PREVIEW SAMPLE

SECOND EDITION

The Midwife as Surgical First Assistant

NELL L. THARPE, CNM, CRNFA, MS, FACNM

AMERICAN COLLEGE of NURSE-MIDWIVES

SECOND EDITION

The Midwife as Surgical First Assistant

NELL L. THARPE, CNM, CRNFA, MS, FACNM

PREVIEW SAMPLE

Acknowledgments

This handbook was updated from the ACNM Clinical Issues Series *The Midwife as First Assistant* and the text from *A Guide to First Assisting for Midwives*, by Nell Tharpe, CNM, CRNFA, MS, FACNM. Essential information in the first edition of the handbook, some of which is included in this edition, was provided by Maureen Chrzanowski, CNM, FNP, MSN; Beth Goodiel, CRNFA, CNM, CNOR, MS; Carolyn Moes, CNM, MSN; Joan Slager, CNM, MSN, CPC; Nell Tharpe, CNM, CRNFA, MS, FACNM; and Frances Thatcher, CNM, MS, FACNM.

DEVELOPMENTAL EDITOR: Nell Tharpe, CNM, CRNFA, MS, FACNM

SPECIAL THANKS: Many people contributed directly and indirectly to this work. It is with deep appreciation that I extend my sincere thanks to the many first assistant workshop and course participants who shared a wealth of information about the first assistant role in midwifery practice in their practice sites; to ACNM Publications Committee members Carrie Jacobson CNM and Jan Weingrand-Smith CNM for their invaluable help and support through the revision process; and to the fabulous ACNM staff who shepherded this revision through publication.

Disclaimer

This publication is designed to provide accurate and authoritative information regarding the subject matter covered. It is produced with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

The publication by ACNM of books on expanded practice procedures is intended to assist experienced midwives when they choose to incorporate new skills and procedures, not to encourage all midwives to do so. When a midwife chooses to expand practice to include the role of surgical first assistant, this book can serve as a tool to help the midwife plan and document a training program consistent with the ACNM Standards for the Practice of Midwifery.

McGraw-Hill Education makes no representations or warranties as to the accuracy of any information contained in the McGraw-Hill Education Material, including any warranties of merchantability or fitness for a particular purpose. In no event shall McGraw-Hill Education have any liability to any party for special, incidental, tort, or consequential damages arising out of or in connection with the McGraw-Hill Education Material, even if McGraw-Hill Education has been advised of the possibility of such damages.

American College of Nurse-Midwives
8403 Colesville Road, Suite 1550 | Silver Spring, MD 20910
Phone: 240.485.1800 | Fax: 240.485.1818 | Email: *PPHP@acnm.org*

To order additional copies of this book or other ACNM publications, visit *www.shopACNM.com*.

COVER PHOTO CREDIT: ©Depositphotos.com/arztsamui

ISBN: 978-0-914324-05-8

Printed in the United States of America.

10 9 8 7 6 5 4 3 2 1

Contents

Additional subjects to be included in the full version:

Chapter 2: Principles of Surgical Practice

Chapter 3: Role and Functions of the Midwife as First Assistant

Chapter 4: Learning the Essential Skills of the Midwife First Assistant

Chapter 5: Assisting Women with Birth by Cesarean

Chapter 6: Serving as First Assistant during Gynecologic Surgery

Appendices

Introduction

The purpose of this book is to provide uniform guidance to the midwife who is expanding clinical practice to include first assistant services for cesarean or gynecologic surgery. The term midwife as used throughout this document refers to certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC) and midwives who are duly registered in Canadian provinces. For women's health professionals who are not midwives, such as registered nurses (RNs) or advanced practice registered nurses (APRNs)/nurse practitioners (NPs), who use this book when expanding practice to include servicing as surgical first assistant, additional guidance or professional expectations may be delineated by the relevant state regulatory agency or professional certifying body. When expanding midwifery practice, it is the responsibility of the individual midwife to ensure that the education and training for the new skill meets the standards or expectations established by the certifying and regulatory agencies and clinical facility.

While much of the knowledge and skills necessary to function safely as a first assistant are included in basic midwifery education for management of birth, and these skills may be included in midwifery education and a student midwife's clinical experience, serving as surgical first assistant is not included within the midwifery core competencies. The Core Competencies for Basic Midwifery Practice[1] represent the delineation of the fundamental knowledge, skills, and behaviors expected of a new practitioner; as such, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy makers, and constitute the basic requisites for graduates of all midwifery education programs accredited by the ACNM Division of Accreditation (DOA). Functioning as first assistant is considered *expanded midwifery practice*, defined by ACNM as "a procedure, skill, or component of practice that may be acquired beyond basic midwifery education."[1]

The midwife who serves as first assistant in surgery functions as a women's health and perinatal birth professional in the perioperative setting. Depending on education, experience, and credentials, the surgical first assistant helps prepare the woman for surgery, provides optimal surgical exposure, participates in tissue dissection, ensures hemostasis, performs or facilitates wound closure, and performs other intraoperative technical functions that assist the surgeon with carrying out a safe operation with optimal results for the woman, given her specific condition and indications for surgery.[2-4] The surgical first assistant performs these functions in collaboration with the surgeon (if a licensed independent practitioner) or under the direction of the surgeon (if a licensed or unlicensed assistive personnel or dependent practitioner) in accordance with hospital policy and consistent with applicable state laws and regulations and individual credentials.[5]

How to Use this Book

This book is intended primarily as a comprehensive text for midwives who assist with cesarean birth and offers core information for the smaller subset of midwives who assist with other obstetric or gynecologic procedures. The content includes didactic learning, first assistant skill set, clinical suggestions for best practice, and recommendations for the development of knowledge and skill as the midwife expands or refines practice to include the perioperative care of women and infants.

The book can be used as a self-study guide, the basis for a facility-based first assistant program, a prerequisite for hands-on first assistant workshops, or as a companion text for a formal didactic and skills course or program on serving as first assistant during cesarean or gynecologic surgery.

The book provides a comprehensive exploration of cesarean birth and an overview of common gynecologic surgical procedures. Each chapter has a discrete focus that addresses the topic from a clinical surgical perspective. The text includes evidence-based information and practice

recommendations for serving as surgical first assistant within the context of midwifery practice that includes woman—and family-centered care. Topics are presented through the lens of midwifery practice to ensure that the intent of being *with woman* is retained in the highly clinical surgical setting. The book further defines the role of the midwife as first assistant.

Experiential Learning Activities and Checklists

Each focus area includes experiential learning activities. These activities are designed to support the transition from learned theory to appropriate clinical practice and critical thinking as an active first assistant on the surgical team. In addition, activities provide an opportunity for each learner to assess personal progress and learning needs and build professional relationships and competency in the surgical setting.

The checklists are provided to support methodical progression through learning goals; to delineate minimum standards for education, experience, and associated documentation; and to support the credentialing process. Checklists are included as appendices.

This book serves as a guide to acting as surgical first assistant as part of midwifery practice. The content and curriculum provide a uniform standard for this skill regardless of the educational modality by which midwives expand their clinical practices.[3] The overarching goal of the publication is to support excellence in expanded midwifery practice with a particular focus on perioperative client care and outcomes.

