

Essential Midwifery Practice

Midwifery is a discipline that melds science with art; it is a humanistic approach to providing quality health care to women, newborns, and their families that recognizes the sacredness of the individual and of the processes of fertility and birth, and that honors women across the life span.

Exemplary midwifery practice is woman oriented and focuses on excellence in the processes and provision of women's health care, with a primary goal of improving maternal and child health (Kennedy, 2000). Exemplary midwives promote the discipline of midwifery through professional actions that benefit women and their families, while allowing adequate personal time for reinvigoration for this important work.

Midwives are blessed with a passion for their work. It is the thoughtful and skilled expression of this passion that women under midwives' care so appreciate and that has helped the discipline of midwifery to thrive.

This book, *Clinical Practice Guidelines for Midwifery and Women's Health*, is designed with the practicing midwife in mind. The text condenses and outlines clinical care, highlighting the art and science behind the midwifery model of care. It is the authors' goal that this book support your professional practice as a resource by allowing you to focus on the women who come to you for care rather than on the administrative task of creating practice-specific clinical practice guidelines.

PURPOSE OF CLINICAL PRACTICE GUIDELINES

The goal of *Clinical Practice Guidelines for Midwifery and Women's Health* is to provide, in a standardized format, a brief, succinct, critically appraised, and referenced synthesis of current midwifery practice including evidence-based, traditional, complementary and alternative medicine (CAM), and empiric options for care. Clinical practice guidelines are used to describe, define, and delineate parameters for evaluation, diagnosis, and care in specific clinical conditions.

Box 1-1 Philosophy of the American College of Nurse–Midwives

We, the midwives of the American College of Nurse–Midwives, affirm the power and strength of women and the importance of their health in the well-being of families, communities, and nations. We believe in the basic human rights of all persons, recognizing that women often incur an undue burden of risk when these rights are violated.

We believe every person has a right to:

- Equitable, ethical, and accessible quality health care that promotes healing and health
- Health care that respects human dignity, individuality, and diversity among groups
- Complete and accurate information to make informed health care decisions
- Self-determination and active participation in health care decisions
- Involvement of a woman’s designated family members, to the extent desired, in all health care experiences

We believe the best model of health care for a woman and her family:

- Promotes a continuous and compassionate partnership
- Acknowledges a person’s life experiences and knowledge
- Includes individualized methods of care and healing guided by the best evidence available
- Involves therapeutic use of human presence and skillful communication

We honor the normalcy of women’s life cycle events. We believe in:

- Watchful waiting and nonintervention in normal processes
- Appropriate use of interventions and technology for current or potential health problems
- Consultation, collaboration, and referral with other members of the health care team as needed to provide optimal health care

We affirm that midwifery care incorporates these qualities and that women’s health care needs are well served through midwifery care.

Finally, we value formal education, lifelong individual learning, and the development and application of research to guide ethical and competent midwifery practice. These beliefs and values provide the foundation for commitment to individual and collective leadership at the community, state, national, and international level to improve the health of women and their families worldwide.

Source: American College of Nurse–Midwives [ACNM], 2004.

These *Guidelines* present a utilitarian practice tool that reflects up-to-date evidence presented in an easy-to-follow format addressing conditions frequently seen in clinical midwifery and women’s health practice.

How clinical practice guidelines are applied in midwifery or women’s health practice is influenced by a number of factors, such as the accepted standards of the midwife’s or women’s healthcare provider’s

professional organization(s), local and regional styles of practice, the practice setting, and individual practice preferences. State laws, in the form of both statutes and regulations, affect the scope of practice, as do hospital bylaws, birth center rules and regulations, health insurance contracts, and liability insurance policies.

Each individual midwife determines her or his scope of practice within these legal and professional boundaries based on the individual’s philosophy of

midwifery practice, educational preparation, experience, and skill level; the community need; and the specific practice setting. A midwife's scope of practice is dynamic and may vary from one practice location to another; it also evolves over time and throughout the individual's career.

Every woman who comes to a midwife for care has a right to information regarding the midwife's scope of practice, usual practice location(s), and indications and provisions for access to specialty medical or obstetric care. Development of professional relationships with multidisciplinary community and regional health-related resources, such as pharmacists, physicians, social service personnel, clergy, and other relevant community organizations, is a valuable asset in fostering continuity of care and ensuring access to comprehensive services for the women whom midwives serve.

Knowledge of evidence-based practice is an expectation in today's healthcare environment. Midwifery, as a discipline, includes domains of knowledge that are quite amenable to evidence-based investigation. At the same time, however, midwifery includes and values knowledge that is not so easily gained from this approach. Midwifery recognizes the importance of considering the "whole" person in a sociocultural-biological context and calls for continuing traditional high-touch, low-tech midwifery care—a perspective that is not typically reflected in current medical research questions, designs, and methodologies. The research evidence base primarily rests on quantitative research methods. This paradigm is often criticized because it reduces phenomena to numerical representations—an approach that does not support holistic understanding. Likewise, this approach does not adequately explore outcomes of midwifery care that are not easily measured with a laboratory test or a Likert scale, such as emotional experiences and spiritual awakenings that result from fundamental life-defining moments such as can occur during labor and birth.

Other valuable types of midwifery knowledge are informed by empiric and traditional midwifery care. Traditional midwifery care includes practices that

have evolved through generations of women providing care to women, whose knowledge and skills have been passed down through centuries and across cultures. Empiric care is care based on observation or experience, and for decades it has formed the basis of most medical decision making. Recommendations for care based on how one was taught and one's experience are examples of empiric care. The practitioner should be aware that a lack of evidence neither invalidates nor supports the effectiveness of empiric or traditional midwifery care practices; rather, it merely indicates that at the present time scientific studies examining the specific practice are lacking.

Midwifery as a discipline applies the domain of midwifery knowledge and the health-related sciences to clinical care using a humanistic approach. Fundamental to midwifery is the honoring of women throughout the life span through recognition of the sacredness of the individual and of the processes of life, fertility, and birth. This recognition is embedded in the language used in *Clinical Practice Guidelines for Midwifery and Women's Health* and is an underlying premise of midwifery literature.

