

# Giving Birth to Midwives

## A Forum for Midwifery Educators

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### Developing a Midwifery Curriculum: A Survey of Midwifery Educators

Heidi Fillmore-Patrick

#### Historical Perspective

The model of education for midwives in North America has historically been apprenticeship training; first in the native communities that inhabited this land and then by the European settlers and African people brought as slaves. Some of the original midwives in the English colonies and then later European immigrants were formally trained in European midwifery training programs, but they passed their skills on to the next generations of midwives in America through apprenticeship. Organized midwifery schools did not exist in North America until the mid nineteenth century and even then, most midwives trained by attending births as an apprentice. Formal programs were few, many did not provide a quality education, and they were inaccessible geographically and financially to most women.

Mary Breckenridge was instrumental in starting the first U. S. midwifery training program that combined nursing and midwifery into the profession of nurse-midwifery (Lobenstine Midwifery School, 1931). This happened at a time when midwifery was fast becoming a thing of the past

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*Students at SMS use swim caps  
to learn fontanel palpation*

### Virtual Midwifery Practices at Miami Dade College

Justine Clegg

When 16 year old Fanny Reed decided to give her baby up for adoption, the midwifery students in the practice took the news hard. Fanny came into the practice early in her pregnancy, and needed a lot of emotional support. She was worried about being able to be a good mother. The students discussed whether they should have referred Fanny to a professional counselor.

Fortunately, Fanny Reed is a fictional client, and the students are in the spring semester here at the Miami Dade College Midwifery Program in the midst of our Virtual Midwifery Practices. This innovative project serves as an experiential learning section for the Antepartum course, MDW 1100C.

Back in the days before the HIPAA law went into effect, students presented real client cases they encountered on their clinical sites for other students to learn from. We identified physical and psychosocial issues during pregnancy, discussed their possible impact on the birth and postpartum, and followed these cases to evaluate the results of care given. This not only presented confidentiality issues even when we de-identified cases, it was also a bit haphazard. So, Diann Gregory, CNM, and Justine Clegg, LM, CPM, the two full-time professors in the Midwifery Program, came up with the idea of the Virtual Midwifery Practices. These are "virtual clients" who present during their pregnancies with various problems

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## School Profile: Maternidad La Luz



Maternidad La Luz was the first MEAC-accredited school of midwifery in the United States and is currently accredited until September 2010. Since its inception in 1987, Maternidad La Luz (MLL) has been both a birth center and school of midwifery. The dynamic partnership of birth center and school benefits the birthing woman as well as the student. MLL clients receive excellent clinical care in a warm, supportive environment; and the students have outstanding midwifery education and training in a hands-on setting, supervised by the experienced Maternidad La Luz staff.

Through an integrated model of academic and clinical training, MLL offers a unique and holistic learning experience for aspiring midwives. The educational program, provided within a busy birthing center, allows students to solidify clinical skills while integrating their academic learning. A student at Maternidad La Luz begins learning midwifery theory and midwifery skills the first day of classes. MLL is the only MEAC-accredited school in the United States that provides all necessary clinical experience onsite with no extra fees or time required.

The school is located in a comfortable house in an historic neighborhood of El Paso. It has two classrooms, a library, administrative office, and kitchen for student use. The birth center is on the same block in a two-story house that includes three birthing rooms, two consultation rooms, a kitchen, waiting room, and a large room for students with Internet, storage, and sleeping areas. The center provides a warm, welcoming, homelike atmosphere for birthing women in Western Texas, Southern New Mexico, and Mexico.

The staff and students at Maternidad La Luz care for approximately 40 to 60 birthing women a month. Since 1987 they have attended over 10,000 births at the center. Women from the ages of twelve to forty-six have had satisfying, natural birth experiences. The majority of clients choose MLL based on the recommendation of women who

have previously given birth at the center. Most of the clients are Mexican or Mexican-American who choose an out-of-hospital birth for a number of reasons:

- A long-standing tradition of midwifery in Mexico
- A desire for woman-centered and women-attended care
- A belief in the normalcy and naturalness of birth and motherhood
- Economic considerations
- And legal considerations including a desire for US citizenship for their children.

Since March 1987, approximately 400 students from over a dozen countries have received professional midwifery training at Maternidad La Luz and are now providing birthing alternatives to women worldwide. MLL's highly challenging program results in skilled, confident midwives who are ready to practice independently, join established midwifery practices, or become valuable senior apprentices.

The student is expected to meet the licensing requirements for the states of Texas and New Mexico—as well as many other states—and the requirements for certification as an entry level midwife by the North American Registry of Midwives (NARM) after successfully completing the one-year program.

Many states and provinces require midwives to attend a three-year program. The three-year program at Maternidad La Luz is a continuation of the one-year program and consists of nine quarters, with quarters five through nine immediately following the first four quarters. The three-year program can be completed in 27 months if done continuously. The Medical Board of California accepted Maternidad La Luz's three-year program as a vehicle for licensure in 2002. As another means to obtain licensure in California, MLL offers the California Challenge Process in which students who complete the one-year program may take a clinical and written exam to test out of the three-year program.

In addition to its one- and three-year programs, Maternidad La Luz offers a three month long Advanced Midwifery Practicum to students who have completed at least one year of another school of midwifery or midwifery apprenticeship, and to practicing midwives and nurse-midwives who wish to gain experience in a busy birth center. A three-month long Beginning

Midwifery Practicum is available to those women wishing to explore the art of midwifery. The Beginning Practicum begins on March 1 and September 1 every year; the Advanced Practicum is scheduled at the convenience of the applicant and Maternidad La Luz.

Maternidad La Luz is planning to celebrate its 20<sup>th</sup> anniversary in March 2007!



## Developing a Midwifery Curriculum:

(Continued from page 1)

as physicians and hospitals were taking over the care of women in pregnancy and birth. As nurse-midwifery became established in the U.S., the education process became more and more formal and standardized for midwives who pursued that route. Other midwives continued to be trained by apprenticeship, especially in the African-American communities of the south and other ethnically distinct groups. Non-nurse, or direct-entry, midwifery schools were no longer available until the 1970's, when the women's movement fueled a new demand for midwives who practiced outside the hospital setting. Granny midwives, sympathetic physicians, and the pregnant women themselves trained a new generation of midwives to meet this demand and the apprenticeship form of midwifery education was rejuvenated. The first contemporary direct-entry midwifery school was opened in 1978 (Seattle Midwifery School) with others to follow.

Curriculum development in the formal midwifery programs has been a process of building on the traditions of midwifery education through the centuries. Mary Breckenridge brought British-style training to the U.S.—a fact that has shaped its curriculum in a way that requires nursing training as a prerequisite. Other European countries developed a different “direct-entry” model of training which non-nurse midwives in North America have looked to for guidance. Nurse-midwifery has been developing its educational model in the U.S. for over 75 years., and all midwifery educators are benefiting from and building on the work that has been accomplished in the development of midwifery curriculum and learning resources. Core competency documents have been written and revised by both ACNM and MANA and form the backbone of most formal midwifery curricula. The textbooks that most midwifery students in the U.S. currently use are now more often written by midwives, particularly nurse-midwives and European schooled midwives due to their stronger and longer academic history and traditions. However, more direct-entry midwives are contributing to this written body of knowledge and I predict will contribute more and more as the profession develops and particularly as our academic institutions are able to support faculty midwives who have an inclination and a gift to write.