REFERENCES

1. American College of Nurse-Midwives. Core competencies for basic midwifery practice. *http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000050/Core%20Comptencies%20Dec%202012.pdf*. Published December 2012. Accessed June 17, 2015.
2. American College of Nurse-Midwives. Standards for the practice of midwifery. *http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards_for_Practice_of_Midwifery_Sept_2011.pdf*. Revised September 24, 2011. Accessed April 21, 2015.
3. American College of Nurse-Midwives. ACNM Position Statement: The certified nurse-midwife/certified midwife as first assistant during surgery. *http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000270/First%20Assist%20April%202012.pdf*. Revised April 2012. Accessed June 17, 2015.
4. Association of periOperative Registered Nurses. AORN position statement on advanced practice registered nurses in the perioperative environment. *https://www.aorn.org/Clinical_Practice/Position_Statements/Position_Statements.aspx*. Revised October 2014. Accessed June 17, 2015.
5. Association of periOperative Registered Nurses. AORN standards for RN first assistant education programs. *https://www.aorn.org/Clinical_Practice/RNFA_Resources/First_Assisting_(RNFA).aspx*. Updated October 2013. Accessed June 17, 2015.
6. The Joint Commission. Ambulatory care program: the who, what, when, and where's of credentialing and privileging. *http://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentialing_booklet.pdf*. Accessed June 17, 2015.

CHAPTER 1:

The First Assistant in Midwifery Practice

Midwifery care is woman-centered care, that is, care that helps to maintain or foster the health, well-being, and autonomy of women. Midwifery as a discipline is distinct from medicine or nursing but includes some characteristics and functions of these disciplines. In an acute obstetric emergency, every effort is made to facilitate birth as quickly as possible. The presence of a skilled midwife at the bedside who can identify and triage complications and move seamlessly to the operating room as a surgical first assistant can result in timely intervention that preserves continuity of care.[1]

Background

Midwifery education and certification recognized by ACNM and the AMCB may require a nursing background (for CNMs) or allow direct entry into midwifery practice without a nursing degree (for CMs). In Canada, direct entry into midwifery education is the norm, and midwives are registered (registered midwife [RM]) by the appropriate regulatory agency for the province in which the midwife practices. Direct entry midwifery education also occurs through the North American Registry of Midwives (NARM), which confers the title certified professional midwife (CPM). CPMs are recognized as specialists in home birth, are licensed in some states, and occasionally practice in the hospital setting in those states.

Midwives as First Assistants

Midwives began serving as first assistants in 1995 with the formal development of a first assistant program for midwives by Frances Thatcher at New York Presbyterian Hospital.[1] Didactic programs were then offered at ACNM annual meetings beginning in 1997. In 1998, the ACNM Board of Directors approved the position statement "The Certified Nurse-Midwife/Certified Midwife as First Assistant during Surgery."[2] Since the introduction of midwives as first assistants during surgery, many CNMs and CMs have been educated and trained to provide this skill through ACNM-approved workshops and continuing education programs and through other programs. ACNM determined that serving as first assistant during obstetric or gynecologic surgery is within the scope of practice of the CNM/CM based on demonstration and documentation of education and competency in that skill.[2] ACNM supports flexibility in education and clinical skill development modalities for the midwife who chooses to expand scope of practice in this way.[3]

Certification by the AMCB allows midwives to function independently and collaboratively across disciplines, and midwives frequently practice within the framework of a hospital-based, health care system.[3] Within the midwifery profession, the primary focus is maintaining and improving the health of women and infants using a woman—and family-centered approach. Serving as first assistant during surgery is a unique opportunity for midwives as perinatal birth professionals to provide midwifery care in the highly technical setting of the operating room.

In order to meet current standards for credentialing of surgical first assistants, all midwives who include serving as first assistants in their scopes of practice are expected to document their relevant education and clinical experience. Midwives must be appropriately credentialed within the organization and in some instances with third party payers. In addition, midwives may be required to update liability insurance coverage when expanding midwifery practice to include the role of the surgical first assistant.

The CNM and CM scope of practice is based on the core competencies for midwifery education and training as well as the scope of practice defined by state regulation, rule, or statute. While many state regulatory agencies refer to

the ACNM-defined scope of practice, others more narrowly define midwifery practice. Each midwife is held accountable for understanding the scope of midwifery practice as defined by state statute or regulations, and facility-specific by-laws or policies.[3]

In order to maximize and improve care throughout the health care system, ideal state scope of practice regulations comprehensively address the education, training, and certification of each professional as described by the appropriate, nationally recognized professional organization. This is consistent with the goals of the Affordable Care Act and fosters professional engagement in providing seamless, affordable, and quality care to the full capacity of one's profession.[4]

Credentials of the Surgical First Assistant

The midwife who chooses to function in the perioperative setting as a first assistant differs from other non-physician first assistants in several ways. The basic education of the CNM/CM includes provision of perinatal care, management of birth, preoperative assessment, postoperative evaluation, tissue dissection and handling, wound assessment, and suturing skills. CNMs/CMs are experienced in functioning independently and are also skilled in developing collaborative and cooperative relationships with physician colleagues.

The CNM/CM scope of practice as first assistant is limited to obstetric and gynecologic procedures and in some instances is exclusive to cesarean birth.[2,5,6] ACNM provides standards that outline a clear mechanism for midwives to expand their practices to include first assistant and midwife-specific materials to support this expanded practice,[2,3] including this book. CNMs/CMs are licensed and regulated under boards of midwifery, nursing or medicine. ACNM is committed to providing a single standard for all midwives certified through the AMCB who practice in the perioperative setting.

ACNM recognizes that aspects of perioperative practice are integral to the practice of midwifery and that many CNMs/CMs function in the perioperative setting. For this reason ACNM has partnered with the Association of periOperative Registered Nurses (AORN) to align relevant position statements and ensure access to foundational AORN first assistant educational materials. The APRN Consensus Model, endorsed by 41 nursing organizations, defines advanced practice registered nurse practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.[7] This information can be used by states to ensure uniformity in the regulation of the APRN role. In a position statement first published in 1995, AORN addressed perioperative practice for APRNs outside of midwifery practice.[8]

The provincial Colleges of Midwives are the regulatory agencies for the Canadian provinces.[9] In Canada, the midwife functions as part of interdisciplinary, perinatal care team.[10] Midwifery practice is expanding in Canada, and acting as first assistants represents a growing trend that is supported by province-specific regulations set by the College of Midwives of Ontario.[11]

Formal certification of first assistants is a growing trend. Midwives certified through the AMCB function as a surgical first assistants under their midwifery certifications. A specific credential external to the midwifery profession for surgical first assistant is indicated only when the midwife chooses to assist with surgery beyond the midwife scope of practice as defined by ACNM. However, for those midwives who choose to attain an additional credential external to the midwifery profession, or when it is requested by regulatory agencies (such as state boards of nursing or medicine) or by the credentialing body of an institution or organization, there are several certification options: certified registered nurse first assistant (CRNFA), certified surgical assistant (CSA), and certified surgical first assistant (CSFA). For more information about certification options and requirements, the reader is encouraged to contact the appropriate certification organization.

