

# Giving Birth to Midwives

## A Forum for Midwifery Educators

A Publication of the Outreach to Educators Project

Vol: 1 Number 2

### The Changing Midwifery Student

by Heidi Fillmore Patrick

The question posed to educators for this issue of the OTEP newsletter relates to a perceived overall shift in the profile of midwives and the midwifery profession away from the fringes of our communities and into a broader spectrum of the population. Midwifery educators were asked, via an internet survey, what changes they have seen in their students in the past 5 years, what they saw as the positive and negative aspects of this change, and how this has affected their programs. There were 15 respondents to the survey, representing 7 midwifery schools in the U.S. One respondent said she had not seen any change, one noticed very little change, and the others all noticed significant change in their student body.

According to responses to questions, I will describe the “typical” applicant to a direct-entry midwifery program today as a woman in her late 20’s with 2-4 years of college education, little exposure to midwifery or birth, without children, and looking for a career in midwifery that can support her financially. As we know, a “typical” student is like an average labor—there is much more diversity than such categorizing might indicate—but it is interesting to note that long time midwifery educators are noticing a shift.

The change in demographics that have been observed are that students are younger, they view midwifery as a career more than a calling, they can be more mainstream

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### How To Be a Successful Preceptor

by Maureen Smith

How does the preceptor midwife go about successfully teaching a student midwife? As Clinical Director at Birthwise Midwifery School, I occasionally hear this question from preceptors of our students. Sometimes the preceptor midwife has worked with many students and is looking for some new suggestions, while other times the midwife is new to being a preceptor and is looking for a place to start. What these preceptors have in common is that they are interested in maximizing the student midwife’s learning during her time in the practice.

Student midwives arrive at the preceptor’s practice with different learning styles and varying levels of experience and confidence. Additionally, preceptors are individuals and each has her own natural style of teaching. While there is no perfect recipe for effective teaching because of these variables, there are ways to help the student midwife maximize her learning. Recently, a survey of Birthwise preceptors and students in clinical settings was conducted and asked for input about how student midwives have not only been incorporated and accepted into client care but also for specific suggestions for instructing a student.

Preceptors and student midwives were asked how students are incorporated into client care. The majority of survey respondents described the use of an incremental approach to incorporating the student in practice. First, the student midwife observes everything at appointments and births and then moves on to taking vitals, charting, and joining in the conversation during appointments. When the student midwife is ready for the next step she is then invited to provide information during informed choice discussions, to perform hands-on skills with client permission (such as fundal height, FHT’s, Leopold’s maneuvers, and vaginal exams) after the preceptor does them, and to provide labor support at births. The student midwife then moves on to leading appointments, performing hands-on skills with client permission and the preceptor checking behind her, performing lab work when appropriate, assisting the preceptor at births, assessing the newborn’s transition to life outside the womb, guiding the birth of the placenta, and performing the newborn exam. When the student develops confidence and competence with this role, she is then invited to practice decision making with input from the preceptor and to guide uncomplicated births. Finally, with continuing practice

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## The Changing Midwifery Student

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in outlook and lifestyle (*“more professional, less hippy”*), they came to their decision to be midwives through information rather than experiencing midwifery care in their own pregnancies, they have been to college before, and they are more interested in the scientific model. These changes were often explained as a reflection of change that is happening in our culture: there is a wider awareness of midwifery, midwives serve a wider spectrum of clients, it is legally sanctioned in many states, information is readily available to most people via the internet, and schools are accredited and some offer degrees and financial aid.

Some of the less desirable characteristics noted in recent applicants were less maturity and life experience, a lack of drive or passion for learning midwifery, an expectation that their education will be handed to them rather than having to take initiative and be resourceful, less ability to think critically and appreciate the adult learning model that most midwifery programs use, and they require more hand-holding to complete their education. Some noticed the common maladies of our society as a whole creeping into their school community in larger numbers such as mental health issues, learning difficulties, traumatic personal histories, and a lack of appreciation for a healthy lifestyle in general.

One respondent said, *“many students don’t remember a time when midwifery was not legal and we had to fight for our survival”*. This observation of the political naiveté of current student midwives was echoed by many, including this comment suggesting current students don’t see the “big picture” in the same way: *“past students understood that midwifery was part of a healthcare revolution”*. Several educators suggested the development of a generation gap—the age difference is widening between student midwife and teacher/mentor perhaps making it harder for the two groups to relate to each other.

Most of the educators saw some aspects of the change as being quite positive. Overall, the diversifying student profile was seen as evidence that midwifery is reaching into the larger community, indicating a real potential for training more midwives. Women are thinking about becoming midwives at a younger age, before they start their own families, which allows them to engage more fully in their education and increases the student success rate. *“Young women are enthusiastic and are willing to be political”*. *“They are a fresh voice and ask great questions”*.

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Some educators saw the perspective that the young new midwifery student brings as important for the development of midwifery: *“These students are not encumbered by an “us” versus “them” mentality. They don’t choose midwifery for negative reasons such as antagonism toward medicine or need to be down-trodden”*. This less burdened perspective allows students to approach midwifery expecting to take their rightful place as respected healthcare professionals with the same rights and privileges as others. *“It’s exciting to be involved with articulate women who will change the image of midwives.”*

These changes have also created some challenges for midwifery educators and institutions. These students can seem more demanding of services and often speak up when things do not meet their expectations. Sometimes this serves to keep educators alert to their responsibilities, and sometimes it creates an adversarial dynamic between educators and students that can interfere with the educational process. Some programs have noticed they have needed to become much more directive in their educational approach as the younger students have become less self-motivated, take less initiative, and need more guidance in learning to think critically. *“One of our biggest challenges is finding the balance between providing sufficient guidance and structure to keep the students on track and at the same time encouraging the self motivation, independent thinking and stamina that it realistically takes to be a midwife.”*

Another long time educator comments on the challenges she is facing: *“For years I was educating “us”. Now with this newer generation, the challenge is to teach students our history and the skills and attitudes they need so they can carry on where we left off. Every “revolution” faces a challenge when the torch of survival is handed down from the founders to those who follow. These students also present a challenge to the precepting midwives who came up through apprenticeship and may see the students as lacking dedication and commitment because they have a different approach to their clinical sites. As to academics and skill level, they are way ahead of where we were when we started, and even way ahead of their preceptors in some areas, which causes challenges.”*

It is a different world today than it was when home birth midwifery made its comeback in the 1970’s, so these new midwives face different challenges: regulation, litigation, malpractice, accountability, insurance reimbursement, and interfacing with the medical community. Educators have had to respond to these needs by including more in the way of “professional issues” in their curriculum such as business skills, preventing litigation, political education, epidemiology and ethical issues for midwives.