### Results of Midwifery Curriculum Survey

Direct-entry midwifery educators are currently held to a common standard (MEAC for accredited schools and NARM for apprentices), although DE midwifery education is far from “standardized” or homogenous. The educational models being used are very diverse and innovative in an attempt to meet the needs of and be accessible to a diversifying population of aspiring midwives. Once again, midwives find themselves outside the box in order to preserve the essence of the midwifery model of care when training new midwives. This of course makes things untidy for accreditors and evaluators, but it's a commitment the

DE midwifery community has made to itself to respect this diversity. It has also sometimes made it more difficult for easy sharing and interaction to happen between schools, between the ACNM and MANA/NARM/MEAC, and between school-trained and apprentice-trained midwives. An atmosphere of judgment and hierarchical ordering can easily emerge when there is a lack of homogenization. Exactly how much does a midwife need to know in order to be considered competent? What is the proper balance between theoretical knowledge and learning clinical skills and protocol in an aspiring midwife's training? Do all midwives need to know the A & P of all body systems or be good writers? These are some of the questions I believe we would find disagreement on within the midwifery community.

These issues and questions could be divisive **or** they could open up a dialogue and encourage more sharing between educators in order to find the answers, create more understanding, or learn from each other's strengths. In order to open an avenue for this interaction to happen, particularly around curriculum development and innovation, I prepared and distributed an internet survey to midwifery educators in the U.S. and Canada. The survey was sent to all MEAC accredited schools, other midwifery training programs we are aware of, most nurse-midwifery programs, and all midwifery programs (direct-entry) in Canada. 37 responses were received to the survey. The respondents are categorized below:

Faculty member of a direct-entry midwifery program	59.5% (22)
Faculty member of a nurse-midwifery program	32.4% (12)
Administrator of a direct-entry midwifery program	24.3% (9)
Administrator of a nurse-midwifery program	21.6% (8)
Preceptor for direct-entry midwifery students	27% (10)
Preceptor for nurse-midwifery students	10.8% (4)

**Total Respondents 37**

My goal in writing this article is not to interpret the results of the survey so much as to simply convey the information found in the responses. Perhaps in so doing, the community of midwifery educators can share with each other what we each have learned through experience. Also, as direct-entry midwives begin a dialog about the role of formal education programs in a changing world of direct-entry midwifery in North America, this sort of information sharing will be important. Listen to the voices of your colleagues.



## Components of an Excellent Midwifery Curriculum

Respondents were asked to rate the following components of a midwifery curriculum as to their importance. See **table A** for the tabulated results of this question.

**Table A**

	Not Important	Mildly Important	Moderately Important	Very Important	Extremely Important
A strong theoretical foundation.	0%	0%	8%(3)	24%(9)	<b>68%(25)</b>
Simultaneous theoretical and clinical learning.	3%	0%	14%(5)	38%(14)	<b>46%(17)</b>
A supportive learning environment.	0%	0%	3%(1)	16%(6)	<b>81%(30)</b>
Varied learning activities.	3%	0%	3%(1)	35%(13)	<b>59%(22)</b>
Student-led learning.	0%	0%	22%(8)	<b>41%(15)</b>	38%(14)
Current resources.	0%	0%	0%	22%(8)	<b>78%(28)</b>
Written tests.	3%	3%(1)	31%(11)	<b>36%(13)</b>	28%(10)
Case studies.	0%	0%	8%(3)	28%(10)	<b>64%(23)</b>
Student research projects.	0%	19%(7)	19%(7)	<b>38%(14)</b>	24%(9)
Knowledge of current medical protocol.	0%	0%	3%(1)	46%(17)	<b>51%(19)</b>
Simulated clinical skills assessment.	3%	14%(5)	8%(3)	32%(12)	<b>43%(16)</b>

**Total Respondents 37**

Most respondents felt all of the listed components were an important part of a midwifery curriculum, with a supportive learning environment and current resources being considered universally most important. Seen as least important were student research projects and written tests.

## Importance of Various Subject Areas in a Midwifery Curriculum

The respondents were asked to rate a list of curriculum areas as to their importance in a midwifery program. The data was then sorted out by type of respondent (Total, CNM, Direct-entry). See **Table B** for the results.

**Table B**

	Not Important	Mildly Important	Moderately Important	Very Important	Critically Important	
<b>Anatomy and physiology of all body systems</b>	0%	0%	16%(6)	41%(15)	<b>43%(16)</b>	<b>Total</b>
	0%	0%	0%	46%	<b>54%</b>	CNM
	0%	0%	25%	37%	<b>38%</b>	DE
<b>Pharmacology</b>	0%	0%	13%(5)	<b>46%(17)</b>	41%(15)	<b>Total</b>
	0%	0%	0%	38%	<b>62%</b>	CNM
	0%	0%	21%	<b>50%</b>	29%	DE
<b>Diagnostic tests and laboratory skills</b>	0%	3%(1)	0%	40%(15)	<b>57%(21)</b>	<b>Total</b>
	0%	0%	0%	23%	<b>77%</b>	CNM
	0%	4%	0%	<b>50%</b>	46%	DE
<b>Counseling/ interpersonal skills</b>	0%	0%	3%(1)	11%(4)	<b>86%(32)</b>	<b>Total</b>
	0%	0%	0%	7%	<b>93%</b>	CNM
	0%	0%	4%	13%	<b>83%</b>	DE
<b>Writing skills</b>	0%	0%	14%(5)	<b>62%(23)</b>	24%(9)	<b>Total</b>
	0%	0%	23%	<b>62%</b>	15%	CNM
	0%	0%	8%	<b>67%</b>	25%	DE
<b>Research skills</b>	0%	8%(3)	14%(5)	<b>46%(17)</b>	32%(12)	<b>Total</b>
	0%	15%	23%	<b>38%</b>	24%	CNM
	0%	4%	8%	<b>50%</b>	38%	DE
<b>Business skills</b>	0%	3%(1)	19%(7)	<b>51%(19)</b>	27%(10)	<b>Total</b>
	0%	0%	31%	<b>38%</b>	31%	CNM
	0%	4%	13%	<b>58%</b>	25%	DE
<b>Leadership skills</b>	0%	0%	19%(7)	<b>46%(17)</b>	35%(13)	<b>Total</b>
	0%	0%	15%	38%	<b>47%</b>	CNM
	0%	0%	21%	<b>50%</b>	29%	DE
<b>Political skills</b>	0%	3%(1)	22%(8)	<b>43%(16)</b>	32%(12)	<b>Total</b>
	0%	0%	15%	<b>47%</b>	38%	CNM
	0%	4%	25%	<b>42%</b>	29%	DE

**Total Respondents 37**

Most respondents agreed that all of the listed curriculum areas were important to include in a midwifery curriculum. However, DE midwives generally felt most areas were not **as** important as CNMs did, especially in the areas of pharmacology, diagnostic tests, laboratory skills, leadership and political skills. Some of this makes sense considering their practice setting and scope of practice. DE midwives felt 3 areas were more important to include than CNMs did: writing skills, research skills, and business skills.