Evidence-based practice is described as "the explicit, judicious and conscientious use of current best evidence from health care research in decisions about the care of individuals and populations" (Sackett, Richardson, Rosenberg, & Haynes, 1997). The process of applying an evidence-based approach to clinical midwifery practice requires the clinician to consider the evidence in light of the specific patient-population served, current recommendations for care and treatment, and the cultural background and unique preferences of individuals by doing the following:

- Asking clinically focused questions specific to the evaluation, diagnosis, and treatment recommendations for specific clinical conditions
- Conducting a focused published literature review using quality peer-reviewed sources
- Critically appraising this literature in light of each study's rigor and adherence to the scientific principles underlying the methodologic decisions

- Applying the results of this appraisal to clinical practice, offering the individual adequate information to make informed decisions and participate in creation of an individualized healthcare plan that recognizes standardized recommendations and treatment (Lydon-Rochelle, Hodnett, Renfrew, & Lumley, 2003)

Various evidence-based resources are available that summarize and synthesize the latest information for busy practitioners, such as the Cochrane Database and the regular feature on evidence-based practice in *Journal of Midwifery & Women's Health*. Nevertheless, the analytical practitioner should be cautious and judicious in applying new evidence in practice. Evidence, as well as our philosophy, beliefs, knowledge and skills, should guide and inform us as we go about the daily business of providing midwifery care to women and their families.

Scientific evidence is developed with clearly defined populations of patients in narrowly focused areas and is expressed in terms of numerical probabilities; our care is delivered to one woman at a time in the context of her specific life situation and is expressed in terms of hopeful possibilities.

All midwives are encouraged to be lifelong learners and reflective practitioners. Reflection in practice involves methodically evaluating our experiences, connecting with and integrating our feelings about these experiences and our role in them, and comparing our clinical practices with our theories-in-use. Reflective practice entails continually building new understandings to inform our actions during situations as they unfold, while remaining aware of the potential for bias and its effect on our thinking (Schon, 1983).

The old adage of “See one, do one, teach one” has lost favor in the recent past, as it is now perceived as an inadequate method for educating and training skilled and competent health professionals. Within reflective practice, however, this adage can

be reinterpreted for the twenty-first century as a motto to remind us of the importance of the following steps:

- Developing and refining clinical judgment through the continual processes of observation, practice, and teaching. From this perspective, the practitioner is encouraged to avoid clinical isolation by seeking opportunities to observe the techniques and practices of peers and colleagues (See One).
- Maintaining clinical skills through deliberate attention to practice, clinical training and simulation; reading of the literature; and application of new knowledge and techniques in the clinical setting (Do One).
- Expanding the individual's skill set and knowledge base beyond the basics to the level necessary to effectively and skillfully teach or mentor new clinicians (Teach One).

Clinical expertise is developed over time and with thoughtful attention to practice. New practitioners and novices are encouraged to maintain heightened awareness of their evolving expertise and to set safe boundaries of practice for themselves. Experienced practitioners are encouraged to remain current in their knowledge and skills and to protect their passion for this work by avoiding the complacency or cynicism that sometimes occurs when practicing midwifery in low-resource settings, in settings hostile to midwifery, or with challenging populations.

WOMEN FIRST

Midwives and other women's health professionals practice within a healthcare system that is increasingly complex. Midwifery and women's health is first and foremost concerned with caring for and about women.

Every individual woman deserves to receive care that is safe and satisfying, that fosters self-determination and her ability to care for herself. Such care, to be effective, addresses the individual's personal, cultural, and developmental needs. Women look to their

healthcare provider to give guidance consistent with the individual's real and perceived health needs and internal beliefs.

As midwives caring for women in our country's diverse communities, the ability to listen and to integrate women's concerns into the care provided is an integral component of midwifery practice. The aim is to provide care based on the woman's expressed and identified needs through a personalized plan of care that is mutually developed and supported by both the woman and the midwife, and that reflects the midwife's awareness and sharing of national, regional, and local expectations and recommendations for care.

Sometimes, women do not have an adequate frame of reference to formulate clear questions regarding their health. Teasing out the health concerns that are important to an individual woman requires skill in directed inquiry and active listening, sensitivity to cultural issues, and knowledge of common health practices, procedures, and preferences. Meeting women's health needs requires consideration of the myriad of options for care or treatment available and necessitates cultivation of a broad-based network of interdisciplinary professional and collaborative relationships.

Traditional midwifery care is based on providing care that fosters the physiologic processes of labor and birth. Modern midwifery and women's health care builds on this physiologic noninterventionist foundation to include interventions only as necessary and as indicated by the individual woman's condition and preferences. Determining which interventions are "necessary" and when they are "indicated" defines our individual practice as midwives, yet can also be a function of the environment of care in which the midwife practices.

The midwife–woman relationship can be developed and nurtured in every environment of care. In a situation of trust, clients whose primary point of reference is mainstream medical care can be supported to embrace noninterventionist care for normal labor and birth. Through development of a trusting

relationship with her midwife, a client whose primary orientation is toward complementary and alternative care can be guided toward mainstream medical care when it is indicated. The potential for the client to derive comfort and feelings of safety is influenced by both the quality of the midwife–client relationship and the environment of care.

ENVIRONMENT OF CARE

The environments where care is obtained and provided affect each individual's health practices and outcomes. The Environment of Care includes the physical location where care is provided, the sociocultural milieu, and the prevailing attitudes evident during caring efforts provided by attending practitioners. A woman's autonomy and her sense of control over her circumstances are shaped by her environment.

The power dynamics between client and provider and between providers varies in different environments. In fact, a woman's physiologic response can be affected by changes in the environment of care; release of powerful stress hormones is mediated by the individual's sense of safety and confidence in her ability to cope with her present circumstances. These physiologic effects can be particularly striking in the environments where labor and birth occur (Lothian, 2004).