Some of the challenges for educators focus on some of the personal characteristics that are different in the new midwifery student. Some of the personal qualities that were naturally present in midwives who were called into midwifery in a more organic way need to be nurtured in and sometimes taught to the student who chooses midwifery as a career from an intellectual place without much exposure to the culture of midwifery prior to this decision. One educator says, *“We are having to teach*

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# Causes and Conditions: A Co-Founder's Story of National Midwifery Institute

by Shannon Anton, CPM, LM



*Shannon on naming ceremony day.*

Where do babies come from?

The naked, patient eye of direct observation reveals the essence of this truth.

Where do midwives come from?

Long ago I accepted the theory that the great cosmic soup of human experience has brought midwives again and again. But how? My own exploration of this deeper question began in my twenties. Viewed from a distance, through the lens of earnest curiosity, I learned that midwives emerge as light bodies from the dark and spinning chaos of medicalized birth. Inert elements drawn together with the chemistry of family and community, pushed and pulled with the G-forces of politics and choice, aggregate interactions forming the compound elements of apprenticeship and motivated study.

My comprehension of the view before me continued to expand. I saw the dynamic interactions between California law and midwifery calling, all coexisting in the whirlwind of the late 1980s. Midwifery in California was unlicensed and underground. The midwives were organized. Homebirth was happening throughout the state, surfacing more in havens of progressive medical environments like San Francisco. That's where I moved from observer to participant.

My midwifery education included serving on the California Association of Midwives board, where I was immediately introduced to the legal struggle and social movement inherent in the midwifery profession. I learned midwifery through apprenticeship in a busy midwife practice. I attended midwifery classes with local midwives, including Elizabeth Davis and Janis Kalman. And my awareness of the larger questions expanded with my growing experience and knowledge.

It was empirically clear to me that the next question had been the real question all along: WHO DECIDES where midwives come from? There were lots of forces shouting the answers to this question, and most of those answers

seemed wrong. My simple observation had become an experiment! And there on the dark horizon appeared a vortex of dense activity: organized bodies taking form from the most basic and true elements. Constellations were forming, bringing light to the present day.

In the night sky there are burning stars radiating their own brilliance, and there are planetary bodies reflecting the light that surrounds them. Some of the planetary bodies are the brightest lights in the sky. And so it was with the emerging professionalization of midwifery. Midwives Alliance of North America, Midwifery Education Accreditation Council, North American Registry of Midwives. Together the MIDWIVES described our profession from the inside out. We sat together and recognized the brilliance of each other, and the constellation of each organization grew brighter.

Elizabeth Davis requested that the California Association of Midwives send a representative with her to the newly planned NARM Task Force meetings. At that time I served on the CAM board's certification committee, and had myself been recently certified. I had strong opinions based in my positive experience with the apprenticeship model, and the CAM board asked me to represent their own certification process in the national dialogue. I was thrilled with the strength of the consensus process used during the NARM CTF meetings. After seven meetings over two years, we emerged with a consensus based model of midwifery certification! I felt we had created something together that we all worked toward: the heart of apprenticeship had survived in the NARM Certified Professional Midwife.

The cosmic soup was coming to a rolling boil. During the two years that the NARM CTF was meeting, midwives in California were hard at work getting legislation passed to provide midwifery licensure-or rather, salvaging the spirit of their intention expressed in the initial language of the bill. On the tail of the new Midwifery Practices Act we were facing the reality of what the law said about us as midwives. The law described three possible routes to licensure: an academic program that looked much like a university model, a challenge equivalent that would grant credit through examination, and reciprocity with another state's license that met the California requirements. The kind of academic program described in the 1993 California Midwifery Practice Act simply did not exist in California.

Simmering in the neighboring galaxy were the activities of the young MEAC board. The announcement was made that MEAC was opening a pilot project to draw new programs into the accreditation constellation. Janice Kalman urged me to start something that could reflect the midwifery that we both knew and loved.

At the time, I had a busy homebirth practice and two apprentices at beginning and advanced stages. The three of us met weekly with a loosely defined group of aspiring and apprentice midwives for open discussion and study: we called it Study Group. It was a blast. We started the evening with sushi at 6pm and then moved to my house for Study Group until just before 10pm, when ER came on TV and everyone headed home while I settled in for a harrowing hour of counting my midwifery blessings. Nonetheless, I felt ignited by the inspiration expressed through Janice's encouragement. I submitted a draft application based on the current community education

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## Causes and Conditions . . .

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model that I was a part of, including apprenticeship. And I started looking for a founding partner.

My first conversation with Elizabeth Davis brought instantaneous recognition and agreement between us. We began to meet, morning till night for a week solid, drafting 10,000 words of policy. The application deadline was close. Our process was simple. We agreed that two of the existing resources in the San Francisco Bay Area had already been identified by many new and upcoming midwives. Our program would include Elizabeth's Heart & Hands Midwifery Intensives, and my own Study Group curriculum. But most important, the heart of the program would be apprenticeship as described by the NARM CPM credential. Our creative challenge was to fit the natural beauty of our vision with the rigidly defined California Midwifery Practice Act-and to translate all of it in terms of MEAC accreditation standards. Thank the starry heavens for a solid working relationship!

A pressing issue was the name of our new school. "Midwifery" was an obvious start. We cycled through several options and returned again and again to the verb, institute. An old dictionary provided the necessary piece that made our decision final: institute, to begin, establish; an organization for the promotion of art, science, and education. "Midwifery Institute" seemed a little nonspecific. We were pretty sure that outside of California, nobody would be interested in another midwifery school...so "California" would be included. Midwifery Institute of California, it was!

Our philosophy and purpose statement came easily: We believe that the study of midwifery is a self-motivated and organic process, springing forth from the fertile ground of community and family. Just as there have always been and will always be birthing women, so the midwife is called into practice. We recognize and value the tradition of the midwifery learning cycle: knowledge being passed from woman to woman, experienced midwife to apprentice. We believe birth is a transformational process with its own intrinsic value for personal growth and development.

We support woman-centered birth and seek to uphold the right of each woman to define her needs and identify her support system. While the midwife sets parameters of safety, it is the birthing woman who, through the process of informed consent, makes her own decisions regarding the care of herself and her baby.