## **The Process of Curriculum Development**

*Following is a list of the ways the respondents and their institutions develop their curriculum as an on-going activity:*

- \* Start with Core Competencies from the professional organization.
- \* Compare curricula of other midwifery and health professional programs.
- \* Solicit feedback from students, faculty, preceptors and community.
- \* Do ongoing current literature review.
- \* Keep abreast of new standards set by accrediting agencies and professional organizations.
- \* Perform periodic comprehensive reviews by faculty and administration (every 3-5 years).
- \* Annual revisions to courses by individual instructors.

### **Individual comments by respondents:**

"Individual faculty are responsible for revising curriculum based on a faculty retreat to review students evaluations of content and clinical preceptor evaluations of their preparation and our 1 and 5 year surveys of graduates."

"Partly faculty led, partly led by student feedback and performance using evaluative tools, partly led by administrators looking at the bigger picture. We hold a yearly meeting that focuses on curriculum review"

"The academic director reviews the syllabus each year and makes suggestions. She also funnels new journal articles, books and other resources to appropriate faculty."  
"A group of students evaluate the change."

"One of the important things we are considering now in our curriculum development are the future trends in the midwifery profession. We are very interested in the environment in which our midwife students will be practicing in the next 5-15 years and want our curriculum to prepare them with skills beyond just technical midwifery skills. We want them to be prepared to be successful and impactful within the challenging environments in which they will be practicing."

"We are developing our curriculum on 4 basic pillars of education: 1. Critical texts and classic works, 2. Simulations, 3. Real life experience, and 4. Mentor relationships. We are developing testing and syllabi materials that focus on critical thinking and creative skills. We are employing more oral exams, simulations, debriefing, and writing experiences."

"Staying in touch with professional issues and changing sociopolitical context for midwives."

## **Techniques, Tools and Innovations for Theoretical Learning**

*Respondents were asked to share particular techniques they have used successfully in teaching theoretical knowledge in midwifery education. Some of their responses are compiled below as a list or as individual comments.*

### **Learning activities:**

- \* Virtual Midwifery Practice case studies.
- \* Small group activities.
- \* Student facilitated discussions and research presentations.
- \* Case studies.
- \* Colloquium (Students and an instructor read a book or an article and then gather together to discuss it)
- \* Skits, songs, poetry, posters, collages.
- \* Role plays
- \* Persuasive presentations
- \* Exams for their steering effect and learning enhancement.
- \* Writing practice guidelines.

### **Teaching Points:**

- \* Scanning images for powerpoint presentations.
- \* Setting an atmosphere of receptivity and encouragement.
- \* Breaking material down into manageable chunks and presenting it in several modalities.
- \* Review of theory while practicing clinical skills.
- \* Detailed comments on written work.
- \* Guest experts for topics from other disciplines.
- \* Assigning reading about a topic from more than one point of view or source.

"Real-life examples and other ways that students can "try out" or apply what they're learning, i.e. students arrive in class with the "news" that a senator was about to introduce midwifery legislation in your "alegal" state—what do you do? Or interviewing family members or seniors in the community about their birth experiences, practicing midwives about what it was like in the 70's and 80's, community people about their attitudes towards midwives or home birth..."

"Students present case studies highlighting what was done, comparing and contrasting with what the literature supports, and incorporating essential midwifery documents (philosophy, code of ethics, Basic Standards for midwifery practice)."

"Our courses are currently incorporating Critically Appraised Topics (CAT): 1 page appraisal of the literature for personal practice on a particular topic, for evidence-based practice."

"We try to use interactive learning techniques as much as possible; anything that gets them out of a passive learning mode that they may be used to."

## Technology Used to Enhance Midwifery Curriculum

*A wide array of technologies are being used by midwifery educators with great success. The following list and comments came from our respondents.*

- \* Human Patient simulator
- \* Much of our theoretical program is on-line.
- \* Email for distance programs to connect the school community, send assignments, following precepting students, faculty/student interaction.
- \* Web-based research (Cochrane and Pub Med).
- \* WebCT to allow for learning at a distance
- \* Paperless syllabus
- \* Laboratory simulations
- \* Power Point
- \* Videotape students in mock prenatal consultations and counseling sessions and require self evaluation in writing.
- \* Online blog and discussion as part of courses
- \* Student egroup
- \* Blackboard postings
- \* Palm pilots

"I am amazed at the deeper level of intimacy the WebCT provides. I was confused at first with this, but then realized that in a regular in-person classroom setting, the extroverts process their information and talk, while the introverts are busy processing internally, and we often don't hear their insights. Online, everyone has the opportunity to process and then respond in their own time, which leads to a depth of interaction missing from regular in-person groups. Then, we they do come together in person, there are no "quiet ones" in the group, since everyone is used to each others' communication style. Remarkable!"

"All our students email us after every clinical shift and we discuss cases."

"We are currently using WebCT for course material, and Horizon Live WIMBA – a virtual classroom – with webconferencing etc. Our students are all over the province and this facilitates their participation. We have a variety of low fidelity simulators and are advancing into high fidelity simulators to enable more practice outside of the clinical environment. We have just required all our students to have PALM handheld PDAs – with appropriate software, and using the PDA will be built into the course tutorials."

## Methods for Assessing a Student's Theoretical and Clinical Knowledge

*Responses to the question, "What evaluation methods do you feel are most effective in assessing a student's theoretical and clinical knowledge and readiness for practice?", are found below as a list and individual comments. The number of respondents who mentioned each method are in parentheses.*

### Theoretical Knowledge:

- \* Written exams (22)
- \* Case studies (9)
- \* Student presentations (7)
- \* Essay (4)
- \* Role plays (3)
- \* Written assignments (3)
- \* Oral exams (3)
- \* Written papers (2)
- \* Pop quizzes (2)
- \* Case Presentations (2)
- \* Classroom discussions (2)
- \* Self evaluation (1)
- \* Practice guidelines (1)
- \* Debates (1)

"Written and oral assignments and examinations that include both knowledge and application of knowledge. The key is the student's ability to exercise good judgment."

"Those that most thoroughly incorporate all theoretical and clinical skills in real-life-like situations requiring fully integrated midwifery management thinking and acting."

"Writing informed choice documents for various tests and procedures is a great way to find out how well the student understands an issue. Also requiring the writing of client information handouts."

### Clinical Knowledge:

- Preceptor Evaluations (12)
- Observation (10)
- Clinical exams (8)
- Repeated demonstration of skills (4)
- Site visits (2)
- Small group tutorials (1)
- Student presentation of clinical cases (1)
- Skills labs with sentient and non-sentient models (1)
- Student journals (1)

"Observation of clinical behaviours over time with good evaluation paper trails."

"A combination of preceptor evaluation in the actual clinical setting and other faculty/third party evaluation in clinical seminar and simulated clinical settings."

*A warm thank you to all who participated in this survey. There will be other opportunities for midwifery educators to contribute their expertise in the future - watch for the survey monkey!*

## MEAC Standard 2: Curriculum

Mary Ann Baul



Midwives are healers and teachers. Robbie Davis-Floyd has helped me understand that midwives have a unique body of knowledge that reflects midwives' lived experiences of attending thousands of unmedicalized births. The body of knowledge that expresses the midwifery model of care guides a school's curricular development and compels faculty to educate and share this knowledge effectively. When a school can document its curriculum, evaluate it, and make improvements based upon that evaluation it is on the way to accreditation.

