A MANUAL FOR PRECEPTORS
Second Printing

By The Stony Brook University,
Health Sciences Center, School of Nursing,
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Dedicated to the many preceptors, throughout the country, who have worked with students from the Stony Brook University Midwifery Program at Stony Brook and to all midwives who have ever precepted a midwifery student

For your dedication, commitment, patience, humor, perseverance, and, ultimately, your love

For ensuring the survival of our profession

I greet
With honor
Those
Who know.

(from Aditi: The living arts of India, Washington, D.C.: Smithsonian Institution Press.)

What office is there which involves more responsibility,
which requires more qualification,
and which ought, therefore,
to be more honorable
than that of teaching?
*Harriet Martineau**

Give a man a fish and you feed him for a day.
Teach a man to fish and you feed him for a lifetime.
*Chinese Proverb**

The function of education is to teach one to think intensively
and to think critically.
Intelligence plus character—that is the goal of true
education.
*Martin Luther King, Jr.**

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State University of New York at Brooklyn (Downstate)
University of Medicine and Dentistry of New Jersey (UMDNJ)

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OBJECTIVES FOR USERS OF THIS MANUAL

At the completion of this study program, the participant will be able to:

- Apply general theories of adult learning to clinical precepting
- Apply theories related to critical thinking to clinical precepting
- Apply the principles of informal learning to clinical precepting
- Identify the components of outpatient and inpatient clinical teaching
  Including
    Psychomotor skills
    Teaching the social aspects of caring for women
    Medical emergencies
    Imparting the philosophy of the midwifery model of care
    Didactic preparation/knowledge base
- Develop methods for integrating the midwifery management process into the clinical setting
- Apply methods of evaluating student progress
- Discuss challenges relating to teaching students with problems

INTRODUCTION

Teaching is like midwifery—a science and an art. Precepting is a special form of teaching, involving both formal and informal methodologies. We have all had teachers, throughout our lives. We remember some fondly, others with disdain, even fear. There are those we would say seem to be gifted, to have an almost instinctive knowledge of how to help someone learn. If we try to categorize what makes us feel this way about a particular teacher, we'd probably come up with a variety of qualities:

Those willing to give of themselves

Those willing to share knowledge, yet encourage self-learning and independence

Those who are humble, able to put the spotlight onto the students

Those who are nonjudgmental, allowing all students to be themselves, who help the students' qualities to shine

Those who use positive, rather than negative, reinforcement

Those who are flexible, allowing students to do things their way, even if that isn't the teacher's way

While it is true that some people have a natural talent for teaching, the skill can be learned. We can all become better at it—no matter how natural it seems to come or not come.

This manual will cover theoretical and practical aspects of clinical teaching. It is based on both extensive reviews of various literature relating to education and mentoring as well as on the collective teaching experience of the Stony Brook Stony Brook University Midwifery Program faculty—which is about 100 years! It will include exercises to help you discover your own strengths and areas for improvement. It will include case studies. You can do this self-study program at your own pace. If you wish continuing education credits from ACNM, then you must submit the case studies. If you have any questions about where to send the case studies for credit, call Pamela Criscuolo at 631 444-3074.

The first exercise you may want to do is to ask yourself why you agreed to precept a midwifery student.

The reasons a midwife may choose to precept are varied. You may agree with the ACNM Code of Ethics that, "Nurse-midwives participate in developing and improving the care of women and families through supporting the profession of nurse-midwifery research, and the education of nurse-midwifery students and nurse-midwives" (The American College of Nurse-Midwives Code of Ethics No. 11 2005). Most community preceptors place the greatest value on the intrinsic reasons for precepting, the enjoyment of teaching. (Latessa 2007).

You may feel that you would like to model future midwives after your own style of midwifery.

You may have been forced to precept in your practice setting.

You may have been persuaded by a persistent student or faculty member. You may have had a friend or nursing colleague who asked you before s/he began school if you would make a commitment to be a preceptor.

Perhaps you were enticed by monetary remuneration offered by some educational programs.

You may precept because by training the future midwives of your community, you will have access to other healthcare providers who share your midwifery philosophy.

You may precept because it is a way to stay current in midwifery practice.

We are not suggesting that there are good or bad reasons to precept. We are suggesting that the type of experience both you and the student have may be influenced by your motivation. Identifying this for yourself, privately, will help you evaluate what you might want to change to become a better preceptor. As we discuss later in the section on informal learning, under all circumstances you will serve as a role model for every student you precept—even if you only substitute for another preceptor for a single clinical session.

A second exercise you might want to do is to think about your own midwifery educational experience. We all were students—recently or long ago. We all had good and less good experiences as students. Make a list of the positive experiences you had as a student and think about what made those experiences positive. Make a list of the less than positive experiences you had as a student and think about what made those experiences less than positive. Think about what you have done as a preceptor that models the behaviors demonstrated in the positive student experiences of your past. Think about what you have done as a preceptor that models the behaviors demonstrated in the negative student experiences of your past.

A third exercise is to think about what you like about teaching and what you don't. One preceptor told us that she loves working with students because they have more current information. She encourages them to share with her and update her. For other preceptors, this may be intimidating. Some preceptors feel they must always know more than the students—for some, this is challenging, for others burdensome. Some preceptors love the idea of "molding" a student into the kind of midwife the preceptor believes will provide the best care for women and babies. Others are fearful that students will not respect the care they provide. This may be especially true in sites where the practice of midwifery requires continual struggle and compromise. The preceptor may fear the student will unfavorably judge the compromises that have been made. So add to your list of why you precept, a list of your likes and dislikes about the task.

Now . . . read on.

THEORIES OF LEARNING

Student-Teacher Relationships

Alone, all alone
Nobody, but nobody
Can make it out here alone.
---Maya Angelou, Alone

Precepting students is a dynamic process. It rewards both the preceptor and the student with growth for which both are responsible. In his work, *Pedogogy of the Oppressed*, Paulo Freire (1997) analyzes the student-teacher relationship. Freire views education as a method of awakening social consciousness. In this process both the student and the teacher simultaneously become learners. "Through dialogue, the teacher-of-the student and and the student-of–the-teacher cease to exist and a new term emerges--teacher-student with students-teachers. The teacher (or preceptor) is no longer merely the one-who-teaches, but one who is taught in dialogue with the students, who in turn while being taught also teaches. They become jointly responsible for a process in which all grow" (pg. 61).

Dialogue is a powerful tool of education. In the educational relationship the students-teachers/precpetors need to be viewed as equal knowers in the experience of determining

what is to be learned. The educational dialogue is more than an exchange of words; it is a relationship built on trust, and faith that trust in the relationship is possible.

A preceptor-student relationship of trust is critical to a successful clinical experience for both the preceptor and the student. Preceptors trust the student will obtain the requisite scientific basis for practice prior to the clinical experience. Students trust the preceptor's goal is a quality clinical experience for the student. Often, this relationship develops into a more expanded relationship of mentorship.

The concept of mentoring is an ancient one. It can be found in Homer's poem, "The Odyssey". In ancient Greek Mythology, Athena, the goddess of wisdom is disguised as a man and calls herself "Mentor". Mentor was a wise and faithful friend of Odysseus, King of Ithaca. Athena, as Mentor, became a surrogate parent, guide, teacher, tutor, and a father to Telemachus the son of Odysseus during the Trojan War. Mentor nurtured and guided the child who grew up and became King of Ithaca thus ensuring the revered role of the mentor to the ancient Greeks.

The role of mentor remains just as important today in the pursuit of professional success. Most if not all successful professionals can cite an influential person who served as mentor during their education or career. The mentor/mentee (also called protégé) relationship is a vehicle for an open and accepting communication for the mentee, where visions and values are shared . The mentor with the greater skill and knowledge provides coaching, counseling and an avenue for critical thinking.

We asked our students to name who were their professional role models and mentors. The most common response was their preceptors. We then asked them what was the most important characteristic of the mentor/mentee relationship. Trust was a predominant theme in their responses. As one student remarked, "*The most important part of the mentor/mentee relationship is the interest both parties have in making this a rewarding relationship. A mentor must be committed to aiding in the growth of the mentee. The mentor/mentee should foster a relationship of trust and a relationship build on shared respect".*

Preceptors (teachers) and students bring to a learning relationship or dialogue a multitude of experiences, values, attitudes and skills. The learning dialogue is facilitated not only by trust but also by understanding how both learners learn best.

Learning Styles

Educators have long understood that people have different ways of collecting and organizing information into useful knowledge. The ancient Greek philosophers were divided into empiricists and rationalists. Empiricism posits that experience is the best way to arrive at knowledge while rationalism claims that reason is the best method.

A variety of learning theories have been developed and researched, all of which have some validity and value. Three major theories of learning have dominated instructional activities in American education-learning as a mental discipline, learning as a response to a stimulus, and learning as a cognitive interaction. The mental discipline of learning utilizes drill, and rote memorization while the stimulus-response theory maintains that learning is produced by either internal or external stimuli which cause an individual to respond in an observable way. The cognitive-interactionist theory of learning views the learner as an active participant in the teaching-learning process. Students become responsible participants in their own cognitive activities with a goal of becoming self-sufficient problem solvers. (Woods 2005) The question for the teacher then becomes how do we arrange the environment for students so the learners are active participants in the process, evaluating and changing their own learning processes to achieve new skills, insights, outlooks, or thought patterns. What processes are most critical to ensuring that the student clinician to arrive at the correct diagnosis?.

The cognitive-interaction theory would answer that question by acknowledging that students have individual differences in learning styles. We know through our experience some students do their best learning through interactions with others, while some thrive with lone study and contemplation. Some learn a skill by performance, some by watching, some by listening and some by reading an instruction manual. (Border, LLB 2007).

Howard Gardner's multiple intelligences theory states that there are many forms of intelligence, many ways by which we know, understand, and learn about our world. Visser (1996, pp. 39-40) identifies Gardner's seven intelligences as:

- Verbal and linguistic—dealing with words and language, both written and spoken
- Logical and mathematical—dealing with inductive and deductive thinking, numbers, abstract patterns, and the ability to reason
- Musical—dealing with the ability to recognize tonal patterns, pitch, melody, rhythms, and tone
- Kinesthetic—dealing with the ability to use the body skillfully and to handle objects adroitly
- Visual and spatial—dealing with the sense of sight and ability to visualize, including creating mental images, thinking visually, and having a keen sense of observation
- Interpersonal—dealing with self-knowledge, sensitivity to one's own values, purpose, feeling

- Intrapersonal—dealing with the cognitive ability to understand and sense our "self."

Some authors have written about styles of learning particular to women. Their learning, knowledge, and assumptions about the world may be acquired through the lens of intuition, sensing, and skilled pattern recognition (Belenky, 1986).

A number of tools and inventories have been developed to identify and measure a person's learning and cognitive style. While cognitive style inventories have been criticized for a lack of standardization, these inventories are used frequently in health care to identify methodologies that best support students' learning needs. Some of the popular inventories include the Myers-Briggs Type Indicator (MBTI) focusing on personality types, the Kolb's Learning Styles Inventory, based on experiential learning theory, Canfield's Learning Styles Inventory emphasizing attitudinal variables, and Hill's Cognitive Mapping focusing on seven elements from which students' learning styles could be interpreted.

Some research has shown that learning is achieved most easily and most completely when the learning styles of the teacher and learning are the same. Of course, this cannot be guaranteed or assumed.

The Myers-Briggs Personality Type Indicator (1985) provides a useful description of learning styles. It is based on the work of the psychologist Carl Jung, and posits four dimensions of learning and for each dimension contrasts two learning styles. Awareness of your style and the student's style will help you understand any problems that emerge in your interaction.

The four domains in the Myers-Briggs Learning Inventory refer to:

- A person's main interests
- How a person perceives the world
- How a person makes judgments
- How a person prefers to live

The corresponding learning styles are:

- Extroversion vs. Introversion
- Sensing vs. Intuition
- Thinking vs. Feeling
- Judging vs. Perception

I. MAIN INTERESTS: Extrovert vs. Introvert
Extrovert Learners. Interested in the outer world, risk takers, action oriented. Think out loud to clarify; learn by doing. Cooperative, work well in groups.

Introvert Learners. Interested in their inner world of concepts and ideas, non-risk learners, avoid taking chances. Need to think things through before responding. Need a sense of space. Self-motivated, explore learning with minimal supervision.

II. PERCEPTION: Sensing vs. Intuition

Sensing Learners. Interested in immediate, real experiences. Systematic, detail-oriented, structured learners. Move cautiously into new learning; prefer set procedures, one step at a time. Dislike abstract theory. Use all senses to learn and need to see practical uses of the learning activities.

Intuitive learners. Interested in the possibilities, meanings, and relationships of experience. Tend to make contextual inferences. Inventive. Non-detail oriented; dislike repetitions and reviews. Level of interest may vary.

III. MAKING JUDGEMENTS: Thinking vs. Feeling

Thinking learners. Make impersonal judgements. Value objectivity. Analyze facts. Need a controlled, well-organized learning environment. Self disciplined, competitive. Tend to criticize and find flaws in situations.

Feeling learners. Make subjective and personal judgements. Weigh values. Need social acceptance and appreciation. Take things personally, including criticism. Value cooperation, consideration, and consensus and dislike competition. Humanistic. View learning as an opportunity for personal growth. Learning enhanced through good relationships with teachers.

IV. HOW A PERSON PREFERS TO LIVE: Judgment vs. Perception

Judgmental learners. Prefer living in a planned, orderly way, desiring to control events. Systematic, non-ambiguous, persistent learners. Strong work ethic. Need planned, scheduled learning activities that include outlines, frameworks, and set dates for exams and deadlines.

Perceptive learners. Prefer living flexibly, spontaneously, desiring to understand and adapt to events. Curious. Open to ambiguity. Perceptive learners enjoy low pressure learning, enjoy many learning styles.

Although this is only way of classifying learning styles, several other systems tend to be similar. Most classifications divide learners in some way into those that need to observe and consider and those that need to do, those who are competitive and those who are cooperative, those who value unstructured learning and those who need more structured situations.

Felder and Soloman (undated) write about:

- Active vs Reflective Learners
- Sensing vs Intuitive Learners
- Visual vs Verbal Learners
- Sequential vs Global Learners

Active versus reflective and visual versus verbal are self-explanatory concepts. Sensing and intuitive follow the Myers-Briggs scheme. The sequential and global dichotomy divides learners into those who are linear, taking logical steps in their thinking and learning (sequential learners) and those who absorb material without necessarily making connections among its various parts before they put it all together (global learners). Global learners can solve problems quickly and create novel solutions but may not be able to explain their thought processes. Global learners must see the big picture before they can absorb the details.

You can find more information about learning styles at these website:
http://www.gsu.edu/~dschjb/wwwmbti.html

You will also find an inventory that can help you identify your own style.

At Stony Brook University Midwifery Program, students are introduced to learning styles and encouraged to identify their learning styles prior to entry into the clinical setting. In a distance education program the students are usually mature and, by nature of the program, are self-directed learners. We hope that, for most students, by the time the student reaches the clinical setting they will be aware of the learning style most appropriate to meet their needs.

Domains of Learning

Utilizing Bloom's taxonomy of intellectual behavior helps in the practical aspects of planning teaching and evaluating learning in the clinical setting. Bloom's taxonomy includes three overlapping domains; cognitive, affective and psychomotor.