Midwives practice in many different environments, such as hospitals of various acuity levels, offices, birth centers, clinics, and homes. Across the globe, some midwives find themselves practicing in impoverished and low-resource settings. While the practice principles may remain the same regardless of the environment of care, the services and procedures offered often vary based on sociocultural factors and on access to resources, equipment, and qualified personnel. Within the ideal supportive healthcare system, midwives will have access to the full range of services, environments of care, and providers necessary for their client's care, including opportunities for collaborative practice focused on meeting the needs of the client.

No matter where clinicians stand on the continuum of healthcare practices, and regardless of the wide

range of environments of care in which they practice, it remains imperative that practitioners understand the broad range of services that are available to the women who come to them for care. The women who seek out midwives for care—our clients—do not live in the healthcare world. Their awareness of which services are available is influenced by issues of access, the effects of advertising and Internet-based information, social and cultural beliefs, the experiences of their friends or relatives, and the ever-present popular media. Practitioners who are knowledgeable of the many options available to clients are prepared to listen and understand which healthcare choices women are making, thereby increasing their effectiveness in addressing women's needs.

HOW TO USE THIS BOOK

You may find it convenient to have several copies of this text: one for your exam room(s), one for your birth setting, and another by the phone at home. These comprehensive *Guidelines* have been formulated to stimulate critical thinking processes and are just one of many references available to inform clinical practice.

Guidelines evolve over time; it has been estimated that 20% of practice recommendations change over a 3-year period (Tillett, 2009). Thus guidelines are inevitably updated on a regular basis. Nevertheless, it remains the professional's responsibility to keep abreast of emerging evidence and recommendations for care, and to determine how to best incorporate clinical practice guidelines and recommendations into practice.

When used in lieu of practice-specific practice guidelines, this text may be individualized by including dated and initialed written additions and deletions, highlighting, and so on. A dated reference copy allows the practitioner to refer back to historical practice parameters should there be a need to describe one's practice at a future date.

Clinical Practice Guidelines for Midwifery and Women's Health uses a system of organization consistent with the way most healthcare providers are taught

to gather, interpret, and act on the data obtained during an individual client encounter. Through this format, the *Guidelines* promote a methodical and consistent approach for client assessment, problem identification, and treatment or referral. Clear identification of documentation essentials and practice pitfalls act as reminders to the busy professional. Although the term "midwife" is frequently used throughout this book, the content and recommendations are equally relevant for other women's healthcare professionals.

Use of a systematic approach is indispensable to providing optimal women's health care in today's busy healthcare environment. A consistently applied method of approach and organization is central to providing women with comprehensive health care that meets each client's need in a thorough and satisfying manner.

Use of Symbols

Symbols are used throughout this text to indicate key areas that require particular attention. The purpose of the symbols is to heighten awareness, stimulate critical thinking in areas that are potentially problematic, and encourage comprehensive record keeping and interdisciplinary communication.



Cultural Awareness

Use of this symbol highlights a need for cultural awareness. The world is fast becoming a global society. No matter where we practice, it is likely that each of us will provide care to women who come from different countries, or from cultures different from our own, or from locations other than where we obtained our primary midwifery education clinical experience.

Cultural sensitivity and humility are essential to ensure quality care of women in our multicultural world. We need to consider each woman as an individual who exists not only in our practice settings but also in the context of her own life circumstances and background. Cultural influences affect birth choices, birth control methods, sexual identity, self-care preferences, and more.

Cultural awareness includes consideration of the client's race, religion, ethnic heritage, age, generation, geographic factors, and cultural mores. Additionally, we need to remember that not everyone from a particular culture embraces the typical beliefs and behavior patterns associated with that culture, and that people can be members of several different subculture groups, some with conflicting beliefs. A client's health beliefs and cultural traditions should be explored and verified as the plan of care is being developed.



Risk Management

Use of this symbol highlights a need to determine whether an identified risk is modifiable through action on the part of the client or the midwife. For risks that are inherent in the client or care practice, careful attention to risk/benefit information and detailed documentation are in order.

Risk management includes thoughtful consideration of factors that can increase risk to the mother or baby, to the well woman, or to the midwife providing care. Identification of those factors that contribute to risk is the first step in reducing their potential impact on outcomes. Risk management as applied to midwifery practice includes careful documentation of care provided, consultations, and case review. Integral components of the midwifery risk management plan are discussed later in this chapter.



Clinician Resources

Use of this symbol denotes a web-based link or application in the Clinician Resources list at the end of each chapter. These resources have been carefully screened and selected for their clinical relevance and usefulness to practice. Each Clinician Resources feature identifies sites providing national practice recommendations, clinical assessment tools, drug resources, screening or testing information, and other essentials critical to keeping the busy midwife up-to-date.



Consultation or Referral

Use of this symbol is a cue to consider whether a client might be best served by the involvement of other professionals in her care, such as dietitians or social workers; whether her condition requires additional expertise to supplement midwifery care through consultation and collaboration; or whether her needs are best met by referral to specialty care for treatment of a specific condition or transfer for continued care.

Consultations and referrals provide for continuity of care when problems develop or when additional expertise is required. Consultations range from informal conversations to detailed problem-oriented evaluation of the client by the consultant. When midwives consult with obstetric/gynecologic (OB/GYN) physicians, they need to remember that the physician practices a different specialty and may employ a different approach to the problem than that taken by the midwife. Consultation requests are documented in the client's medical record. The requesting care provider documents phone consultations, while an in-person consultation is documented by the consultant.



Documentation

Use of this symbol highlights a need for careful documentation practices in accordance with institutional standards and national documentation recommendations. For those midwives or students who seek to improve documentation skills, additional recommendations for documentation are addressed later in this chapter (in Table 1-4, Documentation Standards).

Documentation of care is the basic building block of practice that illuminates and describes midwifery practice. Documentation skills are an essential component of midwifery practice and are the critical means used to describe and validate quality midwifery care and demonstrate differences between the disciplines of midwifery, medicine, and nursing.