MEAC accredited schools are required to teach all the MANA Core Competencies (about 70 rather broad objectives) and all of the items on the List of Comprehensive Knowledge, Skills, and Abilities Essential for Competent Midwifery Practice (AKA the NARM Skills List), which is about 25 pages long. We also expect that for each module, course, or unit of instruction, that schools develop learning objectives, learning activities, learning resources, and evaluation methods.

Let's take a particular skill or level of knowledge; for example, "repairs the perineum", and describe what MEAC expects schools to do regarding documentation of their curriculum. I hope that part of the curriculum would be sharing the wisdom of midwives concerning "preventing lacerations and avoiding episiotomy!"

Some midwifery schools have difficulty describing their learning objectives. They believe if they are teaching, students should be learning. However, instruction that doesn't change the student in some way is not working. So how do you know if your instruction is effective? First you must decide where you want to go, create the means for getting there, and then arrange to find out whether you arrived. This is what we mean when we say schools must develop *learning objectives*—where you want to go; plan *learning activities*—create the means for getting there; and

have *evaluation methods* for those objectives—find out whether you arrived.

A *learning objective* is a collection of words intending to let others know what you intend for your students to achieve.

- It is related to intended outcomes, rather than the process for achieving those outcomes, or the process of instruction. In other words, this is a skill that students might be expected to learn.
- It is specific and measurable, rather than broad and intangible.
- It is concerned with students, not teachers.
- An example would be: "The student can successfully repair a second degree laceration."
- For the topic "repair and healing of episiotomy and lacerations", there might be several dozen specific learning objectives. The midwife should be able to assess whether a laceration is first, second, or third degree, for example. She should be able to provide the birthing woman with direction, warmth and support to prevent tearing. She should also be able to describe the healing process. She should be able to safely perform an episiotomy and describe the circumstances when an episiotomy might be necessary. All of these are learning objectives. They are measurable, and they describe the outcomes.

*Learning activities* are activities that enable the student, through observation or participation, to achieve those learning objectives. Examples include lectures, discussion groups, films, skills demonstrations and practices, role-plays, small group activities, reading and writing assignments, hands-on experiences, etc.

Some specific examples of learning activities would be: a lecture on repair and healing of lacerations, practicing infiltration with syringes, practicing suturing on foam models, creating paper models of the perineal muscles, researching the evidence on different suture materials for effective repair and reporting it, or inspecting a perineum after the birth with the guidance of a clinical preceptor.

*Learning resources* are the texts and tools used to help students achieve the objectives. Be specific; for example: *Frye, Anne, Holistic Midwifery, Volume 2, Care During Labor and Birth, 2004 Edition, p. 782, care of perineal tears*. For this topic, many resources should be used, such as other texts, films, models, and suture equipment as appropriate learning resources.

*Evaluation methods* are ways that the school measures the student's achievement of the learning objectives. Examples include written tests, clinical skills examinations, student presentations, projects or papers.



What must schools do to meet Standard 2, Curriculum? Here are the elements of MEAC's review:

1. In the Self-Evaluation Report (SER), the School specifies where each NARM Skill is taught in the curriculum. It also specifies where each MANA Core Competency is taught. *(MEAC is currently talking about developing a tool for schools to document where these competencies and skills are ASSESSED.)*

2. In the SER, the School provides a sample of course materials, including learning objectives, learning activities, learning resources, and evaluation tools and/or methods, for *one* course, module, or other discrete unit of instruction. This gives us a small example of the depth of the School's curricular development.

3. The School also provides an overview of its entire program, which includes the program objectives, graduation requirements, a list of modules, courses, or other discrete units of instruction, and a description of how students progress through the curriculum. This documentation is usually in the School's catalog.

4. The School submits its policies and procedures for how it accomplishes periodic curriculum reviews, to ensure that new developments in midwifery care are acknowledged, learning resources are current, and learning activities, learning resources, evaluation tools and methods are appropriate to the learning objectives. It has to provide an example of curriculum revision based on the above standard. It also must explain how and when students, faculty, alumnae, and other groups are included in the curriculum evaluation process.

5. Schools must show how their faculty are appropriately qualified to teach, and document how their faculty participates in the development, implementation, and evaluation of the curriculum.

6. In addition to the Self-Evaluation Report, the School undergoes a Site Visit. During the site visit, peer midwifery educators:

- Perform an in-depth review of the courses for two randomly chosen MANA Core Competencies. (Because the School does not know WHICH Core Competencies will be chosen, it is responsible for having its entire curriculum well-developed.) This review includes looking at the learning objectives, learning activities, evaluation methods and resources for each course or group of courses that involve those core competencies. (A core competency may encompass several courses.)
- The site visitors also randomly choose two NARM Skills from the Skills List and evaluate the learning objectives, activities, resources,

and evaluation methods for the courses that include these two skills. This could include "Postpartum: Assessing the condition of the vagina, cervix and perineum..." including "repairing the perineum."

- As peer midwifery educators, we evaluate whether the coursework is appropriate and adequate for the learning objectives, whether it provides the student appropriate and adequate opportunities for learning activities, whether it references current resources and utilizes appropriate learning materials, and whether the methods of evaluation are appropriate for acquisition of the pertinent knowledge and skills being tested.
- In addition, each School must document that its preceptors sign off each student on her acquisition of all NARM Skills.
- Site visitors interview two academic faculty and two clinical preceptors, asking them, among other things, how they participate in evaluation and revision of the curriculum, whether evaluations are taken into account and improvements made, and whether learning resources are adequate to meet the needs of the students.
- If the site visit or review of the SER uncovers weaknesses, then the school may be required to provide interim reports, documenting how they are improving and strengthening their curriculum. MEAC has been known to require that a School submit an entire, improved curriculum in order to meet Standard 2. MEAC has also been known to deny accreditation based on, among other things, failure to meet the curricular standards.
- MEAC evaluators also determine whether the curriculum meets the depth of study required for degree granting, if the School offers a degree. The program should be adequate in length to meet the objectives of the degree being sought, and it should reflect generally accepted practices in higher education. In degree granting programs, it is expected that for each hour in the classroom (or equivalent in courses not based in a classroom), students study two hours outside of class.

MEAC accredited midwifery schools hopefully will safeguard our unique base of knowledge "to transmit and thereby preserve what is known only by midwives who practice independently, outside the hospital." Although the body of midwifery knowledge is always changing, that core knowledge is the essence of a midwifery curriculum.



## Virtual Midwifery Practices at Miami Dade College

(Con't from page 1)

similar to what students encounter on their clinical sites. All the virtual practices are computerized.

Here is how it works. At the beginning of the semester, students are assigned to small groups of 3-4. Each group forms a separate midwifery practice, and the students are partners in the practice. The clients are introduced into the practice one at a time. Students gather clients' initial medical histories from video taped interviews. (Student actors play the parts of clients.) Clients may have medical or psychosocial problems, like difficulties in the marriage or anemia from an inadequate vegan diet. The midwifery students must order appropriate tests, give their rationale for the tests they order, review the results, and develop a care plan. The students chart client progress throughout pregnancy, assessing her health status, recommending treatment, education, consultations, and referrals.

