2014

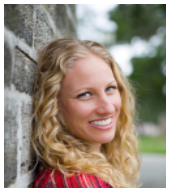
Medical Education Caucus of ACNM (MECA) TOOLKIT 2014

Resources for the Certified Nurse-Midwife working in medical education

Committee Members: Amy Nacht, Suzanne Seger, Jan Salstrom , Edith McConaughey, Karen Schelling, Kari Radoff

TABLE OF CONTENTS


Amy Nacht


Kari Radoff


Edie McConaughey


Jan Salstrom


Karen Schelling


Suzanne Seger

Amy Nacht, CNM, MSN Senior Instructor, Director University Nurse Midwives, CU College of Nursing. Amy has worked with the University Nurse Midwives since 2008. She completed her training at Case Western Reserve University in Cleveland, OH and is currently an MPH student at the Colorado School of Public Health. Prior to joining the University Nurse Midwives, Amy worked in rural Colorado for 6 years. Her professional interests include global health, quality improvement projects, perinatal mood disorders, and medical education. She lectures for both the College of Nursing and the School of Medicine and is actively involved with the University of Colorado Center for Global Health. amy.nacht@ucdenver.edu

Kari Radoff, CNM, MSN received her Masters of Science in Nursing and Nurse-Midwifery degree from the University of California San Francisco in 2010. She is faculty Clinical Instructor at Boston University School of Medicine, Department of Obstetrics and Gynecology. She joined the Midwives of Boston Medical Center and Boston University in 2012 after completing a Fulbright grant in Nicaragua where she developed a radio-based pregnancy education intervention to improve maternal knowledge of pregnancy danger signs. She is fluent in Spanish and provides full scope midwifery care in the Boston metropolitan area. Her research interests include midwives as medical student and resident educators, global maternal health, respectful care during childbirth, and evidence-based obstetric care. Currently she is studying patient experiences in making a collaborative choice for outpatient management or immediate induction of labor for prelabor rupture of membranes at term. Kari.Radoff@bmc.org

Edie McConaughey, CNM, MS Edie began her career at Women & Infants' Hospital in Providence, RI as an RN in labor and delivery, a staff educator for the labor and delivery and high-risk antepartum units, and as a nurse-manager. After completing her Nurse-Midwifery program at the University of Rhode Island in 1995, she worked for both a large HMO OBGYN group and a private OBGYN practice where she provided full-scope midwifery care and was involved with the clinical education of midwifery students and medical students. Edie joined the Midwifery Department at Women & Infants' in January 2003. She is a Senior Clinical Teaching Associate in the Department of OB/GYN at the Alpert Medical School of Brown University/Women & Infants' Hospital. She has 19 years of midwifery experience. Her professional interests include medical education, teamwork training and volunteer midwife/teacher in Kigali, Rwanda. ediemccon@gmail.com

Jan Salstrom CNM, MSN, Clinical Assistant Professor at East Carolina University, Brody School of Medicine in the Department of OB/Gyn. Jan graduated from the University of Kentucky, Nurse Midwifery Program in 1992 and has worked in Medical Education for 20 years. Prior to joining the ECU faculty, she provided midwifery care and taught in West Virginia. Along with direct patient care, she provides lectures in the School of Medicine, College of Nursing Graduate Nurse Midwifery Program and for rural hospital staff of Eastern NC. Professional interests include interdisciplinary education of women's health care, obesity, and hypertensive disorders of pregnancy, osteopathic manipulation and tai chi. Along with an emphasis on educating, she has spent her career caring for rural women and families in the underserved populations of WV and Eastern NC. Jan started her midwifery career as a home birth midwife. SALSTROMJ@ecu.edu

Karen Schelling CNM MS has been a midwife for the past 24 years. She has practiced in a variety of settings including private practice, family planning clinics, homebirth practice and now in a tertiary care center. She spent 5 years teaching masters level midwifery students at the University of New York at Stony Brook. On a national level, she has been a member of the Division of Standards and practice Committee from 2002-2004, then from 2004-2006 she chaired the Continuing Competency Assessment in the Division of Education at the ACNM. Since 2002 she has been practicing full-scope midwifery at Dartmouth Hitchcock Medical Center. DHMC has an active midwifery service; as well the midwives play an active role in the education of residents, medical students and student nurse-midwives. She lives in Vermont, and when not practicing midwifery she can be found biking on the back roads, hiking the hills, swimming in the ponds, or knitting under a tree! Karen.L.Schelling@hitchcock.org

Suzanne Seger, CNM completed her nursing and nurse midwifery degrees at the University of Pennsylvania in Philadelphia. She also holds a master's degree in comparative religion and feminist studies from Harvard University. Seger is an Associate Clinical Professor in the Faculty Practice at the University Of California School Of Medicine in San Francisco, California where she has been since 2005. Her research interests include Intimate Partner Violence and Abuse, health disparities, and education of nurse midwifery and medical students. Prior to joining the UCSF practice, she was at Mount Sinai Midwifery at the School of Medicine in New York. From 2001 to 2007, she was a consultant in the Education, Knowledge and Freedom Unit at the Ford Foundation in New York. Seger was part of the original team that opened the Elizabeth Seton Childbearing Center with the Maternity Center Association and St. Vincent's Hospital which was open from 1996 to 2003. SegerS@obgyn.ucsf.edu

This toolkit is dedicated to midwives, residents, medical students, and all members of the obstetric team that support and promote collaborative practice and recognize its merits and benefits to women, families, and care team members.

Ode to an Intern

Watching as you walk through the pregnant doors of the 4th floor

Confidence stiffened into the collars with starch holding the seams together

I feel inspired

If hallways could talk, they would speak to you, in multi-lingual tone, of the multitudes of events that are splashed on the walls and floors, sifted into the minds allowing only so much in.

If food could speak, the coffee, chocolate, fancy drinks, pies, cookies, birthday cupcakes, and salads- it would all tell you of long nights, slow days, screams, whimpers, cries, laughter, joy, pain, and twilight moments.

Facebook, eharmony move aside, as emerging physicians rise out from the entangled cords, the IT, the 5 pagers, the small pieces of paper crammed into pockets. The phoenix rises from the fire.

Each of you enters and leaves in an individual style. None are unchanged. And I, as observer, and friend and colleague, am duly impressed with the courage, the stamina, determination, and brilliance that is born of you.

I watch, I learn, and I witness the transformation. Be it big or small, the transformation that is you. Be it noticed or not, the transformation that is you.

Believe it or not, there is an imprint left by you, remembered by me.

Running stairs, and fire hot moments. Residency.

Travel swiftly and strong. Carry newness along your side.

Tucked under a wing in flight is always UCH, the stalwart support.

And tucked under a wing in flight is midwifery, and me your friend and supporter.

-Amy Nacht, CNM

INTRODUCTION

HISTORY of the Medical Education Caucus of ACNM (MECA)

Midwives have been involved in medical education for quite some time. In 1981, the first report of midwives involved in OBGYN resident education was published by the American College of Obstetrics and Gynecology, noting that 19% of programs used midwives in their training.[1] More publications followed, both in medical and midwifery journals, describing and outlining the role of midwives in medical education.

MECA began as an interest group formed for midwives engaged in similar activities who desired a forum in which to share information prior to the formation of caucuses in ACNM. In 2009, Michelle Grandy, CNM, was appointed the first Chair of MECA. Now, five years later, the group has more than 200 members across the country and has led a well-attended half-day workshop at the ACNM Annual Meeting & Exhibition for three consecutive years.

MECA encompasses a diverse group of midwives who represent many educational models. Midwives involved in medical student and resident education are either hired as clinical staff or full faculty to medical schools or colleges of nursing. With both medicine and midwifery pushing to build interdisciplinary teams to meet women's diverse health needs, address safety and quality concerns, and improve maternal health globally, MECA is an invaluable asset to ACNM and its members. Members of our caucus are well positioned to lead these efforts as a voice for collaborative practice. Midwives in MECA are sharing the body of evidence-based midwifery knowledge that desperately needs to be shared with all obstetric collaborators.

WHAT IS THE MECA TOOLKIT?

A "toolkit" is an action-oriented compilation of related information, resources, or tools that together can guide users to develop a plan or organize efforts to conform to evidence-based recommendations or meet evidence-based specific practice standards.

A "tool" is an instrument (e.g., survey, guidelines, or checklist) that helps users accomplish a specific task that contributes to meeting a specific evidence-based recommendation or practice standard. (http://www.ahrq.gov/research/publications/pubcomguide/pcguide6.pdf

The **MECA Toolkit,** which in the appendices provides example *tools*, is designed to provide midwives new to medical education and midwives already working in medical education guidance towards planning, implementing, and evaluating educational programs. The goal is to teach normal physiologic labor, along with the midwifery philosophy of care, while promoting collaborative practice within the field of obstetrics that is tailored to the uniqueness of each individual institution, is innovative, and supportive of both midwifery and obstetrics.

This toolkit is not meant to be used prescriptively, but rather as a starting point to review some of the core ideas, literature, and tools currently in use. The creators of this toolkit see this as a living document and hope to continue the development of the tool over time to represent the voices and work of the many midwives working within medical education.

All of the authors of the 2014 MECA Toolkit are available by email for further discussion, and/or to request more samples of curriculum. See BIOS.