A brief description of the categories used in the *Guidelines* can be seen in Table 1-1. Comprehensive

Table 1-1 Clinical Practice Guidelines Format**Key Clinical Information**

Client History and Chart Review: Components of the history to consider

Physical Examination: Components of the physical exam to consider

Clinical Impression: Differential diagnoses to consider

Diagnostic Testing: Diagnostic tests and procedures to consider

Providing Treatment: Therapeutic measures to consider

Providing Treatment: Complementary and alternative measures to consider

Providing Support: Education and support measures to consider

Follow-up Care: Follow-up measures to consider

Multidisciplinary Practice: Consider consultation, collaboration, or referral

descriptions of the categories of information that might be obtained during client assessment, evaluation, and development of a midwifery management plan are provided next in the format that you will find throughout the *Guidelines*.

The Clinical Practice Guideline Format

Clinical Practice Guidelines for Midwifery and Women's Health is designed to stimulate critical thinking about clinical topics using a standardized quick-reference format. Each Clinical Practice Guideline offers a multitude of options for the clinician's consideration based on the following aspects of the case: the needs of the individual woman; the clinician's findings, philosophy, and style of practice; and the practice setting or environment of care. The primary intent is to enhance the clinician's ability to provide safe, satisfying care to women while avoiding unintentional omissions in evaluation, diagnosis, or treatment that can result in harm to women, their babies, and, by extension, the profession of midwifery.

Key Clinical Information

This section provides background information to inform the clinician's interpretation of the content of the Clinical Practice Guideline.

Client History and Chart Review: Components of the History to Consider

This section details information useful to developing a database sufficient to drive clinical decision making. Sources of this information include, but are not limited to, patient or family interviews, chart review, interval history, consultation requests, information from cultural interpreters, and dialogue with other health professionals (case review).

The client history is commonly divided into various categories based on the nature of the encounter, the environment of care, the scope of the practitioner, and the goal or objective of the client visit. Categories can include a comprehensive health history, an interval history, and a problem-oriented or event-specific history. The comprehensive health history can be further subdivided into the client's past medical and surgical history, social history, and family medical history. These subtypes of the history can be again subdivided to allow for focus on specific areas of concern, such as menstrual history, obstetric history, or genetic history.

The review of systems is a review of the major body systems with the client to determine the presence or absence of signs and symptoms of health conditions, illness, or disease. This comprehensive review includes the following systems: constitutional symptoms (weight loss, fever, malaise, fatigue); eyes, ears, nose, mouth, and throat; skin; respiratory; cardiovascular; gastrointestinal; genitourinary; musculoskeletal; endocrine; lymphatic/hematologic; immunologic/allergic; psychiatric; and neurologic systems (American Medical Association [AMA], 2010).

Identifying which components of the history to further explore with the client is a skill that can assist the midwife in efficiently identifying problems or concerns and in developing a working list of potential differential diagnoses. Components of the

history that are included in the client interview are documented, including, when applicable, the client's stated attitude and observed affect or emotional state. The skilled diagnostician is an active listener who can discern which client responses are pertinent and use directed inquiry to elicit further information.

Review of the medical record is an integral part of the client's health history. Many clients provide a limited and necessarily subjective accounting of their health history. The medical record serves to provide an objective overview of the client's health status and can reveal essential details omitted during the client interview. Be aware, however, that the medical record is an imperfect data source that can contain errors and omit or condense a great deal of important information relevant to understanding the client's healthcare needs.

Physical Examination: Components of the Physical Exam to Consider

This section offers suggestions for broadening or narrowing the focus of inquiry and examination once the history has elucidated the indication for the visit and possible working diagnoses are developed.

Every body system has both general and specific elements that may be evaluated during the physical examination. Thorough evaluation of the area(s) of concern is an integral part of client or patient evaluation. Which components are included during the physical examination depends on the nature of the presenting problem or health condition and the individual midwife's scope of practice. Although many midwives care predominantly for women during the childbearing year, others provide comprehensive women's health care, including evaluation and treatment of gynecologic and/or primary care problems and conditions, examination and care of the infant, and evaluation and treatment of sexually transmitted infections in male sexual partners.

Both performance and documentation of the physical examination are most frequently organized in a head-to-toe fashion. Using a consistent technique allows for systematic client evaluation and

comprehensive documentation of results and facilitates review of pertinent information. Standard medical terms are used to describe the presence or absence of findings in an objective manner consistent with the anatomic area under evaluation. "Normal" is a vague descriptor because the range of normal varies widely from client to client. Descriptive terms are used when necessary to enhance the narrative and present a comprehensive report of clinical findings.

Standard terminology is used to identify areas of note (i.e., right lower quadrant, periumbilical, substernal). "Left" and "right" are clearly identified when applicable. Instruments and tests used during the physical examination are identified when necessary to describe the technique used for evaluation—for example: "A speculum was inserted in the vagina to expose the cervix" or alternatively, "Speculum exam demonstrated . . ."

The language should be clear and descriptive, and identify clinical findings and, when indicated, client response to the examination. Notes reflect the midwife's critical thinking process during the examination (italicized in the example that follows): "The left breast was noted to have an irregular fixed mass in the upper outer quadrant, extending into the axillary tail. The mass is approximately 2 × 3 cm, with bluish discoloration over the area, *which may represent increased vascularity*. The mass is firm but not hard; however, it is fixed to the chest wall and accompanied by palpable axillary lymph nodes. *The clinical picture is highly suspicious for breast cancer in spite of a negative mammogram last week.*"

Clinical Impression: Differential Diagnoses to Consider

This segment is designed to aid the practitioner in considering the wide range of diagnoses that are possible with any given set of symptoms and physical findings. The working diagnosis will drive the choices for testing, treatment, and involvement of additional multidisciplinary, collaborative team members.

The clinical impression may be more familiar under the name of "assessment" or "diagnostic impression."

The differential diagnoses list is a brief summary of diagnoses under consideration given the client's presenting symptoms or condition. Differential diagnoses are often documented in the medical record as a running list from most to least important or likely. More than one diagnosis is possible due to shared symptomatology, such as the dual diagnosis of bacterial vaginosis and *Trichomonas* infection in the presence of vaginal discharge, pruritus, and foul odor.