AORN and the Registered Nurse First Assistant (RNFA) Credential

AORN is a professional organization of 41,000 members that represents the interests of more than 160,000 perioperative nurses in the United States.[12] AORN sets the standards and facilitates the management, teaching, and practice of perioperative nursing. It is important for the midwife to be familiar with AORN standards. In some states midwives are licensed and regulated by boards of nursing, and these boards may refer to AORN standards. Operating room staff, hospital credentials committees, and third party payers are typically familiar with AORN recommendations, recognize RNFA and CRNFA credentials, and may require information to validate that the CNM/CM who practices as a first assistant does so under midwifery certification.

In addition to the overview provided below, more detailed information about RN first assistant education, role, and scope can be found on the AORN Web site.[12] AORN has long supported the utilization of RNs as first assistants for surgery and officially recognized this role in 1983. AORN continues to support and develop the RNFA role and to define the educational requirements and scope of practice of the RNFA.[13]

The AORN Core Curriculum for the RN First Assistant is detailed document that addresses RNFA scope of practice issues, principles of asepsis, infection control and epidemiology, communication skills, and surgical technique. It can be a valuable resource for the novice first assistant.[13] RNFA educational programs are open to RNs and APRNs, including CNMs.

American College of Obstetricians and Gynecologists (ACOG)

In a committee opinion published in 2000, ACOG concluded the following:

> *Competent surgical assistants should be available for all major obstetric and gynecologic operations. In many cases, the complexity of the surgery or the patient's condition will require the assistance of one or more physicians to provide safe, quality care. Often, the complexity of a given surgical procedure cannot be determined prospectively. Procedures including, but not limited to, operative laparoscopy, major abdominal and vaginal surgery, and cesarean delivery may warrant the assistance of another physician to optimize safe surgical care.*
>
> *The primary surgeon's judgment and prerogative in determining the number and qualifications of surgical assistants should not be overruled by public or private third-party payers. Surgical assistants should be appropriately compensated.*[14]

American College of Surgeons (ACS)

In the Statement of Principles released in 2008, the ACS stated the following:

> *The first assistant during a surgical operation should be a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions. The qualifications of the person in this role may vary with the nature of the operation, the surgical specialty, and the type of hospital or ambulatory surgical facility.*
>
> *The American College of Surgeons supports the concept that, ideally, the first assistant at the operating table should be a qualified surgeon or a resident in an approved surgical education program. Residents at appropriate levels of training should be provided with opportunities to assist and participate in operations. If such assistants are not available, other physicians who are experienced in assisting may participate. It may be necessary to utilize non-physicians as first assistants. Surgeon's Assistants (SAs) or physician's assistants (PAs) with additional surgical training should meet national standards and be credentialed by the appropriate local authority. These individuals are not authorized to operate independently. Formal application for appointment to a hospital as a PA or SA should include:*

Qualifications and Credentials of Assistants

- *Specification of which surgeon the applicant will assist and what duties will be performed.*
- *Indication of which surgeon will be responsible for the supervision and performance of the SA or PA.*

The application should be reviewed and approved by the hospital's board. Registered nurses with specialized training may also function as first assistants. If such a situation should occur, the size of the operating room team should not be reduced; the nurse assistant should not simultaneously function as the scrub nurse and instrument nurse when serving as the first assistant. Nurse assistant practice privileges should be granted based upon the hospital board's review and approval of credentials. Registered nurses who act as first assistants must not have responsibility beyond the level defined in their state nursing practice act.

Surgeons are encouraged to participate in the training of allied health personnel. Such individuals perform their duties under the supervision of the surgeon.[15]

In 2013, the ACS and other specially surgical organizations conducted a study to examine surgical cases by current procedural terminology (CPT) code and reach consensus on which cases required surgical assistants[16] While the group specifically sought to clarify when *physicians* were indicated as surgical first assistants, they acknowledged that "local resources and patient characteristics can have an impact on the type of professional who may be asked to serve as an assistant at surgery."[16] They further acknowledged that the inclusion of any particular surgery in which physicians were indicated as surgical first assistants should not be interpreted as meaning that qualified surgical assistants other than physicians may not also be appropriate as surgical first assistants based on the specific circumstances.[16]

Midwifery First

Midwives are perinatal professionals who attend women in birth. Therefore, expansion of midwifery care to include functioning as first assistant during cesarean is a natural segue for midwives who wish to provide continuity of care and continue trusting relationships with women who require cesarean. This also allows facilities to optimize access to services when emergencies occur and to make the best use of available resources.

ACNM and other midwifery organizations believe that the overall quality of maternity care can be improved by providing that care within the context of family preferences, limiting interventions unless clearly indicated, and supporting physiologic processes.[17] This physiologic birth approach, which is an inherent component of midwifery practice, can be instrumental in decreasing the cesarean rate while providing high quality, family-centered care. Offering a family-centered approach to women undergoing cesarean and promoting practices that support physiologic transition for infant and mother immediately after birth can provide the same personalization and support to these families as to families of women who give birth vaginally.[18,19]

In many high-risk perinatal settings, *team-led* maternity care that includes midwives results in improved outcomes, reduced rates of cesarean birth, and improved women's satisfaction with care.[20-23] In home and birth center settings, transfer to a hospital where the midwife is able to seamlessly arrange admission, coordinate care, and when needed, assume the role of first assistant supports women and families during the transfer and subsequent birth.[24] Many parents appreciate the continued, active roles of their midwives during birth when unexpected cesareans occur.

Midwives have worked hard to gain recognition and autonomy and provide culturally sensitive care to women in a variety of practice settings. Midwives are skilled at bridging the gap between the needs and beliefs of women who seek holistic, woman-centered care, and the highly technical, medical environment in which many midwives practice. In many ways, the operating room is the epitome of the culture, language, behaviors, and beliefs of the technical model of medical care. Midwives who provide services such as serving as surgical first assistants can bring the family-centered midwifery approach to the surgical setting. In many locations midwives have been instrumental in initiating physiologic birth practices in the operating room, including ambulation to the operating room, delayed cord clamping, early skin-to-skin contact, and early breastfeeding after cesarean.

Prevention of the primary cesarean and support of women who desire to give birth vaginally after cesarean are primary foci of the midwifery profession.[17] In 2015, The World Health Organization (WHO) concluded that cesareans are effective at saving lives only when they are required for medically indicated reasons. At the population level, cesarean rates greater than 10% are not associated with reductions in maternal and newborn mortality rates.[17,25] In 2012, the cesarean rate in the United States was 32.8%.[26,27]

Cesarean is the most common surgical procedure performed in U.S. hospitals, and cesarean rates among hospitals in the United States range from 7.1% to 69.9%.[28] Liberal use of cesarean is associated with excess morbidity in women and infants and in most states increases costs compared to vaginal birth.[29,30] Since 2014, The Joint Commission requires accredited birthing hospitals to report on 5 specific core perinatal outcomes, including the reduction of cesarean rates,[30] and midwives can be instrumental in helping to reduce these rates. Every midwife who reads this book is encouraged to implement and teach physiologic birth practices and actively work to reduce the rate of preventable cesarean births.