Cognitive learning is demonstrated by knowledge recall and intellectual skills such as: comprehending information, organizing ideas, analyzing and synthesizing data, applying knowledge, choosing among alternatives in problem solving, and evaluating ideas or actions (Bloom's Taxonomy, cited in DLRN Technology Resource Guide, 2007). Examples in midwifery practice include knowing Naegle's Rule or the signs of pregnancy. Cognitive domain activities may include correlating symptoms with a particular disease such as vulvar itching and thick white vaginal discharge with a yeast infection.

Affective learning is demonstrated by behaviors indicating awareness, interest, attention, concern, responsibility, ability to listen and respond in interactions with others, and ability to demonstrate those attitudinal characteristics or values which are appropriate to the field of study (Bloom's Taxonomy, cited in DLRN Technology Resource Guide, 2000). Examples of affective learning in midwifery practice include interviewing skills and sensitivity to each woman's or family's needs or experiences.

Psychomotor learning is demonstrated by physical skills; coordination, dexterity, manipulation, grace, strength, speed; actions which demonstrate the fine motor skills such as use of fine instruments or tools (Bloom's Taxonomy, cited in DLRN Technology

Resource Guide, 2000). Examples in midwifery practice include Leopold's maneuvers, bimanual examination, and hand skills for delivery.

A student needs all three of these domains in order to successfully utilize the midwifery management process to assess, diagnose, and provide therapeutic intervention.

For example, a woman comes to your office and states that she has not had a period in three months; she cannot be sure of the date.

The student uses affective domain skills to obtain a health history. The student obtains the history in a non-judgmental, open way that gives the woman the opportunity to share previous or current personal issues that affect her health needs. For example, the woman reveals that she "wouldn't know what to do if she were pregnant." The student responds by helping the woman assess her feelings.

The student uses the psychomotor domain to assess uterine size, evaluate adnexal tenderness, measure fundal height, perform Leopold's maneuvers.

The student uses the cognitive domain to determine the weeks gestation based on a knowledge of physiology.

Very few of us have equal strength in all three domains. In fact, very few of us value all three domains equally.

> "MaryAnn is so smart! I always go to her when I need to know about a topic."
> or
> "Therese has the most wonderful hands, such a nice, gentle touch."
> or
> "Jane's patients love her, she really has a midwifery heart."

Students are admitted into a midwifery program based on various criteria. This has always generated a great deal of discussion in the midwifery community regarding who would make the ideal midwife:

- an applicant who has tons of labor and delivery experience (probably strong psychomotor domain)
- an applicant with a great GPA (probably strong cognitive domain)
- an applicant who states a strong conviction to the art of midwifery and her life long commitment to women and babies and birth (appropriate affective domain)

Take a moment to reflect on your three domains. In which are you strongest? What do you value? Which area would you be most comfortable trying to teach?

Remember, the students you have before you have usually achieved a great deal in their career prior to enrolling in midwifery school. Perhaps a particular student was an experienced Women's Health Nurse Practitioner with an independent client base. Now

this same person is your student and is again the novice (Benner, 1984). Will you be able to value this student's cognitive and perhaps affective domain skills but yet be able to accommodate fledgling psychomotor skills such as clinical pelvimetry or use of a fetoscope? Will you be able to help the student make adjustments in her affective domain in a respectful way, affirming of her self-esteem, as she learns to adopt a midwifery philosophy?

Self-Directed Adult Learning

When the pupil is ready,
the teacher will come.
*--Chinese saying**

Malcolm Knowles (1975) describes self-directed learning as a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes. Like other adult learners, midwifery students come to the clinical setting and learning situations with assumptions, beliefs, and values that determine the way they interpret the world and their experience. These assumptions may be challenged by people, events, and changes in context, crises, or new experiences occurring within a new model of care. Individuals may then be led to an examination of their assumptions, including the sources of these assumptions and the consequence of holding them. In critical self-reflection, learners question whether or not their assumptions are valid. If this process leads to a change in assumptions, it also leads to a new way of interpreting the world, and transformation has taken place. Actions and behaviors will be changed based on the changed perspective.

If a student has learned about birth before entering midwifery school in a highly technical setting without midwifery care as a model, we would expect a critical transformation to take place. This process may be painful to the student as she lets go of what she is comfortable with and expert at knowing in all three domains. While it is rewarding to witness, the preceptor may intuitively sense the student's conflict and facilitate the adaptation of new values and assumptions. The preceptor who understands the process of learning and the student's style of learning will most skillfully facilitate the transformation just as the preceptor artfully facilitates labor and birth.

Informal Learning

May everything I see
teach and instruct me something.
--Margaret Godolphin*

We assume that students are learning in the formal classroom setting, or while working their way through a paper or assigned chapter in a text. We hope that they learn good midwifery management in the clinical setting when we set up situations that will reinforce an aspect of their formal education, or provide them with an unusual clinical

situation that will increase their knowledge and understanding. But there are many other situations where students learn from their teachers and preceptors. We have labeled these experiences "informal."

Informal aspects of teaching and learning include mentoring, coaching, networking, and some forms of apprenticeship, and are best described as learning that takes place without a typical didactic setting or structure.

We all know, however, that students learn from us in even more informal ways as we model by our example. Students watch how we act and react in the clinical setting. They may have a heightened sense of awareness because of the newness of the environment. They listen carefully to how we talk about births or other clinical situations. Everything we do and say while in the presence of our students is a learning situation for them. For this reason, we must take seriously the less formal aspects of teaching our students.

As students prepare to assume a professional role, they seek models to emulate. Preceptors act as role models for students all the time.. They constantly observe what is said and done , and integrate lessons to be learned from these actions. In fact, students frequently name their clinical preceptors as the reason that they became involved with policy related to the profession and continued to stay involved politically (Snow and Laffin 2007).

We can promote learning through role modeling via our own:

- intellectual curiosity
- continuing self-education
- critical analysis of information
- compassion for patients
- cooperation and mutual respect among specialties
- interest in professional associations, community involvement
- balance of professional, personal, and family responsibilities (Snow, interview of Xippolitos 2006).

BEFORE CLINICAL TEACHING BEGINS

We must know what knowledge is available,
how we can obtain it,
and why it is true.
--Socrates

Meeting With The Student

Whenever possible, preceptors and students should meet before clinical begins. This can be done via a telephone conference if the student will be traveling to get to the site and can't arrange a visit in advance.

Preceptors frequently cite “lack of commitment” as a major issue with a student. Precepting is hard work, and perhaps taxing an already overburdened midwife. However, lack of commitment may be confused with an underlying problem of expectations—yours or the student’s.

At the pre-clinical meeting, besides getting to know each other a bit and becoming comfortable, preceptors can share their expectations with the student. This is a good time to discuss learning styles. It is also a good time to review the schedule of the site and make certain that the student can meet this schedule. A student who has very small children and no partner at home may be unable to work a call schedule and may not be appropriate for your practice or service if you require call. Another student may prefer call and be unable to do set shifts because of work responsibilities that she cannot relinquish. If your practice or service cannot accommodate students who work, that must be made clear. Before clinical begins is the best time to decide that you and the student will not be able to work together—for personal or practical reasons.

Give students the dates for rounds or other meetings or conferences regularly offered and invite them to attend. Describe the expectations for dress. Let students know what textbooks and other resources are available and what they may want to bring with them.

Before the student comes to your site, you should review what your expectations of her learning will be. If you expect more than she is yet prepared for, this should be discussed with the faculty member responsible for the particular student. The faculty will be able to evaluate whether your expectations differ from those of the educational program and attempt to develop a plan to meet the site expectations or whether the problem lies with the particular student’s inability to master the necessary requirements.

Students should have the opportunity, at this meeting or at the first clinical session, to review the practice agreements for your site. If they are not too long, giving the student a copy of the agreements is helpful. If they are long, then show the student where they can be found in the office so they can be referred to if necessary.

In Pearls of wisdom for clinical teaching: expert educators reflect, Lichtman (2003) citing Helen Varney Burst gives five questions/information to obtain from a student before clinical the student begins clinical;

1. What are the student’s learning goals for this experience?
2. How much experience does the student already have in this clinical area?
3. Which skills have the student had experience with?
4. A brief discussion of expectations of each other.
5. Reassurance that you are there to help the student learn and that you will ensure the safety of the patient.

In general, students should be prepared to enter the outpatient setting with the following skills:

- Complete history-taking and physical examination
- Breast examination
- Pelvic examination including speculum and bimanual; taking of Pap smear and cultures
- Fundal height assessment
- Leopold's maneuvers
- Fetal heart assessment
- Ability to fit and/or prescribe various contraceptive methods including oral contraceptives, injectable contraceptives, IUDs, diaphragms, cervical caps, and male and female condoms.

Students should be prepared to enter the inpatient or intrapartum setting with the following additional skills:

- Phlebotomy
- Understanding of fetal position and cervical changes
- Hand skills for NSVD, breech delivery, episiotomy and repair of episiotomy and lacerations, knot tying
- Understanding the steps of emergency care: cord prolapse, shoulder dystocia, PPH

Some of these skills will be very basic. Although students can go through the steps, for example, of a bimanual examination, the ability to actually feel ovaries and assess their size will vary among students. This is true for all of the skills mentioned above. Skills such as IUD insertion and suturing will have been practiced only on models. The actual suturing of a live human being differs greatly, from visualization to the idea of putting the needle into a person, to the feel for how tightly to pull the sutures or tie the knots.

STUDENT OBJECTIVES

A tenet of adult learning is that learners should define their own learning objectives. A learning objective is a statement of what the student should be able to do at the end of her course of training (Fabb, Heffernan, Phillips, & Stone, 1976).

New students may have difficulty articulating their objectives. If they know little of what skills a midwife needs in the ambulatory setting, they cannot define objectives. (We do not know what we do not know.)

As the preceptor, you can help students clarify learning objectives. One approach is to use the evaluation tools provided by the student's educational program and discuss or highlight all needed skills. Or you may refer the student to the ACNM core competencies. You may discuss with her what you consider to be essential skills in the particular setting and for the particular clinical experience you offer. For example, managing the woman

during an induction of labor may not be possible or expected in the birth center setting whereas insertion of internal fetal scalp electrodes may be necessary in the tertiary care setting.

USING THE MANAGEMENT PROCESS IN TEACHING

The role of ideas is not that of reporting and registering past experiences but to serve as the bases for organizing future observations and experiences.
--John Dewey
Reconstruction of Philosophy

Critical Thinking
An expert clinician utilizes critical thinking to provide excellent patient care.
Critical thinking can be seen as a two tiered process. The first tier is acquiring or having a set of information and belief generating and processing skills. The second is possessing the *habit* of using those skills to guide behavior.

A well cultivated critical thinker:

- raises vital questions and problems, formulating them clearly and precisely;
- gathers and assesses relevant information, using abstract ideas to interpret it effectively, comes to well-reasoned conclusions and solutions, testing them against relevant criteria and standards;
- thinks open-mindedly within alternative systems of thought, recognizing and assessing, as need be, their assumptions, implications, and practical consequences; and
- communicates effectively with others in figuring out solutions to complex problems.

Critical thinking is self-directed, self-disciplined, self-monitored, and self-corrective thinking. (Schriven 2007). The learner new to the clinical setting has not yet had the opportunity to form this habit of using these skills. (Which may explain why students are often distraught by observing something new or different from what they have learned didactically or experienced before.)

A goal in teaching the student clinician is to utilize critical thinking skills. But can critical thinking be taught? While there are some educators feel there's no such thing as critical thinking skills, only strategies that aid critical thinking, there is little disagreement that critical thinking depends on knowing relevant content and thinking about it, repeatedly, in critical ways (Williamgham 2007), (Woods 2005). To this end, the management

process is an effective tool to apply the relevant content to make accurate assessments of patient encounters.

Teaching to the Management Process

Students learn the management process early in their didactic portion of clinical courses. Students are expected to submit to University faculty cases utilizing the management process. Because the management process "is a clinical problem-solving, decision-making, care-giving process" and "provides a method of organizing thoughts and actions in a logical sequence…."(Varney, 2004, pg. 31) it assists the fledgling midwifery student with organization of management of a patient visit.

The management process:

- elucidates the "behavioral level at which step is to be achieved so as to provide safe comprehensive patient care". (Varney, 2004, pg. 31).

- provides the student with the "means of putting together isolated fragments of knowledge, findings, skills, and judgements into a meaningful whole" (Varney, 2004, pg. 31).

All clinical teaching should be based on the student's use of the management process. The process is quite simple:

Data collection
History, Physical, Laboratory Data
Assessment
Plan
Implementation of Plan
Evaluation

Varney lists the framework from data collection to evaluation in the following seven steps:

1. Investigate by obtaining all necessary date for complete evaluation of the woman or newborn.
2. Make an accurate identification of problems or diagnoses and health care needs based on correct interpretation of the data.
3. Anticipate other potential problems or diagnoses that might be expected because of the identified problems or diagnoses.
4. Evaluate the need for immediate midwife or physician intervention and/or consultation or collaborative management with other health care team members, as dictated by the conditions of the woman or newborn.

5. Develop a comprehensive plan of care that is supported by explanations of valid rationale underlying the decisions made and is based on the preceding steps.
6. Assume responsibility for the efficient an safe implementation of the plan of care.
7. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspects of care that has been ineffective.

Students should be expected to think in terms of the management process. Often, when a student seems stumped or unable to figure out how to proceed in a clinic visit, for example, a simple statement like, “Go back to the management process,” is all the student needs to come up with the next step. The students need to make the assessment and then perhaps return to the patient for additional data.

The concept of differential diagnosis, while not traditionally included in the steps of the management process, is another important teaching tool. Students should always be thinking about the possible diagnoses presented by the woman’s symptoms or complaints. As the student collects more data the differential diagnosis first becomes larger, and then begins to narrow down. Thus, the management process becomes dynamic—the basic data base leads the student to consider the possible diagnoses (known collectively as the differential) which cause the student to return to the data collection step to get more specific information to hone in on the appropriate diagnosis. Sometimes this requires more than one visit as the plan for the day involves further data collection. The steps of the process thus sometimes seem a bit blurred as ordering laboratory data becomes part of the plan. If students understand the process as a dynamic, not static, process, they can more easily recognize its sometimes overlapping steps

For the preceptor to evaluate the student’s use of the management process, evaluating whether the student has a complete database and is using it to think critically to make appropriate assessments, students must present each patient to the preceptor. This is an essential part of clinical teaching.

Beginning students need to present the patient several times to the preceptor—usually after the history-taking, after the physical examination, and before the patient is discharged or leaves the office or clinic. Anytime a patient goes home without the instructor’s knowledge, the student has made an error in judgement.

Case presentations may be difficult for students whose thinking is scattered or who tend to be introverted learners. We must tell all students that the only way we can be sure that they have considered all possibilities in assessment and patient care is to discuss their findings, assessments, and plans with us. When there are options in management—as there often are—they should be encouraged to identify them and reveal how they chose the option they used. Helping beginning students think through the risks and benefits of various management choices is an important function of the preceptor. This is especially important to prepare students for a multitude of work settings. While varying plans should be acceptable to the extent that the site permits this, the student should be assured that only safe plans will be implemented.