The clinical impression identifies the midwife's assessment of the client's health status using standardized terms and billing codes based on the client history, physical examination, and any testing performed on-site. The clinical impression and differential diagnoses then direct discussion with the client and development of the midwifery plan of care, which can include further evaluation and testing, plans for continued care, and indications for consultation or referral. The plan of care reflects and is consistent with the differential diagnoses noted. A firm diagnosis can be deferred until the results of diagnostic testing have been reviewed, making testing part of the overall midwifery plan.

The documented clinical impression is also used for coding and billing purposes. The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) has been the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. However, it is due to be retired in the next few years (Centers for Medicare & Medicaid Services [CMS], 2010c), when it will be replaced with the *International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System* (ICD-10-CM/PCS). The ICD-10-CM is intended for use in all U.S. healthcare settings. Each code in this system consists of three to seven digits, rather than the three to five digits used in the ICD-9-CM. The ICD-10-PCS is intended for use in all U.S. in-patient hospital settings; each of its codes consists of seven alphanumeric digits, rather than the three to four numeric digits used under the ICD-9-PCS. The ICD-10-CM/PCS system has been in use for years in other

nations; however, the complexity of the U.S. health-care and payer system has hampered its adoption here. The ICD-10 system offers more detailed data about patient conditions and procedures and reflects current medical practice and nomenclature.

Although useful to document the clinician's thinking, the term "rule out" is not acceptable for coding purposes. Nevertheless, it remains a useful way of clarifying indications for diagnostic testing to confirm or eliminate ("rule out") a specific listed differential diagnosis under consideration. For example, the differential diagnosis of "urinary urgency" can be accompanied by the phrase "rule out urinary tract infection," when infection has not yet been diagnosed pending laboratory confirmation.

Coding decisions are complex and establish the medical necessity for the services provided. The midwife must use the code that best describes the unique situation of the individual patient. Midwives and other clinicians are responsible for accurately coding the services they provide to their clients. Providers and their billers are required to obtain and use the version of the coding structure in current use. This issue will be especially important during the upcoming transition from the ICD-9-CM/PCS to the ICD-10-CM/PCS slated to occur in the next few years. Always check a current resource to obtain the most up-to-date codes. Codes can be obtained from the following site: <http://icd9data.com/> or <http://www.icd10data.com/>.

Establishing medical necessity is vital to getting paid—if codes do not make sense, are not supported by documentation in the client's medical record, or are nonspecific, the unhappy result may be payment downgrades or payer denials. There is a difference between coding and billing. You can always find a code, but billing rules may prohibit its use—such is the case with some diagnoses that are used in the presence or absence of pregnancy.

Diagnostic Testing: Diagnostic Tests and Procedures to Consider

This section offers a range of testing options related to the most common working diagnoses. In some

instances, reference ranges have been included to guide clinical decision making. Please note that the reference ranges for the laboratory performing the test may vary from those published here; the specific laboratory's reference ranges should always be considered when reviewing test results.

Diagnostic testing includes tests or procedures performed to elicit additional information to accurately diagnose a clinical problem, to verify a health condition, and to evaluate or monitor an ongoing treatment plan. Testing is documented in a brief and straightforward manner, with additional explanations being provided in unusual situations. Testing is often documented as a numbered list using standard terminology. Each test ordered must be clearly identifiable by other healthcare professionals. One area in which confusion can occur is when diagnostic or screening panels are ordered, the names or components of which are not consistent from facility to facility. For example, the panel "PIH labs" (pregnancy-induced hypertension or preeclampsia panel) can include different arrays of tests at different locations. This can become problematic when a transfer of care is necessary and test results are pending.

Test results should be reviewed and clearly documented or filed in an easy-to-find location, especially when they pertain to ongoing care of a problem. Test results come under the heading of "Objective Findings" when writing or dictating a note in the medical record. Anticipatory thinking regarding potential diagnostic test results is documented in the record to support continuity of care when another clinician is responsible for providing continued care, such as occurs in group practice settings, or with a transfer of care.

Providing Treatment: Therapeutic Measures to Consider

This segment details the most common and accepted options for treatment based on the literature and current clinical practice for the select diagnoses. Every effort is made to include well-documented therapeutic options that had previously been considered "alternative" and are now considered "evidence based"

according to the literature. Examples include vaginal birth after cesarean, hydrotherapy in labor, the Gaskin maneuver, fetal heart rate (FHR) auscultation in labor, and physical therapy for low back strain.

Therapeutic measures include the administration, ordering, or prescription of medications and accepted therapeutic treatments. Documentation of medications includes the medication name, indication for use, dosage, timing, and route of administration. Review of medication instructions, known side effects, and adverse effects is an integral part of the prescriptive process. Care is taken to use pictograms or standardized foreign-language handouts when necessary to ensure women have the information needed to understand and properly execute medication recommendations. When off-label medication use is prescribed, it is documented as such, with documentation of relevant discussions with the client regarding clinician recommendations for off-label medication use and informed consent when indicated. Other treatment modalities, such as physical therapy, chiropractic manipulation, and respiratory therapy treatments, are documented as ordered, including the indication for the treatment.

Providing Treatment: Complementary and Alternative Measures to Consider

This section offers treatment options that are less well documented in the literature, that are less common in mainstream women's health practice, for which there is only empiric evidence, or that are generally considered "complementary and alternative medicine" when compared to commonly accepted mainstream women's health practice. Commonly accepted practices that the literature does not address are included in this category.

Alternative treatment measures include CAM therapies such as acupuncture, acupressure, homeopathy, herbal remedies, and massage. Many CAM treatments are not considered to be "prescribed" because they are available to clients for self-treatment. In contrast, other CAM therapies, such as custom compounding of hormones, do require a prescription.

The midwife should be aware of the wide range of therapies available as treatment options, note current evidence regarding the safety and effectiveness of these treatments, and provide advice for their use. Ideally, sources should be cited for suggested measures, and client instruction and pertinent discussion regarding alternative, traditional, and empiric treatments documented.

