Giving Birth to Midwives

A Forum for Midwifery Educators

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Clinical Training for Midwives: A survey of midwifery program administrators

By Heidi Fillmore-Patrick, CPM
Coordinator of the Outreach to Educators Project

Mentoring aspiring midwives, one-on-one, in a midwifery practice is at the center of all midwifery training, whether it be within the apprenticeship model or at a residential midwifery school. Here is where the midwife is made—by the forced integration of all theoretical learning and hands-on skill development with the actual practice of midwifery. In the context of a formal educational program, this component of midwifery training is named the preceptorship. The key difference between a preceptorship and an apprenticeship is that a preceptorship is a relationship among three parties: the student, the midwife and the program or institution. The role of the institution is to create a format for the student's clinical training, and then support and provide resources to both the student and preceptor.

The following survey results of midwifery school administrators show that not all preceptorships or apprenticeships are created equal. This questionnaire was designed to collect data on the clinical components of midwifery schools, and to elicit what current midwifery educators see as the qualities of an effective preceptorship or apprenticeship based on their years of experience guiding students through this component of their programs. The survey was conducted through an on-line survey tool (surveymonkey.com) and was sent to all 10 MEAC accredited schools, 24 non-accredited direct-entry schools, 35 university-based nurse midwifery programs, and the 5 Canadian direct-entry midwifery programs. Each program was asked to submit only one completed survey so as to give each program equal weight in the results. There were 15 responses to the survey, representing 11 direct-entry midwifery programs (7 private, 3 university-based, 1 community college-based) and 4 CNM programs. Five respondents represented distance learning programs. Following is some of the basic demographic data collected from these 15 respondents.

Numbers of students your program has in clinical sites at any one time:

1-5 students	13.3%	26-35 students	20.0%
6-15 students	13.3%	>35 students	26.7%
16-25 students	**33.3%**		

Who finds the clinical sites for your students?

The student	**37.5%**
The school administration	31.2%
Student and administration	18.8%
Other	12.5%

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School Profile:
Student Perspective on Midwives College of Utah (MCU)

By Heather Whitley - Second Year Student at MCU

I found that the paths to midwifery were as varied in their philosophies as their locations. As a mother of three and deeply rooted in my community, it was clear to me that a comprehensive study abroad would not be a good fit. I desired a program that offered a rigorous tempo of academic learning (I majored in finance and had no previous healthcare study) and a clear means for guiding me on my way toward clinical accomplishment. As a three time consumer of midwifery services, I feel that the accessibility of information over the internet brings clients into homebirth who are more informed and seeking credentials than perhaps in other generations. This made me desire a MEAC accredited distance program with a solid base in didactic learning.

With these parameters in mind, I knew I had found the school that was a perfect fit for me when I discovered the Midwives College of Utah. Their mission statement clearly describes the values upheld by former president Jodie Palmer and recently inaugurated president Kristi Ridd-Young. It feels as though every staff and faculty member has this mission integrated into their work. This is demonstrated in their dealings with students.

Midwives College of Utah's (MCU) mission is to build midwives of technical expertise, professional excellence, and personal greatness—namely, Midwives of Excellence®. MCU midwives will be pivotal in the "tipping" revolution of maternity care and birth culture throughout North America in the 21st century.

MCU's method for building Midwives of Excellence® is to meld professional and leadership education. Professional education prepares students for expertise in their chosen profession; leadership education teaches students "how" to think. Together, professional and leadership education will build:

Midwives of Technical Expertise
- Mastery in the depth and breadth of midwifery care
- Access, analyze & apply information
- Think critically and creatively
- Honed sensitivity to inspiration

Midwives of Professional Excellence
- Create community and business resources
- Influence community, political & business systems
- Read, write & speak with impact
- Mastery of the art of relationship and diplomacy
- Committed to professional accountability & ethics
- Committed to life-long learning

Midwives of Personal Greatness
- Personal integrity & professional ethics
- Humility to always be learning
- Clear vision regarding their unique role and mission
- Depth of knowledge necessary for leadership
- Wisdom gained from experience

First and foremost, the MCU program offers a rigorous education that is curriculum-based. This greatly benefits students like me who have no prior background of study in the field of healthcare. My undergraduate business education was from a large university and I underestimated the complexity of a "distance midwifery program". I have been pleasantly surprised at the aggressive tempo and quality coursework offered at MCU. It is clear to me that a great deal of thought has gone into course and curriculum development. The syllabi draw masterfully from varied texts such as Varney's as well as Frye's work simultaneously – giving me some insight as to which texts might be good future references for certain situations requiring review when I am in practice.

The MCU staff has recently implemented major technology upgrades now being utilized by many students. Students can take courses and even exams online, as well as submit coursework securely online. This not only manages tuition by reducing staff time and wasteful paper generation, but hastens grade and feedback time since instructors receive submitted work more rapidly than regular mail. Making payments securely online is another wonderful benefit the school offers. Some students (me) continue to use handwritten assignments, so that we can bring our work to children's activities such as ballet, music lessons, etc. Email correspondence is also handled entirely through the secure MCU messaging system. Now, my school-related emails are organized in a designated place and not commingled with my personal email account.

I have found staff and faculty to be very responsive and encouraging. MCU is committed to offering students coaching and annual assessments of student progress along their major map of study. If I have communication challenges with my local preceptor midwife, MCU staff members are fantastic in coaching me through the "crucial conversation" process to find a solution. The student body is very well connected through online group postings. It is a great forum for students to receive information on course questions, clinical site questions, locate study groups and find support!

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This bulletin is coordinated by the Outreach to Educators Project, a project funded by a grant received by the Midwifery Education Accreditation Council (MEAC) from the Daniels Foundation. The mission of the Outreach to Educators Project (OTEP) is to strengthen the organizational capacities of direct-entry midwifery education. All midwifery educators are invited to contribute to this newsletter. The deadline for submission to the next issue is July 1. Send articles, letters, calendar items, or other submissions to OTEP at birthwise@verizon.net or 24 High St., Bridgton, Maine 04009.

Clinical Training for Midwives . . .

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Types of preceptors used in your program:

	Exclusively		Mostly		Sometimes		Occasionally		Never	
CPMs or Licensed Midwives	0%	0%	**82%**	0%	9%	33%	0%	0%	9%	**67%**
Certified Nurse Midwives	0	25	20	**75**	**50**	0	30	0	0	0
Uncredentialed Midwives	0	0	0	0	10	0	40	0	**50**	**100**
Family Practice Physicians	0	0	0	0	10	0	**45**	33	**45**	**67**
OB/GYNs	0	0	0	0	9	0	**64**	33	27	**67**
Advanced Practice Nurses	0	0	0	0	30	33	**50**	**67**	20	0

Left column= DE programs Shaded= CNM programs

Types of birth sites used in your program:

	Exclusively		>75% of births		50-74% of births		25-49% of births		<24% of births		Never	
Hospitals	0%	25%	11%	25%	11%	**50%**	0%	0%	**78%**	0%	0%	0%
Free standing birth centers	0	0	18	0	9	33	**55**	33	18	33	0	0
Private residences	0	0	27	0	**36**	0	18	0	0	0	18	**100**
Hospitals outside the U.S.	0	0	0	0	0	0	0	0	**78**	33	22	**67**
Clinics/birth centers outside the U.S.	0	0	0	0	0	0	10	0	**70**	33	20	**67**

Left column= DE programs Shaded= CNM programs

How many births must a student document in order to graduate from your program?

	40 Total	50-52 Total	60 Total	75-80 Total	No # requirement
Total #'s of births required	18%	27.5%	9%	27.5%	18%

Do you give advanced status to students who have birth experience prior to enrollment in your program?

Yes 42.9%
No 57.1%

Availability of Clinic Sites:

	Direct entry programs	CNM programs
We have more than enough	0%	0%
We have an adequate number, but not many more	**63.6**	**75**
We struggle to find enough sites	36.4	25

Does your program provide liability insurance for students working in preceptorships?