HISTORY OF MIDWIVES IN MEDICAL EDUCATION

> *"Modeling midwifery philosophy on bright, very grateful, very impressionable medical students is a good investment in women's health."*[1]

Midwives have long been involved in teaching and sharing knowledge with a broad range of individuals including patients and families, student midwives, and interdisciplinary team members. In addition to traditional teaching roles, midwives have been formally and informally participating in the training of medical students and residents for several decades.[2-9]Themes have emerged in research regarding midwives in medical and resident education that describe the importance of this role: 1) teaching the midwifery model of care to learners 2) creating collaborative, interdisciplinary teams and 3) developing professionalism. [2,5,6,10,11]

A variety of changes have occurred in resident education that has influenced the role midwives play as educators in academic medicine. First, in 2003 the Accreditation Council for Graduate Medical Education (ACGME) announced a commitment to an 80-hour resident work week which resulted in Provider shortages and increased demand for midwife availability for both teaching and patient care in academic institutions grew out of this.[10,12] Additionally, continued evidence of the benefit of midwifery care for low-risk women demonstrated the importance of midwifery presence in academic centers. As midwives have taken on these formal teaching roles there has been recognition of their value as teachers, evaluators, and mentors by both medical students and residents who have reported positive clinical learning experiences when being taught by midwives.[13-15] Lastly, there has been a national emphasis on the benefit of multidisciplinary and collaborative teams for medical education and the provision of patient care, of which midwives play a critical part.[14,16-18]

The first documented report of midwife involvement in obstetric and gynecology resident training was published in 1981 by the Junior Fellow College Advisory Council of the American College of Obstetrics and Gynecology, which cited that 19% of programs involved nurse-midwives.[1] Several years later, the first report discussing formal teaching roles of midwives in medical education was published from the academic obstetrics practice at the University of Southern California Medical Center where nurse-midwives were granted faculty appointment in the School of Medicine within a collaborative clinical and lecture teaching model.[19] Following this account, several publications have described inventive practice models in which midwives were responsible for didactic and clinical training of residents and medical students within multidisciplinary teams in a variety of clinical settings.[3,4,7-9,19-21]

The first mixed methods study to describe the role of the midwife in medical education was published in 1998 by Harman, Summers, King, and Harman.[2] Surveys were administered to 133 academic institutions with obstetrics and gynecology residency programs. Of those programs, 54% reported that nurse-midwives were involved as educators, and 18% of programs were considering integrating midwives into formal teaching roles. The majority of midwives who participated in surveys held formal faculty appointments within the school of medicine (58%) and taught both medical students and obstetrics and family practice residents (62%) in clinical and didactic settings. A majority (86%) of midwives also precepted or taught in nurse-midwifery education programs. In open-ended questions regarding the role of nurse-midwives and medical education, several themes emerged

including the desire to teach midwifery care, normalize birth, promote respectful care of women, create collegial professional relationships, and demonstrate the benefits of a multidisciplinary team model on learners. The following selected quotes from Harman et al. explain the motivation of midwives in medical and resident education:

> *"--the philosophy of midwifery care can be practiced by anyone and must be taught to MDs."*
>
> *"Only by knowing normal can one recognize not normal and treat accordingly. I want docs to know normal and allow normal to happen, [to] intervene only when indicated for the welfare of mother/infant."*
>
> *"CNMs provide an example of respectful interaction between patient and provider with decision-making shared with the patient."*
>
> *"We have to work in a team. It is great to be able to educate students how to be team players and respect the professional contributions of other disciplines."*

Although not described as an initial career goal for most midwives in this survey (8%), teaching medical students and residents became an important career goal for most midwives working in academic practices (55%).

Most recently, in 2009 a national survey was conducted of 112 practices that were identified as likely involving midwives as educators in medical and resident education.[5] A total of 547 midwives identified as currently being involved in medical student and resident education, which is three times the number of midwives identified by Harman et al. The majority (80%) taught obstetrics and gynecology residents, family medicine residents (60%), and medical students in their obstetrics and gynecology clerkship (93%). Of the responders, 56% held clinical appointments in the school of medicine while 37% held formal academic appointments in the school of medicine. The role of midwives in medical and education included both didactic and clinic teaching of medical students and most frequently first year residents in labor and delivery, triage, gynecology, antepartum, postpartum, and expanded midwifery skills.

The role of midwives in medical student and resident education continues to evolve. A report of several innovative methods of teaching performed by midwives in medical and resident training programs was published in 2009, describing practices at six academic medical centers in the United States.[11] These programs included novel teaching sessions facilitated by midwives in which students followed a pregnant family throughout their pregnancy, attended their birth, and also participated in lectures; obstetric simulations; chief resident workshops for role development; team building and collaboration exercises; skill building "boot camps"; and resident training in centering pregnancy. These groundbreaking practice models demonstrate the interest midwives have in teaching the next generation of obstetric providers and the success of multidisciplinary teaching models.

Kari A Radoff CNM, Boston University School of Medicine, Clinical Instructor, Director of Midwifery led Resident Education

PLANNING

Planning is a form of investigation, a process whereby an individual or group reviews existing structures, identifies barriers and the potential promoters, and gathers the documentation or evidence that provides the validity to the program or curricular concept. When planning new programs in medical education, (or adding new curriculum to existing programs) consideration needs to be given to the model of collaborative practice that exists within the institution or that could be a good fit. This requires an initial survey of the existing structures within the obstetrics and gynecology department. The survey may include observation, interviews, and/or focus groups.

Simon Senek (https://www.youtube.com/watch?v=l5Tw0PGcyN0) offers a concept called *The Golden Circle*, which applies well to the design of a new program, or new curriculum.[22]

The Golden Circle describes the WHY, HOW, and WHAT of the new program or product that an individual or group is trying to promote. The idea is to start with the WHY, then move to the HOW and then finally the WHAT. This sells the product.

The WHY: Sharing the WHY, When planning a new program being very clear about the mission and vision of the program is key, know the WHY and be ready to share this with all key stakeholders. Below is a list of some of the key players. The idea is to inspire others with your vision.

- Interdisciplinary champions
- Medical Staff Office Leadership
- Legal personnel
- Risk Management
- Clerkship Directors
- Residency Directors
- Midwives
- Hospital Compliance Officers
- Residents and Medical students
- College of Nursing Faculty/ Leadership
- GME Officers

The HOW: It is important when scheduling meetings or interviews with the key players that you think through what that person may see as a barrier and be ready to address these issues within the HOW. Whether building the curriculum for new or existing programs, clearly identifying and expressing the process is essential for "selling" the product.

- Crafting a win-win proposal (how does this benefit the School of Medicine and Nursing?)
- Leveraging practice resources (clinical sites, staff, time)
- Identifying gaps within medical education (where can midwifery expertise fill these gaps)
- Identifying site specific barriers and addressing individually
- Preparing feasible curriculum (within the time, economic, staffing constraints)
- Understanding the Center for Medicaid and Medicare Services (CMS) rules and billing: A midwife must bill for all services and document care per normal standards of practice. (A midwife cannot "supervise" medical students or resident, but can educate).
    - Of note, per CMS: Services provided in teaching settings are paid through the Medicare Physician Fee Schedule if they are: furnished by a non-resident physician; delivered when a teaching physician is physically present during the critical portions of the service; or furnished by a resident under a primary care exception within an approved Graduate Medical Education. Please note that advanced practice nurses and nurse-midwives are not explicitly named here.

The WHAT is the product: An example may be: "Midwives as the primary educators and experts of the normal physiologic process of birth". That said, curriculum will be developed to utilize this resource and ultimately promote safe labor and birth for the mother and the infant developing a foundation from which medical students and residents can grow.

- EXAMPLE from UC Denver, implementation of a NEW program:
    - Phase I: medical students rotating within midwifery service and lecturing to clerkship group. The success of this led to midwives being invited to participate in the skills and simulation lab.
    - Phase II: PGY1 rotating with core group CNMs in labor and delivery. Similar to above, this led to the midwives being asked to develop and teach a skills lab on normal birth.
    - Phase III: Potentially establish a true integrated model with a midwife within the SOM devoted to teaching medical students and residents.
    - EXAMPLE: UCSF Centering

      Phase I: Cross clinic training for Centering Pregnancy with launch to incorporate resident interns within the program. Training of physicians and nurse midwives.

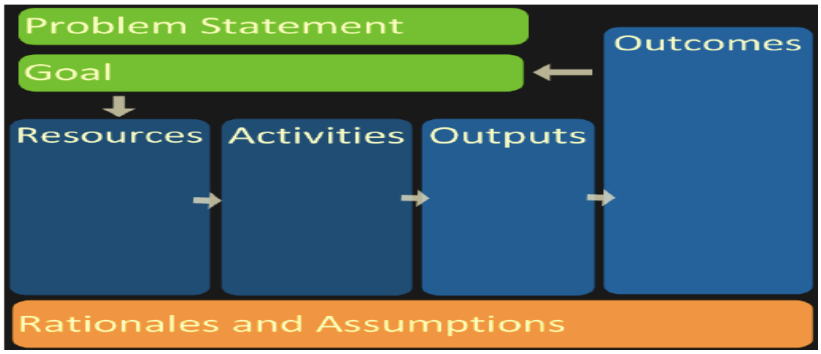
      Phase II: Incorporation at year three of medical students within the midwifery student and obstetric intern groups to normalize the group model of care early in medical education.

Phase III: Obstetric faculty incorporated

Lessons Learned

- Build a road map: Create logic model/checklist
- Be concise and bring documents to all meetings (midwifery practice guidelines, CMS rules, key articles)
- Bring your champions to difficult meetings
- Share your successes with those involved- posters, presentations, lectures
- Build in program evaluation (pre/post surveys)
- Be willing to make changes along the way
- Appreciate and celebrate the promoters of the program

Logic Model Sample



Amy Nacht, CNM, MSN University of Colorado Denver. Director University Nurse Midwives. Senior Instructor

****Program Planning Addendum: Programs that occur out of necessity****

Another route to midwifery involvement in medical and residency education has been more organic and less formalized. Often new programs start with very little lead-time for development. Needs are identified- such as work shortage hours, consumer demand or direct patient care- and midwives are hired. Teaching opportunities then grow out of interactions with nurse midwives in the clinical arena.

Long-range viability will involve needs assessment and evaluation yet, true to its origins, evolution and implementation may happen first. Midwifery presence in residency education can change, can expand or can be phased out with both well-executed and organic models. It is the nature of institutions to be dynamic and midwifery educators would be wise to be adaptable.