Lack of randomized controlled trials can limit recommendations for complementary and alternative measures in some practices, whereas in other practices these time-honored methods of caring for women continue to be discussed on a regular basis. Ethical midwifery practice requires discussion of known risks and benefits of therapeutic measures as well as the limits of our knowledge and documentation of the same. Consider the following example:

Client, G3, P2002, inquired about use of castor oil to stimulate labor at 41½ weeks. The FHR was reactive today; cervix is soft and 1 cm. We discussed her options: expectant care, herbal or homeopathic remedies to stimulate cervical change, and the parameters for use of medications for cervical ripening and/or induction of labor. She expressed interest in castor oil and was provided with information and instructions for use of P.O. castor oil for cervical ripening (Knoche, Seltzer, & Smolley, 2008). She was instructed to call with the onset of labor or return to the office in the A.M. if no labor ensues for monitoring of maternal/fetal well-being.

Providing Support: Education and Support Measures to Consider

This section details ways in which the clinician can enhance self-care and knowledge of the individual. Of particular concern in this section are suggestions or recommendations for means to enhance the woman's commitment to the treatment plan, promote self-care, and encourage healthy choices.

Client education and support are integral elements of midwifery practice and, as such, should be clearly documented. Use of standardized client education

materials can make documentation of education simpler and less time consuming. Maintaining a master file of regularly used client education materials allows the midwife to refer back as needed to see which materials were used during a specific time period. Documentation in the medical record describes patient education content, pertinent discussion, and recommendations for support measures; it also indicates whether patient education and support measure recommendations were provided verbally, in writing, or both. Use of an interpreter or foreign-language handouts is noted. A teaching checklist provides an efficient means to document standardized teaching. The use of written instructions or recommendations allows the client to refer to them after the visit and to refresh her memory regarding instructions or information provided at the visit.

Client support can include coordination of recommended care, such as scheduling of diagnostic tests and coordination of referrals; recommendations for social, psychological, educational, economic, or other resources; and access to off-hours services. Although review of diagnostic test results and clinical planning based on those results fall under the category of follow-up, interaction with the client that includes information about test results, options for care, discussion of alternatives, and a compassionate listening ear occurs within the client support and education framework.

Follow-up Care: Follow-up Measures to Consider

This section details the recommendations for continued care, testing, consultation, or referral that are supported by the literature and/or inclusive of providing thorough, quality, compassionate care. In addition, this section addresses areas of midwifery practice or documentation that enhance positive health and practice outcomes.

Follow-up after a client encounter includes the actual process of documenting care that has been provided, including anticipatory thinking, and recommendations for future care. This documentation

also clearly indicates the timing of recommended appointment(s) for further care or testing. This serves to ensure that the midwife, as well as other clinicians, has a clear impression of the client visit, the care provided, and the anticipated next steps in the ongoing care of this individual.

Identification of expectations for the client's next visit(s) and interval self-care are critical elements to include when documenting the midwifery plan of care. Clients who are informed and aware of what is expected of them, and who agree with the treatment plan, are most likely to follow through with recommendations for care. Follow-up can include events such as returning for a scheduled visit (i.e., a routine prenatal visit) or telephone contact from the midwife after receipt of a test result (i.e., a mammogram performed on a client with a suspicious breast mass). Follow-up also includes reminders to call or present for care if mild symptoms at the time of the examination persist or worsen (i.e., nasal congestion that develops into a productive cough with fever, or scant vaginal spotting that turns bright red and heavy), along with instructions on how to reach on-call personnel during off-hours and where and when to present for urgent or emergency care.

When a deviation from normal or unexpected findings occurs, a detailed plan for follow-up care is developed and documented. In the earlier example of a woman with a breast mass, the documentation might include the date on which results were received; discussion with the client about her options for care; referral to a breast specialist; the date and time of the specialist appointment; documentation of the consult request, including records transferred to the specialist with written client consent; and initiation of a mechanism to verify client follow-through with these recommendations and appointments.

Tracking of clients who are receiving ongoing treatment for unresolved problems is an integral part of the midwifery risk management plan. For the many midwives who provide comprehensive women's health care, an organized follow-up system, such as a file or database, can be useful to

track the ongoing care of clients requiring scheduled follow-up. In this instance, documentation in the client medical record that the follow-up system has been implemented can help with tracking. Depending on patient volume and the complexity of the clinical issues requiring follow-up care, the follow-up system can be a calendar, a notebook, a cross-referenced index card file, or a software program that automatically generates reminders, identifies no-shows, and provides a comprehensive record of problems and follow-up messages sent to the individual requiring care.

Multidisciplinary Practice: Consider Consultation, Collaboration, or Referral

This section addresses midwifery care as part of a multidisciplinary system of care in which midwives consult with, collaborate with, and refer to various other health providers and services such as OB/GYN physicians, nurse-practitioners, pediatric care providers, and other specialty care providers.

Consultations or referrals are made by midwives for many types of services, including counseling, smoking cessation, nutritional evaluation, psychiatric care, substance abuse treatment, and alternative therapies. Such services can be provided by a wide array of individuals, such as pharmacists, physical therapists, social workers, dietitians, herbalists, acupuncturists, chiropractors, or clergy, based on the needs and wishes of the individual and the midwife's scope of practice.

A consultation comprises any request for collaboration with another healthcare professional to provide care for a client for a specific indication. Documentation of a consultation or referral in the client's medical record includes the name and specialty of the provider, the means by which the contact was made (e.g., phone, letter, or directly by the client), the indication for the consultation or referral, and expectations for care.

Written and telephone consultation or referral requests include a brief history of the problem, essential information about the client, the type of service

for which the client is being referred, and expectations regarding care. Providing information about expectations for care allows the midwife to be clear to the consultant about the client's desired course of evaluation or treatment, and to determine whether any conflict in style of practice or management of clinical conditions exists. The goal of a consultation or referral is to obtain appropriate problem-specific care that is acceptable to the client. In some instances, however, differences in philosophy or style of practice are unavoidable; in this scenario, the midwife's primary goal is to obtain best care for the client.