	Direct entry programs	CNM programs
Yes	18.2%	**100%**
No	**81.8**	0

Do your students ever get paid during their preceptorships?

	Direct entry programs	CNM programs
Often	9.1%	0%
Sometimes	18.2	0
Rarely	27.3	0
Never	**45.5**	**100**

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Clinical Training for Midwives . . .

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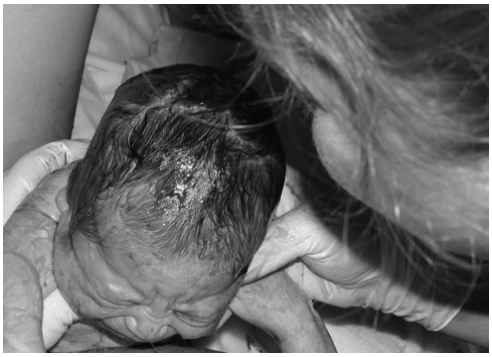
The Making of a Quality Clinical Experience



The response to the questions about quality of clinical sites almost unanimously indicated that the attitude of the preceptor and her relationship and communication with the student were the most important factors in a successful preceptorship. Facility, the volume of births, and preceptor credentials all took a back seat to nurturing qualities of individual preceptors. These were rated as most effective in helping students progress in their education. As this is a survey of administrators of midwifery schools, it is understandable that the answers focused on the fertile environment (classroom) that its preceptors were expected to create, rather than on the responsibilities of the student. Administrators seemed protective of students and believed that a student should be in a quality preceptorship, and not need to extract her own education from a busy and potentially disinterested or demeaning preceptor who seems more interested in free labor the student provides than in her growth as a midwife. I may have gained a different perspective had I surveyed preceptors, but the "school of hard knocks" approach to training professionals, common in many medical school clinical training models, does not seem to have a place in the midwifery model of mentoring new midwives, at least with those who responded to this survey. When remnants of a more Darwinian approach to clinical training were observed by these administrators, they were almost universally dismissed as unhelpful and counterproductive towards the goal of building confidence and skills in students. It was encouraging to see that the nurturing support and empowerment aspects of the midwifery model of care seem to extend to the training of our new midwives. Much of what I heard from the participants in this survey is summarized in the following description of a quality clinical site.

A preceptor who practices safely, is not burned out, who places reasonable demands on the student, communicates effectively, does not engage in gossip or other unprofessional behaviors, understands and supports students through the emotional and psychosocial challenges of midwifery, understands the academic demands on the students, and is a good role model.

Other responses describing what makes for a quality clinical site:

- ***Ability of preceptor to step aside to provide students with the opportunity to learn by experience. X3***
- ***The attitude and professionalism of the preceptor. X2***
- ***Good working relationship with the students. X2***
- ***Supportive , nurturing, experienced preceptors. X2***
- *The best sites are the ones that match the needs of each particular student. Some students need a lower volume, with more time to integrate their didactic training while other students thrive in high volume immersion. Just as we have all types of students we have and need all types of clinical sites for our students to grow in the way that works best for them to become professionals.*
- *Willingness and ability to teach and supervise.*
- *Clients who allow student participation.*
- *The best experiences for students have been with preceptors who have trained by apprenticeship. Those who have limited experience with one-on-one training and continuity of care have expressed the greatest challenges in their work with an apprentice.*
- *Preceptors that understand the student role; such sites will work with students on their schedules without putting undue pressure on the student to be present for clinic duties beyond what is normally expected in a predetermined schedule.*
- *The site should not be dependant on student labor to provide services.*
- *Preceptors need to be able to provide constructive feedback on a regular basis and be able to determine when students are ready to increase their hands-on learning.*
- *Sites that like to work with students, that are more cautious than renegade, that make students feel confident and not intimidated, but always encourage them to step a bit outside their comfort zone in order to learn more hands-on.*

What is the greatest obstacle to finding and maintaining quality clinical sites?

The responses to this question varied, although a major theme emerged: there is a perceived scarcity of preceptors willing/able to work with students. Some of the reasons for the shortage were stated as follows: small numbers of OOH births in the U.S., students perceived as creating too much burden for the midwife, liability issues, resistance of other maternity care providers to help train CPMs, bad past experience with students, and seeing students as future competition, especially if they were planning to stay in the area where the preceptor practiced. Other obstacles to finding clinical sites that were identified:

* *Barriers to midwifery practice in general.*
* *Having clinical faculty feel that they are a part of the total educational process of each student.*
* *I hope midwives can trust the apprenticeship process as much as they trust birth. I hope that the spirit of generosity and reciprocity endures between midwives and apprentices. I hope that gratitude and humility replace entitlement.*
* *The philosophy that the student is used as an unpaid employee.*
* *Laws and regulation in various states and provinces that prevent current midwives from practicing and/or performing certain clinical skills.*

Rank the following criteria in order of importance when evaluating the quality of a clinical site (1 is most important):

	1	2	3	4	5	6	7	8	Ave	Ave. Rank
Volume of births	0	1	0	1	1	2	1	2	5.75	**8**
Credentials of preceptor	0	0	2	2	1	1	2	0	4.88	**6**
Level of supervision	2	1	1	1	3	0	0	0	3.25	**1**
Professionalism	0	1	1	2	2	0	0	2	4.88	**5**
Philosophy of care	1	1	2	0	0	1	1	2	4.75	**4**
Willingness to let students do primary care	2	2	1	1	0	1	0	1	3.38	**2**
Match with the particular student	2	1	1	0	0	3	1	0	4.0	**3**
Quality of the facility	1	1	0	1	1	0	3	1	5.13	**7**

(Only 8 respondents understood my directions for this question and completed it as intended…)

Participants were asked to rate the following methods of clinical training according to its usefulness in training midwives:

	Essential		Import-ant		Can be helpful		Not useful		Has neg effects		N/A	
High volume sites (>10 births per month)	0%	33%	40%	33%	**50%**	33%	0%	0%	10%	0%	0%	0%
Slow one on one mentorships	20	0	**60**	**67**	20	33	0	0	0	0	0	0
Foreign sites	0	0	0	0	**90**	33	0	33	0	0	10	33
Multiple preceptors	10	0	30	0	**60**	**100**	0	0	0	0	0	0
Home birth	**60**	0	30	33	0	33	0	0	0	0	10	33
Birth center	0	0	**60**	33	40	**67**	0	0	0	0	0	0
Hospital	0	0	20	**67**	**60**	33	10	0	10	0	0	0

Left column = DE programs Shaded = CNM programs

Challenges Encountered in Clinical Placements

A section of this survey solicited information from administrators on some of the challenges or difficulties that arise when placing and following students through their clinical training. 85% of respondents acknowledged they often or occasionally had students enrolled in their programs who were difficult to place in a clinical site. Following are some of the strategies used with these students:

- ***Try to find the best match for each student. X4***
- ***Work with them on basic clinical skills, interpersonal relations, and professionalism. X3***
- ***Students sometimes work at high volume sites first to get some experience and confidence. This gives the student a jump start. X3***
- ***Work closely with the clinical faculty to monitor the particular special needs of the student. X3***
- ***Try to remedy the challenging aspects of their persona. X2***
- *We have had students meet with a professional counselor to support and work through the particular concerns or issues.*
- *Any student who may be challenging must have clinical with the (academic) faculty.*
- *Develop explicit behavioral criteria for the student.*
- *Designate a probational "trial" period to evaluate how well the student is progressing.*
- *Work together with the preceptor to give the student feedback and the chance to self-assess and remediate to meet expectations.*
- *We have had a couple of students work with only certain clients in a practice that the preceptor thought would be OK with the student (because of dreads, tattoos, piercings…)*

Handling situations where students are reporting discomfort regarding management practices that are counter to their training.

Many responses to this question were quite similar and can be summarized in this one response:

We encourage the student to address it with the preceptor in private—to approach it as a learning opportunity and explain the discrepancy to the preceptor without judgment. We stress that there are different styles of practice and try to counsel the student on ways she can differentiate between practice variation and just plain poor practice.

Sometimes discomfort with management is the student not entirely understanding the decision.