The students must be continually available to their patients so they rotate being on call. On weekends and evenings, a faculty member posing as a client may call with a problem. The student must return the call within 10 minutes, make decisions and recommendations in response to the client's questions.

One weekend a virtual client called complaining of a backache. The student dismissed the complaint as a normal symptom of pregnancy, recommended bedrest with a heating pad and a reassuring "Don't worry about it." Later the virtual client had a preterm delivery and lost the baby. The practice received a letter from a fictional law firm asking her to provide the client's medical records. "I'll never make that mistake again!" was the student's response.

Students go on to encounter problems with real clients on their clinical sites that they've already learned about through their virtual clients. One student identified symptoms of Fifth Disease on her clinical site and suggested the client be tested for the parvo virus based on what she had learned from her virtual client.

Each week the students in each practice report to the entire class about their individual clients and what has occurred that week, including any problems they missed. They are given class time to get their charts up-to-date and submit them for grading. Class projects are incorporated into the Virtual Midwifery Practice. Each student completes a 3-day diet diary in the name of one of the virtual clients in her practice, and then analyzes the diet diary of another virtual client, makes suggestions about dietary changes, and enters the information in the client's chart.

The client's pregnancies are compressed so that they progress through their entire pregnancies during the semester. Students keep prenatal flow charts and narrative notes. They are responsible for gathering all data, screening, assessments, getting consent forms signed, developing the emergency care plan, making sure the client takes childbirth classes, and is well prepared for the upcoming birth. The chart must be complete and all entries appropriate – dated, initialed, proper terminology, following problem format, and so forth.

At the end of the semester, the virtual clients have arrived at term and are ready for delivery. At the last class, each student reports on her designated virtual client, identifying the problems that presented initially, any problems that occurred during pregnancy, what care was given, and preparations for the labor, delivery and postpartum. The student is graded on week-by-week care and charting.

Students respond very enthusiastically to their virtual practices. They learn the importance of relying on one another, and on one occasion they had such difficulties that they had to dissolve a practice ("our birth center burned down") and join other practices. Some are surprised at how emotionally attached they become, feeling sad when their virtual client has a spontaneous abortion. Students like applying what they learn in lecture to individual client situations. Preceptors report that the virtual practices improve their students' critical thinking abilities on the clinical sites.

### **The Midwives Alliance of North America** *In cooperation with* **The Midwifery Education Accreditation Council**

*Present*

## **MANA 2006**

### **in Baltimore, Maryland October 13-15**

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## **“A Noble Cause” - A Midwives’ Delegation to Sierra Leone, West Africa**

**Shafia M. Monroe**



*Some members of the midwives delegation  
to Sierra Leone*

The International Center for Traditional Childbearing (ICTC) by invitation has partnered with Women for Women of Sierra Leone (WWSL) to lead a national delegation of midwives and educators to Yele, Sierra Leone, on a humanitarian mission to develop best practices with the Yele midwives for reducing the high infant and maternal mortality rates, in their region. Sierra Leone's recent Civil War which was from 1991 - 2002 resulted in tens of thousands of deaths and displaced more than 2 million people, and has negatively impacted access to health care. The Sierra Leone infant mortality rate is said to be one of the highest in the world, currently their infant mortality rate is 143.64 deaths per 1,000 live births and the life expectancy at birth is 39.87.

Headquartered in Portland, OR, ICTC is a non-profit African-centered infant mortality prevention, pregnancy support and midwife training organization. Established in 1991, its mission is to improve birth outcomes, promote breastfeeding and increase the number of midwives. ICTC is an international organization with chapters developing globally to improve birth outcomes and promote midwifery.

ICTC put a call out for midwives and doulas to join them in creating their first midwives delegation. Immediately, we received over nineteen applications, numerous calls, and many exciting emails endorsing the delegation. We were so pleased to find that there are so many midwives, doulas and health care professionals interested in this effort.

Our preparation for the delegation started March 4<sup>th</sup>, our scheduled training day, designed to learn cultural competency, the logistics of the mission and develop team camaraderie. It was a full day, followed by our evening Noble Cause fund-raising dinner; it was hustle, bustle and fun. Trainers Dr. Georgina Abisordun Johnson of Women for Women of Sierra Leone and Judith Rook, CNM, and the participants transformed the training into an interactive

learning experience. Delegates were represented from California, New Mexico, Tennessee, and Washington State, Georgia and of course a strong presence from Oregon, were the training took place. The excitement from the training still lingers in the air at ICTC.

In the Village of Yele, the people endure much difficulty and struggles; the custom of the women eating last often results in malnourishment during pregnancy; and the practice of discarding the colostrum along with female circumcision are common practices. Families have minimal contraceptive choices and toil with the emotional after-math of post-traumatic stress from the Civil War, these are important issues that need to be addressed to help women have improved birth outcomes. Yet, we are reminded that the Yele people have wonderful traditions that continue to provide their community with hope, spiritual and physical health and an underlying strength that is so deeply rooted that it can not be broken.

During our training, information on cultural diet, transportation, and village etiquettes were taught; along with a list of commonly used Creole words to enhance our ability to communicate. Trust is everything in Yele, and it was reiterated that one must keep their word, and that sharing is the culture, so if you give to one, you must give to all. We discussed what denotes an adequate midwife kit, and decided what were essential ingredients. By the end of the training, we had identified our items, learned vaccine requirements, confirmed our team leader. We closed by agreeing that this mission is about giving and receiving and that we are humble guests, working in partnership with the Yele people to help improve birth outcomes in their village.

ICTC appreciates all of the kindred spirits of unity who have reached out to offer a hand to the people of Sierra Leone and their village midwives. We also thank those who attended our March 4<sup>th</sup> Benefit Dinner, our members, volunteers and the men and women that have provided generous donations for this mission. ICTC has had to privately raise funds to make this mission a reality, and your support has been instrumental.

This delegation has brought the ICTC mission full circle, surging like a woman in labor, we have birthed to new heights, because from our inception it has been a goal to assist Africa and validate the contributions of the traditional midwife in the Fertile Crescent of the Mother Land, where life began. Though privileged by the invitation, it has been challenging to prepare for the mission; many things had to be accomplished, personally and professionally to complete the midwife kits and training materials. We are bringing 300 birth kits to be given to pregnant women and 20 midwives kits for the midwives to use at the births that they will attend.

We expect to train approximately twenty village women; some all already traditional birth attendants, and leave them with enough equipment to re-stock their bags. Monetary donations are still needed to cover the cost of travel and room and board. ICTC is a 501(c)3, and your donations are tax-deductible. Please send your donations to ICTC, 2823 North Portland Blvd, Portland, OR 97217.

On June 24<sup>th</sup>, God willing, we will return to our homes, and ICTC will update its web-site as soon as possible about the outcomes. In July the ICTC Summer Newsletter, will have stories and photos on the results of the mission and a delegates panel will share at the 5th Annual Black Midwives and Healers Conference in Phoenix, AZ on Oct. 13-15, 2006.

Please stay connected to this noble cause, a mission that reflects the heart of every midwife, with the intent to help, nurture, educate and listen.

Remember, together we are saving our babies.



## Book Review: Women's Health: A Primary Care Clinical Guide

Third Edition. Ellis Quinn Youngkin, & Marcia Szmania Davis. Pearson/Prentice Hall. Upper Saddle River, NJ. 2004. ISBN 0-13-110026-2.