Serving as first assistant with cesarean is considered a requirement for entry into practice for many midwifery positions in the United States. Midwives who serve as first assistants foster continuity of care and enhanced safety for women who give birth via cesarean. The first assistant skill set can help to improve and maintain the hand and visual skills used during vaginal birth and perineal repair. The midwife should consider various professional issues when expanding midwifery practice to include this skill, such as prior surgical experience, technical proficiency and expertise, and interest in pursuing the required education and training. In most facilities, by-laws for medical staff and professional rules of conduct allow for first surgical assistants who are not physicians. Support from the medical staff and hospital administration facilitates a uniform and systematic process for adding first assistant to the midwife's list of delineated privileges. The applicable statutes, rules, and regulations for the state or states of practice may define the perioperative care the midwife provide and the education and training necessary to act as surgical first assistant.

When undertaking first assistant education and training, each midwife is encouraged to consider how the practice of midwifery affects continuity of care. The ability to participate in the surgical care of women who prefer midwifery care can offer new ways to provide this continuity. The continued presence of a trusted midwife as the surgical assistant in the highly medical environment of the operating room can reduce the woman's anxiety and enhance her sense of control. The decision to incorporate surgical first assistant skills into midwifery practice affects the future of midwifery practice as a whole. Each midwife who participates in perioperative care is challenged to simultaneously apply the midwifery model of care, effectively integrate into the team environment of the operating room, and bring a safe, family-centered approach to the surgical environment.

Standards of the American College of Nurse-Midwives

The ACNM Standards for the Practice of Midwifery define midwifery practice for midwives certified by AMCB.[3] Standard VIII addresses the process by which a CNM/CM may expand midwifery practice beyond the core competencies, and midwives are expected to follow each step of Standard VIII during this process. This section addresses each component of the standard, and an associated checklist can be found in Appendix 1.

ACNM Standards for the Practice of Midwifery

Standard VIII: *Midwifery Practice may be Expanded Beyond the ACNM Core Competencies to Incorporate New Procedures that Improve Care for Women and Their Families*

The midwife:

1. Identifies the need for a new procedure, taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including:
   a. Knowledge of risks, benefits, and client selection criteria.
   b. Process for acquisition of required skills.
   c. Identification and management of complications.
   d. Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.
5. Reports the incorporation of this procedure to ACNM.[3]

The Need for the First Assistant

In settings where midwives do not already function as first assistants, the CNM/CM is expected to determine the community or facility need for midwife first assistant services, which may originate from multiple sources. Need may be identified as a community or facility need based on client request or staffing changes, such as a decrease in resident hours. There may be an increased need for appropriately trained and qualified personnel, especially in areas with limited resources such as small community hospitals to ensure the provision of timely, appropriate, and safe care. The immediate availability of a midwife who can assist with or initiate emergency cesarean can shorten the time from *decision to incision*.

Alternately, the primary driving force may be a logistical or financial issue. For example, the midwife is already present, and calling in another professional becomes redundant and costly. Similarly, it may be a convenience issue in which the midwife works as first assistant with physicians who prefer to work consistently with the same midwife who may have greater flexibility in scheduling than another surgeon or physician.

In many facilities, the need for appropriate and skilled professionals to serve as first assistants is sufficient so that CNM/CM first assistant education has become a requirement of employment. In all instances, the first assistant can validate the value of midwives as part of the perinatal team, enhance continuity of care, and may increase revenue to the midwifery service or practice.

Documents Relevant to Midwives and the Role of Surgical First Assistant

The midwife is responsible for understanding and assembling accurate information related to the surgical first assistant in the relevant state or province and specific practice setting. Documents that support midwives in the first assistant role may include a combination of the following: the applicable professional organization standard,[2,11] applicable state statutes, regulatory agency rules and regulations, official regulatory agency opinions, institutional bylaws, and/or medical staff rules and regulations. Each midwife is encouraged to retrieve these documents and maintain copies in a readily accessible file. Copies of these documents may be required to revise the midwife's delineation of privileges or job description to include the first assistant role, amend clinical practice agreements, change hospital bylaws to support midwives as first assistants, include first assistant services as covered services for liability purposes, or obtain reimbursement for these services. A checklist to assist the midwife in identifying and collecting the appropriate documents is provided in Appendix 2.

Obtaining the necessary documents to support the first assistant role as part of midwifery practice can be a relatively quick and simple process or can be confusing and time consuming. Some states have addressed the issue clearly, and documents are readily available. Other states do not specifically address the first assistant as part of midwifery practice, in which case the language regarding the midwife's scope of practice is reviewed for any prohibitions or restrictions related to the ACNM definition of midwifery and scope of practice.[31]

The midwife should obtain necessary documents by using a web-based search of the *scope of practice* section of the regulatory agency web page (eg, board of midwifery, nursing, or medicine). Once supporting documents have been identified and reviewed, they can be organized within a paper or electronic file so they are readily retrieved when needed.

Learning to be a Surgical First Assistant

ACNM clearly identified the first assistant role as within the expanded scope of practice of the CNM/CM.[2] In order to assure that midwives who serve as first assistants do so safely within the scope of midwifery practice, ACNM requires that "midwives who have not been educated and trained as a first assistants prior to or during their midwifery educations" undergo education and training as a first assistant, which includes a didactic component, skills training, and competency assessment.[2] This section addresses these essential requirements and a variety of methods for obtaining and documenting appropriate education and training as a first assistant. A checklist to assist the midwife in organizing the learning plan to meet these learning expectations is provided in Appendix 3.

Core midwifery education addresses the knowledge and competencies required of first assistants, including client assessment, anatomy and physiology, and principles and performance of wound repair. Midwifery education also includes the development of basic surgical skills such as aseptic technique and suturing. However, foundational education on perioperative surgical practice and the role and skills of the surgical first assistant are not included as part of core midwifery education.

Education and Training as a Surgical First Assistant

As the midwife plans or enters an educational program to become a skilled surgical first assistant, personal and professional focus must center on skill acquisition and development. This book is designed to provide a broad yet detailed overview of the first assistant role and to complement other learning modalities. There are a number of opportunities for education and training as a first assistant, including workshops, home study programs, online tutorials, journal articles, videos, skills labs, observation, and of course, hands-on training. The goal of study is to obtain high quality didactic education related to surgical practice and the first assistant role as well as the specific procedures with which the midwife will assist. Simulation allows the midwife to understand and practice foundational skills before applying them in the clinical setting, which sets the midwife up for success and fosters optimal safety for women. Midwives must determine what style of education best meets their learning needs and practice settings, but education and training as a first assistant are required to meet the standards established by ACNM as outlined in Standard VIII to ensure safe, high-quality, CNM/CM first assistant services.[3]

Formal Study

The core education process for the surgical first assistant is divided into the didactic or knowledge base and the clinical or hands-on skill set. Study should incorporate didactic and clinical components, and the didactic component is completed prior to or simultaneously with participation in surgical procedures. This text provides a basis for a program of formal study or curriculum recommendations for courses designed to teach first assistant skills to midwives. Inclusion of multidisciplinary surgical staff is recommended during the learning process, as this will provide a wide range of experience, expertise, and points of view. Ideally, the learning process should include 1 or more midwives skilled

in assisting during surgery and other first assistants such as RNs, physician's assistants (PAs), obstetricians/gynecologists, certified surgical technologists (CSTs), scrub personnel, circulating nurses, and anesthesia personnel.