Teaching as a Function of the Management Process

To be able to be caught up into the world of thought—that is education.
*---Edith Hamilton**

You utilize the management process in teaching when you:

- take a detailed history of what the student's previous experience in the outpatient setting has been.
- observe her interview, chart review, and clinical skills
- make a diagnosis of her strengths and weaknesses
- make a plan that will enhance her experience
- provide ongoing evaluation, feedback of how both of you think she is performing.

Gathering data about the student requires assessment of not only what she does, but what she is thinking—her thought processes and her ability to utilize the management process. Wheeler (1994) has stated: "Preceptors can also contribute to expanding the student's repertoire of skills by tracing the student's thinking. Knowledge of the thought processes helps the preceptor know whether a decision made by the student is a result of chance or of logical thinking. Misinformation can be corrected … To determine the student's thought processes it is usually necessary to ask questions. For example, a student's initial assessment of a patient admitted to the labor and delivery unit at 4-cm dilation may include a diagnosis of active labor. The preceptor could ask, 'How do you know she is in active labor?' The student may respond, 'Because she is 4-cm dilated.' Information about the student's knowledge base can then be pursued by asking, 'How do you diagnose active labor? What criteria should you use to assess labor status?' (pg. 323).

Questions can be asked about differential diagnosis. When a student presents a series of symptoms experienced by a woman, ask her what the differential is? Then pursue that line of thinking by asking how she will determine which, among the possible choices, is the correct diagnosis. What further information will she need to obtain? Can it all be obtained on the same day? Will the patient need to return for another visit?

The same use of the management process can be implemented to help the student develop a plan. Ask her what the various intervention options are and then ask her to defend her choice of intervention. Remember, always, that early on, students will need more help in choosing management options; they may not have yet covered a particular area in their didactic work. Using the questioning (or Socratic) method of teaching gives you the opportunity to assess ongoing acquisition of knowledge and an increasing ability to apply it to practice. All of this is crucial in evaluating students. Remember, however, that "introvert learners" will have difficulty with this process. They are used to keeping their thoughts to themselves. Do not assume, therefore, that a non-responsive student doesn't have the knowledge. She may be unused to sharing her thoughts and will have to be drawn out. If this can be identified early on, it can save much misunderstanding.

FEEDBACK AND EVALUATION

Self-Evaluation

Education means capacity for further education.
--John Dewey[*]

Once students leave the safe environment of student-hood, they become totally responsible for their actions. The only way they can continue to be safe practitioners is to engage in continual, lifetime education and self-evaluation. Therefore, one of the most important skills students can learn is self-evaluation. The preceptor who provides evaluation without first allowing the student to evaluate herself is actually doing a disservice. Of course, if you are an extroverted learner yourself, one who jumps in and learns through activity, stepping back to allow the student to provide self-evaluation will be difficult for you. Self-awareness followed by self-restraint becomes necessary.

Most, if not all, midwifery education programs have daily evaluation forms for students to complete. The students' self-evaluation is then corroborated or disputed by the preceptor. This must be honest, although provided in an appropriate way. These forms may be the only documentation that a problem is persistent.

The evaluation forms utilized by the Stony Brook program for daily evaluation in each clinical area—well woman gynecology, antepartum, intrapartum, newborn, and psotpartum—are included in this manual as Appendix I. Appendix II has the mid-rotation and final evaluation forms for each of these areas. These summative (end) evaluations are to be filled out by the preceptor, although many preceptors fill them out in collaboration with the student. The Stony Brook forms were adapted with permission from forms developed by the Columbia University midwifery faculty. Forms should not be accepted from the student without evaluative, qualitative comments on their performance. Checkmarks in appropriate boxes do not constitute appropriate or complete self-evaluation.

Preceptor Feedback

The teacher can lead a student to the door;
the acquisition of learning is the responsibility of the student.
--Chinese Proverb

Once the student has completed her evaluation for the day, the preceptor must either corroborate or dispute the student's evaluation. This should ideally be done both in person (verbal) and on the evaluation form (written).

Evaluation of the student occurs ongoing (formative) and at the end of the clinical rotation (summative).

Evaluating or critiquing a performance may produce anxiety for both you and the student. In his *Critique of Pure Reason,* Immanual Kant reinforces that the word "critique" is

derived from a Greek word meaning to "sort" or to "sift out." Critiquing, then, is less judgmental and more analysis. Utilizing the management process, you simply will sort or sift out what the student needs.

Keep in mind that feedback should be:

- as specific as possible
- positive when deserved
- not demeaning when critical
- understandable
- about things which can be changed
- well timed
- descriptive rather than judgmental

Formative evaluation should…

- be based on systematic observation
- emphasize change in behavior and progress toward a goal
- be paraphrased by the learner to see if it is understood
- be conducted in an unhurried atmosphere
- allow the person being evaluated to provide input

An example of a supportive evaluative statement that fits the above criteria would be, "The questions you asked in your interview were very specific and allowed the woman to give you detailed data about her problem. That helped you make your assessment." An example of feedback about the same interview that would not be as helpful might be a statement such as, "Your interview was very good."

For evaluation aimed at changing behavior, consider a statement such as, "You asked a lot of open-ended questions. These are helpful because they the woman to provide information in her own words but there were times when she spent a lot of time giving you unnecessary information. You can sometimes use more directed questions in your interview to save time and get more specific useful information." This would be in place of a statement like, "Your interview was too long and you let the woman ramble too much."

In addition to evaluation provided during the visit which might be necessary to expedite the visit, you should have a post-conference with the student after each clinical encounter, whenever possible. If this is not possible due to scheduling or unavailability of a private room in the clinic or office, then such conferences should be scheduled periodically when both you and student will have uninterrupted time to discuss the student's progress and performance.

How to Determine that a Student Is Ready to Complete Clinical

He knows enough who knows how to learn.
--Henry James[*]

Perhaps one of the most difficult challenges in clinical teaching is the determination that a student is ready to complete clinical, that she has achieved the expected competencies and is a safe beginning practitioner of midwifery. This is difficult because there are no absolute standards that can be applied and because the decision carries significant implications. We are not merely certifying that a student has mastered a body of knowledge, but that the student can apply this knowledge in situations that can on occasion determine life or death.

Evaluation of a midwifery student's performance has always been based on competencies—not clinical hours or numbers. The Stony Brook University Midwifery Program has set minimum numbers of experiences in each clinical area required for all students. These are higher than the numbers suggested by ACNM because of the nature of distance education. These are thought to assure an adequate number of experiences, but are not writ in stone. An occasion student can achieve competency with fewer than the required numbers of experiences (37 deliveries rather than 40, for example) while another student needs more than twice the minimum number to achieve competency.

The guidelines for clinical completion for the Stony Brook program are:

- 10 preconception care visits
- 40 antepartum new visits
- 140 antepartum revisits
- 40 labor managements
- 40 births
- 40 newborn assessments
- 10 breast feeding support visits
- 40 postpartum visits (0-5 days)
- 15 postpartum visits (4-8 weeks)
- Primary Care
    - 40 common health problems
    - 40 family planning
    - 40 gynecologic visits
    - 20 perimenopausal/postmenopausal visits

Once these numbers have been achieved, how does the preceptor determine the level of competency? First, is the reminder of what competency really means. We can guarantee a level of competency no greater than that of "safe beginning practitioner" in midwifery education. That means that most students will need structured orientation periods in their first jobs, with the benefit of supervision from senior midwives. In today's world, of course, we realize that this isn't always possible—one of the reasons we have, in many areas, doubled the ACNM suggestion for the number of clinical experiences for students. Many of our students chose Stony Brook because of the remoteness of their location and the impossibility of attending an onsite program. These students may not have the luxury of even living in a community with other midwives, let alone being supervised by them as new graduates.

Despite this reality, the standard for graduation has not changed. Students need to be safe, but safe at a beginning level. They need to have a complete and up-to-date knowledge base. This is tested through structured examinations administered by the academic faculty and through student submission of case studies. In clinical practice, this is further tested through the question-and-answer method of teaching discussed earlier. It is also tested by the student's ability to provide intervention appropriate to the problems or circumstances presented. If a student has the knowledge base, for example, she will know which medications to prescribe and how to counsel women taking these medications. She will know the appropriate teaching and counseling for any method of family planning or for any gestational age for antepartum women. She will know how to manage various deviations in the progress of labor. She will know how to provide labor support.

Of course, didactic knowledge is the easiest component of clinical practice to assess. Competency at a safe beginning level also includes implementation of the management process, the ability to think in an organized and thorough fashion, the ability to relate well to women, their families, to staff and consultants. It encompasses having basic hand skills necessary to midwifery practice, from the correct performance of breast examination to head control to suturing.

Competency means the consistent performance of a task with accuracy, organization, and minimal discomfort to the patient. A student who occasionally happens on the ovaries, but as often misses them, cannot be considered competent in bimanual examination. Conversely, the student who palpates ovaries most of the time but occasionally misses them can be considered competent. The student whose history is always thorough but whose approach consistently embarrasses women cannot be considered competent. The student who is sensitive to women's needs, but whose data collection consistently misses components of the history cannot be competent in interviewing skills.

If we practice non-interventionist midwifery management, students will get few, if any, opportunities to cut an episiotomy or suture one. This can be practiced on models until the student appears to have gained proficiency. Any such deficiency must be included in the student's final evaluation so the student's first employers will know the work the student continues to need. Similarly, students may have limited opportunity to manage obstetrical emergencies or see the broad scope of gynecologic or antepartum problems during their student days. If the student is proficient in the normal, this constitutes safe beginning practice.

Students should be able to manage all kinds of gynecologic, family planning, and intrapartum situations. They should understand the concept of differential diagnosis, know how to collect data to focus on a specific diagnosis, be confident enough to determine the diagnosis and implement an appropriate plan. They should know the treatments for common conditions and be able to counsel any woman during the antepartum period. They should demonstrate some degree of cultural competence.

Students need not be able to manage an entire caseload in the outpatient setting. They need not be able to "run the board" in a busy tertiary care setting. They should be able to

manage a labor from admission to delivery and through the postpartum period to discharge. They should be able to think through alternative management scenarios. They should be able to manage at least two women in labor simultaneously, although this isn't always possible in all sites in the relatively short time they may be there. Nor should this be expected at the beginning of the student's clinical experience. Regardless of the student's level of competence at the beginning of her clinical rotation, progress should be seen.

The student should fulfill most of the objectives on the evaluation forms, found in Appendix II.

In addition to having acquired, didactic knowledge and technical skills, students must demonstrate an awareness of their own limitations, a willingness to identify when their own knowledge is insufficient, and an ability to seek help when necessary. Indeed, they must demonstrate competency coupled with at least a bit of humility.

If at any time a preceptor is uncertain as to whether a student is ready to be certified to sit for ACC Boards based on her clinical competency, or lack of it, the faculty should be contacted. Site visits are made routinely in all cases at least once during the student's rotation and an additional site visit can be made when the preceptor needs a verifying opinion.

To avoid conflict, student progress and lack of it must be documented on the daily evaluation forms and on the problem identification forms as necessary. The most devastating experience for a student is to be close to graduation and discover that the preceptor believes she is not ready, when all along the student thought the progress made was fine.

TEACHING AND THE MIDWIFERY MODEL OF CARE

I realized that it was necessary, once in the course of my life, to demolish everything completely and start again right from the foundation.
---Rene Descartes, 1637

Much has been written in recent years about the midwifery model of care, sometimes contrasting it with the medical model. The model has a number of components.

Corry and Rooks (1999) have stated: "Based on the midwifery model of care, family-centered maternity care views birth as a normal, healthy event rather than a medical procedure. It focuses on individualized care that meets the needs of women and their families rather than the needs of the institution. Women are encouraged to be partners with their providers in decision making about the kind of care they want for themselves and their babies" (pg. 47).

In a recent editorial in the *Journal of Nurse-Midwifery*, Zeidenstein (2000) concluded: "Midwives must embrace the midwifery model of care and accept that its uniqueness is their greatest strength. They must be committed to the philosophy that the women and their families they serve come first, As they learn their art, midwives will be instilled with a conscious awareness of the beauty of each privileged exchange with a woman who comes to them for care. Midwives must learn how to blend into a large fragmented health care system. They must learn diplomacy and humility while advocating for women . . ." (pg. 85).

Holly Powell Kennedy (2000) conducted an important study of "exemplary midwifery practice" from which she extracted the following as constituting crucial parts of the midwifery model:

- supporting the normalcy of pregnancy and birth
- vigilance and attention to detail
- respecting the uniqueness of the woman
- doing "nothing" well
- gearing health care to help the woman achieve a level of control of the process and outcome

In this study, Kennedy used the Delphi method as her research design. She describes this as a "technique to restructure the group communication process to bring together expert opinions to formulate a prediction or set of priorities" (pg. 5). She goes on to explain that this method is named in deference to the ancient Greek legend of the Delphi oracle who are thought to give wise and authoritative advice" (pg. 5). Plato tells us that a friend of Socrates approached the Oracle of Delphi and asked if there was anyone wiser than Socrates. The priestess replied that there was not. Socrates was deeply puzzled by this as he was aware of his own ignorance. He sought out the wisest politicians, poets, and craftsman in Athens until he came to the conclusion that he was in truth wise because he

was aware that, “I do not know what I do not know.” (Reported by Plato in Protagoras, 313c).

Socrates called himself the “midwife of ideas” (reported by Plato in Theatetus, 149-150). He meant that a midwife does not bear the baby, but merely assists in the labor of bringing a baby forth. True wisdom does not mean we have all the answers, but can help others find the truth within themselves.

In the sections that follow, some very practical concerns of precepting are discussed. In all precepting, however, the concept of the midwifery model of care must remain core. We must reinforce this concept in all teaching encounters, and we must teach with “humility,” and “advocate” for both our students and our patients.

SUPERVISION IN THE OUTPATIENT SETTING

No, it is not easy in all three worlds
to find a teacher like the alchemist’s stone
to turn a student’s raw ore into gold
--attributed to Sankaracharya, theologican-philosopher and founder of a Hindu monastic order, Kerela, 700-800 A.D.)

Adult learners learn best in environments that are non-threatening and collegial (Knowles, 1975).

This is not always easy to achieve. Students in a new role and new environment may be easily threatened. Among the ways you may begin to create this non-threatening collegial environment is to introduce students to the entire staff and provide a sense of welcome. One site hangs a welcome poster in the waiting room on the day the student arrives.

Address basic needs--where the bathroom is, where to park, how to get a cup of coffee. Be very clear about the hours and days the student will be with you. Provide clear directions on how to communicate if the student will not be able to attend a session. Be very specific. Let the students know whether you want them to call you at home or in the office or clinic, or if this differs depending on whether they know in advance that they will miss a session or wake up not feeling well. Let them know whether or not you come in just to supervise them and therefore would appreciate being informed at home before you leave for the office.

Allow for socialization to occur. Let the student know in advance if she may join you for lunch, or if you prefer to have your own private time. (“I always take my lunch break alone, it gives me a chance to make some call backs.”) Tell her about your professional background. Share experiences that have shaped your philosophy and practice.

One obstacle that preceptors encounter is having patients accept students as providers. This can be achieved in several ways. Perhaps most important will be the way you

convey support and trust of students. Patients trust your judgement or they would not have chosen you as their provider.