It is our purpose to prepare midwives for the scope of practice outlined by MANA Core Competencies, North American Registry of Midwives Certification guidelines, California Midwifery Licensing requirements, and the joint mission statement of the Midwives Alliance of North America and the American College of Nurse-Midwives:

"The entry level midwife is a primary health care professional who independently provides care during pregnancy, birth, and the postpartum period for women and newborns within their communities. Services provided by the midwife include education and health promotion. With additional education and experience, the midwife may provide well-woman gynecological care including family planning services. When the care required extends beyond the midwife's abilities, the midwife has a mechanism for consultation, referral and continued involvement."

Dedicated to the new concept of distance learning, Elizabeth and I rewrote our curriculum into modules appropriate for independent study. We submitted our accreditation application to MEAC in October 1995, and it felt as though we held our breath until our spring site visit.

1996 was a meteoric year. California had issued only two midwifery licenses, both through reciprocity. Seattle Midwifery School had been working with CAM to provide a Challenge Mechanism. Once approved, the SMS Challenge provided a route for the next three midwives to be licensed in California-Karen Ehrlich, Maria Iorillo, and myself (LM #05!). I also completed my NARM CPM credential. And, California selected the newly revised NARM Written Exam as the state midwifery licensing exam. Which coincidentally meant that I had to take it again, this time in multiple choice format. The news that would forever alter my orbit came in the form of a registered letter from MEAC: Midwifery Institute of California had been pre-accredited.

The first few years were promising even through their dim ambiguity. California didn't recognize the CPM. The Midwifery Practice Act of 1993 required programs to be reviewed and approved by the Medical Board of California before graduates from those programs would be eligible for licensure. The Medical Board of California felt compelled to wait with board acknowledgment of MEAC's Department of Education standing until final accrediting privileges had been granted. Midwifery Institute of California graduated three students in 2000, and to complete their California licensing process, these grads also had to pass the SMS Challenge Mechanism! By then it had become clear that the hope of basing our school in California had little bearing on program approval by the Medical Board of California, or the appeal to students in that state. And there were other states, several of which had begun a trend toward licensing NARM CPMs!

The unanticipated things are sometimes miracles. I had moved to Vermont in 1998, and had continued my work with the school from there. Our students are all distance students, and the concept of place was truly open for interpretation. The relocation itself was only a matter of paperwork, but for MEAC policy it represented a substantive change at a time when we were in the process of reaccreditation. Our move was complete with a new name, National Midwifery Institute.

We began the plodding task of reapplying for accreditation under our new name and location. It was an opportunity to revisit all of our policies and frame them in terms of current developments. In March 2002 we were pre-accredited once more. By October we had enough graduates to qualify for full MEAC accreditation. We had more students than ever, and each year we grew a little more.

In March 2003 National Midwifery Institute received word that our program had been reviewed and approved by the Medical Board of California. It had been nine years from the time the law was passed for any midwifery program to achieve this; Maternidad La Luz preceded us by a few months. That year, both of our graduates received California midwifery licenses!

Our two graduates from 2003 were the first to be granted California licenses because they graduated from National Midwifery Institute. These two grads illustrate a key aspect of our program: both of them welcomed babies into their families during the time that they were enrolled.

Including our three grads in 2000 (Midwifery Institute of California days), we've graduated twelve new midwives. Four of them had babies during the time they were enrolled with the Institute.

Many of our students are also moms. We offer "leave" arrangements with students during times of big change. It is imperative that our program provides the flexibility appropriate for adult learners with adult responsibilities. It is our sincerest intention that the time spent in midwifery study creates a healthy and sustainable template for midwifery as a life long profession.

National Midwifery Institute is a distance program dedicated to the preservation of community-based midwifery training and education. Our curriculum supports woman-centered birth and prepares graduates to meet national standards as described by the North American Registry of Midwives, the Midwives Alliance of North America, and the California Midwifery Practice Act.

The age of computers has made distance education much more familiar. Almost all of our course work is now sent through email, and there is a student egroup. Research online has replaced the need for medical libraries within a day's drive.

We currently await the Medical Board of California committee meeting on February 2-3, where our Challenge Program proposal will be presented. We have been working on it since 2003, and have gone through numerous rewrites as we work our way through the process of Medical Board review. At this time, an experienced midwife who wishes to relocate to California and resume practice must first spend a year at Maternidad La Luz to complete the only California Challenge process currently available. Thanks again to Kaley for keeping the door open!

We have four students who passed their NARM Written Exams in 2005, and another three qualified for testing early in February. Upon completion of their remaining course work, all seven are expected to graduate in the spring of 2006. We are counting 2006 as our tenth anniversary. What a great year!

## Seattle Midwifery School: A Profile

By Lynne Hughes



*A view from the SMS classroom.*

When Seattle Midwifery School (SMS) was founded in 1978, there were no licensed midwives practicing in Washington State. Members of the Fremont Women's Health Collective took the radical initiative to provide a means for aspiring midwives to meet the educational requirements prescribed in a "forgotten" 1917 law. This law authorized the practice of midwifery by care providers who had completed a course of study meeting prescribed requirements. The school these women founded became Seattle Midwifery School.

Soon after the pilot class of five Seattle Midwifery School graduates began to practice, Washington State lawmakers recognized the need for an updated midwifery law. A 1980 legislative analysis document stated that such a law was under consideration in large part because Seattle Midwifery School graduates were providing maternity care under the 1917 law. The updated midwifery law passed and is the basis for today's law that regulates midwifery in Washington State. More than 200 midwives have graduated from SMS since then.

Twenty-eight years later, the pioneering spirit that drove the birth of SMS lives on in the community of individuals whose efforts and support enable us to keep building on this foundation. From the beginning, our faculty, staff and alumnae understood the need for participation in the development of the profession locally, regionally, nationally and internationally. Many of them became leaders in the midwifery movement and have been involved in midwifery organizations on state, national and international levels, some for more than 25 years. They have played pivotal roles in establishing national certification and accreditation standards and public policies that support midwives, as well as spearheading efforts to heighten awareness of the art of midwifery.