A copy of a written consultation request is maintained in the client's medical record. Documenting information about scheduled consultation or referral appointments can be helpful when following up on diagnosis or treatment of problems. When a consultation is obtained, the consultant's opinion is documented in the client's medical record. When the consultant provides this service via telephone, the midwife requesting the consultation is responsible for documenting the content of the conversation, the consultant's recommendations for care, and the relevance or application of those recommendations to the midwifery plan of care. When the consultant evaluates the client in person, the consultant is responsible for documenting his or her opinion and any care rendered.

This accepted systematic approach to client evaluation and care allows the clinician to collect and present data in an organized fashion. The midwife can then focus on documenting the information collected, care provided, and midwifery management plan in a manner that is reflective of the midwifery model of care. Documentation that reflects the midwifery model of care allows practitioners, researchers, and others to gain a greater understanding of the practice of midwifery.

DOCUMENTATION OF MIDWIFERY CARE

Thoughtful documentation can highlight inherent differences between the midwifery and medical models

of providing women's health care. This recognition, in turn, encourages research that demonstrates positive processes and outcomes for clients cared for by midwives, as shown in seminal midwifery care studies described by Farley (2005). The recommendations that follow provide a general guideline for documenting midwifery care (see Table 1-4).

The "midwifery management plan" reflects an overall plan of care in which the intended course of action for evaluation, diagnosis, treatment, follow-up, and client understanding of that plan is clearly documented and logically follows from the indication for the visit. The midwifery management plan is a comprehensive plan that includes recommendations for diagnostic testing; indications for therapeutic measures or treatments, and which modalities were prescribed; client education and support; plans for continued care or follow-up; and consultations or referrals.

Careful and complete documentation serves as the midwife's legal record of events that have occurred. Standardizing the documentation format frees the midwife to concentrate on the content of the client encounter and documentation or note. The client's medical record lives on long after entries about the care provided to this woman are completed, and over time this information may pass through many hands. Some examples of people who read or review the health record to see which care was provided during the encounter with the client include other providers caring for the client at a later date, billing and coding personnel, quality improvement officers, The Joint Commission, peer reviewers, and perinatal morbidity and mortality reviewers.

The ideal medical record provides the reader with a clear view of the client's presentation, the midwife's evaluation process, and the implementation and results of treatment or recommendations. Meticulous documentation also allows other professionals to follow the course of care provided and to gain insight into the client's response. Client health records are an essential communication tool in a group practice and during consultation or referral. This section

explores the process of documentation from several points of view:

- Documentation as a reflection of the midwifery model of care; describing care that reflects the philosophy and standards of the practice of midwifery
- Documentation using current procedural terminology (CPT) evaluation and management (E/M) criteria; a method of documentation developed by the American Medical Association (AMA) that reflects the complexity and level of care provided to meet current reimbursement criteria
- Documentation as an essential communication tool; a method of recording events and findings for future reference that follows accepted standards
- Documentation as a means of demonstrating application of risk management and collaborative practice processes

Documentation of the Midwifery Model of Care

As professionals, midwives continually work toward the goal of educating both their clients and their colleagues about how midwifery differs from medicine and nursing. Midwifery educators strive to ensure that these differences are reflected in midwifery education programs and in the clinical experiences of those learning midwifery (American College of Nurse–Midwives [ACNM], 2008). Midwifery encompasses the belief that birth is essentially normal, that women have the right to be listened to and heard, and that birth and well-woman care are important events in the lives of women. These beliefs translate into subtle and overt behavioral differences in maternity and women’s health practice that should be reflected in the client’s medical record.

While sharing a number of practices in common with other healthcare providers, midwives need to clearly reflect through documentation how midwifery care is unique. Although many of the behaviors that a midwife, a physician, a nurse practitioner, or a physician’s assistant demonstrate when providing women’s

health care may be similar, the origins, attitudes, and client perception of the care may be substantially different. Documentation of midwifery care should reflect the essence of midwifery: woman-oriented care focused on excellence in the processes of providing care with attentiveness to outcomes.

Evaluation and Management Criteria

The CPT system lists codes for services provided by clinicians using specific criteria that must be present in the documentation of care provided. Evaluation and management (E/M) codes are based on the level of service provided. The level of E/M services provided is determined by the amount of history, physical examination, medical decision making (critical thinking), counseling and coordination of care (client education and support), nature of the presenting problem, and the amount of time required to provide care. Accurate coding practices are essential for receiving appropriate reimbursement for services.

As this book went to press, a major transition was occurring in the United States regarding how health visits are coded. Box 1-2 illustrates the upcoming changes as billing codes shift from the ICD-9 system to the ICD-10 system. To obtain more information on how this change may affect your practice, use the link provided in the Clinician’s Resources feature at the end of this chapter.

The AMA publishes the CPT handbook and offers online CPT assistance (AMA, 2011). These useful products and services can assist the healthcare provider in choosing a code for a service or procedure based on the documentation of the service or procedure during coding and billing. Midwives should become familiar with these resources as well as with ICD-9 or ICD-10 coding resources because they are important for fiscally responsible practice (ICD9Data.com, 2012). A brief overview of the required components for the level of care provided is offered here.

The history and physical examination and the complexity of critical thinking are the key components used to determine the level of E/M service

Box 1-2 Examples of Differential Diagnoses and Code Groups: Comparison of ICD-9 and ICD-10**ICD-9 Codes**

V70: Preventive health visit, not otherwise specified (NOS)

788.1: Dysuria

788.41: Urinary frequency

788.63: Urinary urgency

V22: Normal pregnancy, 10 weeks' gestation by last menstrual period (LMP)

611.72: Lump or mass in breast

V22.2: Pregnancy (incidental to presenting complaint) and

789.03: Right lower quadrant pain

Rule out:

Round ligament pain

Appendicitis

Ectopic pregnancy

Ovarian cyst

ICD-10 Codes

Z00: Encounter for general examination without complaint, suspected or reported diagnosis

R30: Dysuria

R35: Urination, frequent

R31.95: Urgency of urination

N39.9: Disorder of urinary system, unspecified

Z34.01: Supervision of normal first pregnancy, first trimester

Z34.81: Supervision of other normal pregnancy, first trimester

N63: Unspecified mass in breast

Z33.1: Pregnant state, incidental

R10.31: Right lower quadrant pain

Rule out:

Round ligament pain

Appendicitis

Ectopic pregnancy

Ovarian cyst

Source: ICD9data.com, 2012.

provided. The nature of the presenting problem, along with the provision of client education and support, are considered contributory, whereas time spent is considered separately. Time criteria used in E/M are based on the time spent during the face-to-face client visit, whereas the time required for review of diagnostic testing, follow-up, and coordination of care is factored into the time component (AMA, 2011; CMS, 2010b).