Beth Coyote, LM, CPM Faculty, SMS

Finding a suitable text for teaching gynecology to midwifery students has been a difficult task. My co-instructor and I have used several books over the years, including Sloan's Biology of Women and Hatcher's Contraceptive Technology (which we still use). As the Sloan book aged without a re-write, I discovered Women's Health: A Primary Care Clinical Guide. Edited and written by nursing instructors and nurse-clinicians in the field of maternal and women's health, I would recommend it to any MEAC faculty who is looking for a comprehensive text for midwifery students.

The book includes basic principles: assessment, adolescent health, complementary therapies, sexuality and lesbian health needs. Topics in gynecology cover menarche, fertility and infertility, reproductive tract infections, HIV, breast health and menopause and aging. The third section on pregnancy and lactation, while not exhaustive, is a useful addition to Varney and Myles. The final section focuses on primary care and includes

common medical problems ranging from cardiovascular disorders through musculoskeletal injuries, psychosocial issues, disabilities and chronic illness. The index contains emergency childbirth (!), immediate assessment of the newborn and selected lab values.

The format is similar in each chapter. For example, the chapter on reproductive tract infections (RTI) begins with an introduction and a history of the Center for Disease Control and statistics compilations. Then each RTI is described briefly including epidemiology and transmission. The descriptive format is SOAPing, differential diagnoses as the assessment piece. Following the Plan are a few pages on appropriate medications including indications, administration, side effects and adverse reactions, contraindications including alternatives for pregnant clients, anticipated outcomes and client teaching/ counseling. I really like the inclusion of anticipated outcomes because it advises the practitioner how quickly symptoms will clear and gives recommendations for follow-up.

The chapter on contraception begins with the history and politics of birth control (with a nod to Margaret Sanger and Supreme Court decisions). Graphs include methods broken out by cost, effectiveness, convenience, safety etc. Each method is delineated by mechanism of action, effectiveness, advantages, disadvantages, contraindications and considerations, the same formula used in Contraceptive Technology. CT is still, in my opinion, the best text for the latest on birth control issues.

I think the reason why my co-instructor (who is a PA-C with 25 years experience in primary care) and I like this book so much is that it is written with the busy clinician in mind. For example, while seeing a client in my office with a cervical polyp, the page on cervical polyps described polyps and included the differential diagnoses (endometrial polyps, small prolapsed myomas, cervical malignancies), suggested treatments and guidance for counseling the client. Follow-up and referral is also included.

I also appreciate the chapters on common medical problems. While I do not have primary care training, I sometimes see women who have confounding disorders like eczema and asthma, as we all do, and the brief, clear descriptions found in Women's Health are a great resource.

The book is careful to suggest that the clinician not pursue care of a client with a condition they are not trained to treat. The Plan and Follow-up sections contain more than one option for the practitioner to suggest to the client. Midwives could obviously tailor their treatments given the resources available to them.

While no book will be perfect for every teaching situation, Women's Health: A Primary Care Clinical Guide is, I believe, a valuable addition to Gynecology course curriculum. Lois, my teaching partner, and I talk every year about the book we are going to write. In the meantime, we have Contraceptive Technology and Women's Health, which I hope the authors will continue to update. I encourage you to investigate it for yourselves.

## A letter from Karen, a Seattle Midwife in Indonesia

January 2006



*Indonesian midwives Ibu Sinarti and Ibu Yeni*

How about a little bit of a “reality check” from Banda Aceh, Indonesia, a country where midwives are respected, organized, and direct-entry? It’s lovely to see a midwife’s name on a sign on at least one house in every neighborhood and on a storefront on every big street, with prenatal and birthing clinics in the front, and their own home in the back or upstairs. Mostly they attend home births, zipping about on their motor scooters, so elegant in their headscarves and colorful draping clothes. Midwives also catch most of the babies in the hospital as well. They have a ratio of approximately 80,000 midwives to 1600 OBs serving the entire country. The midwifery association is 60,000+ strong, and the books and posters and newsletter they produce are impressive. When I mention to someone I am a midwife (like to the checkout woman at the grocery store), everyone’s face lights up —Oh, Bidan, wonderful! Thank you for being a bidan! (Bidan means Midwife.)

Okay, I know I sound starry-eyed, but please permit me this moment of feeling like midwifery belongs and is honored and is needed. Of course they have their problems, caring for impoverished women, often encountering limited medical assistance when sought, needing peer review, having to be the village general medical practitioner as well as midwife, but still....

I’m here in Indonesia as a consultant for JHPIEGO (of Johns Hopkins), assisting with the rebuilding of 5 birthing centers and community health centers with midwifery services, funded by CARE International. CARE is building the buildings, and JHPIEGO is providing equipment, furniture, and advice. I am meeting so many remarkable people, each one with a story to tell about the tsunami. Below are just a few stories that touched me deeply.

Ten days after the tsunami, my JHPIEGO boss from the Jakarta office, Anne, and my new friend and midwifery leader in Indonesia, Ibu Yeni, were able to get a flight to Banda Aceh to see what midwives could do to help. One of their immediate goals was to find out which midwives were missing, what the death toll might be, who might be displaced or injured or destitute and need help. It took several months, but of an estimated 2000 midwives in Aceh Province, approximately 250 have perished. For most, there will never be proper funeral rites, which is the case for the majority of the deceased who are buried in one of the dozens of mass graves seen all over the province.

Yesterday I visited a midwife who is practicing in a temporary space in a neighborhood home. Her name is Ibu Sinarti. She has supported her 4 kids alone for 14 years, since her husband died. She was in the process of catching a baby, literally the wet baby in her hands, when the tsunami struck her clinic. The wave was taller than the palm trees (a few of which still stand next to the now empty lot where her clinic once stood, with the leaves stripped bare). She was swept away in the huge wall of water, 5 kilometers inland. The mother and baby were lost and never found. Ibu Sinarti’s leg was all cut up and it became infected. She had to go to Jakarta for a month of treatment, but kept her leg, which is badly scarred. She now awaits the rebuilding and restocking of her new clinic, which is underway, and she is again working as a clinical preceptor in her makeshift clinic. Her 4 children attend university outside of Aceh (which she pays for with her midwifery earnings) so were safe.

I also visited Ibu Erni, the midwife who was awarded the White Ribbon Alliance award last summer. Her home and clinic were damaged, but the big hotel across the street took the brunt of the force, thus saving it from complete destruction. But now the local mayor took over her building, so she is in a temporary storefront space with 2 birth rooms while JHPIEGO builds her a new clinic and home in a nearby neighborhood. Her husband, a PhD in education, and 3 of her 4 children died in the tsunami. They were all together at the time of the earthquake, and when the water hit about 15 minutes later, but only 2 of this family of 6 survived their horrible violent journey in that water. That was only one year ago, but here she is, full of energy to rebuild her life, having started a new practice in a new neighborhood, and already doing about 30 births/month. I cannot imagine myself to have even 1% of her strength.