Professional Issues instructor, Jo Anne Myers Ciecko, MPH, who recently stepped down from her role as SMS executive director after 20 years, continues to use her considerable talents, knowledge and political savvy to educate and inspire SMS students and graduates. Jo Anne's work focuses on increasing access to midwifery care locally and abroad; helping midwives to understand

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## Seattle Midwifery School

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and navigate the political landscape; and training students, midwives and consumers in strategies for effecting long-term positive change. Jo Anne has developed and teaches the Professional Issues track for SMS, offers workshops for Washington midwives in advanced political work, serves on the Midwifery Education Accreditation Council board of directors, and is a regular presenter at national and international midwifery and public health conferences.

Suzu Myers, LM, CPM, MPH developed much of the school's core Midwifery Care curriculum and continues to be a lead faculty member. A founding mother of Seattle Midwifery School, Suzu began as an apprentice-trained homebirth midwife with the Fremont Women's Health Collective and continues to work hard to advance the profession of midwifery. She currently sits on the board of directors of the National Association of Certified Professional Midwives, and is a member of the Joint Underwriters Association board, which serves to ensure access to malpractice insurance for the midwives of Washington State.

With staff and faculty involved nationally, SMS became widely known during its early years. As a result, requests frequently arose from aspiring midwives throughout the country who couldn't move to Seattle, asking for distance options so they, too, could attend Seattle Midwifery School. While we did not believe that our curriculum could be translated to a completely distance format, the advent of Internet-based education inspired us to develop a pilot program that we hoped would offer the best of both worlds. This new model was a blend of distance learning and intensive classroom sessions. We called the new model "low-residency" and, to date, evaluations of student competency using this model have produced results as good as and, in a few areas, better than before.

In September 2005, the sixth (and largest) class of students entered the low-residency program. Aside from residents of the greater Seattle area, this new group of 22 women includes those who commute from other parts of Washington, as well as British Columbia, Montana, Illinois, Oregon, California, Colorado and New Mexico. We are thrilled to be achieving our goal of making this program as accessible as possible, geographically as well as to women with jobs, children, and other commitments.

The SMS Midwifery Education Program is three academic years in length. A new cohort enters each September. Classes are held for five days per month at the onset of the program and decrease to one day per month during the final quarters when clinical work predominates. When the clinical aspect of the program begins in the third quarter, students with eligible practitioners in their home communities may not need to move. Students without local opportunities to receive the experience they need, may relocate to anywhere in the US, as long as they are able and willing to travel to Seattle once each month. During the summers, when they have a two-month break from academic work, some students may opt to participate in overseas clinical rotations.

Onsite sessions include skills practice, role-plays, discussion seminars, presentations and other dynamic activities. Between onsite meetings, students participate in learning activities that include extensive reading, by

scheduling check-in time during onsites and supporting camaraderie among our students in any way we can.

In addition to a great curriculum and faculty, SMS is proud to offer an excellent library. Current subscriptions to approximately 40 journals and newsletters include the major peer-reviewed journals covering the field of midwifery. Our book collection consists of approximately 1,500 titles including academic textbooks, conference proceedings, and monographs covering the sociological, biological, legal, political, historical and business aspects of midwifery and maternity care. There are videotapes and audiocassettes, subscriptions to the online Cochrane Library and other journal databases, and membership in the National Library of Medicine's Docline interlibrary loan system. A part-time librarian offers assistance with reference questions, access to resources, and training in conducting computerized literature searches.

In line with our mission, "To educate and inspire leaders in childbirth professions," SMS has been committed to offering related educational programs in addition to the Midwifery Education Program. Penny Simkin first developed and taught our Labor Support Course for birth doulas in 1988. (Penny and SMS staff member, Annie Kennedy, went on to be founders of Doulas of North America.) Since then, we have added Postpartum Doula, Childbirth Educator, and Lactation Educator training programs. Beyond these regular programs, SMS offers continuing education workshops and community forums and events, on our own or as co-sponsors with many of our sister organizations.

As our student body and regional representation grow, SMS is devoted to improving our current programs as well as expanding to include new mission-based programs. In the coming year we are committed to upgrading our Internet-based capacity with new interactive tools for students and faculty; we have developed and are launching a new advanced writing course for childbirth professionals that will fulfill the advanced writing prerequisite for our midwifery program; and we are in the process of submitting our application for MEAC CEUs for a five-week online "Journal Club"—an opportunity for practicing CPMs to increase their understanding of how to critically analyze research articles and discuss their relevance online with CPMs around the country.

## How to Be a Successful Preceptor

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In all of these areas the student midwife additionally moves to managing complications during the antepartum, intrapartum, postpartum and newborn periods. While the method of moving a student midwife through this process of learning the art and science of midwifery is similar with preceptors, the pace does seem to vary from practice to practice and from student to student.

Other preceptors described a variety of "schedules" in their work with student midwives. For example, some have a student midwife observe at five prenatal appointments and then move to assisting at five appointments. After success with this, the student follows the preceptor step by step through five appointments and then finally the student leads appointments with the preceptor following her. The set number varied amongst

preceptors who use this method but common was 2, 5 and 10 appointments in each of the incremental steps. These preceptors felt that students learn best by doing and cited this as the reason to move a student quickly into a leading role in client care while supporting them in this process.

Other kinds of “schedules” that preceptors use when working with students are based on continuity of care, acquired skills, or time. For example, with a continuity of care schedule, the student is expected to attend a minimum number of prenatal visits with the same client in order to attend the birth and lead a minimum number of prenatal visits with the same client in order to work as primary under supervision at the birth. With a schedule based on acquired skills the student works on a list of skills that she and the preceptor have agreed upon and, when proficient in those skills, continues with them and moves on to begin working on another set. Finally, in a time based schedule the student observes in the practice for a period of time (common are one to three months) and then progresses to assisting for a similar period before moving into the primary under supervision role.

While each of these methods of incorporating a student into practice varies slightly they do have common benefits for the preceptor and the student. Each method is systematic, builds on previous successful student experiences, and has clear goals. These are beneficial for the preceptor in that they take some of the guesswork out of the process of teaching a student midwife, and they provide a framework for evaluating a student’s progress after each step. These methods are also beneficial for the student in that they allow the student to build confidence in her abilities as she learns a little at a time, and they also allow her to have clarity about her role throughout the learning process. Preceptors and students in practices where these intentional methods of incorporating the student were in place expressed appreciation for the benefits.

