionnaires were mailed and returned between February and June 2008. Women and Infants’ Hospital Institutional Review Board approval was obtained before the surveys were mailed. The survey tool for this study was mailed to potential participants in the same envelope with a separate survey assessing midwifery involvement in medical education. Stamped self-addressed envelopes to return the surveys were included. Follow up involved remailing surveys on two separate occasions to those with no response.

The survey results were entered into a prepared database (Access 2003) that allowed for a descriptive statistical analysis of all 20 survey items and the documentation of qualitative responses. These qualitative responses were then examined for trends and themes by counting similar responses.

RESULTS

A total of 63 questionnaires were received, for a response rate of 56%. There are fewer participants than in the study
assessing midwifery involvement in medical education (N = 74) because 11 of the practices did not have a midwifery director. The mean full-time equivalents (FTEs) were 6.48 per practice (median, 4.5; standard deviation = 5.29). The FTEs in these academic practices ranged from 1 to 34 FTEs. Geographic distribution included responses from 30 US states and representation from all six regions of ACNM.

Responsibilities and Characteristics of the Midwifery Director Role

In this section, three topics were explored. The first covered the reporting mechanism for the midwifery director. The majority of directors (66.1%) reported to the chairperson of obstetrics and gynecology, 8.1% to the maternal–fetal medicine division, and the remainder (25.8%) to others. The “other” category included the vice chair of obstetrics and gynecology, nursing administrators, and the business director for the department of obstetrics and gynecology. A few directors noted dual reporting mechanisms. A list of selected, key role responsibilities and characteristics for the academic midwifery director involved in medical education is shown in Figure 1.

The second topic was the types of academic and clinical appointments, and 74.6% held some type of faculty appointment (38.1% nonclinical and 36.5% clinical); 4.8% of participants were tenured. Some directors noted dual appointments in both colleges of medicine and nursing. In some institutions, only doctorally-prepared directors could obtain appointments. A few directors noted that...
they had been turned down for nontenured positions in schools of medicine.

The third topic was allocation of work time for the midwifery director, and 5 areas were considered: administrative, clinical, research, publishing, and grant funding. There was a wide range of reporting for each area. The most frequently selected ranges for allocation of time were 5% to 20% of the work week for administrative functions, 50% to 90% for clinical responsibilities, and 5% to 10% for research efforts. Only six directors commented on grant funding, spending between 1% and 33% of their time writing grants. Seven directors commented on publishing, and the majority of those (42.9%) noted that it involved only 2% to 5% of their work time.

**Interaction With Other Medical Divisions and Committees**

The amount of interaction between the midwifery director and the residency or medical education director was evenly split. Slightly more (52.8%) felt they worked closely with this person; 47.2% did not. Qualitative responses detailed some of the working relationship issues with the residency director. The qualities of a close working relationship included supporting the midwifery director role and her (his) values and opinions, allowing midwifery input into resident education, supporting a team approach to educational core values, and soliciting midwifery feedback on resident performance. Characteristics of more distant working relationships included keeping the midwifery director out of the resident education and evaluation process, devaluing midwifery input, limiting recognition of midwifery educational efforts, and setting unrealistic expectations for midwifery teaching performance.

Information about key committee representation was solicited. The highest participation by midwifery directors was in hospital-based committees. Of the medical education committees, representation on resident education committees was the most prominent at 36.5%, compared to medical education at 28.6%. Credentials committee for both physicians and nonphysician providers and quality improvement were the two most commonly attended hospital committees. Other committees included risk management, curriculum, continuing education, collaborative practice, and executive committee.

Most midwifery directors (87.3%) attended faculty meetings, and many noted that they were expected to attend as division director. One attended faculty business meetings and met with the chairperson quarterly. Some attended divisional faculty meetings but not departmental meetings, while others attended monthly division director meetings.

**Budgetary Structure**

The operating budgets (hard monies) included 85.7% of midwifery practice salaries, with only 11.1% of staff midwives on soft monies, such as grant funding or nonoperational funds. Many practices generate salaries through faculty practice revenues, with some practices having multiple salary sources. A few directors noted that they were not involved in their own budget preparation and therefore had no control over the budget process.

The midwifery budget was placed under medicine for 52.5%, nursing for 15.3%, and other departments for 32.2% of respondents. Some budgets were spread among maternal–fetal medicine, other obstetric medical divisions, nursing, or interwoven into the overall departmental budget.

