INITIATION AND MAINTENANCE OF CLINICAL LEARNING SITES IN NURSE-MIDWIFERY*

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ABSTRACT

This article describes in practical terms the approach to selection and maintenance of clinical experience sites for nurse-midwifery educational programs. The responsibilities of clinical instructors, University programs, and student nurse-midwives in clinical settings are examined. Guidelines are offered to assist in providing a sound educational environment for the learning of the role of the nurse-midwife.

The preparation of safe beginning practitioners in nurse-midwifery is the basic purpose of every nurse-midwifery educational program. One might say that the most important concern of nurse-midwifery educators is to help ensure that the child-bearing families of this nation have available to them the highest quality health care and supervision and that this be provided by specialists in family-centered maternity care—nurse-midwives.

The greatest asset in the preparation of a nurse-midwife is inquisitive, creative, and sensitive students! The second greatest asset is the faculty—both academic and clinical. The third greatest asset is the nurse-midwifery client who is willing to provide the clinical learning environment so essential to the student's role development as a nurse-midwife. It is quite obvious to everyone in education that if nurse-midwife clinicians and their clients were to refuse to have students involved with them, there would be no future nurse-midwives.

My intent with this article is to bring academic and clinical nurse-midwives closer together as we work toward the common goal of preparing good, competent nurse-midwives. Neither of us can do it alone—we must work together if we are to succeed.

In an effort to increase understanding of the vital link between classroom and clinical learning, I would like to share some thoughts on what an educational program looks for in a clinical learning site. These thoughts are based on many years of experience practicing and teaching nurse-midwifery, and although quite familiar, they are worthy of mention.

Every educational program needs a clinical learning environment that provides opportunities for 1) the student to *learn* how to function as a nurse-midwife, 2) *positive* channels of *communication* among professionals, 3) the student to provide *nurse-midwifery management* of patient care, 4) *continuity* of patient care, 5) exposure of the student to *alternative care modalities,* 6) exposure to *experienced* nurse-midwifery *clinicians* (role models), 7) *variety* in learning opportunities, such as case conferences, rounds, and 8) an environment of *mutual respect* and *trust.*

I would hasten to add that each clinical setting is unique in its patient population and opportunities for learning the role of nurse-midwife. A given setting is generally selected for its strengths, although not all aspects above may be present. Educational

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programs using a variety of clinical sites will be able to provide more of the positive aspects of a clinical learning laboratory.

I would like to briefly explain each of the aspects of a good clinical site that were listed above.

1. Learning takes time. Students need time to learn and cannot be expected to meet the "service needs" of the site. This may mean that academic faculty will be needed at the site, or that service staff will need to be freed of other responsibilities while teaching/supervising. Students also need time to make mistakes from which they can learn, instead of mistakes incurred because of the pressure to see many patients. The beginning student is not prepared to assume responsibility for service needs, although the advanced student may well provide service coverage with limited supervision.
2. Positive communication channels are essential to good working relationships among professionals. It is important for students to witness positive interpersonal and collaborative relationships among professionals as they are developing their own role in practice. I would like to think that we nurse-midwives pride ourselves on providing care within the team approach. I believe that the families we care for benefit from the various areas of expertise of each team member.
3. When one is attempting to teach a new role, it is imperative to have that role accepted and implemented in practice—visible to the learner. We have all experienced negative learning when we had to remember to practice as we had been taught, and not as we were seeing! I trust that educators and former students will agree with me that the acquisition of clinical judgment can only be gained by practicing clinical judgment repeatedly. It is difficult to learn how to manage the care of a laboring patient when the physician constantly interferes with the decisions being made, or worse, makes his/her own decisions and carries them out before consulting with the supervising nurse-midwife. This happens too often in our clinical sites, usually out of necessity for using sites within a specific geographic distance of the educational program.
4. Continuity of patient care is beneficial to student learning, as the student is able to confirm the accuracy of clinical judgment with repeated exposure to the same clients. It is also beneficial to clients.
5. Exposure to alternative care modalities in nurse-midwifery practice is becoming an important aspect of educational programs. To be able to provide alternatives in care-giving is a goal to be sought, and is in keeping with consumer demands. Whether new practitioners will be taught these alternatives depends on whether service settings are willing to have students involved in their practices. I would quickly add that some alternative care modalities require the judgment of experienced clinicians, something new graduates in nurse-midwifery generally do not possess.
6. Experienced role models are essential to the preparation of sound clinicians. These role models include faculty as well as nurse-midwives in practice settings. The confidence and expert clinical judgment shared with learners assists the students to strive toward the same in their own practice. This exposure also helps the students to begin to develop their own philosophy of care by incorporating the "best" of everyone's practice and tailoring these to their own individual ideas about nurse-midwifery practice.
7. The more quickly students are exposed to the full range of nurse-midwifery activities, the better they can identify with the role. Rounds, case conferences, chart reviews, and lectures provide reinforcement of book knowledge with application to actual care situations. These activities also reinforce the need for professionals to constantly evaluate their own performance.
8. An environment of mutual respect and trust is not only essential to good learning, but to all activities involving human beings working together. The acceptance of the existing nurse-midwifery practice by the health care team in a given setting goes far to ensure the acceptance of nurse-midwifery students. Nurse-midwifery students will be accorded the time and opportunities to learn when they are accepted as members of the health care team. Respect and trust are "catching," like smiles, and provide an atmosphere conducive to good patient care.