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Another way is for students to prepare “bios” of themselves. The bio can contain background information such as their own life experiences, years of nursing background, if applicable, perhaps even a photo. Students can discuss their philosophy about women’s health care. This lends credibility to the student and increases the likelihood that the patient will agree to be seen by the student. One site hangs the student bios on its office bulletin board.

The way the student identifies herself to the patient will have an impact on the student/patient relationship. Students should clearly state their name and role to the patient. They should ask consent to provide care to the patient. A good way to do this is to introduce themselves to the patient in the waiting room as an RN (or other accomplished individual) who is studying to be a midwife. They can tell the patient that they would like to provide her care today and ask, “Would this be all right with you; it may take a bit longer?” This gives the patient a graceful way to say no by indicating that she does not have the time.

Another exercise that you can employ to incorporate students fully into your practice or service is to have them follow a patient through the steps of care--from registering at the desk, to getting lab work, to going to the social worker or nutritionist, perhaps even touring the L&D unit if they will be seeing OB patients. This gives the students inside knowledge about all the members of your staff and gives them the ability to counsel patients on what they can expect from the practice or service. It will also help them determine what their own counseling should entail.

Before you begin precepting, either in the meeting described earlier, or the first clinical session, you should discuss your expectations for case presentations and reporting. Students should know, for example, when in the course of a visit you expect a case presentation. Beginning students ideally should present after the history-taking so you can evaluate its thoroughness and discuss what should be done or emphasized in the physical examination. After the physical, newly acquired information should be added to the case presentation and the plan discussed in detail before the student completes the visit. *A woman should never be sent home without the preceptor’s knowledge* and students must understand this from the beginning.

The student should know the procedure for consultation. Until the student is advanced, by your assessment, the student should always present to the preceptor before presenting to a consultant. Later, once you have given the student permission to do so, the student may present to the consultant and then discuss the consultant findings or recommendations with you. This may never happen, however, depending on how you function in your particular site and how independent the student becomes. Students should be aware of this, so awkward situations are avoided.

Some preceptors prefer to stay in the room with students at the beginning; others do this throughout the student's rotation. In some very busy sites, this is impossible. Students should know what to expect in terms of your physical presence during the patient visits. For some students, depending on their personality types and learning styles, too much supervision may be difficult to accept; for others, too little may be more uncomfortable.

If the demands of your practice or service require that students function independently from the beginning, you can still evaluate their organization, thoroughness, and safety in patient care through their case presentations. If a student tells you a woman has pelvic pain but does not delineate the type of pain, the location, the onset, etc., then you know the interview has been incomplete, whether or not you sat in on the history-taking, for example. Of course, early and late in the student's rotation, a thorough observation should be made of an entire visit—from history-taking through physical examination through implementation of the plan.

On the first day of outpatient clinical, you may prefer that the student be an observer. The student may prefer to observe. Depending on the student's learning style, observation may be helpful or not. For some students, jumping in can be quite anxiety-provoking, for others observing may be frustrating. Again, discuss this in advance and come to an agreement based on mutual respect for each other's learning styles. Of course, what makes you most comfortable will take priority over what makes the student most comfortable, but we ask that you be sensitive to students for whom your style creates anxiety or frustration.

Sometimes a combination of jumping in and observation works best for new students. The student can review one chart, for example, while you see another patient. After the case is presented to you, the student can observe your doing the actual visit.

Generally the sequence of events in outpatient teaching is:

- Introduction of the student to the environment and staff
- Introduction to the chart
    - Chart review:
        - how to glean history, problems and interventions at previous visits, labs, imaging, etc.
        - where to start the review to find the most useful information (e.g., the first prenatal visit; the hospital or birth center admission or discharge sheet; the initial gyn visit)
        - how *not* to read the chart—from cover to cover
        - how to "rewrite" the chart into categories rather than dates
        - how to determine which parts of the chart to skim (e.g., in one hospital, every admission is included in the chart and some women in the prenatal clinic had their own birth records and every well baby visit in their charts)
    - Charting
        - show students examples of your charting style

- discuss the preferred or mandated charted style of the service/practice

- Taking an accurate and thorough history
- Performing a physical (including breast exam)
- Insertion of speculum, taking pap and cultures
- Bimanual examination

In antenatal care, the following components are added:
- Uterine sizing and gestational age assessment
- Fundal height
- Leopold's maneuvers
- Auscultation of fetal heart tones
- Clinical pelvimetry
- The ability to provide sound, safe, knowledgeable counseling regarding:
  - Prenatal care
  - Nutrition
  - Expectations for labor and delivery

As student confidence grows, you may expect students to "layer" additional skills. They should gradually be able to do a thorough chart review, accurately diagnose, recommend appropriate diagnostics and therapeutics, obtain a consultation with other health care providers, and chart thoroughly, but more concisely as they become more adept.

Several authors have addressed the issue of how students acquire motor skills.

The Issues of Speed and Productivity

The world of the student is a privileged one, existing outside the realm of work-place related productivity demands. While students need to learn to deal with the realities of health care delivery in a less-than-perfect system, they also need time and space to learn to provide the best possible care. Beginning students should not be pushed to see a full case-load of patients, or even come close to that expectation. They have not yet learned which corners can be cut and in what directions to cut them. They will simply be incomplete and disorganized if unduly rushed. Disorganization only leads to further delay in care.

The absolute best way to encourage a student to become proficient enough to see a full case-load of patients (a goal which the student may not quite achieve during student days) is to encourage organization. Organization is achieved by following the steps of the management process and conducting examinations in a precise way, repeated each time the examination is done. The more organized students generally provide thorough and safe care and, over time, become faster in the delivery of care. A focus on speed leads to anxiety and frustration and ultimately backfires. A focus on organization leads to speed without thinking about speed itself. On occasion, of course, a student dawdles or spends an inordinate amount of time on one aspect of care, like extending the "chat" she has with women about unrelated issues in their lives—chat that builds rapport but can become

endless if allowed. Some students take too long in chart review and observation or discussion of their approach can lead to fruitful discussions of ways of streamlining this. Other students take too long to chart and this can often be remedied with simple suggestions (don't use whole sentences; write in an outline form; leave out extraneous words such as, "The patient states," unless absolutely necessary).

Students should not be seen as care providers who will increase the productivity of a practice or service. Many times, they will do that—especially as they become more advanced. When this happens, it is a bonus, not an expectation.

One of the major problems that often leads to prodding students into rushing is the "room situation." This is a real issue, as trivial as it may seem. If students are not assigned a room because the site is used to the maximum, then there is a real danger that the patients scheduled for the day will not be seen in a reasonable time-frame. While this situation cannot be entirely overcome, there are some partial solutions that can be implemented. First, students do not need a room for the entire patient visit. There is often a place where they can sit to do their chart reviews while the preceptor uses the room to see a patient (or several). This could be as unlikely a place as the copier room or even a corner of the front desk. Apologize to the student for this less-than-terrific setting and explain that this is the only way you can precept. Students will understand. In some settings, there are even private places where a student can conduct a patient interview—without taking up the room with the exam table. The room where the microscope is kept might work for this or if any staff members who have offices with two chairs are out or on lunch, their rooms may be available. Preceptors of midwifery students need to be as creative with our students as we are with our patients. We've all learned to make pillows out of sheets and create feelings of warmth in the ugliest-looking rooms. This may have to be accomplished with students.

Selection of Patients for the Student Encounter

Competing needs of the patient, the student and the practice may influence patient selection for the ambulatory clinical experience. A Harvard Medical School study of how clinical preceptors selected patients found three dominant themes: time and efficiency, educational value, and the influence of teaching on the provider/patient relationship. (Simon 2003). To maximize time and efficiency, experienced preceptors will have the student start with a patient while the preceptor is seeing several others. Or, a preceptor who is running behind schedule may go out into the waiting room and introduce the student to the patient so the student can use that time while the preceptor "catches up".

A characteristic of ambulatory clinical setting is that the preceptor often has a relationship with the patients the student will be seeing and the preceptor has the expectation that her relationship with the patient will continue long after the student has completed the rotation. This patient relationship may be advantageous to the preceptor's selection because it may allow the preceptor to gauge which patient will be most receptive to the student or may provide the better educational experience. As to the

question of whether a student should be assigned to a "difficult" patient (in terms of personality, demeanor), experienced preceptors were divided. Most felt it was better for the student and the patient not to take on an angry or moody patient, but several felt it was important for a student to experience the challenging patient. (Simon 2003).

SUPERVISION IN THE INPATIENT OR INTRAPARTUM SETTING

The candle that is set up in us shines bright enough for all our purposes.
--John Locke, 1690
An Essay on Human Understanding

One of the essential functions of the preceptor, particularly important in the inpatient area, is to create a climate of safety for students. Students must know that they will not be allowed to harm a patient. Students must know that they will not be asked to perform at a level above their abilities. This doesn't mean that students are not encouraged to take on increasing responsibility. It does mean that evaluation is ongoing, with the preceptor and the student jointly determining the level of independence for which the student is ready.

Shared evaluation may be particularly difficult for the preceptor whose learning style is to jump into every situation. Such preceptors will have to work hard to hold back, to listen to the students' self-evaluation before providing their own. Each student's learning style and readiness for independence must be continually assessed and discussed. The best approach is attentive listening followed by openness with the student. This should always be accomplished with the goal of building students' self-esteem, never bruising it.

Labor Management

For I found myself beset by o many doubts and errors that I came I think I gained nothing from my attempts to become educated but increasing recognition of my ignorance.
---Rene Descartes, Discourse

The management of labor is a skill as important as any of the hand skills midwives use in the intrapartum period. In fact, it is more important as it will have an important role in determining the progress and outcome of the labor as well as the woman's experience of it. Like hand skills, labor management requires utilization of the science and the art of midwifery.

An introduction to the setting is as important in the intrapartum area as it is in the antepartum setting. Students must be introduced to staff and consulting physicians. The more they feel a part of the unit, the more comfortable they will be and the easier it will be for them to function. At the same time, they must be reminded that they are guests in the unit and must follow accepted procedures and policies.

The assignment of patients for the student is an area that deserves thought. At the beginning, students should be assigned, whenever possible, to women laboring without complications. Students without labor and delivery experience or with minimal experience will be better able to focusing on learning about labor and learning midwifery management if they concentrate on women with normal labors. Students with years of experience will be better able to unlearn nursing and learn midwifery if they don't need to be involved with medical management. As students become more advanced, they can start to see women whose labors may not be entirely normal. This way, they will learn consultative management.

Intrapartum is an area where the art and science of our profession really mesh. Sometimes, the midwifery model as described briefly above may have to be modified because of restrictions imposed by the site. This may pose a conflict for some students. Alternatively, a birth center or community-hospital environment may be stressful for a student who has had ten or twenty years experience in a high-tech tertiary care center. She may be uncomfortable managing a labor without using continuous electronic fetal monitoring. A nurse with four or five years experience in a large medical center may have had little experience working with women laboring without epidural or other anesthesia.

All of this needs to be discussed in advance of the student's beginning the clinical experience. As Lange (2006) notes, "Significant differences between actual observations and ideal perceptions of midwifery practice exist…that a theory-practice gap exists" between the theory and the practice of midwifery. Acknowledging this gap may make the student's experience smoother.

Whatever the setting for the intrapartum experience, the preceptor can help make the student's learning as beneficial as possible by always focusing on the issue of options and management choices. "If you were in a birthing center, what might your options be for this woman? At home?" "What if an IV weren't the required policy here? Does this woman really need one? How could we meet her nutritional needs in other ways?" This will be less helpful, perhaps, to the "sensing learner," who needs to experience concrete reality to learn, but it is often the best we can do in the situation. And it will stimulate the thinking of any type of learner.

Let the student know what your expectations of case presentations are. Once she is assigned a patient, how do you want her to report to you? Do you expect an evaluation of the woman and then a thorough chart review? Or would you prefer that she complete both her assessment of the woman and the chart before reporting to you?

At the time of each report, develop a future-oriented plan that includes when you expect your next report. Let the student know, of course, that things may change rapidly during labor and that plans will need constant modification. This may be a stressful situation for the "judgmental learner" whose prefers planned and orderly events, and who likes to control these. Creating as much order as possible in the unordered world of labor will help these learners. As always, identifying the conflict is the first step. The "perceptive

learner", who prefers spontaneity will be better able to adapt to the frequent changes of labor management.

Wheeler (1994) suggests: "As labor progresses, the idea of choice points, moments when options may be exercised, should be introduced. The preceptor might ask, "What are our choices now?" Useful comments to help the student keep an open mind could include, "What would you think of….?" "Would there be any advantage to …?" "What might happen if….?" (pg. 323).

In presenting labor patients, students should remember to include the status of the woman, the labor, and the fetus/newborn and a plan for each component. Dividing up thinking about the process in this manner often helps them get a "handle" on the situation.

Wheeler (1994) also raises the issue of how to handle the possibility of an emergency situation arising. Emergencies are those situations that require an immediate response. Beginning students should be assured that an emergency will be managed by the midwife. As the student progresses, however, her role in these situations will become greater. She will be expected before she completes clinical to be able to function in a variety of emergencies. Wheeler suggests that "In conjunction with the preceptor, the student might write a plan of action for each situation on a 3x5 card that the student is to keep readily accessible while on the labor and delivery unit. Periodically throughout the shift or on–call hours, the student could be drilled on the actions that should be taken to deal appropriately with one of the situations" (pg. 323).

An important issue in precepting students in labor and delivery is how much independence to allow and how much responsibility should the students be given. To determine the level of independence, remember that most students are experienced nurses. These students can be expected to observe and evaluate the laboring woman without undue supervision. Students without this experience will need more close supervision. They may not know when to call you if something unusual arises during labor.

For any student, interventions must be supervised. This includes pelvic examinations. Even nurses experienced in performing pelvic examinations may not know all the skills involved (such as checking station properly). They also may have a different, non-midwifery approach to pelvic examinations. Midwives treat the pelvic examination with exquisite respect for it as an intervention; nurses may see it as a routine function. Students must be encouraged not to see the examination in the light of, "Okay, time to do the pelvic check," but rather in the light of, "Do we absolutely need to do a pelvic examination now? If so, why? What information will it provide us with? Will it change our management? How?" If the information to be gained isn't necessary because it won't affect management one way or anther, then the examination doesn't need to be done in most cases.

Just as the experience of a bimanual examination in the outpatient setting becomes a learning experience only if the preceptor examination *precedes* the student's, so the pelvic examination in labor becomes a learning experience only if the preceptor knows the findings in advance of the student. Then the student who claims the woman is fully dilated can be helped to find the very posterior, but paper thin, cervix and realize that it is only a centimeter open.

In situations where the patient's need and the student's need conflict, the patient's needs, of course, take priority. This may happen, for instance, in the case of the student who needs to practice measuring cervical dilatation, but is working with a woman with ruptured membranes. In any case, interventionist procedures should not be done merely for student learning. If the student has difficulty with particular skills, then the only solution is to have more patient experiences, not to change an individual woman's labor to learn a skill.

Students should begin labor management by working with a single woman and her family, providing labor support and midwifery management. Students may assume nursing functions, depending on the nature of the site and the relationships between the nurses and midwives. However, some students too easily fall back on their nursing skills—their comfort zone--and must be discouraged from doing the nursing care in order to learn midwifery management.