Although all midwives have basic theoretical knowledge of aseptic technique and skills such as suturing as components of their midwifery educations, perioperative nursing experience with competence in circulating and scrubbing can be of great benefit to the midwife learning the role of first assistant. Midwives with limited or no experience in the operating room are expected to plan an orientation to the operating room, to be educated in standard surgical asepsis and practices, and to demonstrate understanding and competency in these core surgical practices as part of their educations as a first assistants.

The practice of surgery is the practice of medicine. The educational process for becoming an effective midwife first assistant includes core information related to providing this service within the context of women's health, including knowledge of the following:

- Relevant surgical anatomy,
- Pathophysiology of existing disease processes and their potential effect on the surgical procedure and the healing process,
- Planned surgical procedure, common surgical techniques, and variations,
- Potential complications of the procedure with preventive and corrective measures, and
- Standard and specialized instrumentation, sutures, and equipment.

The CNM/CM should evaluate potential educational offerings for content using the recommended criteria in the sample course curriculum provided in Appendix 4. Alternatively, the sample course curriculum may be used to create a self-study program or a practice or facility designed course. In either case, all aspects of didactic education and clinical experience should be carefully documented using the standard checklist for education and skills provided in Appendix 5.

Gaining Clinical Experience

Mentored clinical training and experience are essential to becoming a confident, competent, and skilled surgical first assistant. The structured clinical experience provides the midwife with an opportunity to learn the first assistant role in an operating room setting. Here the novice first assistant is supported while developing skills, asking questions, and becoming familiar with operating room routines and surgical procedures. The novice receives mentoring and feedback about performance.

While some midwives receive on the job training simultaneous with didactic learning, immersion in a didactic program prior to beginning a clinical experience as a first assistant is recommended. This allows the midwife to develop a strong foundation in perioperative practice and to demonstrate understanding of critical elements of care through study, simulation, and discussion.

The mentored clinical experience is designed to give the midwife an opportunity to apply what has been learned through formal didactic study in the clinical setting under the guidance of experienced surgeons and first assistants. The clinical experience is planned by the midwife based on the midwife's current level of perioperative experience and the anticipated scope of practice as a first assistant. The mentor's role is to assist the midwife in attaining competence through the acquisition of relevant knowledge, development of the first assistant skill set, and systematic evaluation of progress. Mentors are expected to teach and evaluate clinical performance and competency during the training period.

Each midwife should clearly identify learning goals and strategies for meeting them and evaluate personal progress toward attaining those goals. Personal, case-specific goals for each clinical experience should be identified before participating in the care of the perioperative client. These goals should pertain to individual learning needs and be consistent with quality perioperative care. Goals may be related to a specific skill (eg, becoming proficient in one- and two-handed knot tying techniques), or they be related to demonstration of knowledge and understanding such as identification of anatomic landmarks and layers during dissection and wound closure. Goals can focus on a sequence of events or a continuum. For example, the midwife may observe a cesarean to see the role of the assistant during the procedure before acting as second assist and independently identifying the expected behaviors of the first assistant.

The next phase might include acting as first assistant with supervision and support from another qualified assistant to demonstrate understanding of the role and expectations while moving along the practice continuum from novice to competency.

Documentation of education and training is essential for the credentialing process. The length of the clinical experience is individualized to ensure that specific state, facility, and professional organization requirements for numbers of cases, hours of practice, and demonstrated competency have all been met. Maintaining a clinical case log is recommended. This allows the midwife to document every surgical case in which the midwife assisted and can be integral to the midwife's birth log. The log is used as a permanent record of the midwife's experience as first assistant and is invaluable when the midwife changes practice location.

A surgical learning journal is useful to record the midwife's personal learning experience. The journal is a place to describe learning as it occurs, make observations, raise questions, identify clinical strengths and successes, and determine areas requiring additional focus during the clinical experience. The surgical learning journal is used as a learning tool during the education, clinical mentoring, and learning periods. Reviewing the journal can be helpful in demonstrating professional growth and bolstering confidence when the learning process plateaus. For risk management purposes, protected health information related to the client's, case, or surgeon is excluded from the learning journal.

Clinical Case Log

The clinical case log is a record of the midwife's training and experience as a first assistant. The log can be used as documentation to support application for credentials as a first assistant, whether as a novice applying for initial first assistant privileges or as a seasoned assistant applying for a new position. Case notes or comments can be helpful when used as a reference for peer review.

The case log includes the following categories:

- *Date of service.*
- *Client identification*, such as the medical record number.
- *Location of service* identifies the hospital, clinic, or office where the procedure was performed. This is particularly helpful for the CNM/CM with privileges at more than 1 institution, or who changes practice locations.
- *Time for case* may include all perioperative time when the CNM/CM was involved with the client as a first assistant. This may include the time spent in preoperative history and physical examination, assisting with positioning and anesthesia, the surgical procedure itself, or care in the post-anesthesia unit. Time is usually indicated in 15 minute increments.
- *The procedure* should be described using standard medical terminology and should include primary and secondary procedures. For example: "Procedure: repeat cesarean secondary to CPD, lysis of adhesions, bilateral tubal ligation."
- *Comments* relate to any unusual occurrences during the procedure, such as injuries, excessive blood loss, or significant contamination. Comments regarding a particularly satisfying case are also appropriate. Succinct comments may be helpful in refreshing your memory about a particular case for peer review or litigation purposes.
- *Surgeon:* the name of the *primary surgeon* should be noted. This is helpful when performing an annual review, reapplying for privileges, asking for a reference when transferring to a new clinical location, or if the midwife is requested to provide information for case-related peer review or litigation.

Forms for documenting and evaluating the acquisition of the first assistant skill set are provided in the appendices.

Overview of the Scope of Practice of the Midwife as First Assistant

The midwife should review applicable policies, procedures, and job descriptions that address the expected scope of practice of the midwife who acts as surgical first assistant. Often the first midwife in a facility who expands practice to include the first assistant role assumes the responsibility for developing these documents or participates in the process. The defined scope of practice should be consistent with ACNM requirements[2,3,31] and should clearly identify educational expectations and required behaviors to demonstrate competency. Description of midwife responsibilities during the perioperative period, including expectations for preoperative, intraoperative, and postoperative care, allows for objective evaluation and uniform expectations for practice. The detailed scope of practice for the midwife first assistant is addressed in Chapter Three.

The collaborative nature of the first assistant role provides the midwife with an excellent opportunity to work in tandem with obstetrician/gynecologist colleagues. Coordination of pre and postoperative care can free the physician to attend to more complex cases and provides the CNM/CM with opportunities to expand knowledge about obstetric and gynecologic pathology, complications, and treatments. Inclusion of the traditional midwifery focus on education and client participation can help contribute to overall satisfaction for women who undergo surgical procedures. For the midwife first assistant who includes comprehensive pre and postoperative care within the midwifery scope of practice, a clear mechanism must be developed for consultation and collaboration when complications are suspected or identified.