If it is a situation that clearly seems unsafe, the student may be encouraged to resign from the preceptorship if no resolution can be found, or not participate in certain cases that she is not comfortable with.

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Other responses were:

- ***We support our students and preceptors doing regular debriefing after each birth or clinical situation so that the student understands the rationale for all management decision made. X2***
- *Part of the Clinical Seminar course is an opportunity to speak in a confidential and closed forum with classmates and their instructor about the variety of management decisions they have encountered.*
- *We have had to ask certain preceptors to change practices in order to accommodate the safety requirements for our students.*
- *Our program can remove a preceptors right to precept our students following a peer review.*
- *As responsible adult professionals, students must navigate their own professional relationships.*

Foreign Sites

The use of high volume clinical sites in underdeveloped countries has been controversial in the midwifery community. Some question whether students learn the midwifery model of care, whether students receive proper supervision, and some have ethical objections to students practicing on indigent populations. These and other objections are hard to deny, but some argue that the benefits outweigh the risks, especially considering the lack of options for many student midwives. School-trained and apprentice-trained midwives alike have trained at foreign sites, largely due to the scarcity of training opportunity in their own communities or as a way to accelerate their training. This trend was the impetus behind the minimum of 1-year clinical experience that NARM requires—apprentices can no longer go to a busy birth center and finish all their clinical requirements in 3 months time and expect to sit for the NARM exam.

As shown in the table on page 3, 80% of DE midwifery programs use foreign sites for some of their students, while 67% of CNM programs stated they **never** placed students overseas. When asked what the advantages and disadvantages of foreign sites were, I was given a fairly comprehensive list on both sides. I sense that with better and more options state-side, most schools would prefer their students stay within the U.S. for their preceptorships. For now, however, students will most likely continue to travel to far-off lands to complete their graduation or certification requirements.

Advantages:

- ***High volume X5***
- ***Experience with another culture X4***
- ***Students see many types of birth and complications when are working in poor countries lacking appropriate medical care. X3***
- ***Students gain confidence and trust in their education and their skills. X2***
- ***Lots of autonomy for the student X2***
- *Many births in a short time created a kinetic learning experience that is very powerful.*
- *Suture experience.*
- *Non language communication skills.*
- *Experience a culture which accepts birth as a part of life. There seems to be more widespread belief that birth is normal and low tech methods for working with birthing women are more often employed.*
- *Expanded gratitude and compassion.*
- *Identifying clear priorities in the face of adversity.*
- *Students gain experience in skills they would not have under the rules and regulation in the U.S. (i.e. breech).*

Disadvantages:

- ***Student is exposed to some harsh situations where the U.S. midwifery model of care is not supported or even understood. X4***
- ***Assessing the level of supervision in these sites is difficult. X4 For this reason in our program, foreign clinical rotations are only available to senior level students who have already participated in a significant number of supervised primary level births and who have completed the midwifery complications course***
- ***Language barrier. X3***
- ***Can be emotionally challenging and sad. X3***
- ***We cannot monitor the quality of care or the safety of the facility. X2***
- ***Too fast X2***
- ***Lack of continuity of care. X2***
- *Different kind of practice; need for re-socialization on return.*
- *Some sites are "actively managing" birth, so the philosophy is not midwifery based, though in a midwifery setting.*
- *Preceptor less willing to mentor.*
- *Lack of understanding of the consequences of using "western" birth practices (interventions) without the support system of a hospital in the event that the intervention causes an emergency.*
- *Isolation from support network.*
- *Students may become lax in sterile technique or in using short cuts after working in situations where it is nearly impossible to maintain higher standards (high volume, lack of personnel, no supplies, etc.)*
- *Students need to be properly prepared for third-world environments where they will see less intervention, less attention to the birthing woman's psychosocial and emotional needs, morbidity and mortality treated without the cultural niceties we are used to (and in some cases what we consider barbaric). They need to be taught how to prevent contracting diseases from food and water consumption. They need to be protected and kept safe. They need to be able to debrief after upsetting experiences, and put them in cultural perspective.*
- *Expensive.*
- *Some ethical issues.*

The Ideal Preceptorship

What characteristics of a preceptorship help the students learn and progress most effectively?

- ***Regular evaluations and debriefing sessions. X4***
- ***Nurturance, warmth, open communication X4, flexibility***
- ***Established goals. X2***
- *Clear expectations of thestudent communicated by the preceptor and the school.*
- *Repetitive experience.*
- *Continuity of care.*
- *Confidence in the student's abilities.*
- *Egalitarian interaction.*
- *Good, honest, realistic yet positive feedback, opportunities to practice hands-on skills, adequate supervision, and a supportive nurturing environment. A good student-preceptor fit.*
- *Encouragement when needed, setting limits, and reigning in the student who is too cocky.*
- *A didactic preceptor who pushes the student to progress, encourage the student to think critically and figure out management on her own, sit back and let her take a leadership role.*

What characteristic can inhibit a students' learning and progress?

- ***Correcting or criticizing the student especially in front of the client. X5***
- ***Inflexible preceptors X2***
- ***Miscommunications of all sorts. X2***
- ***Placing unreasonable expectations on the student's time or skill level. X2***
- *Confusion of or lack of clear expectations.*
- *Poor organization and scheduling.*
- *Inability of preceptors to give feedback that is less than positive.*
- *The challenge telling a student that they are not doing well and how they could improve or when the preceptorship is not working out.*
- *Burnt-out preceptors who lack the patience and desire to teach.*
- *Fear of the student taking some of the midwife's business if the student is staying in the same area.*
- *Lack of time to participate in the student's education.*
- *Negative comments about the student's educational program.*
- *Triangulating the student.*
- *Inappropriately pushing the student or holding the student back.*
- *A preceptor who expects the student to learn by osmosis.*

Following are a few descriptions of ideal scenarios for clinical midwifery training offered by the respondents:

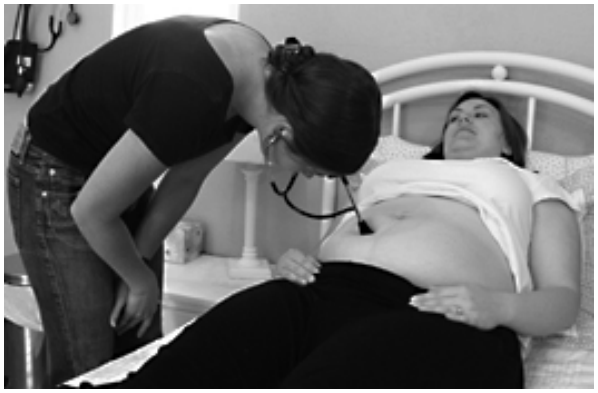
•It would be a site right next door where we could monitor fully the interactions between the students and the preceptors and have the ability for quality control of our students' clinical education.

•Community-based, home birth midwives in a sustainable group or shared practice, surrounded by numerous supportive midwives with diverse life experience and practice styles. I want students to see how midwifery practice can be healthy for the midwife as well as the families she serves.

•Settings that provide high quality care that reflect midwifery standards; provide appropriate supervision; offer students opportunities for hands-on care as they demonstrate their readiness; include students in every aspect of the practice including management meetings, business operations as well as client care; communicate frequently with faculty and are able to operate independent of student 'labor,' keeping the student free to concentrate on learning without feeling guilty for not being involved in keeping the practice viable.

•Preceptors who have good, thriving practices, who are good business people as well as clinicians, who have a large and varied practice, who have enough experience to provide good supervision and clinical teaching, who practice ethically and within the law/rules, and who are not burned out personally or professionally. Preceptors who communicate promptly with the educational program, who answer emails, complete evaluations, and participate in events.

•An abundance of CPMs with fairly busy practices who felt a commitment to training midwives and had a practice style we were comfortable with. 3-4 busy birth centers that continually took our students. 3-4 family planning clinics that would rotate our students. 5-6 hospital CNMs who would rotate our students. A free prenatal clinic for immigrants or other low-income people that would rotate our students. No foreign sites.