The Delivery: Creating a Safe Environment

All learning proceeds by steps.
--Fanny Jackson Coppin[*]

Most students feel especially vulnerable to committing errors in the labor and delivery area, particularly at the time of the birth. In order to help students assume independence, we have developed what we call the "hierarchy of delivery skills." We call it a hierarchy because it is a set of functions which students can assume in a step-wise fashion—adding each new function as they become more adroit, independent, and able to multitask—so necessary in deliveries.

The hierarchy of skills is:

1. The hand skills of delivery
2. Talking to and directing the birthing woman
3. Talking to and directing the staff
4. Managing the instruments of the delivery

For some students, the order of the hierarchy will be different. There are students, for example, who can easily perform the hand skills of a delivery and manage the instruments quite independently, but have trouble communicating with the woman. There are others who easily assume the nursing role and talk readily to the woman, encouraging her pushing or her not pushing, but whose hand skills are clumsy or slow in coming. Such

students often find the nursing role more comfortable and revert back to it whenever possible.

In order for students to feel safe, the preceptor should orchestrate the first few deliveries. This means discussing with the student in advance of the delivery the many tasks that are involved. Students should be assured that the preceptor will be with them at the beginning, gowned and gloved according to site procedure. If necessary, the preceptor's hands will be right on the student's hands. The preceptor should let the student know that early on the only expectation for the student is that the hand skills be performed. The preceptor should be the person talking to and directing the woman and the staff. The preceptor should hand the student all instruments and let the students know beforehand that this will be done. This allows the student the freedom to focus on learning the hand skills of delivery.

This is not to imply that hand skills are the most important part of a delivery. They are only one of its many components. However, if the student is allowed to learn in this hierarchical fashion, anxiety will be decreased and the student will have a sense of security and safety—necessary for optimal learning.

After their first few births, students can begin to make their own assessments regarding how much of the hierarchical skills they can comfortably assume. Of course, the preceptor should never take the student's word entirely at face value---always be available to assist and take on one or more of the roles as necessary, at least for beginning students.

As students become more confident and secure, as well as more proficient, the preceptor can gradually move away, and this is meant in the most literal sense. The preceptor can truly begin to step away from the bed and allow the student to manage all components of the delivery. Of course, the preceptor must never relinquish full control to the student. The preceptor must at the very least be in the delivery room, even if not wearing gloves. All student deliveries must be supervised. This is to assure the woman's safety and the student's safety.

The bottom line for teaching, like the bottom line for patient care, is always safety.

THE ACQUISITION OF MOTOR SKILLS

Kopta (1971) outlines three stages that occur during the acquisition of motor skills:

- Cognition--understanding of the task. Individuals who are provided with a clear description and a demonstration of the task are more likely to master a new skill than those who are not.
- Integration—application of motor skills unique to the task, with the avoidance of inefficient movements.

- Automation—the ability to perform the skill automatically so that there is no need to think about each step.

According to Peyton (1998), the stages in the teaching of a manual skill are

1. demonstration-- instructor demonstrates the skill at normal speed
2. deconstruction-- instructor demonstrates the skill by breaking it down into simple steps
3. formulation--instructor demonstrates the skill while being talked through the steps by the student
4. performance–-student performs the skill and describes the steps

Some preceptors, however, will change Step 3 and talk the student into performing the skill. However, the teaching occurs, remember that even though students come into clinical having practiced skills, they are far from the stage of "automation." They may still need demonstration and instruction.

For noninvasive examination steps, such as abdominal or breast examination, students should be able to perform the examination and present their findings. Until you are comfortable with their skills, you should check significant parts of the examination—thyroid, heart, lungs, and breasts. For the pelvic examination, which is an invasive procedure, preceptors should be present for the speculum insertion, and make should to view the cervix before the student presents her findings. For the bimanual examination, examine the woman first and then allow the student to repeat the examination. This way you can both verify student findings and teach while the student completes the exam. For example, if you palpated a fibroid, you can verbally guide the student to feel. If you wait to confirm a student's examination, you will have lost the teaching opportunity, being able to only say that the student missed something.

Keep in mind, that a student beginning clinical will not have the ability to perform more than one task at a time. For example, the student may not be able to perform a breast exam AND teach the patient self breast examination simultaneously. The student will be extremely focused on the breast and not the woman attached to the breast. This comes after repeatedly performing a breast exam (automation).

In general, students should keep the four activities of outpatient care separate—interview, examination, intervention, including teaching and counseling, and charting. While students will, of course, need to take notes during the interview, they shouldn't write directly on the chart or your service will likely end up with very disorganized records! Similarly, they should try to refrain from counseling during the interview. While an experienced practitioner may begin some teaching during the diet history, for example, students who do this (except, possibly, for those who have functioned as nurse practitioners) will often lose the flow of the interview and end up with a rambling, disorganized, even incomplete history. Again, while the experienced practitioner will do parts of the history during the physical examination, and will certainly use this opportunity to do some teaching, this may distract the student. Despite careful, even repeated, palpation, the student may have no idea of what was felt.

WORKING WITH THE STUDENT WHO HAS PROBLEMS

We may desire the full light of the sun in which to do our work, but we will have to be satisfied with more limited candlelight of the human intellect. ---John Locke

Occasionally a preceptor may encounter a student who is performing less than optimally in the clinical arena. The student may realize that a problem exists or may be unaware that the preceptor perceives there to be a problem. One of the important considerations when dealing with poor clinical performance is to identify the problem as early as possible and quantify the frequency of the problem. In doing so both participants (preceptor and student) become aware of the problem, agree that indeed it is a problem, and can develop a plan to address the problem.

Identification of a student problem may not be as easy as one would expect. Often the evaluation of clinical performance is less objective than evaluation of didactic work. In addition, the mere thought of a problem creates anxiety and stress for the student. This can increase the frequency of poor performance.

Dealing with student challenges follows the management process: early identification, discussion and documentation of the problem, development of a plan to address the problem, the actual application of the plan, and, finally, a revaluation of the plan. If at any time the preceptor suspects a clinical problem the student's faculty advisor or mentor (the University faculty) should be notified. At that time a meeting will be arranged to confirm identification of the problem and initiate a learning contract to address the problem. A review of the student's didactic performance will also take place to verify that the theoretical component of curriculum is adequate.

Preceptors must take extreme care to document student problems as specifically as possible. For example, if the problem is the student's apparent lack of commitment or motivation, charting this alone is too vague to be helpful or useful if a student will be asked to leave a program (which rarely happens, but is a possibility). Instead, the preceptor should note the number of sessions the student has missed, how often the student has been late, when the student has refused to see patients toward the end of the day, takes an inordinately long lunch break, or declined to accept additional clinical time that was offered. If the student has skill-based problems, the specific areas of need should be noted on the evaluation forms such as:

> "Needs to be more aware of head control for delivery."
>
> "Has had 4 nuchal cords but still turns to the preceptor to manage this occurrence."

> "Has repeated difficulty tying knots, despite preceptor's instruction that the student practice at home and during down time in L&D."

If the problem is in use of the management process (e.g., consistent incomplete chart review or data collection, inability to make assessments or lack of a complete data base on which to make the assessment, or inability to develop a plan), this should be noted in language as specific as the following examples:

> "The student has missed on several occasions lab data that required follow-up."

> "The student was unable to correlate the patient's symptoms of vaginal discharge and odor with the appropriate different diagnosis and therefore did not take a specimen for a wet smear."

> "The student is able to obtain a complete data base from the patient, but cannot develop a problem list from which to develop a plan of management. The student presents the patient to the preceptor and continually needs guidance with the next step, despite being prodded to assume this responsibility on her own."

The Stony Brook University Midwifery Program has developed the following procedure for handling a problem in the clinical area.

Procedure For Dealing With A Problem In A Clinical Site

From time to time, students have problems in their clinical sites. It may be a scheduling problem, a problem relating to a discrepancy in the teaching-learning style of the student and the preceptor, a communication problem, a misunderstanding regarding expectations -- any number of problems arise. The faculty of the Stony Brook University Midwifery Program would like students to adhere to the following guidelines should any problem in clinical arise.

1. Remember, always, that we are guests in the institution and that our preceptors have chosen to work with students because of their individual commitment to the profession and/or to a particular student.

2. Whenever possible, speak to your clinical preceptor about the problem. Be open and honest, but non-confrontational. Express a willingness to resolve the problem and to compromise as necessary. You are not expected, of course, to compromise away your principles.

3. If you either cannot speak to the preceptor or do so without resolution, bring the problem to your University Faculty. This can be done via email or telephone. Bear in mind, however, that the University Faculty may find it necessary to speak to the clinical preceptor, the midwifery Serice Director at the site, and/or the Pathways Program Director. She will, however, discuss this with you before speaking to anyone else. You may be asked, at this point, to attend a meeting with any or all of these individuals.

4. If the problem remains unresolved, bring it to the Program Director. Again, the Program Director may choose to speak to your clinical preceptor, University Faculty, and/or the Service Director at your site. You may again be asked to attend a meeting with any or all of these individuals.

5. It is usually in the best interests of the student and site to resolve problems. If this is impossible, however, be prepared to change clinical sites, following appropriate guidelines to be discussed with your faculty member.

The following tools have been designed to carry out the above process. Many midwifery educational programs use such forms and we acknowledge their guidance in developing a problem identification form and in both the concept and implementation of a clinical contract. The Community-Based Nurse-Midwifery Education Program (CNEP) was a pioneer in the development of the formal, written clinical contract. The Stony Brook forms utilize concepts from forms developed by other programs, including CNEP and the University of New Mexico midwifery educational programs. The specific forms utilized, however, were written and designed by Stony Brook faculty.

Each form requires the signature of the student, preceptor, and faculty member to assure cohesiveness rectifying the problem. The Program Director may sign if the director was involved in the clinical conferencing and negotiating of the agreements made.

Stony Brook University Midwifery Program

Problem Identification

Student's Name	Date
Preceptor's Name/Practice or Service Name & Address	University Faculty

Description of the problem

1. Identify the area(s) in which the student has demonstrated a problem or problems (e.g., interpersonal relationships; data collection; development and/or implementation of management plans; lack of didactic knowledge base)

2. Give examples of the problem; be as specific as possible. (Attach copies of daily evaluation form(s) as appropriate and available)

3. Identify what has been done to date to resolve the problem (e.g., conferencing with the student; student assignments such as additional chart reviews or write-ups, essays about didactic material; consistent case presentations, etc.)

Has preceptor spoken with student? YES ☐ NO ☐
Date(s)…

Does student agree that there is a problem? YES ☐ NO ☐

Problem Identification (continued)

Plan for Improvement

Include goal setting, specific behavioral objective, plans for communication among student/preceptor/faculty. Be as specific as possible.

Date for re-evaluation_____

Is a clinical performance contract needed at this time? YES_____NO_____
(If yes, see Clinical Performance Contract)

If specified contract activities do not result in accomplishment of goals, what plan/action is recommended? (academic warning, change of student progress through program, change of clinical site, break from clinical for didactic review)

Signatures
Preceptor(s):
University Faculty:
Student:
Program Director (as appropriate):

DATE:

Stony Brook University Midwifery Program

Clinical Performance Contract

Student's Name	Date
Preceptor's Name/Practice or Service Name & Address	University Faculty

Description of the problem

3. Identify the area(s) in which the student has demonstrated a problem or problems (e.g., interpersonal relationships; data collection; development and/or implementation of management plans; lack of didactic knowledge base)

4. Give examples of the problem; be as specific as possible. (Attach copies of daily evaluation form(s) as appropriate and available)

Clinical Performance Contract (continued)

Identification of Goals

1. Identify specific goals to be attained. These must be agreed upon by the student, preceptor, University faculty, and Program Director, as appropriate. Goals are more general than behavioral objectives, in #2 below. Examples of goals might include:

Student will be able to consistently apply the management process in all clinical encounters; student will demonstrate evidence of practice within the midwifery model

2. Identify behavioral objectives to be achieved. These are specific to the goals above. Examples of behavioral objectives to demonstrate achievement of the goals set above might:

Student will demonstrate consistently thorough and organized chart review and case presentations; student will include teaching and counseling in all management plans.

3. Identify plans for achieving these objectives. This might include issues such as scheduling (e..g, the student will increase the number of clinical days to 4 per week for at least one month; the student will present every patient to the preceptor after the history and before the discharge; the student will do chart reviews for ½ hour each clinic session and will therefore arrive early to accomplish this).

4. Time frame for accomplishing goals and objectives. This might be an academic semester or several months.

Clinical Performance Contract (continued)

Date for reevaluation:

Signatures
By signing this contract, the student, preceptors, and faculty agree that the terms delineated above regarding goals, objectives, and a timeframe for their achievement will be adhered to the best of each individual's ability:
Student:
Preceptor:
University faculty:
Program Director (as appropriate):

DATE:

Clinical Performance Contract (continued)

Outcome of Contract

☐ **Goal(s) and objective(s) attained:** no further contract or program action:

☐ **Progress being achieved:** extend this contract and re-evaluate on (date)_____
Include examples**.** Be as specific as possible.

☐ **Goals not attained:** jeopardy in program progression exists.
Include examples**.** Be as specific as possible.

Specify action or actions:
- Student to be placed on academic warning
Notification to Program Director and Assistant to the Dean for Student Affairs
- Student to take a break from clinical to work on didactic knowledge base
- Student to be placed with a different preceptor in same site
- Student to be placed in another site
- Student to be placed in Stony Brook "intensive clinical site" with a faculty member as preceptor
- Other

DATE FOR REEVALUATION:
(Complete new form at that time)

Signatures **DATE:**
Student:
Preceptor:
University faculty:
Program Director (as appropriate):

CULTURAL COMPETENCE IN CLINICAL PRECEPTING

We are more alike, my friends,
than we are unalike.
---Maya Angelou, Human Family

Cultural competence is as important in clinical precepting as it is in patient care. Until recently, appreciating what a particular cultural group eats and doesn't eat, what holidays they celebrated, and how they dressed was considered to encompass the necessary skills for relating to persons from a variety of cultural backgrounds. Today, we realize that this hardly touches the surface. In fact, the vision of the Health Resources and Services Administrations's Maternal and Child Health Bureau (MCHB) is for …" equal access for all to qualtity health care in a supportive, culturally competent environment, which is family-centered and community- based." (National Center for Cultural Competance 2004).

Experts in the area of cultural competence have defined a number of concepts, including cultural knowledge, cultural awareness, and cultural sensitivity. Cultural competence encompasses all of these and goes beyond them. It has been defined as behaviors, attitudes, and policies, held and practiced by a system, an institution, or a group of professionals, that enables effective cross-cultural working (Cross, Barzon, Dennis, & Isaacs, 1989). Cultural competence incorporates cultural knowledge, or familiarity with a culture's characteristics, history, values, and behaviors. It incorporates cultural awareness, which involves developing sensitivity toward various groups. It incorporates culltural sensitivity, which implies recognition of differences and similarities among cultural groups, without the assignment of values to these differences and begins by a vigorous self assessment (NCC 2002).

If we are to be culturally competent, we embrace and value diversity. We truly believe that we are enriched by our associations with people from various cultures, races, ethnicities, nationalities. This goes beyond tolerance, even beyond acceptance. It involves recognition of the value added to our lives through our association with people different, in whatever ways, from ourselves.