Expectations for Clinical Competency

Demonstration and documentation of clinical competency are required by ACNM for all aspects of practice and are necessary for the credentialing, privileging, and review processes. Evaluation of competency using objective criteria prevents inadvertent or deliberate prejudice or bias and supports appropriate privileging. Midwives who do not yet meet competency requirements continue with clinical mentoring and targeted remedial education when necessary until competency is attained.

While ACNM requires demonstrated competency, many facilities and a few states require a minimum number of cases to be performed under supervision before credentialing can occur.[6] The learning needs of each midwife will vary based on previous experience in a surgical setting, the number and frequency of opportunities for mentored clinical experience, innate manual dexterity and coordination, and quality of mentoring received.

Many midwives come into practice with experience in the operating room, while others are entirely new to the perioperative setting. Recommendations for attaining competency are based on skill assessment rather than a number of cases or hours. However, in order to provide practical guidance for midwives and credentialing bodies, the following minimum recommendations for clinical experience are provided:

- Orientation to the operating room, including but not limited to observation of 5 cases, each with a distinct focus area:
  - Aseptic technique,
  - Instruments,
  - Anatomy,
  - Sequence of procedure, and
  - Role of the first assistant.
- Participation in 5-10 mentored cases as the first assistant or as many cases as needed to demonstrate competency.
- Participation in 10 cases related to postoperative care, assessment and triage of complications, or as many cases as needed to demonstrate competency.

Evaluation and Reporting

At the close of each *case* during the learning period, the surgeon or assigned preceptor and midwife should meet briefly to complete an objective case evaluation form (see Appendix 6). Objective criteria are used to identify current skill levels, and comments can be helpful in directing further study. These evaluations validate that clinical education and training have been obtained and competency demonstrated. This documentation demonstrates to the credentials committee that requirements to expand midwifery practice to include the role of first assistant have been met.

The evaluation process is an integral part of any clinical specialty. Whether the midwife first assistant is in independent practice, is employed by a physician practice, or is employed within a hospital, there must be a mechanism for evaluating competency. It can be beneficial for the midwife first assistant to participate in the development of the role description and work as part of the team that develops and approves the specific evaluation tool. The first assistant evaluation tool provided in Appendix 6 can be adapted as needed to meet facility specific requirements.

Professional Issues

Credentialing

The credentialing process requires that the first assistant role be included in the midwife's delineation of privileges. Through appropriate documentation, the midwife is expected to demonstrate that she or he meets national professional standards and state and facility requirements. Proof of professional liability insurance coverage that includes the first assistant role is required. Many health insurance companies also require that midwives are credentialed through their organizations as first assistants before they will reimburse for midwife first assistant services.

For the midwife who chooses to assist with cases other than or in addition to cesarean birth, documentation of additional education and training as a first assistant can be accomplished by maintaining a first assisting education log, found in Appendix 5. In locations where the CNM/CM is the first midwife to expand midwifery practice to include the first assistant role, changes to the delineation of privileges for midwives may be required, and this process is typically approved through a credentials committee. Suggested language for the addition of first assisting to the privileges form should be determined by the midwifery service director in conjunction with an obstetric/gynecologic or perinatal committee. Once committee approval has been obtained, the recommended language is moved through the standard medical staff administrative process to the credentials committee. The midwife should be prepared to present information and supporting documents at any step of the process should any questions arise during the approval process.

Risk Management

The risk management process includes evaluation of benefits, potential harms, and any client selection criteria that may determine the role of the midwife as first assistant. In most instances, the benefits of the first assistant role are clear, and associated risks can be limited by prudent and thoughtful practice. Client selection is frequently the jurisdiction of the surgeon; however, the midwife or surgeon may request the presence of another physician or more skilled first assistant when indicated based on individual factors such as the complexity of the procedure, the indication(s) for the procedure, the woman's health history or condition, and/or other issues that may affect safety or performance of the procedure.

Benefits of including the first assistant as part of midwifery care can include

- Shortened time from decision to incision,
- Rapid availability of qualified surgical assistant,
- Continuity of care,
- Improved client satisfaction,
- Improved collaboration with physicians,
- Opportunity to maintain and improve hand skills, and
- Improved midwifery service value or revenue.

Potential risks when including the first assistant as part of midwifery care can include

- Increased exposure to liability,
- Risk of injury from sharps,
- Exposure to blood-borne pathogens,
- Increased latex exposure,
- Mechanical injury related to procedure or technique, and
- Outcomes related to limits of midwife experience or skill.

Intraoperative Hazards and Complications

Every midwife who functions as a first assistant is expected to be aware of potential intraoperative hazards and related complications that may require action. Hazards and complications can cause injury to the client or a member of the perioperative team.

The midwife first assistant is expected to be competent, professional, and accountable for her or his actions in the event of an adverse outcome. While the surgeon directs

the performance of the surgical procedure, members of the operative team are expected to function to the extent of their education and training and to maintain vigilance to ensure optimal client outcomes. Every member of the operating room team is responsible for maintaining awareness and acting to decrease the potential for an accident or injury. Intraoperative hazards and complications are addressed in Chapters Two and Three.

Liability

The midwife who expands practice to include the first assistant role must ensure that the professional liability insurance policy covers this role. Adequate liability coverage should be investigated and obtained prior to participation in surgical procedures. While the level of coverage needed to attend women during birth is generally equivalent to the coverage needed for the surgical first assistant, notifying the liability insurance company regarding this expansion of midwifery practice safeguards the midwife against an inadvertent gap in coverage. Confirmation of liability coverage for the first assistant may be required prior to expanding the midwife's delineation of privileges.

Quality Management

Quality management is a mechanism by which the quality of care provided is assessed and evaluated. Operative procedure outcome statistics are frequently kept by the quality management team and are generally categorized by provider. The midwife is encouraged to participate, as indicated, in quality management case review and may be required to maintain a separate log of all CNM/CM first assistant cases to report to the obstetric/gynecologic or perinatal committee or quality management team.

Client satisfaction with midwife first assistant services can be documented by adding midwife first assistant services to routine satisfaction surveys. Internal customer satisfaction (such as labor and delivery staff, surgical staff, midwives, and surgeons) can be evaluated at the outset of a new midwife first assistant program and periodically thereafter. Feedback allows for identification of issues, exploration of opportunities for improvement, and initiation of change in practice through standard administrative and clinical mechanisms.

The Value of Midwifery: Coding and Billing for First Assisting Services

Midwives provide first assistant services in a wide range of settings, and every setting should have 1 or more mechanisms to identify, record, and assign value to the services provided. In many practice settings first assistant services are billed as fee for service, that is, the woman or her health insurance carrier is billed a fee for the midwife's first assistant services using the midwife's National Provider Identification (NPI) number. First assistant services are billed separately from the *global* fee for maternity care services. In settings where the midwife is a hospital employee, billing for first assistant services may be included in the total professional fees charged. In other settings, first assistant services are captured exclusively under productivity, and bills for professional services are not generated. In every instance, there should be a mechanism for the midwifery program director to review the first assistant services of each midwife to determine the relative value to the practice. This value is important when negotiating contracts, midwifery coverage, and salary parameters.