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The Syllabus: The First Step Toward Student Success

Justine Clegg, MS, LM, CPM
Miami Dade College Midwifery Program Coordinator and Faculty

The syllabus is a very important part of a course. It serves as a blueprint or recipe for the student to follow to understand what is expected to successfully pass the course. Each individual course should have its own syllabus, which should be given to the student at the beginning of the course. I like to spend the first hour of the first class going through the syllabus page by page, so students know exactly what to expect. From the syllabus, the students should know what textbooks to buy, what assignments are due and when, what class activities and other events will take place, when quizzes and tests will be given and what they will cover, how the final grade for the course will be determined, and any other specific requirements you have for the course.

Additionally, a syllabus can serve as a vehicle for "articulation" – the process whereby a student can transfer credit for course content learning from one educational institution to another. If a student takes and passes ENG 1101 at the local community college and it has the same content as ENG 101 at the local university, she should be able to transfer credit and not have to repeat the course. If a student takes and passes a course called "Life Before Birth" at a Bible College which was the same in length and similar in content to the Midwifery College's course "Embryology," she needs your syllabus as well as her transcript to request credit via course substitution, another method of articulation.

The syllabus begins with the course number and title, the term/semester it will be taught, the number of credits, and the days, dates, hours and location that the class will meet. For example:

Course:	MDW 101 Introduction to Midwifery
Semester:	Fall 2007
Credits:	3 credits/45 hours lecture, 1 credit/30 hours lab
Schedule:	Monday 9:30 am to 12:30 pm September 10 – December 17, 2007
Location:	Building 1 Room 23

The next section tells the name and credentials of the person teaching the course, the department, the instructor's office hours/availability to the students, and contact information (telephone, fax and email). This lets students know when you are available to meet with them individually, how to submit assignments via fax or email, and how to reach you in case of emergency. For example:

Instructor:	Susan Smart-Midwife, B.S., L.M., C.P.M.
Department:	Midwifery
Office:	Building 2 Room 15
Office hours:	Mondays 1:00-3:00 pm and by appointment
Telephone:	123-456-7890
Email:	smart.midwife@abc.edu

The course descrip-tion is a brief, one paragraph summary of what you will teach in the course. It should match the description in the school's catalog. For example:

> Course Description: An introduction to the fundamental principles of midwifery with emphasis on basic health care skills, medical terminology, charting, documentation, history taking, physical assessment, communication skills and consumer advocacy.
>
> Prerequisites: Anatomy and Physiology, Doula certification
>
> Co-requisites: MDW 102 History of Midwifery
>
> Instructional Approach/Strategies:
> Lecture, demonstration, small group assignments, practicum skills in lab, written tests and exams and skills demonstration.

Course competencies and objectives tell the student what skills she's expected to possess after successfully completing the course. For each competency there will be several objectives. Each competency and objective uses a verb to give a behavioral explanation of the knowledge and skills the student will learn from this course. The lectures, learning activities, and assignments teach the content. The quizzes, exams, and skills testing evaluate how well the student has learned the content. For example:

MDW 101 Course Competencies
Competency 1: The student will document a comprehensive and thorough assessment of client health status

1.1 define medical terminology used in midwifery documentation
1.2 take a complete client history by using midwifery-appropriate charting forms and language
1.3 perform a complete physical exam by using appropriate equipment including stethoscope, blood pressure cuff, otoscope, ophthalmoscope and taylor hammer
1.4 compare and contrast the normal physiologic changes of pregnancy with the woman during the non-pregnant state by a review of systems
1.5 use principles of therapeutic communication to elicit client information
1.6 identify and use methods for infection control by applying OSHA requirements and universal precautions in client care
1.7 safeguard client confidentiality by adhering to HIPAA regulations

The student needs to know what textbooks, supplies and equipment she will need for this course. Often textbooks and equipment will cost more than the tuition for the course. Students can be directed to book loan programs, scholarships, grants, and sources for purchasing used books and equipment. Some student grants will only allow the student to purchase books and equipment from the

college bookstore. A group of students can contact a publisher or medical supply distributor and arrange for group discounts and free shipping to buy textbooks and equipment at reduced prices. The students will need the author, title, publisher, year, and ISBN number, so the syllabus should supply this information. For example:

Textbooks
- Dillon, Health Assessment, 6th Ed. Davis Publ. ISBN 0-8036-0882-9 (2 CDs)
- Weaver and Evans, Practical Skills Guide for Midwifery, 4th Ed, Morningstar Publ. ISBN 0-9642387-0-5
- Varney, Helen, Midwifery 4th Ed. Jones & Bartlett
  Davis, Elizabeth, Heart and Hands: A Guide to Midwifery, 2nd Ed. Pub Group West. ISBN: 0-912528-222
- Frye, Anne, Holistic Midwifery, Vol. I & II. Labrys Press.

Medical dictionary, latest edition, choose one of these:
- Taber's Cyclopedic Medical Dictionary, F. A. Davis, or
- Mosby's Medical, Nursing and Allied Health Dictionary, Mosby-Year Book, Inc

Equipment: required
- Blood Pressure Cuff
- Stethoscope
- Watch with second hand
- Tape measure in cm and inches
- Penlight/flashlight

Equipment: suggested/optional
- Taylor (percussion) hammer
- Otoscope/Ophthalmoscope
- Tuning fork
- Thermometer

Course requirements let the student know the schedule of assignments, the teaching calendar, the course outline, dates that assignments are due, and the dates and procedures for withdrawing from the course. This allows students to prioritize their assignments and allocate the time required to meet deadlines. Include a schedule of class content, activities, quizzes, tests, homework and assignments due for each day the class is taught. Include emergency information; for example, we include hotline contact information for pending hurricane information.

Classroom regulations explain your policies: attendance requirements, what to do in case of emergencies, whether students will be excused to attend births, whether eating and drinking is allowed in class, policies regarding cell phones and pagers, babies and children in the classroom, penalties for turning in assignments after the due date, and so forth. Each instructor may set her own policies, or program-wide policies may be adhered to for all courses. The policies should be detailed enough to be clearly understandable, flexible enough to accommodate emergencies and firm enough to maintain structure and order. Be as precise as possible in order to avoid questions and problems that may develop later. Students appreciate clarity and equitable policies.

State your course policies for attendance, lateness, class participation, making up missed assignments, illnesses/emergencies, extra credit, academic honesty, classroom behavior (acceptable/unacceptable), students with special needs, student feedback of instructor, use of student work, emergency procedures and safety rules.

The instructor needs to take control of the teaching environment by enforcing the policies as set forth in the syllabus. If exceptions are allowed, they should be clearly explained in the syllabus and applied fairly to all students. Methods of dealing with chronic problems can be built into the syllabus. For instance, if students tend to arrive late, the instructor can assign a short quiz at the beginning of each class to cover the previous week's material. The instructor could allow students to make up these quizzes under specific circumstances, or not at all. If the total for the quizzes was 10% of the course grade, then students know at the beginning of the course how much their grade will be affected by being late and not taking the quizzes.

The student needs to know how the course grade will be determined, what percentage of course mastery is required to pass the course and for each letter grade. The more specific you are about your expectations and requirements, the clearer it will be for the students.

Grade determination
The student's final grade will be determined as follows:

15% quizzes
15% assignments
20% lab skills
10% small group project
20% final written exam
20% final practicum exam

Lab skills
Each lab skill must be passed before progressing to the next skill level. A minimum grade of C is required for each lab skill. The skills grading criteria is as follows:

A = consistent superior ability, needs no direction
B = consistent above average ability, minimal direction needed
C = demonstrates acceptable ability, requires some direction
D = inconsistent performance, not competent in all requirements, needs ongoing guidance and frequent direction
F = unacceptable performance, lacks competence, unable to function without direct guidance

Grading system
The student is required to pass each course with a grade of C or better. The grading system for the Midwifery Program assignments, quizzes and examinations is:

A = 94% 100%;
B = 87% 93%;
C = 80% 86%;
D = 72% 79%;
F = below 72%

(Continued on page 10)

The Syllabus . . .