I have briefly described the aspects of a clinical learning environment conducive to positive nurse-midwifery education. Now I would like to list the actual details or requirements that I as an educator am seeking in a clinical site. Four years ago I developed guidelines for the evaluation of clinical sites (available

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on request) and the following items are included in these guidelines:

1. Existence of an established nurse-midwifery practice with a written philosophy of care and protocols in keeping with the philosophy of care espoused by the educational program.
2. Interest in and willingness of nurse-midwifery staff to have students/faculty in their setting and to be active collaborators in providing and evaluating the quality of education in the setting.
3. Support of the educational philosophy of the nurse-midwifery program by staff nurse-midwives.
4. Existence of qualified medical backup willing to continue coverage when nurse-midwifery students/faculty are in the setting.
5. Sufficient volume of patients to meet the student's learning needs (preferably a minimum of two students at a time).
6. Minimal conflict with other students in the setting in care-giving activities (residents, nurse-practitioners, medical students).
7. Some flexibility in scheduling clinical practice for students when they have other class requirements.
8. Willingness of nurse-midwifery staff to accept teaching responsibility where appropriate.
9. Reasonable distance from the educational setting with additional transportation costs minimal.
10. Willingness of administration to enter into a signed agreement/clinical affiliation contract with the educational setting.

The above criteria of clinical settings are examined during the preliminary, exploratory phase of development of clinical practice sites. Guidelines for the actual implementation of clinical sites have been developed by the faculty of the Columbia University Graduate Program in Nurse-Midwifery and are also available on request.

The final thoughts I would like to share with you involve those times when nurse-midwives working in practice settings agree to participate actively in the supervision of nurse-midwifery students. I have developed 3 separate "expectations" for consideration by all who are interested in becoming clinical instructors.

I. *Educational Program Expectations of Clinical Nurse-Midwifery Faculty*

A clinical faculty member in nurse-midwifery will:

1. Accept and be committed to the philosophy of education and patient care espoused by the educational program.
2. Accept the responsibilities of a clinical instructor which include:
   a. Knowledge and support of the nurse-midwifery curriculum
   b. Support/protection of student's need to learn (buffer)
   c. Knowledge and support of individual student's learning objectives as defined by student and confirmed by faculty liaison member
   d. Selection of appropriate clinical learning situations for students in collaboration with the University faculty liaison
   e. Provision and delineation of the boundaries of "safe" practice within this setting
   f. Support of the student's approach to nurse-midwifery practice as long as it meets criteria of safety, accuracy, and minimal discomfort to the patient and is supported by a sound rationale given the political realities of the setting
   g. Provision of one's own theoretical rationale for clinical practice when requested or needed by the learner
   h. Supervision of the student's clinical practice and cosigning records as appropriate
   i. Evaluation of the student's clinical performance in daily oral conferences and signature with comments as appropriate on clinical tools (validation of student's self-evaluation)
   j. Maintainance of communication with faculty liaison on student progress
3. Participate in evaluation of the nurse-midwifery curriculum as requested by the University faculty or as need identified.
4. Be evaluated as a clinical teacher by the students in the setting and University faculty liaison on request.

I offer the following guidelines for clinical nurse-midwives contemplating the teaching role.

II. *Clinical Site Expectations of University Program*

The University will provide:

1. Faculty coordinator who will be oriented to work in the setting as needed and who possesses evidence of certification and liability insurance.
2. Details on the program curriculum and orientation.
3. Details on progress of students to date with suggestions on successful teaching modalities used with individuals.
4. Vita on students assigned to the setting prior to their arrival.
5. Help with clinical teaching and evaluation processes. In-service education workshops at request of site.
6. Specific goals for student learning in this particular setting.

The final portion of the guidelines is the important corollary of student responsibilities.

III. *Responsibilities of Student Nurse-Midwives in Clinical Sites*

A student nurse-midwife in an extended clinical site will:

1. Be responsible for his/her own learning by:
   a. Defining objectives clearly and validating with faculty
   b. Discussing written objectives with clinical preceptor prior to assignment to the setting or day of actual practice
   c. Seeking direction in choosing appropriate clinical experiences available in the setting to meet the objectives
   d. Evaluating progress daily using Clinical Evaluation Tool and obtaining validation from the clinical instructor within 48 hours of the actual experience.
2. Demonstrate knowledge of and sensitivity to personnel and institutional policies.
3. Know and practice within nurse-midwifery protocols.
4. Be prepared for each clinical assignment through reading, prior practice, and definition of learning needs.
5. Present evidence of nursing licensure and malpractice insurance on request.
6. Evaluate the instructor's teaching ability.
7. Maintain experience records for self and for the institution.
8. Evaluate the site as a learning environment.
9. Communicate progress to University faculty liaison.

These guidelines, clarifying the responsibilities of all people involved with the clinical education of nurse-midwives, have been useful in this educator's experience. When everyone understands their particular responsibilities in the teaching/learning process, true learning can take place. The combination of what to look for in a clinical learning environment and what to expect of the participants in the education of nurse-midwives will hopefully lead to the preparation of competent nurse-midwives of the future.

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