I don’t know much about Johnson & Johnson (the corporation), but thanks to a program they instituted soon after the tsunami, the women of Aceh were able to obtain midwifery care from Indonesian midwives. Pink vouchers provided by J&J were distributed in all the affected areas where those who survived were in camps and barracks. The pregnant women took the voucher to the midwives (whatever midwife they could find; it was a chaotic time) for what prenatal, birth, and pp/nb care could be provided, and then the midwives could present the voucher to get reimbursed from a J&J fund specially set up for that purpose. This helped many midwives earn some money to start to get back on their feet, continue to feel like they have a purpose, and reconnect with the life force.

It’s a fulfilling time here, mostly because of the people I am so fortunate to have met. Don’t know what my contribution will be in the end. I’m working hard on making sure there are enough sinks installed in the new clinics — the architects don’t believe me when I talk about how much midwives need sinks! And trying to convince someone to drain the swampy standing water around some of the clinics because malaria and dengue here are so deadly to moms and babes. And trying to get them to paint each room with color; there’s an idea here that the new clinics and birth centers should be all white — to look like hospitals! Yikes!

Love and Peace, Karen Hayes

## **Book Review: Crucial Conversations. Tools for Talking When Stakes are High.**

By Kerry Patterson, Joseph Grenny, Ron  
McMillan, Al Switzler (2002).

Heather Leigh Whitley, Masters Student, Midwives  
College of Utah

Our role in cultivating woman's birth rites will be pivotal in the next decade. The pivot point for mothers, babies, women healers, and the greater good of society lies where each of us decide to communicate effectively. Midwives hold critical conversations with women of childbearing age under their care, and with members of society who have the power and influence to assist with the paradigm shift we hope to witness in American birthing practices in our lifetime. *Crucial Conversations; Tools for Talking When Stakes are High* by Patterson, Grenny, McMillan & Switzler (2002) is a book worthy of mass integration in the midwifery education model. It delivers practical techniques for staying in dialogue, a skill that few of us can claim mastery. The following describes how this book shows midwifery students ways to hold meaningful dialogue with partners, clients and other professionals to enhance their personal and professional lives.

Many marriages are claimed to divorce in the midwifery profession. When midwives acquire tools to hold crucial conversations with their partners, marriages will strengthen rather than succumb to the long hours, low pay and risk of litigation or prosecution. *Crucial Conversations* gives midwives the tools to help themselves and their partners feel safe in uncomfortable dialog and find middle ground, rather than create adversarial positions to promote a single-sided agenda.

The second area students and midwives might implement the skills offered in *Crucial Conversations* is with clients. Negotiating financial terms or diet and health expectations require midwives to effectively communicate with expectant mothers, and their partners. All parties wish for mutually beneficial relations and safe outcomes. As pregnancy often brings about dramatic life shifts for women, midwives are catalysts of this change in areas of spirituality, nutrition and wellness. Students of midwifery can be encouraged to have difficult and truthful conversations with clients to coach them along their path of awakening. These sensitive conversations, when coming from the heart, can be life-altering. *Crucial Conversations* gives students skills to recognize when they or their clients do not feel safe in dialog and the steps they can take to re-engage rather than entrench themselves in non-productive communication.

Thirdly, midwifery students planning on hanging a shingle in this environment of 30% cesarean rates cannot afford

to jeopardize crucial conversations with other professionals. *Crucial Conversations* reminds us that we must start by believing that there is room at the table for all of us. As we come to this table to discuss delivery of safe services to women and their families, midwives should be as effective as possible in spreading our message in mutually beneficial terms. If transport should occur at a birth, midwives can expect to hold some crucial conversations with EMTs, physicians and members of the medical team. Should a bad outcome occur, midwives today are expected to communicate their perspective to lawyers, peer groups or regulatory bodies.

If tomorrow's midwives can be taught and encouraged to stay in dialogue with their families, clients and other professionals, they can transform difficult conversations into safe and productive exchanges where everyone walks away a winner.

### **Association of Midwifery Educators Forming**

The Outreach to Educators Project, which was initiated by the Midwifery Education Accreditation Council one year ago, is currently making plans to become a self-sustaining and independent Association of Midwifery Educators (AME). A website for AME is being designed and will be launched this summer to provide an on-line resource center and networking tool for midwifery educators. It will also be a place where aspiring midwives can go to find out about their educational options. All midwifery educators (accredited and non-accredited schools, distance courses, midwives who work with apprentices, short introductory or supplementary courses) will be invited to become a member of AME and will have a chance to be charter members for the first year at a discounted rate charge (more on this). Charter membership promotion will be coming this summer.

**The first official meeting of AME will be held at the MANA Conference in Baltimore on Saturday, Oct. 14.** This organizational meeting will begin to make a plan for the creation and sustainability of this on-going association. If you are involved in educating midwives we would love to have you attend this meeting!

If you are not currently on the email list that receives notices from Heidi, our coordinator, and you would like to be, please email her with your address at [birthwise@verizon.net](mailto:birthwise@verizon.net).



## Resources Used by Midwifery Educators

The following list of texts and journals was generated by a questionnaire completed by 7 midwifery programs in the U.S. and Canada. Educators were asked to check or list the resources that have been the most useful to them in their programs. The prices are those currently listed on Amazon.com.

### MIDWIFERY OR OBSTETRICAL TEXTBOOKS:

Varney's Midwifery, Helen Varney Burst, 4<sup>th</sup> Ed, 2004 \$127.95  
Human Labor and Birth, Oxorn-Foote, 1986, 5<sup>th</sup> Ed  
Heart and Hands, Elizabeth Davis, 2005  
Williams' Obstetrics, Cunningham et. al, 22<sup>nd</sup> Ed, 2005, \$145.00  
Maternal, Fetal, and Neonatal Physiology, Blackburn, 2<sup>nd</sup> Ed, 2002, \$99.95  
Holistic Midwifery II, Anne Frye, 2005, \$141.37  
Holistic Midwifery I, Anne Frye, 1998, \$69.00  
Myles' Midwifery, Fletcher, Fraser, Cooper, 14<sup>th</sup> Ed, 2003, \$69.65  
Midwifery: Community-based Care During the Childbearing Year, Walsh, 2001, \$69.95  
Mayes' Midwifery, Davis, Henderson, Macdonald, 13<sup>th</sup> Ed, 2004, \$64.95  
Maternal/Fetal Medicine, Creasy, 5<sup>th</sup> Ed, 2003, \$155.00

### NEWBORN TEXTS:

Physical Assessment of the Newborn, Tappero, 3<sup>rd</sup> Ed, 2003, \$44.95  
Assessment and Care of the Well Newborn, Thureen, 2<sup>nd</sup> Ed, 2004, \$49.95

### NUTRITION TEXTS:

Nutrition in Pregnancy and Lactation, Worthington-Roberts, 6<sup>th</sup> Ed, 1996, \$35.77

### COUNSELING TEXTS:

Ended Beginnings, Panuthos, Romeo, 1984, \$23.95  
Women's Moods, Sichel, Driscoll, 2000, \$10.78  
Drinking: A Love Story, Knapp, 1997, \$7.70  
Black & Blue, Quindlen, 1999, \$7.99  
The Gift of Fear, DeBecker, 1997, \$10.78  
When Survivors Give Birth, Simkin, 2004, \$32.95  
Lost Art of Listening, Nichols, 1996, \$11.67