(Continued from page 9)

A student who is having difficulty earning a grade of C or better is responsible for seeking assistance from her instructor or clinical preceptor. Every reasonable effort will be made to assist the student to provide opportunity for extra practice with laboratory equipment and supplemental assignments. A student who is unable to earn a grade of C or better, or is unable to pass a clinical skill, will be required to repeat academic and/or clinical course work until she is able to earn a satisfactory grade.

A student who maintains an average below 80% will not be allowed to continue with clinical course work or clinical experiences.

The next section of your syllabus should explain what support services are available to help students, with contact/ access information: library, labs, learning resources, tutorials, web resources, study groups, and so forth.

You may also want to include one or more of these in your course syllabus:

- Statement about your teaching/learning philosophy
- Supplementary material to help students succeed
- Space for the student to write down 2 - 3 class members' names, telephone, and email to contact if they miss class
- Contract & signature
- Your suggestions for success
- What you expect of students and what they can expect from you.

Some teachers like to have students sign a statement that they have received the course syllabus and have had a chance to ask questions, to avoid any claims in the future that she did not understand what was required. This can be added to a card for each student in which she gives her emergency contact information, gives permission for her contact information to be distributed on the class list, and so forth, that is customarily obtained at the beginning of each semester.

Here are some sources of additional information on developing a syllabus

- How to Construct an A+ Syllabus (A Teaching for Success Quick Course) http://webftp2/ctd/tfs/index.htm
- Designing a Learning-Centered Syllabus http://cte.edu/syllabus.htm
- New Faculty Survival Guide-Syllabus Preparation http://www.csun.edu/~newfac/syllabus.htm
- Constructing a Syllabus http://www.brown.edu/Administration/SheridanCenter/Publications/Syllabus.htm
- Creating a Syllabus http://teaching.berkeley.edu/bgd/syllabus.html
- Grunert, Judith. The Course Syllabus: A Learning Centered Approach. Anker Publishing Co. Bolton, MA, ISBN 1-882982-18-5

Clinical Training for Midwives . . .

(Continued from page 7)

Conclusion

Conducting and collating the results of this survey has been a fascinating process. In conclusion, I would like to highlight a few of the observations I have made as I have conducted this survey.

Style of training

It seems clear that the midwifery model for mentoring midwives is a supportive one, where the preceptor's role is similar to the role of a midwife with her client. Students are believed to respond well to a nurturing mentor who can guide her gently and at the same time, assure her she is capable of the challenges that midwifery training presents. A deliberate approach to clinical training that guides and encourages the student to step into a primary caregiver role as she becomes ready and does not rely on intimidation to motivate seems most effective in a midwifery setting.

Shortage of quality sites

Most of the respondents of this survey experience a lack of abundance of quality clinical sites for their students. I suspect many of us resort to less-than-ideal sites for our students because of this scarcity. For CPMs, this hardship may be relieved as the numbers of OOH births increase or as CPMs become more familiar to other maternity care providers. There may be a place, however, for more support and training for midwives who are working with students, and a gentle reminder to practicing midwives of their professional responsibility to participate in the training of our future midwives.

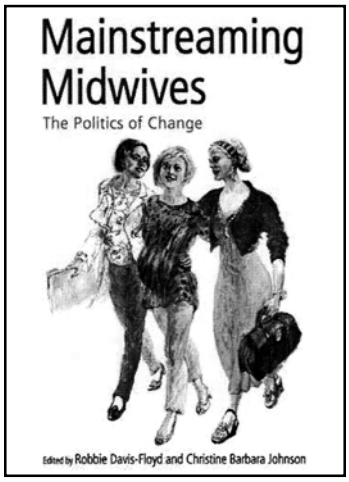
Foreign sites are useful on a limited basis

Although most direct-entry programs currently use foreign clinical sites for their students, there are many acknowledged disadvantages to these sites. I sense that as more local sites become available, the foreign sites may be phased out or used on a very limited basis. The stated advantages of foreign sites— volume, autonomy, broader range of experiences, cross-cultural experience— perhaps should become a goal for educators to strive for within our own regions.

Maternity clinics in underserved areas of the world are an exciting and potentially useful mission for midwives to support, especially if they are designed to empower native care providers to continue the care once we leave, but perhaps fully trained midwives would be the more appropriate ambassadors to send into these sometimes harsh and poorly supervised settings.

Uniting Midwives for the Mothers

Book Review by Allison D. Israel, MA, Interim Board Vice President of MEAC



"Realizing where you came from can help you fully see where you are." Melissa Denmark, Mainstreaming Midwives, page 256.

All of healthcare is in the process of transformation and potential healing. If we are going to heal midwifery, we need to read *Mainstreaming Midwives*. Be it midwife or midwifery advocate/consumer, it is of utmost importance that we realize the culture of midwifery and childbirth in the United States. We need to see what unites us and what fragments us within the cause.

After two years on the board of MEAC and as a fellow anthropologist, (author/editor Robbie Davis-Floyd is a cultural anthropologist), I have been attempting to understand the riffs within midwifery so that I may be a part of the healing process. After reading *Mainstreaming Midwives*, I see that Robbie and co-author/editor Christina Barbara Johnson have done such work.

Robbie reminds us of her term 'postmodern midwifery' that she had coined in a previous work (2002). The self-reflective nature of postmodern midwifery potentially inspires all participants in the midwifery movement and alternative birth movement. Self-reflection and assessment creates an opening within ourselves to see the true impact that bridging the professional and the political with conscious child birthing can bring to our fragmented world.

I can understand why some content of this book may be viewed as controversial. As the modern world pushes towards more information and more formalized education, often at the cost of emotional and physical well-being, midwifery presents the next paradigm: a focus on wellness within birth as a normal, natural, non-medical part of life.

> What I observe over and over is that every time these midwives face a choice between enhancing their public image as healthcare commodities and compromising their values, their practices, or their training programs, they let go of image and concentrate on what works and what in their eyes, preserves the essence of who they are. (Robbie Davis-Floyd, page 195).

Mainstreaming Midwives teaches us about the culture of midwifery and challenges us to see the obstacles we may not have realized were preventing the future success of "creating a midwife for every mother." Uniting as midwives together, within the profession is crucial for this future. "And when the midwifery community publicly displays its divisions, that community becomes less able to articulate its needs and more vulnerable to scrutiny and criticism"(page 281). This leads to one conclusion of the important goal of bringing all midwives together, including the organizations to which they belong; "to acknowledge the contributions of each to the survival of midwifery" (page 534).

Another key point the authors pose is that midwives continue being conscious of the culture in which they exist and their relationships with one another. The questions to be asked by midwives are: "What is my responsibility to the 'other' midwife? What is the best way to address this issue from a position of higher consciousness…?" (page 467)

The last chapter, "Why Midwives Matter," brought tears to my eyes. The authors bring words to describe the essence of why midwifery is so important— for the empowerment of women and families. Empowerment of the pregnant woman, her birth experience not only creates a positive outcome for birth but also for life. Robbie reminds us why we are all here involved with midwifery: "Midwives who fundamentally trust birth are more likely to be able to create an atmosphere within which women can find their own power and trust themselves to give birth" (page 172).

Providing examples of legislative successes and challenges in several states, the authors encourage the advocates of midwifery to indeed, try this at home.

I would recommend *Mainstreaming Midwives* to all consumers, activists of midwifery services, midwives, and midwifery educators; with this bigger picture of the culture and challenges of midwifery, consumers, advocates, and midwives can observe, critique, and then formulate a plan for the future of midwifery—together.

School Profile: . . .

(Continued from page 3)

MCU has incorporated financial incentives for students to stay on track. During the annual student review a monetary discount for next year's tuition is issued if a student has completed work according to the major map.

MCU is committed to graduating students who have the tools to open a sustainable practice. There is a deep dedication to the advancement of midwifery and out-of-hospital birth. Core midwifery classes are the backbone of the program with a variety of holistic credits completing a well-rounded curriculum. I have also received coursework in personality profiling and communication, not only to help me understand myself and my work habits but to identify common personality traits displayed by others. I am confident that this will greatly benefit me in gaining and retaining clients, partners, and members of the healthcare team. I find that faculty members are open to feedback. MCU is constantly evaluating and revising syllabi to make the coursework more meaningful to students.