Examples:

1) A Massachusetts job in obstetric triage filled by midwives to capture billable work then leads to new roles as the institution expands.
2) Two nurse midwives are hired by a New York City hospital to work as laborists in order to address resident work hour violations. After receiving feedback that prenatal clinics would not receive funding without a midwifery service, the hospital expands and hires four midwives and adds the two laborists who begin full scope practice. Clinic expansions then leads to hiring a complement of full time midwives
3) A Southern California hospital midwifery service is told that due to low volume for the obstetric resident training program they must have obstetric interns attend the births with them. The practice is now incorporating midwifery and obstetric students.
4) A Texas program asked nurse midwives to assume an increased role in the residency training program and gave them two weeks lead time until their first lectures.
5) A Northern California integrated practice in which CNM faculty begin training emergency department interns in addition to obstetric interns.

IMPLEMENTATION and PROGRAM MAINTENANCE

Mission Statement

It is important that a Midwifery Service, working within an academic department, have a clear mission statement. This will focus how the group will contribute to the larger mission of the department and school. The focus of the mission statement can be educational, clinical, or research based. For a totally integrated model of faculty CNMs and CMs within a School of Medicine (SOM), it is likely that the main focus will be interdisciplinary education. For a pre-existing midwifery practice that is integrating resident or medical education into a current clinical setting of midwifery patients (parallel model), the main focus will likely be more clinically focused to preserve the existing structure of the midwifery model.

Factors that will influence this mission statement may change over time depending on changing economic demands, national residency (RRC) requirements, Center for Medicare and Medicaid Services (CMS) rules and regulations or local departmental and university needs.

Organizational Structures

There are several ways an integrated model of midwifery practice can sit within an OB/GYN department. One possibility is a separate midwifery division. This model is consistent with other divisions of specialty services and providers within the department such as maternal fetal medicine (MFM), generalist obstetrician-gynecologists, and uro-gynecology, etc. The division chief would then answer directly to the Chair of the department or the obstetrics section head depending on the organizational structure for that particular department. The advantages of having a midwifery division are clearer lines of autonomy and more direct communication with the departmental chair to address arising issues.

Another option is to have a midwifery service that sits within another division in the department, such as the generalist division or the MFM division. This structure can work well but can also have drawbacks as the needs of the midwifery service can be superseded by the larger needs of the division with less input to and more distance from communication with the department chair.

In a parallel model, the existing midwifery practice will be crossing over to the department of OB/GYN or communication and will not be incorporated within the OB/GYN dept. This will necessitate an acting liaison to address the needs of the learners with the medical education clerkship director or residency director while representing the needs of the midwifery practice.

Multidisciplinary Education

It is feasible to incorporate multiple types of learners within a clinical setting with clear expectations of the learners including: background; knowledge; experience; contribution to learning; and learning objectives. It is very important that each learner is clear on their role for the clinical experience to minimize disruption of patient care.

Medical Students

Medical students' learning objectives are nationally defined and can be found at the APGO website.

https://www.apgo.org/faculty/online-resources/med-student-objectives.html

Medical students have their didactic learning concentrated in the first two years of their training with the third year used for clinical rotations through the various medical disciplines. When the third year medical student comes to a midwife for a clinical experience in labor and delivery they will be very knowledgeable of many pathologic conditions but may have very little didactic learning in obstetrics outside of their orientation at the start of their obstetrics clerkship rotation. Their experience with direct patient care and charting will be

dependent on when within the year their obstetrics rotation falls. If it is in July, it may be their very first time in the role of interviewing, obtaining a history, and providing care to a patient. The obstetrics clerkship is typically six to eight weeks in length. The fourth year allows the student to focus on areas they are considering specializing in for residency training.

Residents

Midwives are mostly likely to precept residents who are first year interns. This includes residents in obstetrics, family medicine, and emergency medicine. If the resident is rotating from family medicine or emergency medicine for obstetrical training, their rotation is generally one month long. These residents will have a set goal for the numbers of deliveries they need to attend to complete their requirements. Their experience in obstetrics will be limited to their rotation as a third year medical student.

In contrast, the first year obstetrical resident is similar in training and interest to the level of the nurse-midwife student. Ob/GYN residents have core competencies that are outlined by the American College of Graduate Medical Education.

ACGME Website for Obstetrics and Gynecology

- http://www.acgme.org/acgmeweb/tabid/138/ProgramandInstitutionalAccreditation/SurgicalSpecialties/ObstetricsandGynecology.aspx

Website has common program requirements and resident requirements for:

Program Personnel and Resources

Faculty

Resident Appointments

Educational Program

Scholarly Activities

Evaluations- both formative and summative & residents evaluate faculty annually

Clinical Competency Committee

Resident Duty Hours in the Learning and Working Environment

Educational Approach

Although both midwifery and medicine's educational roots are based on the apprentice model, they have taken a divergent course over history. Medical education has a focus on large numbers of experiences often with a somewhat brief review of the experience unless there is unusual pathology whereas midwifery has a tendency to milk the experience, evaluating for improvements with a detailed look at all the various parts while also evaluating the patient's experience of the event. This difference in approach for midwifery training has been

influenced by competition for student access to clinical experiences thereby having smaller numbers of experiences from which to learn.

Students and residents often express appreciation for the detailed teaching approach midwives bring to the academic team. Another asset midwives bring to education is a strong knowledge of hand skills and a low technologic approach to caring for the woman and her family.

Challenges

The challenges faced by midwives working in medical education will vary with the organizational model of the midwifery service or practice, as this will dictate the mode of interaction with the obstetrical team.

In an integrated model, where the midwife is employed within the obstetrics and gynecology department, the midwifery service will often be totally integrated within the team providing care. For example, when on labor and delivery, the midwife will be working with the MFM specialist, the attending obstetrician, the resident team, the medical students, and the off service resident(s) rotating on obstetrics. All will be sitting down at the table at the beginning of the day for teaching rounds, and then will disburse for the day's activities of caring for the patients on the units. The midwife needs to know the roles of everyone at the table and her role well, with a very clear sense of identity to be able to maneuver through the day working in different capacities that are dependent on the needs at hand. She (he) may be teaching a medical student during a triage evaluation, then move to being the acting attending for precepting a resident for a birth, then back to helping to cover the unit providing direct patient care while the residents and attending are in a cesarean surgery.

This requires skills for establishing a quick rapport with patients never met before, as well as with team members and various learners, juggling multiple patient needs, the ability to quickly refocus and change roles, and good communication skills to interact with a large number of people so others know which role the midwife is providing, while holding the midwifery model of care intact.

This can frustrate the midwife who is longing for a guaranteed midwifery experience for the patient, or the midwife who is working without clear expectations of her (his) role. Often others will forget that the knowledgeable midwife is not physician trained and they will not know the limits of the midwifery scope of practice. Boundary lines can blur very easily. These expectations and boundaries often have to be clarified and reviewed for others, as the people on the team will change from week to week and month to month.

Trying to institute a change in a residency learning experience can also take much longer than one might expect. Depending on the teaching role of the midwife and where the change is interjected, it is quite possible to take four years or more for the change to be integrated into the residency culture as the upper level residents do a large amount of teaching for the lower level residents.

The challenges for the midwife working in a parallel model, who is in an established midwifery practice, that find themselves asked to take on a medical student or a resident intern into their clinical practice can be very different. Often the midwife practice and the residents are employed by the same hospital, or larger entity. The midwifery practice may be faced with the task of how to get recognition or compensation for taking on additional work in what can be a very challenging role on top of providing existing patient care while preserving the cherished experience of the patient and family during their birthing experience. There is also the challenge that

the midwife is asked to teach outside of her (his) own profession and to learn what knowledge base is expected for the medical student or resident.

Learning to be a good clinical educator requires an additional set of skills, in addition to being a good clinician. It takes perseverance, good communication skills, being up to date on the latest research and evidence based practice, confidence in giving constructive feedback, patience, having realistic expectations of your learner, willingness to receive feedback from your learner, and time.

Advancement and Promotion

In academia, there is the tenure track and the clinical track. There are typically fewer tenure track positions available with an agreed upon timeline to meet the set goals. This is negotiated upon being hired. Most midwives in medical schools are on a clinical track or in a fixed term contract position. The outline for advancement or promotion will be dependent on the departmental guidelines. It is always a good idea to be familiar with these guidelines. There will commonly be a promotions and tenure committee within the department that reviews the applicant's accomplishments for recommendations to the chair of the department. This committee is comprised of tenured faculty. Timing is an important component for the applicant to request a promotion. This will depend on the politics of the department, the economic health of the institution and your length of service.

Practice Tips

It takes courage to step outside of one's profession and comfort zone to teach in another's profession. I think this has received little recognition within the profession of midwifery. It is important for this courage to be recognized even if it is only within our own individual's midwifery practices, as this will give each other appreciation for the hard work that is done.

Finding a mentor can assist with looking at the problems faced from a system's approach. With experience in the field, this person can save you from repeating mistakes and promotes the subspecialty of midwives working in medical education, to move forward in developing this field of work. We need to pass on our hard earned knowledge to others coming into the profession behind us before retiring. We do not need to keep reinventing the same wheel.

Being flexible is essential as the amount of changing needs and varying demands on the midwife who does this work can be enormous. Expect that schedules will change over time to meet the changing needs within a department.

Ask for what you need. Others will not necessarily know what is needed from your perspective. This is a part of educating others to what you do and what you need to perform the job well. Medicine has been dominated by men for many years. Midwives are more commonly women. Gender issues should not be playing a role in how we interact with our colleagues. Raises, bonuses and discretionary funds or continuing education funds are flexible within a department. Funds are typically available for special projects, research and education. The financial health of a medical school is often tied to the ownership of a hospital facility as well as the endowment foundation.

Celebrate your successes no matter how small and pick your battles. Decide how much time and energy you want to commit to making a change. Sometimes it is necessary to fight a small battle that can be completed in a

short amount of time to avoid being overwhelmed. Every small success makes progress toward the greater goal of safe, kind and excellent care for women.

Having a strong collegial group of midwives will not only help to sustain you personally but also strengthen the contributions that can be made by midwives involved in medical education. We teach to improve care to women over our student's career lifetime, to educate physicians on what midwives can contribute to the team, and to promote more midwifery positions in the workforce at large.