Preceptors and students were also asked in the survey if students were accepted by clients and how this was facilitated. The survey respondents reported that in general students are readily accepted as part of the client’s care giving team and that this is facilitated by providing information to clients about the student’s role, introducing the student, exhibiting confidence in the student’s abilities, and encouraging the student to form a relationship with the client. Many preceptors relayed the importance of educating their clients in a matter of fact way about student midwives in their practice. They include information in their initial information packet about midwifery education and training, the student midwife’s role on the care team, and autobiographical information about the student herself. Then they introduce the student as an integral part of the team. Many students felt, in fact, that their preceptor’s glowing introduction of their training, skills, and importance in the practice was a key factor in client acceptance of them. After informing the client about the student’s role and introducing her, preceptors felt that exhibiting confidence in the student’s abilities in front of the client contributes to the student’s acceptance. Many preceptors

relayed the importance of refraining from overt teaching during appointments by allowing time before and after the appointment for student education. They also felt that not correcting the student in front of the client and asking for the student’s input during appointments fosters confidence in the student’s abilities and acceptance. The final way in which preceptors facilitate the client’s acceptance of the student is by encouraging the student to develop a relationship with the client. For example the student midwife teaches childbirth education to clients, schedules appointments, returns client phone calls periodically, spends time chatting with the client before the midwife enters the room for appointments, and is encouraged to make a connection with the client’s other children. Survey respondents were very positive about student midwives being accepted by clients, and they felt that this was facilitated successfully by a variety of ways.

Finally, preceptors and students were asked in the survey for specific tips and suggestions for teaching a student midwife. The following suggestions for preceptors were common from preceptors and students alike:

- Try to understand the student’s learning style and help her use this to her advantage. The student may learn best by writing things down or by understanding the why behind a certain action or by following lists, etc.
- Be clear and up front with the student. Openly discuss expectations and whether the student is meeting them. This helps her know where she stands and what she can expect.
- Avoid surprising the student by asking her in front of the client to do something new. Allow her time to prepare in advance.
- Let the student try. Be prepared to help her if she needs help, but try to avoid taking over at that point if possible. Remember that generally students learn best by doing.
- When needing to talk the student through a skill try addressing the client and saying things like, “Now you’ll feel Patty’s hands doing \_\_\_\_\_.” or “Patty is going to check for a cord now.” This allows the student to focus on what she is doing while listening to you describe what she is doing to the client.
- Allow the student to develop her own personal style. Some skills need to be done a specific way, but there often are many acceptable ways to do things.
- Avoid correcting the student in front of the client. When it is absolutely necessary to do this, try to do it unobtrusively and respectfully.
- Make time for questions and answers or debriefing session after each experience in the practice. This may be a time set aside at the end of each appointment or at the end of the day. If this is a routine part of the student’s experience in the practice, she will know that her questions are important and there will be a time to review them.

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## How to Be a Successful Preceptor

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- Set a time for periodic evaluations. Start out with what the student is doing well and move to areas for the student to improve or do differently.
- Periodically run through complicated scenarios with the student to help her practice visualizing what she would do in the moment.
- Carpool with the student when possible and use the time to discuss aspects of care, answer questions, debrief after births and challenging appointments, and build a relationship with the student.

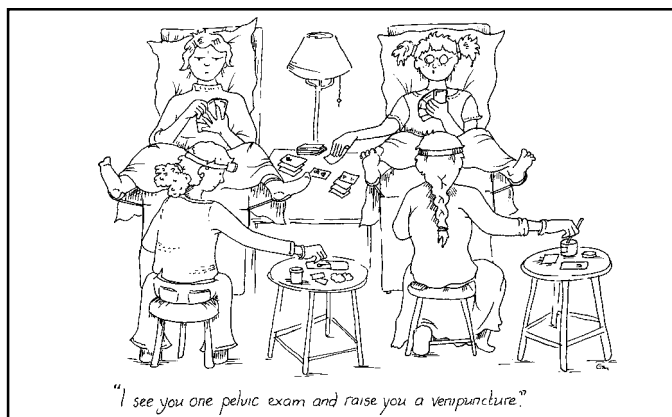
Whether a midwife is new to being a preceptor or has worked with many students, the information gleaned from the responses to this survey suggest ways of maximizing student learning and successfully teaching student midwives.

## The Changing Midwifery Student

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*these women to trust in their intuition and the spiritual side of midwifery*". Other accommodations educators have made to the changing student are greater overall support for students as they pass through their programs, requiring participation in the local midwifery organizations, increasing the depth of medical knowledge offered to and expected of the student, and including foundational educational skills such as writing and research into the curriculum.

The general sense I gleaned from the responses to this survey was that most educators have noticed changes in their students in past years, but they understood much of the change was to be expected as the profession of midwifery becomes more mainstreamed. Certainly it presents new challenges to educators who are accustomed to working with students who were more self-reliant, mature, and more closely shared their own views and lifestyles, but it is a positive shift because it means more women will be served by this more diverse set of midwives. Some adjustments have been made in the midwifery education programs in order to meet student's expectations and increase the success rate of the students as well as to keep up with the changing environment student midwives are faced with. As always, the trick is to adapt to a new reality while keeping the essence of midwifery intact.



## Tools for Accreditation: Standard 1

Dear Schools of Midwives,

*This is the first in a series of articles that talks about the INTENTION of each MEAC standard. Here is the first tool in your toolbox for understanding MEAC accreditation.*

### This is Standard 1, "Success with respect to mission."

Standard 1 is a core standard. It looks at the value of a program using an outcomes-based approach. In other words, what are your results? It is a very exciting standard because it allows us to look at a whole variety of programs, small, large, apprenticeship based, academic based, and ask: "How successful are the students, no matter what the design of the program?" This standard basically says that MEAC wants schools to be clear about their mission and educational purposes, and to demonstrate how well they are accomplishing them. In this way, MEAC accreditation can focus on the quality of student learning without specifying, beyond core competencies, what the learning should be – in short, to promote **standards without standardization**.

For MEAC Board members, using this strategy as a common denominator is what makes accreditation inclusive and satisfying!

Standard 1 requires that accredited schools have a mission statement. A mission statement is a broad statement of the purpose of your institution or program. It is the backbone or foundation of your plan, the mission and vision. Furthermore, every accredited school evaluates whether it is achieving its OWN mission and objectives with respect to the outcomes of its students.