### PHARMACOLOGY TEXTS:

Pharmacotherapeutics: A Primary Care Clinical Guide, Youngkin, et al., 2004, \$99.95  
Pharmacology for Primary Care, Edmunds, Mayhew, 2004, \$89.95  
Drugs in Pregnancy and Lactation, Briggs, 7<sup>th</sup> Ed, 2005, \$99.00

### PHYSICAL ASSESSMENT TEXTS:

Bates' Guide to Physical Examination and History Taking, Szilagyi, 2004, \$78.95  
New View of a Woman's Body, Federation of Feminist Women's Health Centers, 1991, \$19.95  
Physical Examination and Health Assessment, Jarvis, 4<sup>th</sup> Ed, 2003, \$76.95  
Mosbys' Guide to Physical Examination, Seidel et al, 2006, \$24.95

### LABORATORY TESTS/ SKILLS TEXTS:

Understanding Diagnostic Tests in the Childbearing Year, Anne Frye  
Mosby's Manual of Diagnostic and Laboratory Tests

### PROFESSIONAL ISSUES TEXTS:

Epidemiology, Gordis  
Understanding Health Policy, Bodenheimer  
Statistics: Concepts and Controversies  
Principles and Practice of Research in Midwifery, Elizabeth Cluett (2000)

### HISTORY TEXTS:

Midwifery and Childbirth in America, Judith Rooks(1997)  
Witches, Nurses and Midwives, Ehrenreich, 1972, \$6.50  
Lying-in: A History of Childbirth in America, Wertz, 1989, \$22.00  
Social Transformation of American Medicine, Paul Starr, 1984, \$26.00

### WELL WOMAN CARE TEXTS:

Women's Encyclopedia of Natural Medicine, Tori Hudson, 1999, \$15.72  
Women's Health: A Primary Care Clinical Guide, Davis and Youngkin, 2003, \$50.41

### SUPPLEMENTAL TEXTS:

Ambulatory Obstetric, Star, 1999, \$85.00  
Wise Woman Herbal for the Childbearing Year, Susun Weed, 1985, \$9.95  
Aviva Jill Romm's many books  
Homeopathic Medicines for Pregnancy and Childbirth, Moskowitz, 1992, \$12.89  
The Herbal for Mother and Child, Anne McIntyre, 2003  
The Tentative Pregnancy, Barbara Katz Rothman, 1994  
Breastfeeding: A Guide for the Medical Professional, Lawrence and Lawrence, 2005, \$69.95  
Breastfeeding Answer Book, Morbacher/LLL, 2003, \$42.84  
Breastfeeding and Human Lactation, Riordan, 3<sup>rd</sup> Ed, 2004, \$107.95  
Successful Breastfeeding, Royal College of Midwives, 2002, \$24.95



Human Anatomy and Physiology, Marieb, 6<sup>th</sup> Ed, 2003, \$156.67  
 Anatomy and Physiology for Midwives, McCandilish, Coad, Unstall, 2<sup>nd</sup> Ed, 2005, \$56.00  
 Women's Experience of Sex, Sheila Kitzinger, 1985, \$14.83  
 A Cooperative Method of Natural Birth Control, Nofziger, 1992, \$8.95  
 Contraceptive Technology, Hatcher, Trussell, Nofziger, 18<sup>th</sup> Ed, 2004, \$37.77  
 Neonatal Resuscitation Manual, American Heart Association  
 Vaccination, The Issue of our Times, O'Mara, 2006, \$9.72  
 Business Mastery, Sohnen-Moe, 1997, \$24.95  
 Labor Progress Handbook, Simkin et al, 2005, \$29.95  
 Healing Passage, Anne Frye, 1995, \$79.99  
 Having Faith, Steingrabber, 2003, \$10.78  
 A Guide to Effective Care in Pregnancy and Childbirth, Enkin, 2000, \$42.50  
 Practical Skills Guide for Midwifery, Weaver and Evans  
 Childbirth Education, Nichols and Humenick, 2<sup>nd</sup> Ed, 2000, \$64.95

## JOURNALS:

Journal of Midwifery and Women's Health  
 Midwifery Today  
 Birth: Issues in Perinatal Care  
 Mothering  
 American Journal of Obstetrics and Gynecology  
 Canadian Journal of Midwifery  
 Journal of Perinatal and Neonatal Nursing  
 MIDIRS Midwifery Digest  
 Contemporary OB/GYN  
 Journal of Obstetric, Gynecological, and Neonatal Nursing  
 British Journal of Midwifery  
 MCN: The American Journal of Maternal Child Nursing  
 Obstetrics and Gynecology  
 The Practising Midwife  
 Royal College of Midwives Journal  
 British Medical Journal  
 Journal of the American Medical Association  
 Journal of Human Lactation  
 Journal Watch- Women's Health, published by NEJM  
 Women's Health Issues  
 ACOG Practice Bulletins & Committee Opinions



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Earn CEU'S, *online*, on *your* schedule,  
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### *Reading the Medical Literature--an Online Journal Club for Midwives*

*How many CEU's will I earn?* You will earn 12 contact hours (1.2 CEU's) approved by MEAC and ACNM, while sharpening your skills in critiquing the medical literature.

*Do I need to be online at set times?* No, you only need about 2-1/2 hours each week during a 5-week session (next session begins June 19, 2006).

*What exactly will I be doing?* Each week, you will read a journal article (all articles are relevant to midwifery practice and published within the last year and a half). You will complete an online post test and post your answers to a series of questions to the workshop discussion board. There, you will engage in an open discussion with other midwives. SMS epidemiology instructor, Sarah Huntington, CPM, MPH, will facilitate the discussion and be available by email to answer your questions.

*What does it cost?* The workshop fee is \$175 plus a \$25 tech fee (the workshop is on WebCT, an online educational interface). This fee includes technical assistance, if needed.

For more information on this workshop and all our programs, visit us at  
[www.seattlemidwifery.org](http://www.seattlemidwifery.org) or call us at 800.747.9433.

## **NEED CEU REVIEWER**

**Dear Midwifery Educator,**

**Are you interested in being a MEAC reviewer for CEU programs? Do you like to correspond via Email? I have always enjoyed being on the inside, getting a first hand look at all the great conferences that are coming to midwives. If you are interested in joining our Electronic CEU Review Committee, contact <info@meacschools.org> for more information.**

**Thank you! Mary Ann Baul**



# *Reclaiming Midwives*

*A traveling exhibition  
curated by  
Linda Holmes*



Stills from *All My Babies*

## **Birth Center Hosts Smithsonian Exhibit**

The Birth Center of Gainesville and the Florida School of Traditional Midwifery are proud to display “Reclaiming Midwives: Pillars of Community Support,” an exhibition from the Smithsonian’s Anacostia Museum and Center for African American History and Culture, at 810 E. University Ave.

The exhibit will open at 7 p.m. May 6 during Gainesville’s 19<sup>th</sup> Annual International Midwifery Day Celebration.

The display features photos that Robert Galbraith took during the making of “All My Babies,” a 1953 film that documents the role of “granny midwives.”

The Georgia Department of Public Health produced the film as an educational tool for midwives. The United Nations and the World Health Organization used it to train midwives around the world.

The Library of Congress recently recognized “*All My Babies*” as one of 25 films to be preserved for all time.

*For more information call: 352-246-3142 or visit [www.BirthCenterOfGainesville.org](http://www.BirthCenterOfGainesville.org)*

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