Jan Salstrom CNM, MSN, Clinical Assistant Professor, East Carolina University, Brody School of Medicine, Dept. Ob/Gyn

EVALUATION

Evaluation is meant to focus on the midwife as evaluator of individual residents clinical functioning. For many midwives it is challenging to provide meaningful evaluations, especially those that involve criticism. Evaluation is a process by which one critically examines elements of a particular performance. The purpose is to make an assessment about the performance within a particular rotation, to establish where the resident is within the continuum of their residency and to highlight places for improvement.[23]

The evaluation should define observable behaviors that students must demonstrate over the course of their resident training. This involves considering the six domains as articulated by the Accreditation Council for Graduate Medical Education (ACGME) in the 2002 initiative called the Outcome Project.[24] The six ACGME Core Competencies are: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. Each competency is made up of different milestones residents are required to master at key stages of their medical training.

Most recently A Joint Initiative of The Accreditation Council for Graduate Medical Education, The American Board of Obstetrics and Gynecology, and The American College of Obstetrics and Gynecology released new reporting guidelines that require a semi-annual review of resident performance in ACGME-accredited programs called "Milestones".[25] These milestones provide a framework for evaluating the development of competency, from less to more advanced, in a residency specialty through the course of time. The milestones are targets for performance as the resident progresses from intern to graduating chief resident. For the sub-specialty of OB/GYN the milestones will be implemented in July 2014, with the first reporting required November/December 2014. Table 1 shows these new guidelines as they pertain to the care of intrapartum patients.

Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge

Residents must be able to demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Practice-Based Learning and Improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Interpersonal and Communication Skills

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates.

Professionalism

Residents must be able to demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Systems-Based Practice

Residents must be able to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Table 1: The Obstetrics and Gynecology Milestones: Obstetrics, ACGME Report Worksheet

Care of Patients in the Intrapartum Period — Patient Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates basic knowledge of routine/uncomplicated intrapartum obstetrical care including, conduct of normal labor	Provides intrapartum obstetrical care for women with uncomplicated pregnancies (e.g., identification of fetal lie, interpretation of fetal heart rate monitoring, and tocodynamometry) Differentiates between normal and abnormal labor Recognizes intrapartum complications (e.g., chorioamnionitis, shoulder dystocia)	Manages abnormal labor Manages intrapartum complications (e.g., cord prolapse, placental abruption)	Provides care for women with complex intrapartum complications and conditions Identifies indications for consultation, referral, and/or transfer of care for patients with intrapartum complications Effectively supervises and educates lower- level residents in intrapartum care Collaborates and provides consultation to other members of the health care team in intrapartum care	Applies innovative approaches to complex and atypical intrapartum conditions and implements treatment plans based on emerging evidence

Evaluations may be familiar to midwives from their own education and from precepting midwifery students. A typical schedule for evaluating residents in obstetrics would be an end of rotation evaluation after the first 6-week block for the intern followed by an end of year evaluation. For the chief resident a standard would be to provide two evaluations, the first is the clinical based form and the second is focused on professional conduct. Examples of these can be found in the Appendix C.

Because providing effective evaluations is often challenging some examples of well-written evaluations have been provided. Evaluations should provide a narrative that gives specific examples of the residents conduct. Critical evaluation must highlight problem areas and suggest a pathway for change and improvement. The following provides topics that are on our mind when completing an evaluation.

Considerations : arrives on time, caseload , adjustment to the program, case conference preparation and presentation, thirst for learning,

Documentation: timely completion of clinical notes, thoroughness.

Medical Education: fund of knowledge, basic versus advanced questions, confidence level

Professionalism: boundaries with supervisor and clients, ability to contain personal issues, awareness of cultural implications & differences, ,open to feedback, self-care

Teamwork: what it's like to sit with them / Energy, demonstrates awareness for other team members, works collaboratively

Clinical Skills: understands connections between theory & practice, able to develop management plan, ability to implement interventions, willingness to take appropriate risks

Examples: Positive Feedback PGY-1

Dr. Resident has done a great job integrating into the (XXX) community. She is bright with excellent foundational skills. She is always appreciative of feedback. Dr. Resident has been a total star as an intern. She is delightful to work with, organized, knowledgeable, down to earth, terrific with patients. She has excellent hand skills.

Dr. Resident has had a great 1st block on the OB service. She is organized, eager to learn and has been a joy to work with. She is a fast learner and her skills are excellent for a new intern.

Dr. Resident shows excellent critical thinking skills, is adept at learning and demonstrating competency with basic hand skills such as ultrasound and vaginal exams. She is already a valuable team member. She is open to learning, requests and responds positively to feedback. She has strong interpersonal skills.

Areas for Improvement:

Continue reading and challenging yourself Dr. Resident tends to be soft spoken so one goal for her will be to speak up during deliveries. She is already working on this and as her skills and confidence improve, she will find her "command voice." Continue developing good basic skills and deepening knowledge base.

Other Comments: It's a pleasure working with you Dr. Resident Great job Dr. Resident! Looking forward to working with you in the future! Dr. Resident is a pleasure to work with and to teach.

Examples: Positive Feedback

Dr. Resident continues to be an active learner, open to feedback and critique. Dr. Resident is energetic and has good patient and team rapport. Sometimes, Dr. Resident's high energy translates into Dr. Resident appearing scattered or rushed. I recommend Dr. Resident continue to practice maintaining focus, objective thinking, accurate assessment of patient status and plan of care, and clear communication with others. Ultimately, Dr. Resident should be able to differentiate between normal, urgent, and emergent situations and maintain the above skills throughout."

Examples: Positive Feedback

Dr. Resident always demonstrates willingness to triage patients, admit them and participate in their labor management as well as their birth. Dr. Resident always demonstrates willingness to triage patients, admit them and participate in their labor management as well as their birth. She quickly establishes rapport with the patient and family. Dr. Resident continues to demonstrate sound OB knowledge and skills, confidently utilizing both when caring for women. Dr. Resident is not afraid to ask for assistance. Feedback provided following last birth we attended together included: anticipation of possible difficulties (i.e. maternal tissue dystocia versus infant shoulder dystocia during delivery; providing a "less hands on approach" when pushing efforts are adequate and placental detachment seems appropriate. Accepts feedback willingly and seems to feel comfortable addressing

feedback provided. Great to work with!" Quickly establishes rapport with the patient and family. Dr. Resident continues to demonstrate sound obstetric knowledge and skills, confidently utilizing both when caring for women. She is not afraid to ask for assistance. Feedback provided following last birth we attended together included: anticipation of possible difficulties (i.e. maternal tissue dystocia vs infant shoulder dystocia during delivery; providing a "less hands on approach" when pushing efforts are adequate and placental detachment seems appropriate. Accepts feedback willingly and seems to feel comfortable addressing feedback provided. Great to work with!

Examples: Critical Feedback

Professional Attributes: Dr. Resident is very smart and eager to learn. Dr. Resident is a kind and compassionate team member who works well with his peers. I have observed Dr. Resident to be extremely supportive to classmates. Dr. Resident has done a great job on the OB service with his 1st rotation. Dr. Resident 'skills and fundamentals of knowledge have steadily improved and he responds well to feedback. Dr.Resident has a kind-hearted easy going personality and truly cares about the patients he is managing. It is a pleasure working with Dr. Resident ....very good overall skills. Works well with midwifery faculty. Dr. Resident did well during this first OB block making a successful transition to residency. H Dr. Resident is bright and demonstrates compassion and excellent interpersonal skills with patients, families and other members of the team. Dr. Resident is smart, has excellent rapport with patients, and has tremendous potential to be a great doctor. Dr. Resident works well with the midwives and is an excellent team player. Dr. Resident is intelligent, establishes excellent rapport with the patients, and listens well to feedback.

Areas for Improvement:

Goals for Dr. Resident include: honing case presentation skills to be formal, detail oriented and thorough; improving on notes in all areas to be clear and complete done in a timely manner; it may be helpful to seek out immediate feedback on patient interactions and reports in order to be able to focus on the some of them more subtle Inter-personal skills caring for a diverse patient population. Also, observation of respected senior residents may be helpful in developing these skills.

One goal for Dr. Resident is to allow himself time to be a learner. Dr. Resident sets high expectations for himself that are not always realistic for a new intern. Dr. Resident has solid beginning level skills and will continue to grow and improve with more experience. Continue to work on skill competency and checkouts in triage Continue reading to broaden your knowledge base to care for more complex OB patients. Continue working on efficiency and comprehensiveness with patient work ups Dr. Resident needs to be more systematic in his chart review, presentations, and documentation. Getting the basics down at the beginning of residency, will allow Dr. Resident to excel in more complex patient situations. Some suggestions: develop systematic approach to each patient with check lists to ensure details are not omitted. Be comfortable being a learner. **Other Comments**: Dr. Resident has all the components of an excellent resident. All that needs to happen is to allow the necessary learning both in skills and professionalism happen. It's been a pleasure S! I am looking forward to your second OB block already! Keep up the good work!! It's a pleasure working with you, S. Wonderful working with you and looking forward to next block.

Examples: Critical Feedback

Dr. Resident is hardworking and studies well. However applying to knowledge to clinical practice has proven challenging. In Dr. Resident's desire for autonomy there is often a lack of discussion with the midwife attending. In this intern rotation it is the expectation is that the plan of care will be discussed prior to implementation, this has been discussed and met with resistance.