Accreditation can be a good opportunity to make plans for continuous improvement. Let's say the mission/vision of a program includes "preparing midwives for practice in the state of California," or, "to prepare midwives to interface with the medical personnel in their own communities." How are you assessing whether you are meeting these goals? It is very important to set clear learning goals, that speak to both content and level of attainment. Preparing midwives for California licensure is a clear objective; easy to measure. Preparing midwives to interface with the medical community is not so easy – how would you measure that? It can be done, but the school will have to work harder to assess and provide evidence that this is indeed happening with their graduates.

What evidence can you gather that your graduates are successful with respect to your mission and objectives? Some sources of evidence are direct: i.e., the NARM exam results, other clinical performance evaluations, and faculty-designed examinations. Some sources of evidence are indirect: portfolios and work samples, follow-up surveys of graduates, self-reporting by graduates, employer or client ratings of performance. Using more than one result provides more multi-dimensional evidence (which we think strengthens your program.)

Why is this important? In higher education, there are more demands on institutions and programs to provide evidence that students are actually learning, and to show that there is a value to the education (which is increasingly more expensive, isn't it?) Educational quality is one of the core purposes of a school, and when an institution or





Mary Ann Baul in the new MEAC office

program fulfills its declared learning mission, it is a fantastic way to demonstrate educational quality.

In fact, the U.S. Congress Higher Education Act of 1965 requires accreditors to have standards that effectively address the quality of the institution or program in terms of its “success with respect to student achievement in relation to the institution’s mission, including, as appropriate, consideration of course completion, state licensing examination, and job placement rates.” This U.S. DOE regulation has become the foremost standard by which accrediting agencies must judge the effectiveness of their programs and institutions.

Students, employers, and the public want assurance of academic quality. One of the ways to measure this is to focus on evaluating a student’s competencies in order to assure the knowledge, skills and other attributes students seek are achieved during their schooling.

There was a time when accrediting agencies designed curriculum standards to be a list of required subjects and courses and the required hours of instruction in each. (And some still do this.) But with U.S. DOE’s insistence on outcomes, it is far more likely today to have standards as a set of competencies that students are expected to achieve before they graduate. These are entry level standards, which define very specific knowledge, skills and abilities that graduates must possess. We are fortunate to have the MANA Core Competencies and the NARM Skills that articulate essential midwifery abilities.

But core competencies must change with changes in scope of practice, technology and public needs. It is a challenge to integrate new national or international core competencies into an existing educational program. To create or change competency-based criteria, midwifery must involve both educators and practitioners in a thoughtful and planned conversation. This ensures not just that the competencies are current, but also that there is an informed discussion and consensus between and among educators and practitioners as to what a student must know and be able to do in order to function at an acceptable level upon entry into the profession. The MANA Board is currently proposing a revision of the Core Competencies; *MEAC is encouraging educators and practitioners to join the dialogue and be represented in the decision-making process.*

Because U.S. DOE is quite directive in its approach to student outcomes for vocational programs, MEAC uses specific benchmarks to evaluate success with respect to mission.

These benchmarks are:

- 1) Greater than 50% of matriculating students complete the program, including the required clinical experiences, within the timeframe stated. (I.e., if the program is 27 months, greater than 50% of students complete the program within that timeframe.)
- 2) Seventy percent of graduates in the past three years who sought state licensure or national certification have been successful.
- 3) The majority of graduates (greater than 50%) in the past three years have been state licensed; certified by NARM, or are working as midwives or in related fields.

MEAC accredited schools complete student enrollment and graduate placement reports annually in order provide this information. We also encourage schools to have their students sign a release so that NARM can provide the pass/fail results for each student taking the NARM exam. We would also like NARM to share with schools the overall strengths and weaknesses in test sections so that a school can modify and improve its educational program.

Ultimately, the information the school provides in meeting Standard 1 can facilitate improvements in their program. And that’s really what accreditation seeks to do—to encourage a school to continually improve its outcomes based on its own mission and objectives.

(Any questions? Give us an Email [info@meacschools.org](mailto:info@meacschools.org))  
Mary Ann Baul, Executive Director, MEAC

## Midwifery Education: International Connections

By Jo Anne Myers-Ciecko



Thousands of midwifery educators around the world are engaged every day in the same issues that we face here in the U.S. – how best to prepare competent and caring new midwives, design curriculum, set admissions criteria and teacher qualifications, secure adequate clinical sites, establish budget priorities and maintain program funding. When midwifery educators anywhere in the world get together, we can always share a laugh over some of the more mundane challenges, like dealing with a student whose dress or demeanor isn’t a good fit with her clinical site. But midwifery education is also central to some of

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## Midwifery Education: International Connections

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the biggest questions faced by the midwifery profession – how do we prepare midwives who will be leaders capable of shaping and defending an autonomous profession, effective advocates for women and health policy, and skilled researchers who will examine pregnancy and midwifery?

Forty-eight midwifery educators from a wide range of countries discussed questions like these during a workshop organized by the Education Standing Committee of the International Confederation of Midwives in Brisbane, Australia last summer. MANA Vice President Abby Kinne is co-chair of the ICM Education Standing Committee. She reports that workshop participants considered whether ICM should set educational standards for midwifery teachers, including whether educators should have advanced degrees and/or degrees in education. They also talked about how programs can incorporate ICM and WHO policy statements into midwifery education. The final report of the workshop is not complete, but for those readers who would like more information or to participate in the Education Standing Committee, you may contact Abby at [MANA1stVP@aol.com](mailto:MANA1stVP@aol.com).

I urge readers to visit the website of the International Confederation of Midwives at [www.internationalmidwives.org](http://www.internationalmidwives.org) to view the following core documents and position statements:

- Basic and Ongoing Education for Midwives
- Essential Competencies for Midwives
- Qualifications and Competencies of Midwifery Teachers
- International Code of Ethics for Midwives

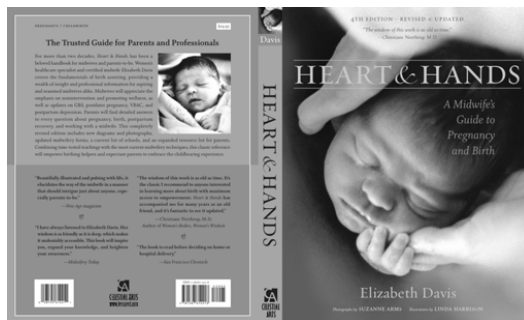
My students have been very excited to learn about the ICM and many are particularly drawn to the Code of Ethics, which provides an interesting contrast to similar documents adopted by MANA and ACNM.