Several exercises are valuable as first steps in achieving cultural competence. First, think about your own culture. Perhaps the very first step in doing this is to realize that everyone has a culture. Often, people from the "mainstream" culture in a particular society think that culture is just something that "minorities" have. This is similar to thinking that everyone has an accent, except people from your part of the country.

Culture can encompass many things. You may consider yourself a part of a national group and relate to that as your culture. You may be from an ethnic group within a country and feel that that has defined you. You may consider your sexual orientation as the defining component of your culture, or as one its components. Some religions confer a culture on their practitioners. Lifestyle has come to define culture for some people—

YUPPIES, for example, “Young Urban Professionals” (or, as it’s also been called, “Young Upwardly-Mobile Professionals”) constitutes a cultural group.

So, think about your culture. How would you define it? What characteristics do you have that are based on your culture, that you share with others from your culture? What values do you have from your culture? How do others see you? How would they define your culture? Is it the same as you would? How does that make you feel? What biases or prejudices do you think others have, if any, toward people from your culture. What stereotypes are out there? How do they make you feel?

As a follow-up exercise, think about stereotypes of other cultures. Make a list of at least 3 groups that you see as having distinct identities in this society. For each group, make a list of cultural stereotypes that you have heard about this group. Which of these do you believe? Why or why not? In what ways might these beliefs affect your ability to interact fairly and on terms of equality with people from this group? In what ways, in particular, might these affect your precepting of somebody from a particular cultural group?

Remember, the first step in overcoming assumptions and prejudices is to recognize and acknowledge them.

In teaching, cultural competence may come in various forms. For example, a student who seems not to have a good knowledge base may simply be reticent in sharing it. Perhaps this is because she is an “introvert” learner, but it could also be because she is from a culture that instilled in her that women are meant to be circumspect. She may have received her basic education in a system that values rote learning rather than critical thinking or that tells the student that the teacher’s voice is the main one to be heard. She may not even look the teacher in the eye, out of respect.

One issue that must be faced when thinking about cultural competence is that of power. Although in adult learning, we believe in establishing collegial relationships with students, the reality is that any teacher-student encounter involves an uneven distribution of power. The faculty or preceptor could declare a student not competent to become a midwife and end the possibility of the student achieving a desired goal. In any society that has not yet reached full equality, and where inequity is based in many circumstances on social, economic, racial, gender, appearance, disability, sexual orientation, and cultural differences, these factors can further influence the division of power. The first step in overcoming this inequity is to recognize it.

When a student feels that there has been an incident of discrimination or prejudice, this must be faced squarely, regardless of the lack of intent or the preceptor’s feeling that this has not been the case. There may be unconscious and very subtle cues being given, cues which are not intended. Issues of racism, as painful as they can be, are real and need to be overcome, not brushed aside. Students’ feelings must be carefully considered and an attempt made to correct the behavior on the part of the preceptor or faculty to the extent possible. If necessary, the student’s program faculty and the Program Director should be

part of such a discussion. Of course, the situation could be reversed and the preceptor or faculty be the one facing such discrimination. This, too, must be addressed.

In addition to respecting the student's culture (and expecting respect for yours as well), students often must learn to care for women from a variety of cultures. Many midwifery practices today serve women from a variety of countries, various socio-economic and racial and ethnic groups. Some students have more experience with such diversity than others. Students will need to both understand the customs and norms of the cultural groups with whom you work and any available literature developed in your practice or service should be shared with them. Perhaps the social service department can meet with new students to orient them to the variety of cultural practices they will encounter. Most important, of course, is for the students to respect and value their interaction with diverse groups of women and families.

Kleinman, Eisenberg, & Good, (1978) propose a model of cross-cultural health care delivery that incorporates the individual woman's experience of health and illness. They suggests asking the following questions in health encounters:

1. What do you call the problem?

2. What do you think has caused the problem?

3. Why do you think it started when it did?

4. What do you think the sickness does? How does it work?

5. How severe is the sickness? Will it have a short of long course?

6. What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?

7. What are the chief problems the sickness has caused?

8. What do you fear most about the sickness?

When there is an intervention to be implemented, Carillo, Green, & Betancourt, (1999) recommend that the practitioner:

- Describe specific management options in understandable terms
- Prioritize management options
- Determine the patient's priorities
- Present a reasonable management plan
- Determine the patient's level of acceptance of this plan
- If conflict remains, focus on higher priorities

Incorporating these steps may be difficult for a student, especially a beginning student. Further difficulties may be encountered if there is a language barrier. Translators may be the woman's family members or friends and sensitive subjects may be difficult or impossible to explore.

In all encounters, if an attitude of respect prevails, conflicts and difficulties will be minimized. Because students traditionally spend a good deal of time with patients and listen intently, they are often in the best position to relate well to women from any cultural or ethnic group.

If ever there appears to be a problem based on a student's inability to relate to the women in their care for reasons that seem to be prejudicial, this must be discussed. The University faculty and Program Director must be contacted and involved so such issues can be effectively dealt with.

Much more could be written about this topic. So much of developing cultural competence, however, depends on the experience of relationships. We cannot provide such experience for preceptors. What we can do is suggest reading any or all of the following. They are the closest one can come to experiencing different cultures. For the most part, they are not pedantic or didactic readings, but provide a context for submersion into a culture. They are not limited to health issues, but tell the stories of women's lives.

The books include fiction, poetry, memoir, biography, and scholarship. Some are contemporary, others historical. Some tell the stories of exceptional women, others the stories of everyday women. This list is hardly complete. Because we are fortunate to live in a cross-cultural society, we have continuing access to new and wonderful readings about people from all over the world. The following list is a personal compilation that focuses on women. It is listed in alphabetical order by the first author's last name. We would be happy to receive suggestions of other readings that immerse us in women's lives in various cultures.

Recommended Multicultural Readings

Chinua Achebe
Things Fall Apart

Dorothy Allison
Bastard Out of Carolina

Isabel Allende
Of Love and Shadows

Hanan al-Shaykh, Catherine Cobham (Translator)
Women of Sand and Myrrh

Maya Angelou
I Know Why the Caged Bird Sings

Gloria Anzaldua, Melanie Kaye Kantrowitz
Making Face, Making Soul/Haciendo Caras: Creative and Critical Perspectives by Women of Color

Elisabeth Burgos-Debray, Rigoberta Menchu
I, Rigoberta Menchu : An Indian Woman in Guatemala

Sandra Cisneros
The House on Mango Street

Alice Echols
Daring to Be Bad: Radical Feminism in America, 1967-75

Nawal El Saadawi
The Innocence of the Devil
Woman at Point Zero

Buchi Emecheta
The Bride Price
The Joys of Motherhood

Louise Erdrich
Love Medicine

Evans, Sara
Personal Politics: The Roots of Women's Liberation in the Civil Rights Movement and the New Left

Anne Frank
Anne Frank: The Diary of a Young Girl

Shirley Geok-Lin Lim, Mayumi Tsutakawa, Donnellym Margarita, Shirley Geoklin, editors
The Forbidden Stitch (Asian American Women)

Carol Gilligan
In a Different Voice: Psychological Theory and Women's Development

Nadine Gordimer
July's People

Jennifer Harbury
Bridge of Courage: Life Stories of the Guatemalan Companeros and Companeras

Patricia Hill-Collins
Black Feminist Thought: Knowledge,Consciousness, and the Politics of Empowerment

bell hooks
Bone Black: Memories of Girlhood

Jeanne W. Houston
Farewell to Manzanar

Jamaica Kincaid
A Small Place
Annie John

Barbara Kingsolver
The Bean Trees
Pigs in Heaven
The Poisonwood Bible

Maxine Hong Kingston
China Men
The Woman Warrior: Memoirs of as Girlhood Among Ghosts

Jane Lazarre
Beyond the Whiteness of Whiteness: Memoir of a White Mother of Black Sons

Sarah Lawrence Lightfoot
Balm in Gilead
I've Known Rivers: Lives of Loss and Liberation

Audre Lourde
Zami, a New Spelling of My Name

Alev Lytle Croutier
Harem: The World Behind the Veil

Leslie Marmon Silko
Ceremony
Almanac of the Dead

Paulie Marshall
Brown Girl, Brownstone
Praisesong the Widow

Mary McCarthy
Memories of a Catholic Girlhood

Lynn Mikel Brown, Carol Gilligan
Meeting at the Crossroads: Women's Psychology and Girl's Development

Toni Morrison
Beloved
The Bluest Eye

Gloria Naylor
Linden Place
Mama Day
The Women of Brewster Place

Peggy Orenstein
Schoolgirls: Young Women, Self-Esteem, and the Confidence Gap

Rosa Parks, Gregory Reed
Quiet Strength: The Faith, the Hope, and the Heart of a Woman Who Changed a Nation

Margaret Randall and Lynda Yanz
Sandino's Daughters : Testimonies of Nicaraguan Women in Struggle

Jean Rhys
The Wide Sargasso Sea

Andrea Rudd, Darien Taylor
Positive Women: Voices of Women Living with AIDS

Amy Tam
The Joy Luck Club
The Kitchen God's Wife

Kate Simon
Bronx Primitive

Barrie Thorne
Gender Play: Girls and Boys in School

Liv Ullman
Changing
(This book is out of print, but Amazon.com will conduct a search for you)

Harriet Wilson
Our Nig; Or, Sketches from the Life of a Free Black, in a Two-Story White House, North. Showing That Slavery's
Shadows Fall Even There With an introduction by Henry Louis Gates
Considered the first novel by an African-American published in the United States

Winterson, Jeanette
Oranges Aren't the Only Fruit

Diane Yen-Mei Wong, Emilya Cachapero, Diane Yen Mei Wong, editors
Making Waves: An Anthology of Writings by and About Asian American Women

Janet Zandy, editor
Calling Home: Working-Class Women's Writings: An Anthology

In Summary: Characteristics of Expert Preceptors

Preceptors are expert clinicians. We have attempted to provide some tools to assist the clinician to effectively teach in this manual. What makes the expert clinician an expert preceptor? A list of the characteristics of the expert clinical teacher is provided by Raisler (2003):

- Competence
- A broad base of knowledge in their chosen field
- Enjoyment of teaching and patient care
- Respect for students and patients
- Accessibility and supportiveness
- Being well-organized
- Giving clear direction to students about what is expected
- Limiting the amount of content that they teach in a given encounter
- Teaching in a practical, engaging manner

- Providing frequent, nonthreatening feedback
- Preparing materials and planning teaching experiences ahead of time
- Taking advantage of teachable moments that arise in the clinical setting
- Teaching at the student's level
- Continuously reflecting on their teaching successes and failures
- Remaining open to change and experimenting with new approaches

NOTE:

*These quotes are from Criswell Freeman's *The Teachers' Book of Wisdom* (1998). Nashville, TN: Walnut Grove Press.

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CASE STUDIES FOR REVIEW

Here are some examples of clinical situations that require some intervention. Whenever appropriate, think about these using the steps of the management process.

You will be eligible for .5 CEUs approved by ACNM upon submission of the following case studies. Please use the readings and discussions in the manual to assist you with your responses.
To submit for CEUs, include your name, ACNM certification number, your Social Security number and a return address. You should receive a response within 4-6 weeks. Please mail case studies and required information to:

Stony Brook University Midwifery Program
Attn: Preceptor Case Studies
Level II
Health Science Center
Stony Brook University
Stony Brook, New York 11794-8501

Or, follow the information for emailing on the School of Nursing Website, Department of Midwifery.

Case Study #1
Margie has just begun her outpatient clinical experience with you in your private practice. You have agreed to precept Margie because her faculty (who is a good friend of yours) persuaded you to precept her. Margie's faculty described her as a good student who has a B+ average.

When you interviewed Margie, she told you that she was a labor and delivery nurse for 20 years. She told you that she had always wanted to be a midwife, but had put off going back to school until her children were older.

Margie relates well to patients, but does not seem to have a grasp of the theory needed to manage a patient visit. She always needs time to "look things up" before she can answer your questions.

In which domain of learning does Margie appear to have a weakness?

Explore two reasons why Margie seems "clueless" and how you would discuss this with her.

Case Study #2

Nancy has been your student in the gynecologic and family planning setting for three weeks. She has very good technical skills and is able to do an accurate bimanual examination, a good speculum insertion, and take a Pap smear and cultures. However, Nancy seems to miss quite a bit when taking a history. She frequently forgets to ask about history of STIs, take a thorough sexual history, or get information about a woman's current relationship,

What do you suspect as the problem? What domain of learning is involved in this issue?

What approach could you use to intervene?

Case Study #3

You were approached by University faculty to precept Kathy. The University faculty explained that Kathy had been placed in a low tech, low volume community hospital and had 10 births experiences. The student needs to come to your tertiary care hospital with its large patient population. The University faculty stated that Kathy's last preceptor gave her a very good evaluation and really felt that she had the heart of a midwife, although very little labor and delivery experience. You are having a great deal of difficulty precepting Kathy. Her labor management plans do not seem appropriate and she frequently disagrees with any intervention you propose. Today, after Ms. Smith had a nine pound baby, you asked Kathy what she would use to repair the 2nd degree perineal laceration. Kathy's reply was, "I won't repair it, we never repaired lacerations at my last site."

To what areas of Kathy's background do you attribute the conflict?

What techniques could you employ to achieve a change in attitude?

Case Study #4

Wendy has been your IP student for 12 weeks. Today, a woman gave birth to a 9 pound 6 ounce boy. Unfortunately, the patient sustained a 4th degree laceration, and Wendy is very upset with this outcome.

How would you counsel Wendy?

Case Study #5

Helen has been your student in the office for three weeks. With your assistance, today she palpated the right ovary on a 72-year-old woman during an annual exam. Helen reports this finding to you and you tell her to present this case to Dr. Harris. Helen becomes nervous and pleads for you to present to Dr Harris.

How can you assist Helen now?

What could you have done prior to this to instill confidence?

Case Study #6

Lola has your student for 4 weeks at your busy gyn clinic. You have a very diverse population, mostly gynecology patients and about 10% prenatal. Lola had been with your colleague at another site for 4 sessions. Today, Lola says she does not think she will be back as she has enough gynecology experiences and wants to find a site with more OB.

What action can you take?

RESPONSIBILITIES OF THE PRECEPTOR IN CLINICAL

Stony Brook University Midwifery Program
Stony Brook University

1. Become familiar with the Stony Brook Stony Brook University Midwifery Program curriculum. This is provided to you in our preceptor packet. Please let the student or University Faculty member with whom you have a liaison know if you have not received this.

2. Orient the student to the physical site. Introduce the student to all staff members, including clerks, nurses, midwives, physicians, allied health personnel, and any other people with whom the student will come into contact.

3. Acquaint the student with the midwifery practice agreements of the site in all areas in which the student will be practicing.

4. Discuss in advance with the student your expectations and teaching style.

5. Have the student present each patient to you in a complete and organized fashion.

6. Always teach to the management process—expect the student to do a complete data collection, assessment and plan. The student should be able to implement the plan, although the student will require assistance until s/he becomes familiar with the clinical site policies and procedures. Please assist the student with these, especially at the beginning.

7. Where the site practice agreement and policies do not necessarily reflect the midwifery model of care, or where other options may be acceptable care, the student must, of course, practice according to the requirements of the site. We encourage preceptors, however, to allow students to offer alternative managements even if they cannot be implemented, for the student's learning.