Like statutes and regulations that govern scope of practice, regulations regarding insurance and reimbursement vary considerably from state to state. In addition, internal policies of individual payers (HMOs, PPOs, etc.) vary regarding reimbursement for first assistant services. Medicare covers first assistant services for CNMs as APNs. (Medicare is the federal government insurance program for the elderly and disabled. This is different from Medicaid, which provides coverage for low-income families.) Medicare sets the gold standard for reimbursement, so regardless of whether a midwife provides services to women who are covered under Medicare, knowing what is covered can be critical for negotiating third party payer reimbursement for first assistant services.

Most health insurance companies reimburse a professional fee for midwives who provide first assistant services. When these services are considered in a new location, it can be worth investigating the reimbursement experiences of midwife colleagues in the state or region as part of the planning process. When questions about reimbursement are noted, it can be useful to make inquiries with the carriers common to the practice prior to the substantial investment of time, money, and energy that is required to complete the

education and training necessary to become credentialed as a first assistant.

For midwives credentialed as CNMs, it may be more effective to inquire about reimbursement as an APRN rather than as a midwife. Many insurance company personnel are not familiar with CNMs/CMs or their authorized scopes of practice, but they may be familiar with processing reimbursement for services provided by APRNs.

Communicating with Health Insurers

Ask clear, directed questions that require specific answers. Plan your questions in advance. It can be helpful to supply the desired answer within the question.

For example, rather than asking whether credentialing is required by a certain health insurance company, ask: "I am a certified nurse-midwife/certified midwife who assists with cesarean births. Can you please send me the appropriate application materials so I may become credentialed for this procedure with your company? I will be billing under my NPI number and plan to use the modifier -80." This allows the insurance to acknowledge whether they require credentialing, identify any other documentation necessary, and request the use of a different modifier.

Some commercial insurance payers cover first assistant services provided by the CNM/CM, while others may try to limit payments exclusively to physicians. The process of becoming credentialed with the insurance company includes negotiating precisely which services will be reimbursed, including first assistant services. When the midwife is already credentialed with the company, documentation is provided to support adding first assistant to the midwife's reimbursable services. For the midwife who is not an approved provider with a health insurance carrier, the reimbursement rate is usually dropped to the out of network rate of 40%-60% of the usual and customary reimbursement, and the remainder can be billed to the client.

The standard billing procedure varies from state to state, with most first assistants billing 15%-20% of the surgeon's fee for the procedure. Medicare rates pay 16% of the surgeon's fee to physicians and CNMs/CMs who assist with surgery. NPs and PAs are paid 85% of the 16% physician allowance (or 13.6%), and some commercial carriers include midwives in this category. These rates are further reduced by any contractual allowances or agreements.

Common procedure terminology (CPT) codes are used to identify the exact procedure performed, while modifiers are used to delineate the type of service rendered by a specific provider. Occasionally, the insurance carrier will request a copy of the dictated operative record to verify the first assistant of record. It is helpful to be sure the surgeon correctly identifies the midwife's name and credentials when identifying the midwife first assistant. Claims clearly identify professional midwifery services through inclusion of the CNM's/CM's NPI number on the claim. When services are billed using physician provider numbers, they are likely to be rejected, as the surgeon cannot function as the primary surgeon and as the first assistant.

Common Code Modifiers for Surgical Assistants[32]

- (80) Assistant Surgeon (100% of physician rate)
- (81) Minimum Assistant Surgery (65% of physician rate)
- (82) Assistant Surgeon when qualified resident is not available (100% of physician rate)
- (AS) Non-physician Assistant at Surgery (95% of physician rate)

Midwives who serve as first assistants should bill using their NPI provider identification numbers and the modifier specified by the payer using their usual method of billing. Surgical assistant claim forms must use the identical CPT code as the surgeon for claims to be accepted. Some insurance companies also require the same type of submission (eg, electronic) for both claims. The midwife should check with the health care insurer to confirm acceptance and interpretation of modifiers. When billing Medicare, midwives are entitled to receive 100% of the physician reimbursement rate and therefore must use modifiers –80 or –82; however, commercial insurers may opt to use modifier –AS for reimbursement of non-physician first assistants and pay at the lower rate.[33]

Common Information Required for First Assistant Billing

Client information to collect (from hospital face sheet or surgeon's office)

- Full name, address, and phone
- Date of birth
- Social security number
- Employer address and phone number
- Name and address of insurance company
- Insurance policy ID number
- Policy holder's name
- Policy holder employer name and ID number
- Secondary insurance information, when applicable

Procedure information to collect (from medical record or surgeon's office)

- ICD Diagnosis code(s)
- CPT Procedure codes
- Surgeon's name and/or provider number
- Surgical procedure as dictated on the Operative Note
- Copy of the Operative Note documenting the midwife as first assistant
- Surgeon's fee for procedure
- Client status as inpatient or outpatient
- Name of facility where procedure performed

CNM/CM information to collect

- CNM/CM National Provider Identification (NPI) number
- Fee schedule for procedures (unless percentage of surgeon's fee is used)
- First assistant modifier(s) for insurance companies

Learning Activities

- Create a credentialing file. Review state rules, regulations, or statutes regarding midwifery practice for reference to ACNM scope of practice and any inclusion or exclusion of expanded midwifery practice or first assistant role. Keep a copy in your file.
- Review any hospital or medical staff by-laws related to the surgical first assistant role.
- Review any obstetric/gynecologic department and midwifery policy, procedure or guidelines for including the first assistant role in the midwifery scope of practice. Identify potential revisions necessary to include the first assistant role in the midwifery scope of practice.
- Follow Standard VIII of the Standards for the Practice of Midwifery for incorporation of new procedures.[3]
- Network with peers and connect with midwives in your state or region who function as surgical first assistants to discuss topics such as education, experience, scope of practice, learning resources, and billing.
- Identify 1 or more mentors and begin formulating personal goals and strategies for first assistant education and training.
- Share the learning plan with mentor(s) and discuss the role of mentor.
- Outline a personal vision of the role of midwife as first assistant as it relates to your practice and compare it to those of area midwives and those of the obstetric team.
- Meet with the operating room supervisor and discuss an orientation to the operating room suite and surgical practices.
- Meet with the midwifery program director and/or billing department to verify that they bill for your services under your name and NPI number and discuss how to access provider-specific reports of billable services and reimbursement.
- Work with your billing office to set up a billing system for first assistant services using the information listed in common information required for first assistant billing.
- Contact your professional liability insurer and initiate discussion regarding coverage of the midwife as first assistant.

Summary

While ACNM supports that a number of different education, training, and credentialing mechanisms are appropriate for midwives who choose to serve as first assistants for obstetric or gynecologic procedures and opposes the requirement of a separate first assistant credential, each CNM/CM is responsible for meeting the requirements set forth by the relevant state, regulatory agency, or facility and must be cognizant of and abide by applicable statutes, rules and regulations, and bylaws and/or official opinions.[2] Developing and maintaining a surgical first assistant file that includes relevant information and documentation allows the midwife to easily access necessary documentation. Convenient checklists for first assistant education, clinical skill development, and credentialing are provided herein as appendices.