Areas of concern

- difficulty prioritizing
- meeting administrative goals of charting
- time management
- not receptive to feedback and can become defensive when corrections are made
- Hand maneuvers for birth
- improve consultation with attending providers

Expectations for the future

- prioritize patient care over charting
- ask for help from peers - for tips on how to speed up administrative requirements.
- discuss plan of care with the attending prior to acting on this.
- Improve receptivity to feedback without defensive responses Thorough, concise verbal presentation of triage patients
- apply classroom knowledge to clinical setting
- work on basic hands skill for normal birth

Examples: Critical Feedback – in need of immediate intervention

This evaluation is generated from two recent clinical interactions that I had with Dr. Resident during a weekend shift on the intrapartum floor. I have spoken with Dr. Resident about my concerns, and given him some constructive and specific recommendations during our debriefing, which occurred within an hour of the second birth. Dr. Resident is energetic and committed to being a working member of the OB team. Clinical judgment and the plan of care that Dr. Resident develops are within standards of care, and safe practice. Implementation of the care is another issue. **Areas of concerns** As expressed by Dr. Resident there exists a deep level of internal anxiety or panic during the actual birth, which leads to a breakdown in basic clinical skill for the completion of a safe and smooth birth. Dr. Resident agrees that (s)he is panicked at the time of birth, and in Dr. Resident words would like that the birth "just happen and be over". During our debriefing we talked about this anxiety and that a healthy level of "awareness" is important to bring to each birth experience but a level of panic, is not only not helpful but is potentially harmful. Dr. Resident is also in agreement that this anxiety creates an environment within the work that makes Dr. Resident hasten the steps necessary for a safe birth, and therefore lose focus on basic hand skills. It also hampers the ability to speak to the patient in a calm, coherent manner that in and of itself can often help with the birth process. During our debriefing I was encouraged by Dr. Resident's apparent

dedication to learning, honest desire to “do no harm”, and openness to listening to my concerns without making any rationalization for the observed actions.

Plan of Action

- Schedule meeting with director of residency program, and midwife attending to further explore areas of concern
- Dr. Resident is to do some private self-reflection regarding choice of specialty
- Review basic hand skills for birth
- Consider some type of meditation to be used in situations of internal anxiety
- Consider need for more specialized evaluation

PGY4 Evaluation

Dr. Resident is a very competent provider in her clinical skills and knowledge. She works hard to be a professional and effective consulting physician.

Dr. Resident is always open to and available for consultation either with patients or colleagues. He continues to build his OB clinical skills and is an eager participant.

Dr. Resident is very respectful of others and is a good listener. I appreciate being able to go to her with any questions or concerns that I have caring for CNM patients.

Dr. Resident is a personal favorite. Why? Put quite simply she is an excellent care provider. What does this mean? She is both a leader of the team, and a listener. This means that she is able to act when necessary, and allow for processes to unfold when appropriate. She has a keen political sense that puts women and families first. And she is a top clinician, with excellent hand skills and assessment! It's a pleasure to work with her, and I look forward to more of it.

PGY-4 positive evaluation

Professional Attributes:

Dr. Resident is an “outstanding chief resident”

- organized; clearly defines expectations for the team
- helps juniors set goals and objectives
- is involved but not micromanaging
- bright with an excellent knowledge base

Dr. Resident did a stellar job as Chief

- straight-forward communicator
- on top of the service while allowing juniors to learn and grow
- a great role model, extremely knowledgeable
- makes excellent clinical decisions while inviting the team's opinions.

Dr. Resident did an excellent job as the OB chief this rotation.

- had some fairly complicated clinical situations to deal with and provided solid clinical guidance for the team
- available for deliveries and truly takes ownership of managing and mentoring the team.

Dr. Resident is a very strong, competent and kind chief resident.

- handled many complicated medical and interpersonal situations during the block on OB with aplomb
- able to meet with the team and individualize teaching for each team member
- readily available for consults and present for any complication that arose
- able to both delegate and stay very aware of the whole service

Areas for Improvement:

By setting expectations and providing feedback to the junior residents you are becoming a solid role model, it has been great to watch this skill develop for you!

PGY-4 critical evaluation

Professional Attributes:

Dr. Resident is a very organized chief and has excellent skills and fund of knowledge. There were times during this rotation when her communication style to staff and junior residents was unprofessional and demeaning. She has been spoken to about these issues and hopefully will be more respectful of her team in the future.

Areas for Improvement:

Keep seeking feedback and assistance when needed, we are here to help you be the best resident you can be. Dr. Resident was not her best self this rotation. She was disrespectful and dismissive to faculty and colleagues. She made little effort to set expectations for and give feedback to her junior residents.

Karen Schelling CNM, MSN, staff midwife at Dartmouth Hitchcock Medical Center, instructor at Geisel Medical School (formerly Dartmouth Medical School)

APPENDIX A

RESOURCE LIST

WEBLINKS

ACNM Medical Education Caucus

http://www.midwife.org/Medical-Education-Caucus

CREOG: ACOG division of obstetric and gynecology resident education

- Core curriculum in obstetrics and gynecology
- milestones for obstetric and gynecology residents

http://www.acog.org/About_ACOG/ACOG_Departments/CREOG

Association of Professors of Gynecology & Obstetrics (APGO). (2009). Medical Student Educational Objectives, 9th Ed.

https://www.apgo.org/binary/Final%20EDUC%20OBJ.pdf

Interprofessional Education Collaborative Expert Panel. (2011). Core Competencies for Interprofessional Collaborative Practice.

http://www.aacn.nche.edu/education-resources/ipecreport.pdf

PEER-REVIEWED ARTICLES

COLLABORATION IN ACADEMIC OBSTETRIC CARE

American College of Nurse Midwives, American College of Obstetricians and Gynecologists. Joint statement of practice relations between obstetricin-gynecologists and certified nurse-midwives/certified midwives. (2011). http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000224/ACNM.ACOG%20Joint%20Statement%203.30.11.pdf

Waldman R, Kennedy H, Kendig S. Collaboration in maternity care: possibilities and challenges. *Obstet Gynecol Clin N Am.* 2012;39(3):435-444.

Waldman R. The long and winding road to effective collaboration. *Obstet Gynecol Clin N Am.* 2012;39(3):xix-xxii.

Waldman R. Collaborative intelligence. *Int J Gynaecol Obstet.* 2011;114(3):213-214.

RESEARCH RELATED TO MIDWIVES IN MEDICAL/RESIDENT EDUCATION

Angelini D. A national survey of the midwifery director role in academic midwifery practices involved in medical education in the United States. *J Midwifery Womens Health.* 2009;54:275-281.

McConaughey E, Howard E. Midwives as educatros of medical students and residents: Results of a national survey. *J Midwifery Womens Health.* 2009;54(4):268-274.

Harman P, Summers L, King T, Harman T. Interdisciplinary Teaching: A survey of CNM Participation in Medical Education in the United States. *J Nurse-Midwifery.* 1998;43(1):27-37.

Eskew P, Watt G. Postgraduate medical education in obstetrics and gynecology. *Obstet Gynecol.* 1981;58:642-645.

MIDWIFERY ACADEMIC PRACTICE MODELS WITH RESIDENT EDUCATION

Angelini D, O'Brien B, Singer J, Coustan D. Midwifery and obstetrics: Twenty years of collaborative academic practice. *Obstet Gynecol Clin N Am.* 2012;39(3):335-346.

Avery M, Montogomery O, Brandl-Salutz E. Essential components of successful ollaborative maternity care models. *Obstet Gynecol Clin N Am.* 2012;39:423-434.

Cordell M, Foster T, Baker E, Fildes B. Collaborative maternity care: three decades of success at Dartmouth-Hitchcok Medical Center. *Obstet Gynecol Clin N Am.* 2012;39(3):383-398.

Waldman R. The long and winding road to effective collaboration. *Obstet Gynecol Clin N Am.* 2012;39(3):xix-xxii.

DeJoy S, Burkman R, Graves B, et al. Makit it work: successful collaborative practice. *Obstet Gynecol.* 2011;118(3).

Collins F. Models of organizational structure of midwifery practices located in institutions with residency programs. *J Midwifery Womens Health.* 2009;54:287-293.

Feinland F, Sankey H. The obstetrics team: Midwives teaching residents and medical students on the labor and delivery unit. *J Midwifery Womens Health.* 2008;53:376-380.

Angelini D, Afriat C, Hodgman D, Closson S, Rhodes J, HOldredge A. Development of an academic nurse-midwifery servic program: a partnership model between medicine and midwifery. *J Nurse-Midwifery.* 1996;41(3):236-242.

Sedler K, Lydon-Rochelle M, Castillo Y, Craig E, Clark N, Albers L. Nurse-midwifery service model in an academic environment. *J Midwifery Womens Health.* 1993;38(4):241-245.

Platt L, Angelini D, Paul R, Quilligan E. Nurse-midwifery in a large teaching hospital. *J Nurse-Midwifery.* 1985;66:816-820.

MIDWIFERY ACADEMIC TEACHING MODELS WITH RESIDENT EDUCATION

Cooper E. Innovative midwifery teaching for medical students and residents. *J Midwifery Womens Health.* 2009;54(4):301-305.

Blake K, Magrane D. Reorganization of postpartum rounds. *Acad Med.* 1995;70:432-434.

Swanson, M., DePineres, T., Seger, S., &Robertson, P. 2009; "Latina Health Elective: A New Model in Medical Education." Poster.

MIDWIVES TEACHING RESIDENTS IN PRENATAL CARE

Makoff R, DeVore N, Freda M. Orientation of obstetric/gynecology residents to ambulatory care: a nurse-midwifery approach. *J Nurse-Midwifery.* 1994;39:375-380.

MIDWIVES TEACHING STUDENTS CENTERING PREGNANCY

Kolb, H. Picklesimer, A.H., Covington-Kolb, S., Hines, L. (2013). Centering Pregnancy Electives: A Case Study in the Shift Toward Student-Centered Learning. J.S.C Med Association. August 108 (4) 103-105.

Novick, G., Reid, A.E., Lewis, J., Kershaw, T.S., Rising, S.S., Ickovics, J.R. (2013) Group Prenatal Care: Model Fidelity and Outcomes. American Journal of Obstetrics and Gynecology, August, 209 (2) 112.e1-6.

Ickovics, J.R., Reed, E., Mapgriples, U., Westdahl, C. Schindler Rising, S. (2011) Effects of Group Prenatal Care on Psychosocial Risk in Pregnancy: Results from a Randomized Control Trial. Psychological Health, Feb. 26 (2), 235-250.