Approximately one-third of the midwifery faculty generate adequate revenue from provider billing and reimbursement to fully cover all salaries, one-third are offset in the budget by monies from other departments or sources, and one-third have salaries partially covered by provider billing and reimbursement. Some directors had varied sources for financial reimbursement, including graduate medical education dollars and grant funding sources. Four directors had direct hospital financial support for their practices/divisions. One hospital is currently subsidizing midwifery salaries for a grace period while third-party billings and reimbursement increase. Some were offered bonuses if salaries were completely covered by practice revenues. In one practice, midwifery salaries are placed under the nursing union contract, and salaries are negotiated. Many directors commented that they were working to strengthen billing and revenues. For most directors, the annual midwifery budget was $250,000 to $1 million (55.1%) or $1 million (34.5%).

In terms of billing and reimbursement, 82.5% billed for all clinical services, 31.7% billed specifically for triage services, and 19% billed for intrapartum services only. Relative value units (RVUs) were used approximately 13% of the time for billing. RVUs measure productivity and clinical care and are applied to medical procedures for reimbursement and provider fees, especially when supervising residents. Medicare physician reimbursement is calculated by assigning RVUs to physician services based upon complexity of care. Additional billing sources included specific procedures, such as circumcisions, colposcopy, and cryosurgery, and first assist at cesarean deliveries. One director noted that contracts with third-party payors were negotiated by the institution with no midwifery input.

**Interaction With Learners**

Midwifery directors interact with various learners: 92.1% work with some type of residents, 85.7% specifically with obstetric residents, and 55.6% with family practice residents. More than 90% of directors interact with medical students, 74.6% with midwifery students, 9.5% with emergency medicine residents, and 41.3% with allied health students (e.g., nurse practitioner, paramedic, and nursing
students). Findings regarding the amount of time spent with specific learner types are noted in Table 1.

The impact of changes in resident work hours on midwifery directors and academic practices was evaluated and trends were noted. Directors perceived that these work hour changes enhanced midwifery in the following ways: increased resident exposure to midwifery care, added new midwifery positions to the budget, expanded midwifery clinical responsibilities, enhanced teamwork with residents, showcased midwifery’s role, and had potential for further collaborative efforts with medicine. However, directors expressed the additional burden placed on midwifery faculty during the time of resident work hour changes. These include rapid expansion of midwifery into more clinical sites and midwifery faculty overextended to cover additional work responsibilities.

Less than half (40.3%) of the directors reported that evaluations by medical students and residents were part of the annual performance appraisals of the midwives. When these evaluations are used, they may be forwarded to the department chairperson directly or to the midwifery director. Other directors commented that midwifery performance appraisals are tied to 360-degree evaluations performed by residents and medical students.

**Clinical Schedules**

Work hours for midwifery practices were explored, and 25.4% of the midwives worked only daytime hours; 42.9% were involved in some type of on-call system; and 38.1% worked shifts, some with a combination of 12-hour shifts and on-call hours. Many worked shifts in triage and labor and delivery, and covered nights and weekends when resident coverage was not fully available. Two-thirds of directors noted that administrative time was provided for staff. Fifteen directors reported the hours per week, which ranged from 2 to 10 hours (average, 5.6 hours).

**Job Satisfaction**

Directors were asked to comment on the most satisfying and challenging aspects of their role. The most common satisfying aspects were medical exposure to the midwifery model of care and collegial collaboration. The most frequently identified challenges were balancing the numerous responsibilities of the director role and budgetary constraints. Responsibilities the directors described included balancing the needs of many learners, managing administrative and clinical duties, assigning time schedules for full- and part-time staff, and managing different models and philosophies of care. Budgetary issues included obtaining appropriate reimbursement for services when supervising residents and obtaining approval for new midwifery staff positions to cover additional or expanded clinical activities.

When asked who the one person is who champions the most support for the midwifery director, more than half of respondents identified the departmental chairperson. Other champions included maternal–fetal medicine physician subspecialists, other division chiefs, residency directors, residents, hospital administrators with oversight for obstetrics and gynecology, labor and delivery nurse managers, and medical student clerkship directors. A few directors noted that the dean of the nursing college championed them. One director felt that the physician who championed her was trained by midwives and, therefore, valued midwifery contributions. A few directors felt they had no champion or had to champion themselves.

Integration with physicians in the academic practice setting was explored. Most directors (65%) perceived that they were successfully integrated with physician colleagues; 35% did not. Full integration was still a goal, “a work in progress,” or had room for improvement for some directors. Some felt midwifery faculty were key partners, while others lacked faculty appointments and felt that they were only treated as faculty when it was favorable to do so. Some directors commented that they were more fully integrated than the other midwives in the practice. Some directors did not feel respected by the entire medical faculty.