REFERENCES

1. Moes CB, Thatcher F. The midwife as first assistant for cesarean section*. *J Midwifery Womens Health*. 2001;46(5):305-312.
2. American College of Nurse-Midwives. ACNM position statement: The certified nurse-midwife/certified midwife as first assistant during surgery. *http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000270/First%20Assist%20April%202012.pdf*. Revised April 2012. Accessed June 17, 2015.
3. American College of Nurse-Midwives. Standards for the practice of midwifery. *http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000051/Standards_for_Practice_of_Midwifery_Sept_2011.pdf*. Revised September 24, 2011. Accessed April 21, 2015.
4. Institute of Medicine. The future of nursing: leading change, advancing health. *http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx*. Published October 5, 2010. Accessed June 17, 2015.
5. Association of Surgical Technologists. New Jersey qualified first assistant. *http://www.ast.org/legislation/documents/NJ_Qualified_First_Assistant.pdf*. Accessed June 17, 2015.
6. Texas Board of Nursing. Frequently asked questions–advanced practice registered nurse. What requirements need to be met for advanced practice registered nurses who want to first assist and be reimbursed for their services? *https://www.bon.state.tx.us/faq_practice_aprn.asp*. Published 2013. Accessed June 17, 2015.
7. APRN Consensus Work Group, National Council of State Boards of Nursing APRN Advisory Committee. Consensus model for APRN regulation: licensure, accreditation, certification & education. *https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf*. Published July 7, 2008. Accessed June 17, 2015.
8. Association of periOperative Registered Nurses. AORN position statement on advanced practice registered nurses in the perioperative environment. *https://www.aorn.org/Clinical_Practice/Position_Statements/Position_Statements.aspx*. Revised October 2014. Accessed June 17, 2015.
9. Canadian Association of Midwives. Midwifery practice—standards and guidelines. *http://www.canadianmidwives.org/standards-guidelines.html*. Accessed June 17, 2015.
10. Stoll K, Kornelsen J. Midwifery care in rural and remote British Columbia: a retrospective cohort study of perinatal outcomes of rural parturient women with a midwife involved in their care, 2003 to 2008. *J Midwifery Womens Health*. 2014;59(1):60-66. doi: 10.1111/jmwh.12137.
11. College of Midwives of Ontario. Surgical assistant in obstetrics. *http://www.cmo.on.ca/?page_id=1037*. Published July 2014. Accessed June 17, 2015.
12. Association of periOperative Registered Nurses. About AORN. *http://www.aorn.org/AboutAORN*. Accessed June 17, 2015.
13. Association of periOperative Registered Nurses. First assisting (RNFA). *http://www.aorn.org/Clinical_Practice/RNFA_Resources/First_Assisting_%28RNFA%29.aspx*. Accessed June 17, 2015.
14. American College of Obstetricians and Gynecologists. ACOG committee opinion: statement on surgical assistants. *http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Statement-on-Surgical-Assistants*. Reaffirmed 2013. Accessed June 17, 2015.
15. American College of Surgeons. Statements on principles. Surgical assistants. *https://www.facs.org/about-acs/statements/stonprin*. Adopted September 1987. Accessed June 17, 2015.
16. American College of Surgeons, American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, et al. Physicians assistants at surgery: 2013 study. *https://www.facs.org/~/media/files/advocacy/pubs/pas%202013.ashx*. Accessed June 17, 2015.
17. American College of Nurse-Midwives, Midwives Alliance of North America, National Association of Certified Professional Midwives. Supporting healthy and normal physiologic childbirth: a consensus statement by ACNM, MANA, and NACPM. *http://mana.org/pdfs/Physiological-Birth-Consensus-Statement.pdf*. Published May 14, 2012. Accessed June 17, 2015.
18. Magee SR, Battle C, Morton J, Nothnagle M. Promotion of family-centered birth with gentle cesarean delivery. *J Am Board Fam Med*. 2014;27(5):690-693. doi: 10.3122/jabfm.2014.05.140014.

19. Brigham and Women's Hospital. The gentle cesarean: a new option for moms-to-be at BWH. *BWH Bulletin*. *http://www.brighamandwomens.org/about_bwh/publicaffairs/news/publications/DisplayBulletin.aspx?issueDate=6/14/2013%2012:00:00%20AM*. Published June 14, 2014. Accessed June 17, 2015.
20. Children's Hospital of Philadelphia. CHOP celebrates 1,000 deliveries in Garbose special delivery unit. *http://www.chop.edu/news/chop-celebrates-1000-deliveries-garbose-special-delivery-unit#.VYH8vq3bJjo*. Published April 16, 2015. Accessed June 17, 2015.
21. Hutchison MS, Ennis L, Shaw-Battista J, et al. Great minds don't think alike: collaborative maternity care at San Francisco General Hospital. *Obstet Gynecol*. 2011;118(3):678-682.
22. McLachlan HL, Forster DA, Davey MA, et al. Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. *BJOG*. 2012;119(12):1483–1492.
23. Sandall J. The contribution of continuity of midwifery care to high quality maternity care. *https://www.rcm.org.uk/sites/default/files/Continuity%20of%20Care%20A5%20Web.pdf*. Accessed June 17, 2015.
24. Vedam S, Leeman L, Cheyney M. Transfer from planned home birth to hospital: improving interprofessional collaboration. *J Midwifery Womens Health*. 2014;59(6):624-634. doi: 10.1111/jmwh.12251.
25. World Health Organization. WHO statement on caesarean section rates. *http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1*. Published 2015. Accessed June 20, 2015.
26. Centers for Disease Control and Prevention. Births—methods of delivery. *http://www.cdc.gov/nchs/fastats/delivery.htm*. Updated January 22, 2015. Accessed June 18, 2015.
27. Martin JA, Hamilton BE, Osterman MJK, Curtin SC, Matthews TJ. Births: final data for 2012. *Natl Vital Stat Rep*. 2013;62(9):1-68.
28. American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine. Obstetric care consensus: safe prevention of the primary cesarean delivery. March 2014. *http://www.acog.org/-/media/Obstetric-Care-Consensus-Series/oc001.pdf?dmc=1&ts=20141023T1442309328*. Published March 2014. Accessed June 18, 2015.
29. National Partnership for Women and Families. Facility labor and birth changes by site and mode of birth, United States, 2009-2011. *http://transform.childbirthconnection.org/resources/datacenter/chargeschart*. Accessed June 18, 2015.
30. The Joint Commission. Specifications manual for Joint Commission National Quality Measures (v2013B). Perinatal care measure set. *https://manual.jointcommission.org/releases/TJC2013B/MIF0167.html*. Published 2013. Accessed June 18, 2015.
31. American College of Nurse-Midwives. Definition of midwifery and scope of practice of certified nurse-midwives and certified midwives. *http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000266/Definition%20of%20Midwifery%20and%20Scope%20of%20Practice%20of%20CNMs%20and%20CMs%20Dec%202011.pdf*. Published December 2011. Accessed June 18, 2015.
32. Center for Medicare Services. Medicare claims processing manual. *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*. Revised October 17, 2014. Accessed June 18, 2015.
33. Group Health. Payment policies. Assistant surgeon. *https://provider.ghc.org/open/billingAndClaims/claimsProcedures/assistant-surgeon.pdf*. Published August 1, 2014. Accessed June 18, 2015.