Courtesy of Stony Brook University Midwifery Program

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, nonmidwifery 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 another, 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).

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