**DISCUSSION**

The results of this study portray an active role for the midwifery director involved in medical education. Access appears to be a critical finding across role responsibilities of the midwifery director involved in medical education. The ability to fully access the residency director, acquire membership on critical medical education and hospital-based committees, and obtain academic faculty promotional opportunities was not realized for all directors. Having
a stakeholder voice in medical education and decision-making continues to be a struggle for many midwifery directors, as does being considered a full partner. In addition, being denied access to academic promotions limits the value placed on midwifery and parity for the midwifery director with physician colleagues. Further research into the specific barriers to academic promotions for midwifery directors involved in medical education is needed.

It is difficult for midwifery leadership to have a clear voice in medical education if lines of communication are blurred, connect through a third party (and not the chairperson), or are nonexistent. Careful attention to organizational structure and reporting mechanisms often supports clear lines of communication. Minimizing “lost opportunities” for committee membership and forums for direct input and communication by midwifery directors are critical.

Changes in resident work hours have provided opportunities and burdens for midwifery practices and the midwifery director role specifically. The potential these changes raised for collaboration versus the demands for rapid expansion of midwifery services placed the director in a pivotal position as change agent. As discussion ensues regarding further changes in resident work hours, the director must be proactive in developing an action plan to minimize midwifery staff being overextended yet promoting a midwifery model for future partnership and collaboration with medicine. How best to restructure the future direction of midwifery practices vis-à-vis further changes in resident work hours is worth consideration by the profession.

Budgetary considerations are a vital realm for the midwifery director involved in medical education. Fiscal survival and competition for medical education dollars and billing and reimbursement pervade the domain of the director. In light of health care changes and reimbursement adjustments, there is a continual struggle to develop a more solid revenue-generating business plan with sufficient income to sustain a viable midwifery division. Although most directors operated practices that were funded on hard monies (salaried positions), additional avenues for billing and reimbursement to offset operating expenses are unending. Exploration into graduate medical education monies and additional billing sources, such as triage and first assisting at cesarean deliveries, is needed to offset salaried expenses. Midwifery directors need to become more actively engaged in strategies for third-party contractual billing as workload indexes, such as RVUs, play a more prominent role in billing and compensation, especially regarding resident teaching.

Tracking educational evaluations by medical students and residents is crucial to document the significance of midwifery teaching. These evaluations were used less than half the time in midwifery performance appraisals. This appears to be a lost opportunity to both focus on customer satisfaction and promote pay for performance. These evaluations of clinical teaching are often the basis to support new midwifery positions in the budget, a key consideration for directors.

Mentorship for midwifery directors involved in medical education stems primarily from departmental chairpersons and other mentors in medicine and nursing. However, some directors perceived that they had no champion or had to sustain mentorship themselves. The critical issue of mentorship for the director role in this setting still warrants attention, and possible groups within which this could occur include ACNM and the Association of Professors of Gynecology and Obstetrics. Informal peer support exists, including the ACNM medical student education listserv. However, there is currently no formal support mechanism, professional recognition status, or formal networking opportunities available specifically for midwifery directors in this role. A wider net should be cast to develop more champions for midwifery directors within hospital administration and medical schools. This could be undertaken by departmental chairpersons in partnership with the public relations department and in conjunction with formalized medical educational and professional organizations.

Directors perceived that they were constantly balancing potentially competing interests such as medicine and midwifery, clinical and administrative time, and the midwifery philosophy of care and medical model. A reallocation of time to address expanding administrative responsibilities for the director might help to advance midwifery interests and partnership with medicine through activities such as attendance at committees with key stakeholders and forming partnerships with other divisional directors. It appears that the more fully integrated the midwifery director is, the more fully integrated midwifery is in that institution. Strategies that support full integration of the midwifery director into departmental services include improving academic faculty appointments, expanding the working relationship with residency directors, and having a greater voice and representation in resident curricula.

Limitations of this study include incomplete demographic data about the directors. Directors were not asked the number of years of experience in the administrative position and their educational preparation. Response bias may exist because directors needed to recall detailed data, some of which occurred years before the survey items were solicited. A new survey tool would take into consideration additional demographic data about directors and pursue exploration of findings by geographic region or practice size.

CONCLUSION

This study describes the academic midwifery director involved in medical education and suggests considerations for the future development of this position. The leadership role of the director is crucial for these practices to develop, sustain viability, and become successful. The academic
midwifery director involved in medical education is in a pivotal position to impact the education of future obstetricians and consultants while showcasing the midwifery model of care.

REFERENCES