Ickovics, J.R., Kershaw, T.S., Westdahl, C., Magriples, U., Massey, Z., Reynolds, H. (2007). Group Prenatal Care and Perinatal Outcomes: A Randomized Control Trial. Obstetrics & Gynecology, August (110) 330-39.

MIDWIVES TEACHING RESIDENTS IN OBSTETRIC TRIAGE

Angelini D, Stevens E, MacDonald A. Obstetric triage: models and trends in resident education by midwives. *J Midwifery Womens Health.* 2009;54:294-300.

MIDWIVES TEACHING RESIDENTS IN POSTPARTUM CARE

Blake K, Magrane D. Reorganization of postpartum rounds. *Acad Med.* 1995;70:432-434.

MEDICAL STUDENT/RESIDENT KNOWLEDGE OF MIDWIFERY

Hanson L, Tillett J, Kirby R. Medical students' knowledge of midwifery practice after didactic and clinical exposure. *J Midwifery Womens Health.* 2005;50(1):44-50.

Howard F, Leppert P. Reaction of residents to a teaching collaborative practice. *J Nurse Midwifery.* 1998;43:38-40.

BILLING AND DOCUMENTATION FOR MIDWIVES PROVIDING RESIDENT TRAINING

Wilson-Liverman A, Slager J, Wage D. Documentation and billing for services provided by midwives teaching obstetrics and gynecology residents and medical students. *J Midwifery Womens Health.* 2009;54(4):282-286.

APPENDIX B: Sample Curriculum

Curriculum for PGY1, UC Denver

Table of Contents

Physiologic Pregnancy and Birth Lecture Series
Presented by Midwives of Boston University School of Medicine
Department of Obstetrics and Gynecology

1. Intern Bootcamp: Skills development for new intern orientation
    - Sterile vaginal examinations
    - Placement of FSE and IUPC, performing AROM
    - EFW/Leopold maneuvers
    - Hand maneuvers for NSVD
    - Estimating blood loss

2. Normal Birth Lecture series: Didactic training for first year interns
    - Physiologic labor and birth
    - Phone triage
    - Fetal Heart Auscultation
    - Non-pharmacologic pain relief in labor
    - Management of the second stage of labor
    - Birth outside of the labor and delivery suite

3. Prenatal Care and Postpartum care
    - Didactic: Prenatal care: nutrition, common maternal concerns, common discomforts of pregnancy
        - Ambulatory clinical rotation: prenatal new intakes, continuity clinics
    - Didactic: Care of the normal postpartum woman, postpartum course, breastfeeding
        - Postpartum rounding rotation with CNM
4. Consulting and Collaboration with CNMs
    - Didactic lecture for chief residents
5. "Midwifery Madness": review of an article from peer-reviewed literature related to non-pharmacologic pain relief and intrapartum midwifery management. First Monday of each month

Intern Reading List (Brown)

June 2014

Required:

Electronic Fetal Monitoring / Fetal Surveillance

1. Macones GA, Hankins GDV, Spong CY, Hauth J, Moore T. The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring. Obstet Gynecol. 2008; 112 (3), 661-666.

2. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetricians-Gynecologists. Management of Intrapartum Fetal Heart Rate Tracings. Number 116, November 2010.

Antepartum Testing

3. Devoe LD. Antenatal Fetal Assessment: Contraction Stress Test, Nonstress Test, Vibroacoustic Stimulation, Amniotic Fluid Volume, Biophysical Profile, and Modified Biophysical Profile – An Overview. Semin Perinatol. 2008; 32: 247-252.

Intrauterine Growth Restriction (IUGR)

4. ACOG Practice Bulletin. Fetal Growth Restriction. Number 134, May 2013.

Trauma in Pregnancy

5. Gabbe SG, Niebyl JR, Simpson JL et al. Obstetrics Normal and Problem Pregnancies; 6th Edition. Chapter 25 – Trauma and Related Surgery in Pregnancy, pages 581-590.

Third Trimester Bleeding

6. Gabbe SG, Niebyl JR, Simpson JL et al. Obstetrics Normal and Problem Pregnancies; 6th Edition. Chapter 19 – Antepartum and Postpartum Hemorrhage, pages 415-426.

Hypertension in Pregnancy

7. The American College of Obstetricians and Gynecologists (ACOG). Executive Summary. Hypertension in Pregnancy. Obstet Gynecol. 2013; 122 (5): 1122-1131.

Preterm Labor

8. Gabbe SG, Niebyl JR, Simpson JL et al. Obstetrics Normal and Problem Pregnancies; 6th Edition. Chapter 28 – Preterm Birth, pages 627-656.

Premature Rupture of Membranes

9. Gabbe SG, Niebyl JR, Simpson JL et al. Obstetrics Normal and Problem Pregnancies; 6th Edition. Chapter 29 – Premature Rupture of Membranes, pages 659-670.

Trial of Labor after Cesarean (TOLAC)

10. ACOG, "Vaginal Birth After Previous Cesarean Delivery", Practice Bulletin Number 115, August 2010.

Post-Term Pregnancy

11. Gabbe SG, Niebyl JR, Simpson JL et al. Obstetrics Normal and Problem Pregnancies; 6th Edition. Chapter 34 – Prolonged and Post-term Pregnancy, pages 769-774.

Postpartum Hemorrhage

12. Gabbe SG, Niebyl JR, Simpson JL et al. Obstetrics Normal and Problem Pregnancies; 6th Edition. Chapter 19 – Antepartum and Postpartum Hemorrhage, pages 426-441.

Suggested Readings:

13. Eshkevari, L, Trout KK, Damore J. Management of Postpartum Pain. J Midwifery Women's Health. 2013. 58:; 622-631.

14. Angelini D, LaFontaine D. Editors. Obstetric Triage and Emergency Care Protocols. New York: Springer Publications. 2013 (30 chapters).

Skill Checklists (BROWN)

PGY-1 OB Triage Checklist

Nurse Midwifery Section

PGY-1 Name:

S = Satisfactory **CNM** **Date**

U = Unsatisfactory **Initial**

IUGR	_____	_____
Trauma	_____	_____
Gestational Hypertension / Pre-Eclampsia	_____	_____
Preterm Labor	_____	_____
PROM at Term	_____	_____
PPROM	_____	_____
Third Trimester Bleeding	_____	_____
Decreased Fetal Movement	_____	_____
Post Term Evaluation	_____	_____

1st Month CNM Initial / Date 2nd Month CMM Initial / Date

☐ AFI _____ ☐ Vaginal Delivery _____

☐ Sterile Vaginal Exams _____ ☐ Suturing _____

☐ BPPs_____

Final Signature _____ Date _____

Intern Orientation Schedule (Brown)

June 18, 2014

7:30 – 8:00	Introduction
8:00 – 8:45	EFM
8:45 – 9:00	Epis / Lac / Repair
9:00 – 10:00	Practice of Above
10:00 – 10:15	Break
10:15 – 11:00	Cardinal Movements / Hand Maneuvers
11:00 – 11:30	PPH
11:30 – 12:00	Shoulder Dystocia
12:00 – 12:30	Lunch
12:30 – 1:45	Practice of Above – All CNMs
1:45 – 2:30	Vaginal Exams / AROM / Prolapse
2:30 – 3:00	FSE / IUPC
3:00 – 3:15	Break
3:15 – 4:15	Practice of Above – All CNMs
4:15 – 4:30	Simulation
4:30 – 5:00	Wrap Up / Evaluations

Resident Cards/Tip Sheets: Routine OB Care (Brown)

ROUTINE OB VISIT (WPCC)*

1st visit	Complete H&P
	G/CT, Pap if indicated, UA/ C&S, PPD
	Determine EDD, PNVs, Flu Vaccine
	Social Services (if high risk), DV screen
	Blood work (CBC, T&S, HBsAg, RPR, Rubella, HIV, Hb elect, ?HepC, ?CF)
	Integrated Quad Screen
	#1 @ 10 to 13 weeks, NT @ 10 to 13'6
	#2 @ 15 to 22'6 weeks
	Maternity 21 @ >10wks if AMA
2nd visit	Nutrition /Weight gain
	BMI <18.5 gain 28-40#
	BMI 18 – 25 gain 25-35#
	BMI 25 – 30 gain 15-25#
	BMI >30 gain 11-20#
	Early DS if obesity, hx macrosomia/GDM
16-18 wks	AFP Quad (range 15'0-22'6)
18-20 wks	Fetal movement, Formal anatomy US
24-28 wks	DS (< 130; 3 hr GTT – FBS < 95; 1 hr < 180;
	2 hr < 155; 3 hr < 140),
	CBC, TdaP, T&S/Rhogam if Rh neg,
	PTL-family planning, DV screen
	Circumcision consent
28-32 wks	third trimester HIV&RPR
35-37 wks	GBS (w/ sensitivities if PCN allergic)
	Defer if +GBS bacteriuria this pregnancy

?GC/CT – if high risk

?CBC if indicated

PPBCM, Pedi, Br/bottle, car seat, DV screen

Scan for presentation

≥41 wks 2x/wk NST, AFI (or IOL at 41w)

contact OB chief for delivery plan

Triage vs. slip for IOL→ put H&P in chart!

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*OB visits: q 4 wks.; 28 wks. – q 2 wks.; 36 wks. – 1 wk.

UTEACH: A Unique Teaching Experience About Childbirth and Health (UCSF)

UTEACH is an innovative UCSF program developed for medical students in the first and second year of their training to broaden exposure to obstetrics prior to the clinical ward year three. It is often cited as a formative event in their medical school education and is believed to contribute to the high number of medical students choosing obstetrics as their specialty. Started in 1995 by nurse midwife Tekoa King with the assistance of Dr. Patricia Robertson, UTEACH grew out of student interest. In its nineteenth year, it is a two-credit medical school elective which meets over ten weeks. Students serve as coordinators of the elective and are guided by nurse midwifery directors around exploration of topics to cover. Currently, discussions of normal physiologic birth as well as obstetric complications occur. Coping with labor pain, options for pain relief, prenatal care overview as well as inter-professional collaboration.