8. Check all student assessments, especially pelvic, until you are confident that the student is making appropriate assessments. Be present in the room for these assessments. We advise doing the pelvic examination first so that when the student is doing the examination you can assist her/him in making an accurate assessment. Remember, these are students, so if the woman has a particular problem or risk factor, such as high risk for breast cancer, please check the student assessments.

9. Try to find a private place in the unit where the student can present patients to you and where you can pre- and post-conference. Try to find the time for these pre- and post-conferences.

10. Students are required to complete a daily clinical evaluation tool, specific to each area of practice. Students must evaluate themselves on the check-off part of the form *and* the narrative. Preceptors are asked to review these forms and corroborate (or not) the student's self-evaluation. Preceptors are asked to be specific in commenting on the student's clinical performance. These forms should be used as a daily evaluation tool during the initial months of the student's clinical practice. They may be used as a weekly tool if and when the preceptor deems this appropriate—i.e., when the student has reached a level of competence with which you are comfortable.

11. The student must present to you two copies of a Mid-rotation/Final Evaluation Form for each clinical area for which you work with the student (WWG/AP/IP/NB/PP). Please fill these out at the mid-point and end of the student's rotation with you in that area. Conference with the student about the evaluation and allow the student to enter comments on the forms. These forms are to be submitted to the students University Faculty.

12. Contact the student's University Faculty and/or the Stony Brook University Midwifery Program Program Director at any time that you feel necessary. We will try to maintain open lines of communication at all times, but if you feel we have not contacted you frequently enough, please let us know. Pathways faculty are available via email or telephone at all times.

13. If there is ever a conflict between patient needs and student needs, we are aware that patient needs come first. Pathways' students should be aware of this as well.

14. Be familiar with the following Stony Brook University Midwifery Program documents: "Responsibilities of the Student in Clinical" and "Procedure for Dealing with a Problem in a Clinical Site." These are in the preceptor packet. If at any time you believe the student is not following the guidelines set forth in these documents, please discuss this with the student and/or the University Faculty.

15. Try to protect the student if at all possible from the internal politics of the unit, but require student accountability at all times.

Adopted by the Stony Brook University Midwifery Program Faculty
January 1999
Revised and Adopted
October 1999/January 2000

RESPONSIBILITIES OF THE STUDENT IN CLINICAL

Stony Brook University Midwifery Program

Stony Brook University

1. Report to the clinical site on time and in appropriate professional dress. If a laboratory coat is routinely worn at the site, the student should wear a laboratory coat. In intrapartum, the student is responsible for wearing scrubs and appropriate shoes. Name tags should be worn.

2. Learn the appropriate phone numbers to call if at any time you are unable to attend clinical. For example, if you do not know until the morning of clinical that you are sick, it may be best to call the site, but if you know the evening before, it may be best to call your preceptor at home, if that is acceptable to your preceptor. Make such arrangements with your preceptor as soon as you begin at the site.

3. Identify yourself to all staff and patients as a Registered Nurse who is studying to be a midwife.

4. Become familiar with the physical layout of the site and with the midwifery practice agreements of the site. Learn the formulary and procedures for following-up laboratory work.

5. Make sure it is acceptable to the patient to be cared for by a student before undertaking her care. Let her know that it may make her visit longer and make certain she is not in a rush.

6. Discuss with your preceptor the following before beginning clinical:
   a. your past experience, even if minimal or none
   b. your overall goals and objectives for the clinical experience
   c. your strengths and weaknesses
   d. your needs as a learner

7. Identify at each clinical session your goals and objectives for the session. Bear in mind, of course, that whether or not these can be met may depend on circumstances beyond your control. Therefore, be flexible.

8. Identify and seek learning experiences necessary to complete your goals and objectives. For example, in a particular site, the midwives may not do newborn physical examinations. As this is a Core Competency for midwifery education and a requirement of the Stony Brook University Midwifery Program program, you may need to discuss with your preceptor the possibility of working with a nurse-practitioner or pediatrician to complete this portion of your clinical objectives. Make certain that you also discuss this with your University Faculty.

9. Complete a daily clinical evaluation form and submit to your preceptor for feedback after each clinical session. You must include descriptive comments on your performance as well as completing the check off portion of the form. You must include updated statistics on these forms. Copy these forms MONTHLY and send them to your University Faculty.

10. Make sure your preceptor receives two copies of the Mid-Rotation/Final Evaluation Form for each area for which you are working with that preceptor. The preceptor will fill out these forms and you have the opportunity to make comments once they are presented to you by your preceptor.

11. Present all patients to your preceptor in a complete and organized format.

12. NEVER allow a patient to leave the clinic/floor without a sign-off report to your preceptor.

13. If a consultation is required, first consult with your preceptor, until you and your preceptor determine that you are ready to consult with a physician or other health care provider without first informing the preceptor. This may never happen and that is acceptable.

14. Do not perform any component of care that involves touching a patient or any intervention without first discussing it with your preceptor, unless you and your preceptor determine that you may do so without first consulting with the preceptor. Your preceptor should be in the room when you perform pelvic assessment and check your assessments until s/he determines that you may perform these assessments on your own. You may suggest to your preceptor that s/he perform the pelvic examination before you so that s/he can help you make the correct assessment during your examination. Always report findings, therefore, during the examination. Explain first to the patient that you will be doing this.

15. Always remember that patient care is the most important objective of the clinical site and midwifery education secondary. If ever there is a conflict between your learning needs and the patient's needs, the patient's needs will be considered over the student's.

16. If at any time you encounter a problem in the clinical site or with your clinical preceptor, following the guidelines outlined in the Stony Brook University Midwifery Program document, "Procedure for Dealing with a Problem in a Clinical Site."

Adopted by the Stony Brook University Midwifery Program faculty
January 1999
Revised and adopted
October 1999, January 2000, May 2000

APPENDIX III: Stony Brook Daily Clinical Evaluation Forms

Stony Brook University: Stony Brook University Midwifery Program

Daily Clinical Evaluation Tool: Well Woman Gynecology

Student	Preceptor	Site	Date	Evaluation key: 1 –identified learning need 2 – performs well in part 3 – performs well completely NA – not applicable

Clinical Objectives	Self Evaluation	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data				
Reviews chart				
History: med/surg, fam, ob/gyn, contraceptive, sexual, social, nutrition				
Interviews woman				
Demonstrates appropriate interviewing skills				
Obtains a complete history				
Obtains an interval history				
Obtains history related to presenting problem				
Performs Physical Exam				
Complete or interim PE				
Breast exam				
Abdominal exam				
Speculum				
External genitalia/bimanual				
Orders/performs/interprets lab tests				
Routine screening labs				
Symptom related labs				
II. Makes appropriate assessment/diagnosis				
Existing problems				
Potential problems				
III. Develops a plan with rationale				

Presents organized case to preceptor				
IV. Implements plan				
Initiates appropriate contraceptive method Specify:				
Provides teaching/counseling as appropriate				
Provides appropriate anticipatory guidance				
Manages problems re: contraceptive method				
Orders/manages appropriate therapeutics				
Consults/refers appropriately				
Provides for appropriate follow-up				
V. Documents findings				
Charts accurately				
Charts concisely				
VI. Evaluates plan				
VII. Assumes appropriate SNM role				
Comes prepared				
Seeks appropriate guidance				
Works within setting protocols				
Recognizes when beyond scope of pract/exper.				
Follows the midwifery model in all care				
VIII. Performs self evaluation				

Student: Comments, feelings, specific learning needs and goals of this clinicial experience.

Preceptor: Comments, feelings, specific learning needs and goals of this clinical experience.

Preceptor Signature: **Student Signature:**

TYPE OF CARE	TODAY	TO DATE	TYPE OF CARE	TODAY	TO DATE	TYPE OF CARE	TODAY	TO DATE
Hours spent			**Infertility visit**			**Rx/therapeutics (specify):**		
New/Annual exam (H&P)			**STD-focused visit**			**Consults/Referrals**		
1^0 care problem (specify):			**IUD insertion/removal**			**Wet mount or other microscope**		
4-6 week postpartum visit			**Pill initiation**			**Other (specify):**		
Perimenopausal visit			**Pill problem**					
Postmenopausal visit			**Diaphragm fit**					
Preconceptional visit			**Diaphragm check**					

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

Stony Brook University: Stony Brook University Midwifery Program
Daily Clinical Evaluation Tool: Antepartum

Student	**Preceptor**	**Site**	**Date**	**Evaluation key:** **1 –identified learning need** **2 – performs well in parts** **3 – performs well completely** **NA – not applicable**

Clinical Objectives	**Self Evaluation**	**Preceptor Evaluation**	**Objective Achieved**	**Comments**
I. Collects Data				
Reviews chart				
Hx: med/surg/ fam/ob/gyn/contracep/sex/soc/nut				
Current pregnancy				
Interviews woman				
Demonstrates appropriate interviewing skills				
Obtains a complete history				
Obtains an interval history				
Obtains history related to presenting problem				
Performs Physical Exam				
Complete or interim PE				
Leopold's/FH/EFW (circle)				
FHT: Doppler				
FHT: Fetoscope				
Speculum exam				
Bimanual exam/Clinical pelvimetry (circle)				
Orders/performs/interprets lab tests				
Routine AP				
Symptom related				
Fetal screening				
II. Makes appropriate assessment/diagnosis				
Existing problems				
Potential problems				
III. Develops a plan with rationale				
Presents organized case to preceptor				
IV. Implements plan				

Provides appropriate teaching and counseling				
Provides appropriate anticipatory guidance				
Orders/manages appropriate therapeutics				
Consults/refers appropriate				
Provides for appropriate follow-up				
V. Documents findings				
Charts accurately				
Charts concisely				
VI. Evaluates plan				
VII. Assumes appropriate SNM role				
Comes prepared				
Seeks appropriate guidance				
Works within setting protocols				
Recognizes when beyond scope of prac/exp.				
Follows the midwifery model in all care				
VIII. Performs self evaluation				

Student: Comments, feelings, specific learning needs and goals of this clinical experience.

Preceptor: Comments, feelings, specific learning needs and goals of this clinical experience.

Preceptor signature: **Student signature:**

TYPE OF CARE	TODAY	TO DATE	TYPE OF CARE	TODAY	TO DATE	TYPE OF CARE	TODAY	TO DATE
Hours Spent			**1° care problem (specifiy):**			**Rxs/therapeutics (specify):**		
New AP Visit								
Return AP Visit			**Problem visit (specify):**			**Consults/Referrals (specify):**		

Tool adapted with permission from Columbia University School of Nursing Midwifery Program.

Stony Brook University: Stony Brook University Midwifery Program

Daily Clinical Evaluation Tool: Intrapartum

Student Name	Preceptor	Site	Date	Evaluation key: 1 –identified learning need 2 – performs well in part 3 – performs well completely NA – not applicable

Clinical Objectives	Self Evaluation	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data				
Reviews chart				
Obtains relevant IP history				
Obtains complete history				
AP history				
From chart				
From woman				
Hx: med/surg/fam/ob/gyn/contra/sex/soc/nut				
From chart				
From woman				
Demonstrates recognition of appropriate IP priorities in history taking				
Interviews woman				
Demonstrates appropriate interviewing skills				
Obtains a complete/interval history (circle)				
Obtains history related to presenting problem				
Performs Physical Exam				
Complete or interim PE				
Leopold's/FH/EFW (circle)				
FHT: Doppler				
FHT: Fetoscope				
Contraction pattern				
Status of membranes				
Bloody show, bleeding				
Emotional/support system/response to labor				
Orders/performs/interprets lab tests				
Routine AP				
Symptom related				
Fetal screening				

II. Makes appropriate assessment/diagnosis				
Maternal status				
Fetal status				
Labor status				
III. Develops a plan with rationale				
Presents organized case to preceptor				
IV. Implements plan				
Provides appropriate teaching and counseling				
Provides appropriate anticipatory guidance				
Demonstrates appropriate delivery techniques: Head/Shoulders/Body (circle)				
Appropriately manages third stage of labor				
Performs appropriate immediate newborn PE				
Orders/manages appropriate therapeutics				
Consults/refers appropriately				
Provides for appropriate follow-up				
V. Documents findings				
Charts accurately				
Charts concisely				
VI. Evaluates plan				
VII. Assumes appropriate SNM role				
Comes prepared				
Seeks appropriate guidance				
Works within setting protocols				
Recognizes when beyond scope of pract./exp.				
Follows the midwifery model in all care				
VIII. Performs self evaluation				

Stony Brook University: Stony Brook University Midwifery Program
Daily Clinical Evaluation Tool: Intrapartum (continued)

Student: Comments, feelings, specific leaning needs and goals of this clinical experience.

Preceptor: Comments, feelings, specific learning needs and goals for this clinical experience.

Preceptor signature: **Student signature:**

TYPE OF CARE	TODAY	TO DATE	TYPE OF CARE	TODAY	TO DATE
Hours Spent			**Immediate PP hemorrhage**		
Intrapartum management			**Shoulder dystocia**		
Labor Support			**Prolapsed cord**		
Complicated IP management: Specify			**Consults/referrals**		
AROM			**Initiation of breast feeding**		
Application Fetal Scalp Electrode			**Newborn resuscitation**		
Application of IUPC			**Prescriptions/therapeutics**		
Vaginal delivery: Head Shoulders Body			**Wet mounts or other microscope**		
Laceration repair. Specify degree:			**Immediate newborn evaluation**		
Episiotomy					
Episiotomy Repair					

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

Stony Brook University: Stony Brook University Midwifery Program

Daily Clinical Evaluation Tool: Postpartum

Student Name	Preceptor	Site	Date	Evaluation key: 1 –identified learning need 2 – performs well in parts 3 – performs well completely NA – not applicable

Clinical Objectives	Self Evaluation	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data				
Reviews chart				
Hx: med/surg/fam/ob/gyn/contracep/sex/soc/nut				
Current pregnancy and delivery				
Interviews woman				
Demonstrates appropriate interviewing skills				
Obtains a complete history				
Obtains an interval history				
Obtains history related to presenting problem				
Evaluates psychological response to birth				
Performs Physical Exam				
Complete or interim PE				
Breasts				
Abdomen				
Uterus/involution				
Perineum/Rectum/Lochia				
Extremities				
Evaluates mother-infant interaction/feeding				
Orders/performs/interprets lab tests				
II. Makes appropriate assessment/diagnosis				
Existing problems				
Potential problems				
III. Develops a plan with rationale				
Presents organized case to preceptor				
IV. Implements plan				
Provides appropriate teaching and counseling				

Provides appropriate anticipatory guidance				
Orders/manages appropriate therapeutics				
Consults/refers appropriately				
Provides for appropriate follow-up				
V. Documents findings				
Charts accurately				
Charts concisely				
VI. Evaluates plan				
VII. Assumes appropriate SNM role				
Comes prepared				
Seeks appropriate guidance				
Works within setting protocols				
Recognizes when beyond scope of prac./exp.				
Follows the midwifery model in all care				
VIII. Performs self evaluation				

Student: Comments, feelings, specific learning needs and goals of this experience.

Preceptor: Comments, feelings, specific learning needs and goals of this experience.