In summary, MCU has exceeded my expectations in every way. I expect to graduate as a woman with a richer and broader perspective than before I enrolled. I will posses the tools to serve women and infants as a Midwife of Excellence.

Socrates the intellectual midwife

by Seán Moran

Introduction

The ancient Greek philosopher Socrates (470-399 BCE) was the son of a midwife. He often uses ideas from childbirth as metaphors for teaching, and in this dialogue, in which he tells the boy Theætetus of his midwifery credentials:

> Socrates: *"And have you never heard, simpleton, that I am the son of a midwife, brave and burly, whose name was Phænarete?"*
> Theætetus: *"Yes, I have"*
> Socrates: *"And that I myself practice midwifery?"*
> Theætetus: *"No, never"*

Socrates goes on to explain that he is a midwife of *knowledge.* He will help his companion deliver his thoughts and then conduct a health-check on them, but he is no teacher, for he has no ideas of his own to give to his student. Some of these claims strike modern teachers and tutors as a bit odd, and, as we shall see, a number of his midwifery allusions are horrifying to present-day childbirth practitioners. Nevertheless, he still has some valuable things to say to us about teaching and learning in today's obstetrics environment.

Claim to know nothing

A modern midwife might temporarily adopt a pose of ignorance and say to a student: "I want you to imagine I'm a primagravida and explain to me, step-by-step, what will happen during labour." But Socrates isn't just acting; his stance rests on a genuine belief that he knows nothing for sure. He expresses this professed ignorance via the fact that in his day, it was traditional only for women past their child-bearing years to become midwives:

> Socrates: *"You forget, my friend that I neither know, nor profess to know, anything about these matters; you are the person who is in labour, I am the barren midwife"*

Socrates shows a humane concern for his students and their difficulties in dealing with new ideas, expressed once again in the form of midwifely analogies:

> Theætetus: *"… I cannot shake off a feeling of anxiety"*
> Socrates: *"These are the pangs of labour, my dear Theætetus; you have something within you which you are bringing to the birth"*

Exposure

However, once an idea is born, Socrates does not deal with it in a nurturing manner, but rather puts it to the test to determine whether or not it should be allowed to survive:

> Socrates: *"Then this is the child, however he may turn out, which you and I have brought into the world. And now that he is born, we must run around the hearth with him, and see whether he is worth rearing, or is only a wind-egg and a sham. Is he to be reared in any case and not exposed? Or will you bear to see him rejected, and not get into a passion if I take away your first-born?"*

Here where we part company with Socrates, both pedagogically and ethically, but the reasons for his harsh views are worth exploring. The practice he mentions of running with the baby around the fireside - a sacred place in the ancient Greek house - was part of a naming ceremony *(Amphidromia)* which traditionally took place between 5 and 7 days after the birth. After surviving the first week, the baby was felt to be worth naming. However, if the child was disabled in any way, or was the product of a 'shameful' union, or in some cases simply had the misfortune of being the mother's first-born, he or she would often be 'exposed' by being left out in the open to die or be adopted by a passer-by. The neonate would be placed on the ground by the mother, and if the father picked the baby up, he or she would be looked after. If not, 'exposure' was the outcome. (Incidentally, some attribute to this ritual the origin of the phrase "to raise a child"). We may think of traditions such as this (and stories such as Oedipus' abandonment and the biblical account of Moses being abandoned in the bulrushes) as relics of the past, but unfortunately exposure and other forms of infanticide - particularly female infanticide – is still common in many countries, including China and India. For example, 60 million girls are estimated as 'missing' from the Indian population, according to a recent United Nations report (Leidl, 2005)

However, Socrates only personally deals harshly with unwelcome ideas, not unwanted babies. Can we accept this as a legitimate way of dealing with our students' misconceptions and intellectual wind-eggs (phantom pregnancies) or do we nowadays hold more enlightened views on these too?

Putting students' ideas to the test

Socrates' technique of dealing with the ideas born of his students - a process called *elenchus* - involved him in revealing fully and examining carefully their beliefs, by means of a relentless, forensic questioning. *Elenchus* is his intellectual version of running around the hearth with the baby, or the modern post-partum examination. At some point during this process, the illuminating power of the dialogue would bring to light inconsistencies among the various statements made by the student, who would then have to concede that the claimed knowledge was in fact illegitimate. This rather shamefaced admission would then lead to the 'exposing' of these intellectual babies, to make way for sounder offspring - a sort of educational eugenics. Socrates would first check for any multiple births:

Socrates: *"Are we in labour then, with any further child, my friend, or have we brought to birth all we have to say …?"*

The student would then be invited to think again:

Socrates: *"… try to conceive afresh … If you succeed, your embryo thoughts will be the better as a consequence of today's scrutiny, and if you remain barren, you will be gentler, and more agreeable to your companions, having the good sense not to fancy you know what you do not know."*

Socrates saw an apparently negative result - the demonstration of the limitations of a student's knowledge - as valuable in its own right. Also, his insight that education can usefully consist in 'drawing out' (from the Latin *educare*) putative knowledge from his student - instead of just cramming it in - and his willingness to engage fully with the ideas offered by the student – rather than simply dismissing them without showing how they are flawed - are valuable ones, but in both cases he goes too far.

Furthermore, shaming students into abandoning hard-won theories - flawed or not - is harmful both to their self-esteem and also to the tutor-student relationship. This habitual use of *elenchus* caught up with Socrates in the end and he made many enemies, who eventually saw to it that he was condemned to be executed (by drinking hemlock-juice [*Conium maculatum* – the active ingredient of which is a muscle-paralytic]) on a trumped-up charge of corrupting the youth of Athens. Of course there may be times in an emergency when a point has to be made unambiguously, and perhaps assertively – for example when the health of the mother or baby is in danger of being compromised by inadequate knowledge on the part of the midwifery student - but this should not be a routine educational technique.

Many trainee midwives have had significant previous experience as general nurses, so encouraging them to examine critically their own ideas and practices for flaws and opportunities for improvement is a more appropriate and professional starting-point for discussion than a merciless pointing-out of their shortcomings. An internalised Socratic interlocutor (a sort of 'inner teacher') is in many ways more useful, and certainly more available, than an external one. However, the change in status from experienced nurse to beginning midwife can be a stressful one, and students naturally feel exposed and underconfident, so support and esteem-building are vital accompaniments to more robust Socratic and didactic methods.

Conclusions

So what lessons has the philosophical son of an ancient Greek midwife for the present-day education of midwives? I feel that there are four:

1. Mentors and tutors of midwives can act as 'midwives for knowledge' by helping students to articulate their own pre-existing ideas. This is often a much better starting point for discussion than the stating of unchallengeable assertions by 'the expert'
2. Students are uncomfortable in delivering their new ideas and need reassuring that such discomfort is both natural and normal. A patient, supportive, nurturing manner is just as desirable during the training of midwives as it is during the delivery of babies.
3. The ideas articulated by the students can be put to the test during dialogue, and any misconceptions gently rejected. This joint construction of viable knowledge takes longer than a simple dissemination by the 'expert', but it is worth it because the learning which results is more firmly embedded in the minds of, the participants in the dialogue.
4. Having one's newly-delivered ideas rejected is distressing, but necessary if learning is to proceed. Some of these misconceptions are remarkably resilient, though, and will not always succumb immediately to simple exposure.