Recruitment of women in the prenatal clinics by medical student course directors and midwifery directors aims to pair students with a childbearing woman. Medical students attend prenatal visits as well as the birth as an observer. In 2012, the course became interdisciplinary with directors Rebekah Kaplan and Judith Bishop. The current course directors are Suzanne Seger and Rebekah Kaplan and UTEACH has become a required elective for all UCSF nurse midwifery students.

Planning & Timeframe

UTEACH student and faculty coordinators meet in early summer after spring email exchanges on the upcoming year. A review of topics covered in previous years and what was well received, what was useful is discussed. The UTEACH elective occurs in the fall semester and thus women with due dates in the spring are targeted for student clinical observations, often the most satisfying part of the elective. The elective is completed by December with the practicum of labor and birth observation can extend into the spring. The national academic calendar for medical school includes a summer off after completion of first year course work. Because medical and midwifery students do lab or clinical volunteer experiences that take them away from campus that summer, it is essential to offer the elective in the fall semester window.

Outside speakers are invited in the summer for the fall calendar. Students take the initiative to invite faculty but are often assisted by course directors in making connections.

Funding

Student course directors receive a small stipend to cover their recruitment efforts for the program. Funding from the medical student education office has fortunately been available since the elective's inception.

Course Organization Overview

FACULTY directors:

Suzanne Seger, CNM UCSF segers@obgyn.ucsf.edu

Rebekah Kaplan, CNM SFGH kaplanr@obgyn.ucsf.edu

Administrative Help:

Matthew Leavitt, Medical Student Program Coordinator

Julie Lindow, Medical Student Program Administrator

To Do's:

- Choose class weeks, 10 sessions, 8 to pass, P/F grade
- Book the room (Matt)
- Review and revise forms and make copies: student registration form, Mom flyer
- Ad flyer-in color to post in offices
- Hand out for opening class-course description, class dates, speaker schedules, rules
- Ad flyer for class at student fair
- I-Rocket materials- review & update
- Choose speakers/topics/dates
- Speaker coordination: invite, confirm, arrange AV needs, parking stickers (Matt), thank you's
- Trouble shoot change of schedule needs
- Greet, set up and introduce speaker at every class

Advertising/recruitment incoming students to class

Faculty recruitment –letter from Suzanne to remind faculty UTEACH recruitment commencing

Mom recruitment and matching-matching students and moms –Suzanne trouble shoots

Beepers to facilitate contacting students – 3-4 weeks prior to due date, student gets beeper. Suzanne places in electronic medical record so OB team pages the student.

Attendance – Julie/Matt

Food – Matt confirms budget, orders, arranges, decides which classes have food – first class with food

Audio/Visual –set up/expertise for speakers/movies – Matt/Suzanne

Evaluation/feedback mechanism

Organizing meeting and debrief to evaluate what was strong/ what needs to change

Skills Checklist (BU)

Intern skills check list for normal L&D

Skill	**#to assess**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Accurate SVE	20																				
SSE for ferning	5																				
Wet prep	5																				
US assessment of fetal presentation	5																				
Leopold's maneuvers & EFW	5																				
NSVD	10																				
-flexion of vertex																					
perineal support																					
-management of nuchal cord																					
-delivery of shoulders																					
-Delivery of the placenta																					
Intermittent auscultation	5																				
Identification of FHT pattern	20																				
Repair of 1st or 2nd degree lac-eration	10																				
FSE placement	5																				
IUPC placement	5																				
AROM	5																				
Foley balloon placement	5																				
Informed Con-sent for NSVD	3																				
Informed con-sent for TOLAC	3																				
Informed Con-sent for c/s	3																				

Skills check list is a way to feel confident in your skills
and quickly build independence.
New interns may ask CNM, OB, FAM med attending or
chief resident to sign off on skills.
Ideally completion of the skills check list will be done within
the first weeks of your rotation.

APPENDIX C

Sample Evaluations (DARTMOUTH)

(Print) Evaluator's Name:_____ Student's Name: _____ Site/Block: DHMC -B-6.3

_____ Dates of rotation: _____ Sept 23-Oct 25,

Evaluator's Role: q Attending q Resident q CNM/APRN q Other

Nature of contact with student: □ Office □ Surgery □ Labor & Delivery □ On Call

My contact with this student was over _____ weeks and was: q Daily q Frequent q Occasional

COMPETENCY SPECIFIC EVALUATION:

Evaluate the competency specific performance using the anchors described below:

- Outstanding: Outstanding performance, usually top 10% of Geisel students at current level of training
- Advanced: Above average performance for a Geisel student at current level of training
- Meets Expectations: Solid, capable performance; at expected level for a Geisel student at current level of training
- Below Expectations: Fair performance for current level of training, but needs more practice
- Unacceptable: Inadequate performance for current level of training that needs attention
- Unable to Evaluate

Medical Knowledge
Identifies and explains OB/GYN knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences, and applies this knowledge to patient care.

	Unacceptable	Below Expectations	Meets Expectations	Advanced	Outstanding	Unable to Evaluate
Knowledge of obstetrical and gynecologic diseases and pathophysiology	□ Inadequate	□ Gaps	□ Effective fund of knowledge	□ Beyond expected level	□ Superior in breadth and depth	□
Application of obstetrical and gynecologic knowledge to patient care	□ Cannot relate biomedical science to clinical context	□ Often has difficulty applying knowledge to clinical context	□ Usually applies knowledge to clinical decision making	□ Always applies knowledge to patient care	□ Sophisticated application of knowledge to clinical context	□

Patient Care

Provides patient- and family-centered care that is compassionate, appropriate, and effective for the treatment of obstetric and gynecologic problems, and well woman care, with specific attention to the important clinical skills that are necessary in order to deliver excellent patient care.

	Unacceptable	Below Expectations	Meets Expectations	Advanced	Outstanding	Unable to Evaluate
History-taking skills	□ Often misses important information and patient concerns	□ Sometimes misses important information	□ Identifies and describes important information in an organized way	□ Identifies and fully characterizes all important information, patient concerns, & biopsychosocial concerns in an organized way	□ Identifies ALL important clinical issues and points out previously missed data	□
Physical exam skills	□ Unable to perform an organized obstetrical/ gynecologic exam	□ Technique is not always correct.	□ Technique is correct.	□ Technique is correct, exam is organized.	□ Technique is always correct and exam is organized and focused.	□
Diagnostic Reasoning	□ Unable to formulate a clear differential diagnosis	□ Able to formulate a limited differential diagnosis	□ Able to formulate a clear and full differential diagnosis	□ Consistently formulates clear and thorough differential diagnoses with prioritization	□ Consistently formulates clear, thorough, prioritized differential diagnoses with discussion of each	□
Treatment planning	□Unable to formulate safe and effective treatment plans	□Generally able to formulate safe and effective treatment programs, but misses some important interventions	□ Usually formulates evidence-based, safe and effective treatment programs	□ Consistently formulates evidence-based, safe and effective treatment programs	□ Consistently formulates evidence-based, safe and effective treatment programs with literature support	□
Speculum Exam Skills	□ Unable to perform a speculum exam	□ Able to perform a speculum exam with guidance.	□ Able to perform a speculum exam.	□ Able to confidentially perform a speculum exam with ease.	□ Consistently able to skillfully perform a speculum exam with challenging patients.	□
Surgical/Operating Room Skills	□ Consistently unaware of the OR culture, or unprepared for Surgical case.	□ Unable to integrate into the OR setting or distracted during cases.	□ Able to integrate in the surgical team, shows interest.	□ Able to assist and always prepared, focused cognitively prepared.	□ Is a natural in the OR with technical skills fluent knowledge of procedure.	□

Interpersonal and Communication Skills

Demonstrates interpersonal and communication skills that result in clear, appropriate and effective information exchange with patients, their families, health professionals and staff.

	Unacceptable	Below Expectations	Meets Expectations	Advanced	Outstanding	Unable to Evaluate
Communication with patients and families	□ Has significant challenges in communication	□ Encounters obstacles in communication with patients and families, misses some concerns	□ Uses language effectively, avoids jargon, identifies non-verbal cues	□ Consistently uses language effectively, identifies non-verbal cues and shows empathy	□ Consistently uses language effectively, identifies non-verbal cues shows empathy and identifies hidden concerns	□
Patients Notes	□ Inaccurate, with excessive cutting and pasting	□ Poorly organized, somewhat unclear, cut and paste overused	□ Thorough and precise notes with clear assessment and plan	□Thorough and precise notes which integrate EBM into assessment and plan	□ Consistently original, thoughtful and thorough notes on the level of PG-1 house staff notes	□
Case presentations	□ Inaccurate, incomplete, and/or disorganized	□ Struggles to organize and present clearly, and convey a history timeline	□Communicates all important information in an organized form	□ Thorough but concise, conveying clearly the history timeline and all exam features with a logical impression and plan	□ Complete, concise, and presented at a skill level similar to PG1 resident without written prompts	□

Habit of Inquiry and Personal Practice Improvement

Develops the habit of inquiry into and improvement of one's own personal practice, by reflecting upon and evaluating the student's own direct patient care, and accessing the best information and practices available.

	Unacceptable	Below Expectations	Meets Expectations	Advanced	Outstanding	Unable to Evaluate
Reads appropriately in ob/gyn and specifically about current cases	□ Seems not to read or investigate current literature	□ Makes cursory attempts to investigate current literature relating to patients	□ Significant reading in texts and journals about some conditions is evidenced by notes and presentations	□ Extensive reading in texts and journals is consistently made clear during case discussions, presentations and chart notes	□ A self-motivated learner who develops a deep body of knowledge concerning all patients' illnesses; teaches team	□
Presents and correlates current EBM with patient care	□ Is at a loss when asked for evidence-based information which might help with decision making	□ Can share minimal information about current EBM knowledge as it applies to patients	□ Shares useful information about current EBM knowledge as it applies to some patients	□ Consistently provides applicable EBM information to the team	□ Consistently provides EBM information which directly improves patient care	□

Professionalism

Forms a mature, responsible, and ethical professional identity, as manifested through a commitment to carrying out all professional responsibilities in a timely manner, adherence to ethical principles, and understanding the social contract between society and the profession of medicine.