Preceptor Signature: **Student Signature:**

TYPE of CARE	Today	To Date	TYPE of CARE	Today	To Date	TYPE of CARE	Today	To Date
Hours Spent			**PP Day 3**			**Complications (Specify):**		
PP Day 1			**PP Discharge**					
PP Day 2			**Brstfdg Support**					

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

Stony Brook University: Stony Brook University Midwifery Program

Daily Clinical Evaluation Tool: Newborn

Student Name	Preceptor	Site	Date	Evaluation key: 1 –identified learning need 2 – performs well in parts 3 – performs well completely NA – not applicable

Clinical Objectives	Self Evaluation	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data				
Reviews chart				
History: antepartum, intrapartum, family				
History of adaptation to extrauterine life				
Evaluates feeding				
Interviews mother of baby				
Demonstrates appropriate interviewing skills				
Obtains a complete history				
Obtains an interval history				
Obtains history related to infant				
Performs Physical Exam				
Complete PE				
Developmental exam				
Neurological exam				
Assesses gestational age accurately				
Orders/performs/interprets lab tests				
Routine newborn labs				
Symptom related				
II. Makes appropriate assessment/diagnosis				
Existing problems				
Potential problems				
III. Develops a plan with rationale				
Presents organized case to preceptor				
IV. Implements plan				
Provides teaching and counseling				
Provides anticipatory guidance				

Orders/manages appropriate therapeutics				
Consults/refers appropriate				
Provides for appropriate follow-up				
V. Documents findings				
Charts accurately				
Charts concisely				
VI. Evaluates plan				
VII. Assumes appropriate SNM role				
Comes prepared				
Seeks appropriate guidance				
Works within setting protocols				
Recognizes when beyond scope of pract/exp.				
Follows the midwifery model in all care				
VIII. Performs self evaluation				

Student: Comments, feelings, learning needs and goals of this clinical experience.

Preceptor: Comments, Feelings, Learning needs and goals of this clinical experience.

Preceptor signature: **Student signature:**

TYPE OF CARE	TODAY	TO DATE	TYPE OF CARE	TODAY	TO DATE
Hours Spent			**Feeding evaluation**		
Complete newborn physical exam			**Complications (Specify):**		
Developmental exam			**Consults/Referrals**		
Neurological exam					

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

APPENDIX IV: Mid-Rotation and Final Clinical Evaluation Forms

Stony Brook University: Stony Brook University Midwifery Program
Mid-Rotation/Final Clinical Evaluation Tool: Well Woman Gynecology

Student	Site	Preceptor	Date	Evaluation key: 1 –identified learning need 2 – performs well in part 3 – performs well completely NA – not applicable

Clinical Objectives	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data			
Reviews chart			
History: med/surg, fam, ob/gyn, contraceptive, sexual, social, nutrition			
Interviews woman			
Demonstrates appropriate interviewing skills			
Obtains a complete history			
Obtains an interval history			
Obtains history related to presenting problem			
Performs Physical Exam			
Complete or interim PE			
Breast exam			
Abdominal exam			
Speculum			
External genitalia/bimanual			
Orders/performs/interprets lab tests			
Routine screening labs			
Symptom related labs			
II. Makes appropriate assessment/diagnosis			
Existing problems			
Potential problems			
III. Develops a plan with rationale			

Presents organized case to preceptor			
IV. Implements plan			
Initiates appropriate contraceptive method Specify:			
Provides teaching/counseling as appropriate			
Provides appropriate anticipatory guidance			
Manages problems re: contraceptive method			
Orders/manages appropriate therapeutics			
Consults/refers appropriately			
Provides for appropriate follow-up			
V. Documents findings			
Charts accurately			
Charts concisely			
VI. Evaluates plan			
VII. Assumes appropriate SNM role			
Comes prepared			
Seeks appropriate guidance			
Works within setting protocols			
Recognizes when beyond scope of pract/exper.			
Follows the midwifery model in all care			
VIII. Performs self evaluation			

Student: Comments, feelings, specific learning needs and goals of this clinicial experience.

Preceptor: Comments, feelings, specific learning needs and goals of this clinical experience.

Preceptor Signature: **Student Signature:**

TYPE OF CARE	Final Statistics	TYPE OF CARE	Final Statistics	TYPE OF CARE	Final Statistics
Hours spent		**Infertility visit**		**Rx/therapeutics**	
New/Annual exam (H&P)		**STD-focused visit**		**Consult/referral**	
1^0 care problem (specify):		**IUD insertion/removal**		**Wet mount or other microscope**	
4-6 week postpartum visit		**Pill initiation**		**Other (specify):**	
Perimenopausal visit		**Pill problem**			
Postmenopausal visit		**Diaphragm fit**			
Preconceptional visit		**Diaphragm check**			

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

Stony Brook University: Stony Brook University Midwifery Program
Mid-Rotation and Final Clinical Evaluation Tool: Antepartum

Student	Preceptor	Date	Evaluation key: 1 –identified learning need 2 – performs well in parts 3 – performs well completely NA – not applicable

Clinical Objectives	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data			
Reviews chart			
Hx: med/surg/ fam/ob/gyn/contracep/sex/soc/nut			
Current pregnancy			
Interviews woman			
Demonstrates appropriate interviewing skills			
Obtains a complete history			
Obtains an interval history			
Obtains history related to presenting problem			
Performs Physical Exam			
Complete or interim PE			
Leopold's/FH/EFW (circle)			
FHT: Doppler			
FHT: Fetoscope			
Speculum exam			
Bimanual exam/Clinical pelvimetry (circle)			
Orders/performs/interprets lab tests			
Routine AP			
Symptom related			
Fetal screening			
II. Makes appropriate assessment/diagnosis			
Existing problems			
Potential problems			
III. Develops a plan with rationale			
Presents organized case to preceptor			
IV. Implements plan			

Provides appropriate teaching and counseling			
Provides appropriate anticipatory guidance			
Orders/manages appropriate therapeutics			
Consults/refers appropriate			
Provides for appropriate follow-up			
V. Documents findings			
Charts accurately			
Charts concisely			
VI. Evaluates plan			
VII. Assumes appropriate SNM role			
Comes prepared			
Seeks appropriate guidance			
Works within setting protocols			
Recognizes when beyond scope of prac/exp.			
Follows the midwifery model in all care			
VIII. Performs self evaluation			

Student: Comments, feelings, specific learning needs and goals of this clinical experience.

Preceptor: Comments, feelings, specific learning needs and goals of this clinical experience.

Preceptor signature: **Student signature:**

TYPE OF CARE	Final Statistics	TYPE OF CARE	Rinal Statistics	TYPE OF CARE	Final Statistics
Hours Spent		**1^{o} care problem (specifiy):**		**Rxs/therapeutics (specify):**	
New AP Visit					
Return AP Visit		**Problem visit (specify):**		**Consults/Referrals (specify):**	

Tool adapted with permission from Columbia University School of Nursing Midwifery Program.

Stony Brook University: Stony Brook University Midwifery Program
Mid-Rotation/Final Clinical Evaluation Tool: Intrapartum

Student Name	**Site**	**Preceptor**	**Date**	**Evaluation key:** **1 –identified learning need** **2 – performs well in part** **3 – performs well completely** **NA – not applicable**
Clinical Objectives		**Preceptor Evaluation**	**Objective Achieved**	**Comments**
I. Collects Data				
Reviews chart				
Obtains relevant IP history				
Obtains complete history				
AP history				
From chart				
From woman				
Hx: med/surg/fam/ob/gyn/contra/sex/soc/nut				
From chart				
From woman				
Demonstrates recognition of appropriate IP priorities in history taking				
Interviews woman				
Demonstrates appropriate interviewing skills				
Obtains a complete/interval history (circle)				
Obtains history related to presenting problem				
Performs Physical Exam				
Complete or interim PE				
Leopold's/FH/EFW (circle)				
FHT: Doppler				
FHT: Fetoscope				
Contraction pattern				
Status of membranes				
Bloody show, bleeding				
Emotional/support system/response to labor				
Orders/performs/interprets lab tests				

Routine AP			
Symptom related			
Fetal screening			
II. Makes appropriate assessment/diagnosis			
Maternal status			
Fetal status			
Labor status			
III. Develops a plan with rationale			
Presents organized case to preceptor			
IV. Implements plan			
Provides appropriate teaching and counseling			
Provides appropriate anticipatory guidance			
Demonstrates appropriate delivery techniques: Head/Shoulders/Body (circle)			
Appropriately manages third stage of labor			
Performs appropriate immediate newborn PE			
Orders/manages appropriate therapeutics			
Consults/refers appropriately			
Provides for appropriate follow-up			
V. Documents findings			
Charts accurately			
Charts concisely			
VI. Evaluates plan			
VII. Assumes appropriate SNM role			
Comes prepared			
Seeks appropriate guidance			
Works within setting protocols			
Recognizes when beyond scope of pract./exp.			
Follows the midwifery model in all care			
VIII. Performs self evaluation			

Stony Brook University: Stony Brook University Midwifery Program
Mid-Rotation/Final Clinical Evaluation Tool: Intrapartum (continued)

Student: Comments, feelings, specific leaning needs and goals of this clinical experience.

Preceptor: Comments, feelings, specific learning needs and goals for this clinical experience.

Preceptor signature: **Student signature:**

TYPE OF CARE	Final Statistics	TYPE OF CARE	Final Statistics
Hours Spent		**Immediate PP hemorrhage**	
Intrapartum management		**Shoulder dystocia**	
Labor Support		**Prolapsed cord**	
Complicated IP management: Specify		**Consults/referrals**	
AROM		**Initiation of breast feeding**	
Application Fetal Scalp Electrode		**Newborn resuscitation**	
Application of IUPC		**Prescriptions/therapeutics**	
Vaginal delivery: Head Shoulders Body		**Wet mounts or other microscope**	
Laceration repair. Specify degree:		**Immediate newborn evaluation**	
Episiotomy			
Episiotomy Repair			

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

Stony Brook University: Stony Brook University Midwifery Program
Mid-Rotation and Final Clinical Evaluation Tool: Postpartum

Student Name	Site	Preceptor	Date	Evaluation key: 1 –identified learning need 2 – performs well in parts 3 – performs well completely NA – not applicable

Clinical Objectives	Preceptor Evaluation	Objective Achieved	Comments
I. Collects Data			
Reviews chart			
Hx: med/surg/fam/ob/gyn/contracep/sex/soc/nut			
Current pregnancy and delivery			
Interviews woman			
Demonstrates appropriate interviewing skills			
Obtains a complete history			
Obtains an interval history			
Obtains history related to presenting problem			
Evaluates psychological response to birth			
Performs Physical Exam			
Complete or interim PE			
Breasts			
Abdomen			
Uterus/involution			
Perineum/Rectum/Lochia			
Extremities			
Evaluates mother-infant interaction/feeding			
Orders/performs/interprets lab tests			
II. Makes appropriate assessment/diagnosis			
Existing problems			
Potential problems			

III. Develops a plan with rationale			
Presents organized case to preceptor			
IV. Implements plan			
Provides appropriate teaching and counseling			
Provides appropriate anticipatory guidance			
Orders/manages appropriate therapeutics			
Consults/refers appropriately			
Provides for appropriate follow-up			
V. Documents findings			
Charts accurately			
Charts concisely			
VI. Evaluates plan			
VII. Assumes appropriate SNM role			
Comes prepared			
Seeks appropriate guidance			
Works within setting protocols			
Recognizes when beyond scope of prac./exp.			
Follows the midwifery model in all care			
VIII. Performs self evaluation			

Student: Comments, feelings, specific learning needs and goals of this experience.

Preceptor: Comments, feelings, specific learning needs and goals of this experience.

Preceptor Signature: **Student Signature:**

TYPE of CARE	Final Statistics	TYPE of CARE	Final Statistics	TYPE of CARE	Final Statistics
Hours Spent		**PP Day 3**		**Complications: Specify**	
PP Day 1		**PP Discharge**			
PP Day 2		**Brstfdg Support**			

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

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Stony Brook University: Stony Brook University Midwifery Program
Mid-Rotation/Final Clinical Evaluation Tool: Newborn

Student Name	Site	Preceptor	Date	Evaluation key: 1 –identified learning need 2 – performs well in parts 3 – performs well completely NA – not applicable		
Clinical Objectives				**Preceptor Evaluation**	**Objective Achieved**	**Comments**
I. Collects Data						
Reviews chart						
History: antepartum, intrapartum, family						
History of adaptation to extrauterine life						
Evaluates feeding						
Interviews mother of baby						
Demonstrates appropriate interviewing skills						
Obtains a complete history						
Obtains an interval history						
Obtains history related to infant						
Performs Physical Exam						
Complete PE						
Developmental exam						
Neurological exam						
Assesses gestational age accurately						
Orders/performs/interprets lab tests						
Routine newborn labs						
Symptom related						
II. Makes appropriate assessment/diagnosis						
Existing problems						
Potential problems						
III. Develops a plan with rationale						
Presents organized case to preceptor						
IV. Implements plan						
Provides teaching and counseling						
Provides anticipatory guidance						

Orders/manages appropriate therapeutics			
Consults/refers appropriate			
Provides for appropriate follow-up			
V. Documents findings			
Charts accurately			
Charts concisely			
VI. Evaluates plan			
VII. Assumes appropriate SNM role			
Comes prepared			
Seeks appropriate guidance			
Works within setting protocols			
Recognizes when beyond scope of pract/exp.			
Follows the midwifery model in all care			
VIII. Performs self evaluation			

Student: Comments, feelings, learning needs and goals of this clinical experience.

Preceptor: Comments, Feelings, Learning needs and goals of this clinical experience.

Preceptor signature: **Student signature:**

TYPE OF CARE	**Final Statistics**	**TYPE OF CARE**	**Final Statistics**
Hours Spent		**Feeding evaluation**	
Complete newborn physical exam		**Complications Specify:**	
Developmental exam		**Consult/referral**	
Neurological exam			

Tool adapted with permission from Columbia University School of Nursing Midwifery Program

Pre/Post Test

1. You would expect a student who is strong in affective domain skills to do which of the following?

a. Obtain a thorough and sensitive history from a patient
b. Discuss the half-life of a medication before prescribing it
c. Perform an accurate bimanual examination

2. As a preceptor of a student beginning outpatient clinical, you should expect your student to accurate perform a physical examination while obtaining additional historical information from the patient.

a. True
b. False

3. A student is ready to complete her clinical experience when she has gotten the numbers required by her educational program.

a. True
b. False

Pre/Post Test Questions with Answers

1. You would expect a student who is strong in affective domain skills to do which of the following?

a. Obtain a thorough and sensitive history from a patient
b. Discuss the half-life of a medication before prescribing it
c. Perform an accurate bimanual examination

Answer: a
Performing an accurate bimanual examination falls into the psychomotor domain and knowing the half-life of a medication falls into the cognitive domain. Although the student may indeed possess these skills, they are not included in the affective domain.

2. As a preceptor of a student beginning outpatient clinical, you should expect your student to accurate perform a physical examination while obtaining additional historical information from the patient.

a. True
b. False

Answer: b—False
There exists a hierarchy of clinical skills and beginning students need to focus on the history and the physical as separate entities until they reach a comfort level with both.

3. A student is ready to complete her clinical experience when she has gotten the numbers required by her educational program.

a. True
b. False

Answer: b—False
The emphasis is on achieving competency.