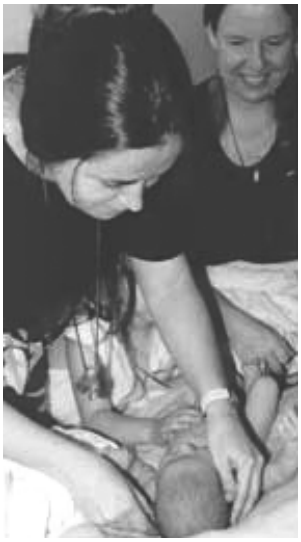
However, valuable as Socrates' insights are, there are two further conclusions with which he would not agree:

1. Not all learning can be 'drawn out' of the student. Some conceptual and procedural knowledge clearly has to be provided and demonstrated for the trainee midwife, but we should find ways of making this 'adopted' knowledge take its place in the student's family of ideas, alongside their own legitimate intellectual offspring.
2. Self-esteem is important for professionals, and too relentless a process of *elenchus* will undermine this in a harmful way. Just how far to go in a critical dialogue is a matter for judgement, based on intuition, experience and knowledge of the student. We should bear in mind the pressure that the students (and their tutors/mentors) are under during placements, and try to nurture the protégés into becoming better practitioners, rather than dispatching their misconceptions too cruelly.

Socrates clearly thought highly of midwives – *"…this midwife's art is a gift from heaven; my mother had it for women…"* – and believed that he too could act as a sort of midwife, but for learners. Today's tutors and mentors of midwives should take heart from their illustrious forebear – possibly the finest teacher the world has ever seen – and his midwife mother. His notions about teaching are not perfect, but we can draw inspiration from them nevertheless, and give birth to our own ideas – a result which the intellectual 'midwife' Socrates would be delighted.

Sean Moran lives in Tipperary, Ireland and teaches on three Master's Programs at Waterford Institute of Technology, a university level institution in the south east of Ireland. His particular specialities are pedagogy, adult education and mentoring, and he is currently undertaking doctoral research in the philosophy of education. This article is being published for the first time here.

Feasibility Study for Midwives



Following is a copy of a letter sent to MEAC from Ann Geisler at Dean Insurance:

You may have heard about this project over the past several months and I'm now contacting you directly for your support. Due to my long time devotion and programs for your profession, the insurance industry respects my opinions regarding the insurance needs for midwives/ birthing centers/schools. I was contacted mid-2006 by reinsurers who would like to support us in any efforts we may have to provide an insurance program in the future.

Before any undertaking can take place for another insurance program, I identified two critical areas:

1) past and current insurance programs have not been profitable for insurance companies due to claims. How do we prevent claims? How do we control their outcome and the costs? The only solution I could find is…arbitration…binding arbitration. And if it is implemented properly, will keep all claims out of the traditional legal system where we cannot win, even if we can defend, we cannot win with lay judges and juries.
2) The midwives/birthing centers need to "own" their insurance program and control their destiny to stop the roller coaster cycles that have occurred since the mid-70's. This is now possible through many different cost effective arrangements…captives, risk retention groups, etc.

Simply put, we need to control rates and claims outcomes. Ater conducting two "brainstorming" meetings last year (Albuquerque and Baltimore) attended by anyone interested in discussing this further, there was general consensus that this makes sense. Midwives are tired of insurance companies telling them how to practice, charging them rates that are unexplainable and settling claims that should be defended.

The next step…employ an actuary (a mathematician) to conduct a feasibility study. The actuary takes our data/outcomes/ exposures/demographics, factoring in the effect of arbitration to produce a rate that is actuarily sound, adequate, fair to all and can be interpreted by reinsurers, who help assume frequent or catastrophic losses to the group.

The initial study will cost $15,000. This document will take about 60 days to produce and the results will be available to all members funding the project. It will be a landmark study, one that has not been done before, with no bias placed by any one insurance company/reinsurer/underwriter. This is not just about homebirth midwives, hospital only births, or exclusive to birth centers.

This is not an easy process and one usually left up to the insurance company but wouldn't you want to know the outcome? I'm willing to continue investing time, effort and money (Dean Insurance has contributed $1,500) so all midwives will have a meaningful document to support and validate their professions goals to many audiences (consumers, peers, regulators, hospitals, managed care, and others). I'm hoping you will seriously consider this project and welcome your call!

Sincerely,
Ann A. Geisler, CPCU, CEO
(800) 721 – 3326, x202
ageisler@deaninsurance.cc

Median Salaries of College Administrators

In case you didn't read the recent articles in the Chronicle of Higher Education on the median salaries of college administrators by job category here is a sampling for your amusement:

Category	Master's level	Bacca-laureate	2-year program	Category	Master's level	Bacca-laureate	2-year program
Chief executive of a single institution	$212,800	$208,531	$146,718	Chief business officer	$139,900	$129,619	$98,477
Chief academic officer and provost	146,878	130,500	103,373	Chief admissions officer	73,844	72,500	60,400
Dean, nursing	104,572	80,044	80,000	Director, student financial aid	68,000	63,000	60,504
Dean, health-related professions	117,420	94,770	80,952	Director, distance learning	64,368	62,000	64,233

June, Audrey Williams, The Chronicle of Higher Education, VolLIII, Number 26, 2007

The Evolving Role of Seattle Midwifery School's Faculty

Suzy Myers, LM, CPM, MPH - Faculty, Seattle Midwifery School

(This article appeared in the Fall, 2006 issue of Giving Birth to Midwives with significant portions inadvertently omitted. The complete version is reprinted below.)

The recent faculty survey conducted by Heidi Fillmore-Patrick coincided with discussions underway at Seattle Midwifery School focusing on the role our faculty has played and changes we want to make to improve our program.

In 1978 when SMS began, the founders were all informally trained in an apprenticeship model with 2 family practice physicians and 1 lay midwife as our teachers. What we envisioned for our fledgling school was a formal program that, not only would lead to state licensure, but provide a strong "liberal arts" education for midwives, including, in addition to core midwifery knowledge and skills, a broad range of subjects such as statistics and epidemiology, the sociology and anthropology of the family and the role of birth in culture. We wanted our graduates to have a working knowledge of genetics and embryology, of gynecology and of childbirth education. We envisioned midwives who could negotiate their way in a changing and ever more complex health care environment, one in which, we hoped, professional midwifery would play an important role. We researched European midwifery schools and interviewed graduates of formal programs to glean what we could about structure and content of a curriculum. And all of this with no money!

Our first faculty were all volunteers, recruited to the worthy cause our pioneer midwifery school represented because they shared our passionate belief that this was a timely, needed project. In that first year, we had 2 CNM's who developed the core midwifery courses in antepartum, intrapartum and postpartum care, a Ph.D. geneticist on faculty at the University of Washington, a renegade (and underground) resident physician in obstetrics, a naturopathic physician, and several political scientists. We gave them carte blanche to create their own courses, with little specifications except title (i.e. "Genetics") and length (i.e. "30 hours"). And we, the 4 founding lay midwives, were the pilot class and first students. I am still amazed, impressed and grateful for these generous and smart people who gave us the kernel of our curriculum, much of which is still in use today. The template developed by Kathy Carr, CNM, (today she is the current President of the ACNM) for midwifery care courses has remained a cornerstone of our program.

We had articulated certain educational principles in those founding days that still guide us today:

- All members of the school community work in partnership to create and maintain a positive, mutually respectful learning environment;
- Importance of recruiting students who represent the racial, ethnic and cultural diversity of our country;
- Use of a variety of learning resources and teaching methods to meet the various learning needs of our students;
- Recognition of the importance of critical thinking, literature review and research, public education and leadership as key skills for midwives;
- Inclusion, rather than exclusion, of a variety of perspectives and points of view, encouraging students to critically evaluate the effectiveness of different approaches;
- Value of client autonomy and right to make informed choices that may differ from that of the midwife.

Specific to our faculty, we articulated that we valued teachers who came from many disciplines, were expert in their field, and who provided students with diversity of opinion, style and points of view.

Over the years, the faculty changed, grew, and evolved, along with the rest of the school. In the 1980's our faculty, by then numbering more than a dozen, were all working somewhere else and taught at SMS as a very part-time job, more for the commitment to the program than for the financial rewards. While all were actively working and expert in their subject areas, most had never taught before coming to the SMS faculty. Some inherited their course syllabus from their predecessor, while others toiled to develop a course by the seat of their pants!