In April 2004 I attended the Americas Regional Conference of the International Confederation of Midwives in Trinidad where I participated in a two-part “Educators Workshop” that drew participants from nearly every country in the Western hemisphere. Unfortunately, I was the only person present with any direct knowledge of direct-entry midwifery education in the U.S. and many more connections might have been made if there had been more of our schools and educators represented. Nevertheless, I found that we have much in common with our colleagues in other countries and, where we are different, I believe we have something worthwhile to share. What sets us apart, of course, is our experience in out-of-hospital birth and community-based education. Most midwifery education programs in other countries are publicly funded and administered – as are most health services. That means the professional midwifery education is generally hospital-based and/or university-based.

Workshop participants were very interested in sharing curriculum models and developing collaborative midwifery education projects across the Americas Region. Midwives from the Caribbean were also interested in clinical teaching, midwifery textbooks, and integrating traditional midwifery knowledge into midwifery curriculum. So many of our students and apprentices from the U.S. travel to other countries for part of their clinical experience, yet very few of us have established inter-institutional relationships or organized faculty exchanges. Wouldn't it be great if we could think of ways to weave better connections that would be mutually beneficial?

## Book Review: Heart and Hands

4<sup>th</sup> Edition by Heidi Fillmore-Patrick



Sitting with all four editions of Elizabeth Davis' book Heart and Hands in front of me is a bit like witnessing the evolution of direct-entry midwifery in the past 25 years from my office chair. The original edition, published in 1981, was an important resource for midwives, students and pregnant women in a time when we were just beginning to reclaim birth in its natural form. The photos alone speak of the provocative role this book played in the natural birth movement—four naked pregnant ladies looking so comfortable on the sofa, birthing women looking so strong and beautiful in their own homes. Women were learning from birthing women and the courageous midwives that were pioneers of the profession of midwifery in its new (or very old) form. Elizabeth was one of those midwives. Her manual for midwives was one of precious few resources available to midwives working outside the hospital.

After selling 60,000 copies of her original book, the greatly expanded second edition was published 6 years later, in 1987, and another expanded third edition in 1997. Each time Elizabeth includes more topics and expands and updates existing information. The telling photos and some of the best birth illustrations I have seen (thank you Linda Harrison), make all of these editions beautiful and communicate more than words could ever convey.

Her latest edition, published in 2004, presents like the culmination of 25 years worth of wisdom in a form that is lovely to look at and a pleasure to read. I see Heart and Hands as the entry point for student midwives. It is the grounding place, the jumping off place, the milky breast that the student, like a toddler, can return to for comfort and guidance after exploring a much less nurturing world. I know this is the role it played for me when I read it for the first time 20 years ago. It submerged me in and oriented me to the world of birth and midwifery in an important way. As I branched out and delved deeper into the science, the evidence, the theoretical details of midwifery, Heart and Hands still held within its pages the essence of midwifery that I could return to for grounding.

This is the role this book can play within a midwifery education curriculum—to be a manual for the beginning midwifery student that orients her to the information she needs as a midwife, but more importantly, to the essence of midwifery care. This should especially be required reading for the new generation of midwifery students who may not have experienced midwifery care themselves, or even have witnessed it as an observer. As for the seasoned midwives, an occasional browse through Heart and Hands could serve to keep us on track as well as be a great resource for our more curious clients.

# Stories from Afghanistan Bring Perspective

By Karen Hays, CNM, SMS class of 1992

I am always fascinated to take note of the law of unintended consequences. Who would have thought that on September 11, 2001, 19 airline hijackers would initiate a chain of events that would result in the US government funding direct-entry midwifery education in Afghanistan? But that is indeed what has happened.

Recently, I spent three months in Afghanistan working as a Technical Midwifery Advisor for the Safe Motherhood Unit of the USAID/REACH program. As many of you know, I have participated in clinically oriented midwifery in many foreign countries; but this time my focus was different. This was an opportunity to be involved with government agencies and educational institutions that are setting policy and standards of practice to help reduce the disastrous maternal mortality situation there.

Traveling and working in Afghanistan required special preparations. Not only did I need more education about participating in midwifery at a policy-making and administrative educational support level, but the country is not set up for foreigners, let alone women, to travel alone. I took a weeklong course offered by JHPIEGO, an affiliate of Johns Hopkins University, for nurses and midwives interested in international consulting. I made contacts and submitted my resume, and soon I was hired by JHPIEGO to be a midwifery consultant in Afghanistan. I read up on Islam, Afghan traditions, and how I should behave in this culture. I spoke to other midwives who had worked there to learn from their experiences.

My assignments with JHPIEGO were varied, but one in particular was important to me. I worked on the preparations for the upcoming accreditation of the new direct-entry midwifery education programs. My years of being a student, teacher, and clinical preceptor for SMS were a great background. I sought help from SMS staff to send me SMS documents for reference when drafting school policies (thanks, Terri Turner-Carney!) and I recruited another SMS graduate, Marijke van Roojen, to come to Kabul to help with improving the quality of education at the largest midwifery school.

The process of working towards accreditation is dynamic and collaborative and when it is complete, midwifery education in Afghanistan will enable Afghan midwives to be members of the first accredited profession ever in that country! We did pre-accreditation assessments at the schools and organized accreditation workshops. An independent accreditation board will visit the programs to assess if they are meeting the standards, help set goals for improvement, and award accreditation status. The goals are to promote international standards for midwifery education, quality of instruction, and accountability.

Just as in the US, midwives and student midwives in Afghanistan have many barriers to education and practice. Some of these are the same as ours: lack of respect for the profession, minimal support from physicians, financial stress, and family constraints. But students there have additional challenges. To attend school, many students have to travel long distances through rugged conditions, and all must have written permission from either a father

or a husband. Women are not supposed to be out after dark or travel alone, so clinical experiences are limited. Schools may be closed temporarily because of security threats. Some students struggle with marginal literacy skills, and for the rural schools, they must live in dorms during the 18-month program. However, some of the schools have onsite childcare and the students bring their smaller children to live with them in the dorms! No one knows exactly what will happen to the students after graduation. Will their families give them permission to work? Will there be healthcare facilities to work in or transfer clients to? Will it be safe for them to attend women in their homes? Will their communities use their services?