	Unacceptable	Below Expectations	Meets Expectations	Advanced	Outstanding	Unable to Evaluate
Respect and compassion	□ Disrespectful of others, intolerant, untrustworthy	□ Difficulty with showing empathy, not careful with confidentiality	□ Treats patients and colleagues with respect, is careful with boundaries	□ Consistently respectful, shows empathy, seeks to understand others' point of view	□ Exemplary; teaches and models empathy, compassion, and boundary behavior to others	□
Responsiveness to feedback	□ Becomes defensive, blames the system or others	□ Some defensiveness, resists guidelines and change	□ Appears receptive and appreciative to constructive criticism and sees the benefit	□ Appears receptive and appreciative to constructive criticism and helps to create a plan to improve	□ Receptive and appreciative to constructive criticism, creates and monitors a plan for growth; reassesses	□
Reliability, Accountability & conscientiousness	□Undependable, disorganized, rarely punctual	□Assumes responsibility only if asked, sometimes late or disorganized	□Often assumes responsibility without being asked, punctual, organized	□ Consistently assumes responsibility, always punctual, and dependable	□ Consistently assumes responsibility, helps others, develops new tools	□

Systems-Based Practice and the Science of Healthcare Delivery

Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

	Unacceptable	Below Expectations	Meets Expectations	Advanced	Outstanding	Unable to Evaluate
Integration with medical team and colleagues	□ Poor teamwork, disruptive	□ Has difficulty integrating with team, misunderstands role at times	□ Finds proper role in team, clear communications	□ Well-integrated with team, always communicates important information in a timely manner	□ Grasps responsibilities immediately, and functions at the level of a PG1 most of the time.	□
Displays awareness of cost effectiveness and delivery of healthcare	□ Seems unaware of costs of care, patient socioeconomic status, access to resources	□ Understands economic pressures on some patients and occasionally offers cost/benefit ideas	□ Is aware of patients' economic pressures, is knowledgeable about cost v. benefit thinking	□ Discusses economic strains on each patient as well as on the system as a whole, makes good cost/benefit decisions	□ Consistently investigates economic strains on each patient; finds affordable resources that improve patient care	□

GENERAL COMMENTS: Please describe specific attributes that best characterize this student's performance. Whenever possible, relate specific instances that form the basis for your comments. Comments here may be used in the final grade letter at the discretion of the clerkship director

Strengths:

Recommendations for improvement:

Did you discuss this evaluation with the student?	Yes □	No □
Are there aspects of performance that suggest the need for remediation?	Yes □	No □
If yes, please describe:		
Would you like the clerkship director to call you to discuss this student?	Yes □	No □

Best time to call _____ Phone # _____

EVALUATOR'S SIGNATURE_____ _____Date _____ _____

Evaluation due back by:__*Return to: OB-Gyn Clerkship Administrator*

Sample UC Denver: Daily Evaluations (UC Denver)

Resident:_____

Date:_____

Evaluator:_____

Final Evaluation Date:_____

	Unsatisfactory			Satisfactory			Excellent		
Patient Care/Clinical Skills: Performance of history and physical exams, data analysis, differential diagnosis and formulation treatment plans	1	2	3	4	5	6	7	8	9
Interpersonal & Communication Skills: Demonstration of relationship building with patients, families, and colleagues through listening, narrative and non-verbal skills; effective oral presentation of patient data/treatment plan; records complete and accurate	1	2	3	4	5	6	7	8	9
Professionalism: Manifests respect, compassion, honesty, reliability; acknowledges errors; sensitive to diverse patient population	1	2	3	4	5	6	7	8	9
Systems-Based Practice Effective access/utilization of health system resources and team-based care; promotes error reduction and systems improvement	1	2	3	4	5	6	7	8	9
Practice-Based learning & Improvement Evaluates effectiveness of own practice; uses technology to manage information for patient care/self-improvement; applies principles of evidence based medicine	1	2	3	4	5	6	7	8	9
Medical Knowledge Knowledgeable about established and evolving biomedical, epidemiological and social behavioral sciences and the application of this knowledge to patient care	1	2	3	4	5	6	7	8	9
Comments Final Evaluation of PGY1	What did you learn in your day? What were you hoping to learn?								

Sample: Post Survey: To be completed at the onset and end of the CNM rotation by PGY1 (UC Denver)

Have you worked with midwives previously?

Never Some A lot

Midwives provide full scope obstetrical care to patients.
Strongly agree Agree Disagree Strongly disagree

Midwives have a small role in obstetrical care in the United States.
Strongly agree Agree Disagree Strongly disagree

Midwives can practice independently in the state of Colorado.
Strongly agree Agree Disagree Strongly disagree

Midwives encourage a "nonmedical" approach to obstetrical care to patients.
Strongly agree Agree Disagree Strongly disagree

Obstetrical care provided by midwives is evidence based.
Strongly agree Agree Disagree Strongly disagree

Midwives should not care for any patients with medical complications.
Strongly agree Agree Disagree Strongly disagree

The scope of practice for midwives is not clearly defined and subject to interpretation.
Strongly agree Agree Disagree Strongly disagree

Patients cared for by midwives have more delivery complications than patients cared for by physicians.
Strongly agree Agree Disagree Strongly disagree

Patients of a midwife cannot receive pain medication in labor.

Strongly agree Agree Disagree Strongly disagree

Cesarean section rates are higher in patients cared for by midwives.
Strongly agree Agree Disagree Strongly disagree

Within the profession of midwifery there are varying credentials.

Strongly agree Agree Disagree Strongly disagree

All midwives attend births in the home

Strongly agree Agree Disagree Strongly disagree

APPENDIX D

Qualitative Date

I AM A MIDWIFE: “The philosophy of nurse-midwifery care can be practiced by anyone and must be taught to MDs”

I AM A MIDWIFE: *“Only by knowing normal can one recognize not normal and treat accordingly. I want docs to know normal and allow normal to happen, [to] intervene only when indicated for the welfare of mother/infant.”*

I AM A MIDWIFE: with decision-making shared with the patient.”

I AM A MIDWIFE: “It is important to solidify ‘team’ concept of obstetrics/gynecology care.”

I AM A MIDWIFE: “I think it benefits patients and the professions when we work together. It demystifies midwifery care for the MDs.”

I AM A MIDWIFE: “modeling midwifery philosophy on bright, very grateful, very impressionable medical students is a good investment in women’s health.”

I AM A MIDWIFE: “In order for midwifery to continue to be available in this country we must establish good working relationships with MDs.”

I AM A MIDWIFE: “When people have learned from you they have a higher regard for your abilities, your sense of responsibility.”

I AM A MIDWIFE: “It is good for students to be introduced to midwifery early while still learning before they are completely indoctrinated in the medical model.”

I AM A MIDWIFE: “We have to work in a team. It is great to be able to educate students how to be team players and respect the professional contributions of other disciplines.”

I AM AN OBGYN RESIDENT: “This noncompetitive, integrated educational practice model has been a successful and collaborative effort between obstetrics and midwifery using midwives as clinical faculty within an academic department of obstetrics and gynecology. The model highlights resident teaching by midwives primarily in low-risk obstetrics in collaboration with attending obstetricians in the labor unit and in the obstetric triage/emergency setting.”[13]

I AM A MIDWIFE: “Midwives involved in medical education are in a pivotal position to affect the education of the next generation of obstetricians and consultants while showcasing the midwifery model of care. This approach opens the dorr to the future of collaborative practice through innovation in obstetrics/gynecology residency education. “[13]

I AM A MIDWIFE: “Midwifery students who receive clinical training in the practice here are equally exposed to this model of care, and have the opportunity to work with medical students and residents. For example. The chief resident may review a triage plan of the midwifery student before it is presented to the faculty midwife, or an advanced midwifery student may have a medical student observe a birth and talk about why she or he makes certain choices about birth position and support techniques.”[13]

I AM A BIRTH CENTER MIDWIFE: “The birth center serves as a clinical site for those wanting to learn about the midwifery model of care including medical residents, nursing students, midwifery students, childbirth educators, and doulas. Every effort is made to offer educational opportunities and encourage a learning environment while keeping the personal, home-like environment of the birth center intact. When asked their permission first, clients are generally very gracious about allowing observation or participation of sutdents.[13]

I AM AN OBSTETRICIAN: “…the interprofessional workplace and clinical training environment…has been integral to the sustained cohesion, viability and productivity of the collaborative practice. The members of the collaborative credit interprofessional education with successes that include effective quality improvement programs, superior trainees, excellent outcomes, and longevity of the clinical service.”[13]

I AM A STUDENT MIDWIFE “…the residents not only welcomed me with open arms but also immediately began carving out clinical opportunities for me, including me in their conversations about patients and even offering me birth opportunities.”[15]

I AM A STUDENT MIDWIFE: “The first baby I caught…was a woman who was a continuity patient of one of the residents. The resident who had stayed three hours post-call for this woman’s birth, allowed me to be the primary catcher…she precepted me as we were both precepted by my midwifery preceptor, the attending for the patient. Then, after watching a painstakingly slow hour of my novice suturing work, the same resident thanked me for giving her the opportunity to teach. It is the first time someone has ever said that to me during my training as a midwife and I love the significance such a statement gives to the importance of teaching.”[15]

I AM A MIDWIFE: “I want to tell you all that the universe [sent] me a young woman on Wednesday night who TRULY had a Birth Center birth - all auscultation, no NICU, all quiet and reverential, with two medical students who could have been doulas, a nurse who gets it and a resident whose heart was truly touched!” *direct correspondence from BMC midwife*

I AM A RESIDENT: “One of ‘five of the best reasons’ that I like being a resident [in this center] is because of the midwives.”

NOTES:

NOTES:

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