As is so often the case with independent non-profits, over the years our school experienced many difficult cycles of strained resources and scarcity which impacted faculty, as well as every other aspect of the program. No one was earning compensation that came close to matching their worth or their time, let alone commensurate with the "market" for higher education faculty. When a faculty member left and had to be replaced, we found ourselves over and over again being the "beggars" rather than the "choosers". Yet, even so, those who did come to teach at our school were almost uniformly devoted and responsible to the task at hand.

Through the 1990's, we had a fairly stable faculty. In 1999, we made the bold decision to transform our curriculum from a residential program in Seattle to a "low residency" on-line format that would allow students to remain in their home communities, traveling to "on-site" classes only once a month. In addition, we answered the request from midwives in the northeastern U.S. for a formal education program by launching a classroom sited in New Hampshire, recruiting students and hiring a regional director and faculty to teach there. Dubbed "Midwifery Education Program 2000", this represented an enormous effort on the part of staff and faculty to completely overhaul and restructure the curriculum, as well as create partnerships between east coast and west coast instructors, who were co-teaching the same material to their respective cohorts. (For many reasons beyond the scope of this article, our efforts to sustain the northeast classroom failed and in 2003 the Board of Directors made the difficult decision to close the classroom). Faculty were challenged to learn to teach in a completely new environment: the internet. Communication with students as well as with co-teachers was substantially altered.

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The Evolving Role of Seattle . . .

(Continued from page 1)

Teaching materials and methods had to be adapted so as to deliver the information, while remaining interesting and interactive. For some, this transition was exciting, for others it was painful and difficult. For most, I imagine, it was some of each.

But this period of reorganization was an important milestone, as the Seattle faculty unified around the work required to accomplish a fundamental change in how our program was structured. Old courses were remodeled, new courses were developed and when we were done, the program looked quite different. In addition to all of the issues involved in becoming a web-based curriculum, this change also challenged us to think beyond our local experience as more and more students came from out of state. No longer was it appropriate to teach only about midwifery in Washington State. Our curriculum needed to reflect broader diversity of practice and regulation while maintaining the core values we held.

Today, we have just welcomed the seventh cohort of students into our remodeled midwifery education program. Our faculty number 22 people who teach 37 different courses throughout our three year program. Of these, 14 are graduates of our program, 9 are practicing midwives, 12 teach at least 2 courses, 6 have Master's degrees, 1 has a Ph.D. and 6 have been on the faculty for more than 10 years. This provides us with a rich pool of talented and dedicated teachers! In the last several years, the school's financial standing has improved, allowing for much needed faculty compensation increases, as well as improving the environment (a new location, better technology, etc.) for learning and teaching. We find ourselves now, in 2006, at an interesting juncture in our development. We have achieved a financial stability we have not before enjoyed which has enabled us to think again about the possibilities, but this time from a more realistic, mature and strategic perspective.

Recently a group of staff and faculty met to brainstorm the critical issues related to faculty roles at SMS. This was followed by our quarterly faculty meeting, where some of our future direction discussions included:

- The creation of core faculty positions held by people for whom SMS faculty would be their primary, if not their sole, professional focus.
- Development of a curriculum review process that serves to regularly evaluate and update course content, materials, and integration.
- Improving student support by creating a mechanism by which each student receives regular oversight of her progress, mentorship and guidance regarding post-graduation planning.
- Bringing clinical preceptors more fully into the role of adjunct faculty by providing better links with the school, continuing education and on-going involvement in planning and evaluation of students' clinical training.

Perhaps most importantly, we are now engaged in bringing our founding principle which articulated a commitment to training midwives who represented "the racial, ethnic and cultural diversity of our country" to the forefront. All segments of the SMS community, including faculty, have made a commitment to examine and educate ourselves about issues of racism in our organization, to become an organization that is anti-racist and effectively trains culturally competent providers. This is important and serious work that we expect to be ongoing and have influence in all aspects of the school's life. A "Change Team" composed of students, staff, board and faculty is ready to get started.

Because the future of our profession is tied to the success of the students we train today, nothing feels more important to me than quality midwifery education. It's an exciting time, being part of a school that is working hard on this every day.

Outreach to Educators Project

24 South High Street
Bridgton, ME 04009

A Call for Leadership for the Association of Midwifery Educators!

As the Outreach to Educators Project (OTEP) grant cycle comes to a close this year, its offspring organization, the Association of Midwifery Educators (AME), is gearing up to continue the work that this grant-funded project started. A brief history of the OTEP initiated organization is outlined below:

- •A website was launched in Fall 2006 at www.associationofmidwiferyeducators.org
- •The charter meeting of AME was conducted in Baltimore in 10/06 with 16 in attendance
- •A charter membership drive was initiated in November, 2006
- •A non-profit corporation, The Association of Midwifery Educators, was filed in 3/07
- •A call for nominations for officers of AME is made in 3/07

The possibilities for AME are broad and exciting but we need your participation and leadership! Following are the possible ways you can become involved in AME:

Join as a member of AME
Become a member of the board of AME
Be part of the "Giving Birth to Midwives" newsletter committee
Write an article for "Giving Birth to Midwives"

If you would like to be part of the formation of this important organization that will bring midwifery educators of all types together, please indicate your interest by joining AME or contacting the OTEP coordinator at coordinator@associationofmidwiferyeducators.org.

This is your last free issue of "Giving Birth to Midwives"!

The Summer issue of "Giving Birth to Midwives" will be sent to subscribers and members only as AME begins the gradual separation process from it's mother organization, the Outreach to Educators Project (OTEP). As many of you know, OTEP was initiated by the Midwifery Education Accreditation Council (MEAC) in 2005 with the goal of facilitating avenues of support for direct-entry and other midwifery educators in order to become more excellent educators, share resources, cooperate on common interests and collaborate to promote midwifery as a profession. As the grant period for OTEP draws to a close, it leaves behind an on-going organization, the Association of Midwifery Educators (AME) to continue the work that it started.

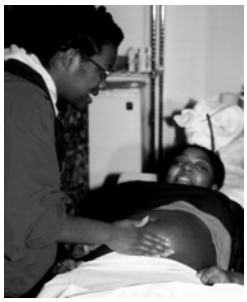
AME will need to become self sustaining in the near future and is already making plans for this to happen. A membership drive has begun which hopes to bring many midwifery educational programs and institutions, faculty, administrators, preceptors, and individual newsletter subscribers into its membership. The current list of member institutions/programs is listed below. If you do not find your program listed, consider joining AME now. If you would like to continue to receive the "Giving Birth to Midwives" newsletter 3 times each year, join as a subscriber now so you don't miss an issue. To join or subscribe, go to our website www.associationofmidwiferyeducators.org for membership rates and online registration, or complete the membership/ subscription form below.

Current Charter AME Member Institutions/Programs:

Seattle Midwifery School
The Farm Midwifery Workshop Program
Birthwise Midwifery School
Birthingway Midwifery School
NYU College of Nursing Midwifery Program
The Florida School of Traditional Midwifery
National Midwifery Institute
Nizhoni Institute of Midwifery
Heaven and Earth Midwifery Programs
Association of Texas Midwives Course
WomanCraft Midwifery
SUNY Downstate

ASSOCIATION OF MIDWIFERY EDUCATORS
MEMBERSHIP REGISTRATION FORM





There are several ways that you can support AME, so find the right category for you:

Individual member: Faculty members, administrative or staff members, or preceptors for a midwifery education program.

Institutional member: A midwifery program or institution

Supporting member: Any individual or organization that would like to support the work of AME

If you would like to become a member of AME, please complete the following membership registration form and mail with payment to: **AME 24 S. High St. Bridgton, ME 04009**

Name of school or individual:_____

Address: _____

Town, State, Zip: _____

Phone:_____Email:_____

Relationship to midwifery education: _____

Membership Categories:

___ **Individual Membership**, 45.00/ year

___ **Institution Membership:**
small (1-3 employees) 150.00/ year
mid sized (4-12 employees) 200.00/year
large (13+ employees) 300.00/year

___ **Supporting Member** 35.00/year

___ **Newsletter Only** 25.00/year