Although much of the reality in Afghanistan is dire and desperate, it is also extremely exciting to see midwifery education organized and functioning so quickly after 25 years of virtual non-existence during the Soviet war, civil war, and Taliban rule. We can attribute this to the dedicated Afghans and others who value midwifery care, and USAID, the European Union, and many NGOs who are providing grant money and technical advice. With on-going funding, vision, and dedication, Afghans will continue to work towards lowering the second highest maternal mortality ratio in the world by educating midwives.

## WHAT CAN WE DO TO SUPPORT THE AFGHAN MIDWIVES IN THEIR EFFORTS?

Midwives may offer their support by joining the Afghan Midwives Association as a foreign midwife for \$25/year. (Contact Mary Yglesia at Seattle Midwifery School, maryy@seattlemidwifery.org, if you are interested in joining.)

NGOs supporting midwifery education:

JHPIEGO (affiliated with Johns Hopkins University)	<a href="http://www.jhpiego.org">www.jhpiego.org</a>
AgaKahn Development Network	<a href="http://www.akdn.org">www.akdn.org</a>
International Medical Corps	<a href="http://www.imcworldwide.org">www.imcworldwide.org</a>
Save the Children - US	<a href="http://www.savethechildren.org">www.savethechildren.org</a>
Merlin (Great Britain)	<a href="http://www.merlin.org.uk">www.merlin.org.uk</a>
Swedish Committee	<a href="http://www.swedishcommittee.org">www.swedishcommittee.org</a>
World Vision	<a href="http://www.wvi.org">www.wvi.org</a>

## My Vision for Midwifery

*by Lisa Tilden,  
Student at Birthwise Midwifery School*

While I did have some idea of the role of CPMs in American maternity care before coming to school, it is sometimes daunting to realize that I will be practicing within, or rather – outside of - a system that has different ideals and does not value the kind of care that I will give. It is my fantasy that in five years, by which time I will hopefully be an established midwife with a thriving practice, that this will not be the case. I envision a system of maternity care in which the midwife's model of care is well understood, respected and demanded by consumers, birth is viewed as normal event and CPMs are integrated into mainstream care. By integrated I do not mean that CPMs will be working in hospitals, but rather that they will be respected by and viewed as colleagues of those who do. I envision this kind of integration to have four components.

*Cont.inued on page 12*

## My Vision for Midwifery

*continued from page 11*

1. Legality – By working together and organizing for the next five years, CPMs (and their equivalents) will no longer be illegal in any state. No family will be forced to receive care that they would not choose if midwifery were not illegal and no one will have to choose care with the fear that they will be punished for it. No midwife will be forced to practice in secret or with the fear of legal retribution. In addition, all the variations of normal will be accepted, allowing women to VBAC, birth twins or a breech baby at home if they so chose.

2. Referral and cooperation – In my fantasy situation homebirth will be an option for every healthy woman with a normal pregnancy. This means that if a woman sees a healthcare professional and it is confirmed that she is pregnant, she will be presented with her options: hospital birth, birth center birth or homebirth. Doctors might say to their clients, “I think you are a good candidate for homebirth, here are the numbers of some excellent midwives in the area.” In this kind of system every midwife would have no problem finding a doctor for back-up and referrals. If a client needs to transfer care or if she needs consultation, the attitudes of OBs will be welcoming and not at all derisive. Furthermore midwives would have no troubles in setting up lab accounts or scheduling ultrasound appointments when needed. If a CPM has to transport during labor, the hospital will not be difficult or accusatory, but simply recognize that this particular labor needs the next level of care, just as small hospitals can transfer patients in need of increasingly specialized care to large tertiary hospitals. In these situations the midwife will still be considered the primary attendant and get to participate in management decisions.

Perhaps midwives will even participate in the education of new OBs, providing lectures on how to keep birth normal and offering clinical rotations to those students who desire them. This will help ensure that the next generation of OBs is well informed and understands the midwifery model of care. It will also help them to screen out clients that are inappropriate for their care – that is, normal healthy pregnant women – who will be cared for by midwives, CNMs in the hospital and CPMS or CNMs at home and in birth centers. This will ultimately lead to a much greater proportion of midwives in relation to the number of OBs, who, not being so numerous, will only have time to care for those truly in need of a specialist/surgeon’s care as they continue to refer clients to midwives. This will also mean that they will not be taken for granted and viewed as primary caregivers by the community but will receive the recognition they deserve as highly trained specialists, caring for women with special needs.

3. Insurance Coverage – CPMs will be covered under every insurance policy that includes maternity care (and they all will because no one should be denied access to maternity care). No client will have to pay an insurance premium and a midwife’s fee. The reimbursement provided to the midwife will not be complicated to receive and will merely require the usual filling out of forms, not a long-term struggle with the insurance company. Liability insurance will not be mandatory for this coverage. In addition, CPMs will be able to receive health insurance for themselves and their families through MANA at a reasonable price.

Also, it will be standard for health insurance companies to cover the costs of doulas, post partum doulas and lactation consultants. All women will receive from their employers a minimum of 12 weeks paid maternity leave and extended breastfeeding or pumping breaks from their employers for the first year. Fathers will receive generous paternity leave packages and will be encouraged to take them.

4. Community attitude – It is my hope that in the years to come midwifery and homebirth will become increasingly familiar to and accepted by the community. While homebirth will still probably be the minority, perhaps it can be a large minority, like in the Netherlands where 30% of women give birth at home. And, the majority of women who do not have homebirths will still be attended by midwives. Homebirth will be normal, not something that receives raised eyebrows or protests of concern. People in movies and on TV will have normal, non-emergent, non-precipitous births and some of them will even have them at home. In fact it will be so common that upon learning a woman is pregnant her acquaintances may ask, “Who is your midwife?” or “What room do you think you want to birth in? I’ve always thought your breakfast nook would be a lovely spot.” Babies R Us will carry homebirth supply kits and they will be among the top sellers on their gift registries, along with slings and breast pumps and cloth diapers. Of course the big-ticket item will be the Aqua Doula.

As I write this I realize that I am entering into the realm of fantasy, (which is fun) but not necessarily by very much. Simply put, in five years time I envision a system of maternity care that truly makes a place for midwifery as a profession and a realistic option for all women.

### A Call for Student Presenters at MANA Baltimore

Do any of your students have some excellent research to share with practicing midwives and educators? There will be an opportunity for midwifery students to present research papers at the MANA Conference in Baltimore October 13-15. Any interested persons please contact Heidi Fillmore-Patrick at [Birthwise@verizon.net](mailto:Birthwise@verizon.net) for more information. All proposals should be received by March 1, 2006.