The E/M evaluation considers four types of history and physical examination (see Table 1-2). The complexity of clinical decision making required reflects the complexity of reaching a diagnosis and/or of formulating a management plan. The more health records, tests, or other information to be reviewed,

the more complex the evaluation becomes. The greater the number of differential diagnoses and potential plans to be considered, the more complex the management decision making becomes. The higher the risk of complications, morbidity, mortality, or comorbidity related to health problems or recommended testing, the more complex the management decision making becomes. Decision making is evaluated as being straightforward or of low, moderate, or high complexity (AMA, 2010).

Standards for Documentation: Transition to Electronic Health Records

Documentation standards for paper-based health records have been developed to allow use of the

Table 1-2 E/M Categories of History and Physical Examination

TYPE OF VISIT	VISIT COMPONENTS
Problem-focused visit	Brief history of the reason for the encounter and an examination that is limited to the affected area
Expanded problem-focused visit	Adds a pertinent system review and examination of additional body systems that might be affected by the presenting problem
Detailed visit	Adds pertinent history related to the reason for the encounter and a thorough examination of the affected area and related organ systems
Comprehensive visit	Adds a complete review of systems, comprehensive review of the client history and risk assessment, and either a comprehensive physical examination or thorough examination of a single organ system

client's medical record as an effective means of communication between professionals, verification of services provided for billing and reimbursement purposes, and analysis of care provided for quality and appropriateness. Many of these standards will apply as the nation's healthcare information infrastructure transitions to use of a computerized documentation system. It is important to understand that the electronic health record (EHR) is not just a scanned version of the written patient record (CMS, 2010a). Rather, EHRs hold the promise of functions that cannot be achieved by a paper record, such as immediate availability, currency, and completeness of client health information. Computing functions can link the EHR to educational resources specifically tailored to the client's needs. Error reduction, particularly with regard to medication errors, is possible through computer cross-checking of a patient's medications with known allergies, dosing regimens, and potential adverse interactions with other medications the client is taking. Decision support capabilities, such as context-sensitive alerts and eligibility determination for particular therapeutic regimens, can assist clinicians in formulating diagnostic and management plans; Table 1-3 provides some examples of these decision support (and other) apps.

As this edition of this book went to press, federal initiatives were in place to assist healthcare

professionals and institutions in the adoption of technologies to convert to an EHR system (CMS, 2010b). Widespread transitions are actively evolving our understanding of the benefits and challenges of EHR. What is clear is that today's midwife will have to embrace and master the skills required to effectively interface with a variety of EHR systems and platforms to ensure that documentation of midwifery care is accurate, complete, and well represented in the record in service of the client's healthcare needs.

The term "app" is short for "application" and refers to a computer software application that relies on common web browsers to render the application executable. While this term has been used by those in the computer industry for years, it became newly popular with the emergence of smartphones and tablet computers. These smaller computer devices can easily accompany the midwife for use at the point of care. Decision support for the clinician is provided through ready access to up-to-date information, calculators designed for specific healthcare purposes, visual illustrations, and algorithms for diagnosis and treatment decisions. Apps are a rapidly expanding market, particularly in healthcare applications with the potential for enhancing practice.

Table 1-3 “There’s an App for That”

APPLICATION	PURPOSE
Examples of Decision Support Applications for Clinicians	
Epocrates	Drug reference
My Natural Healer	Complementary and alternative therapies reference
Perfect Wheel	Gestational age calculator
Pocket Lab Values	Medical laboratory test reference
LactMed	Effects of medications on the nursing couplet
STD2010	CDC guidelines for STD treatment
BishopScore	Bishop’s score calculator
Diagnosaurus DDX	Differential diagnosis reference
EFM Glossary	Electronic fetal monitor terms and illustrations
NeoTube	Guide for endotracheal intubation of the neonate
Examples of Apps for Client Use and Education	
iPeriod	Tracking of menstrual and fertility indicators
BabyCenter	Pregnancy and prenatal care resource
Baby Namer	Name selection reference
iKeegel	Guide for pelvic floor exercises
Baby Motion	Fetal movement tracker
Birth Buddy	Timer and graph for contractions
Baby Checklist	Baby supplies organizer
Breast Feeding Friend	Tracks feedings
iNew Mommy Postpartum Adjustment	Screening quiz for postpartum depression

Documentation as Communication: Skills and Techniques

Thorough documentation provides midwives and other healthcare professionals with a clear view of each woman’s individual presentation, concerns, and preferences for care. The client record also serves as a means of following the midwife’s thought processes regarding development of the working diagnosis and ongoing plans for continued client care. Clear, concise documentation is the key to validating quality care and is an integral part of the midwife’s risk management program.

The goal of each note is to present a record of care provided and other essential information to guide the

midwife and other healthcare professionals in the event of a transfer of care, such as might occur after problem-oriented referral, transfer to physician care for a high-risk condition, or simple cross-coverage arrangements. Table 1-4 summarizes the standards that must be met in regard to documentation.

In the event of legal action, the ideal medical record provides a clear picture of the client presentation, concerns, participation in care decisions, and response to care or treatment. The medical record identifies the midwife’s assessment process and working diagnoses; it also includes her or his anticipatory thinking and planning for diagnosis, treatment, and continued or ongoing care. The midwifery plan

Table 1-4 Documentation Standards

STANDARD	PERFORMANCE MEASURES
1. Elements in the client's health record are organized in a consistent manner.	<ul style="list-style-type: none"> • The client record is organized in a clear and systematic fashion. • Records are entered in chronologic order.
2. Client health records are maintained and secured in a manner that protects the safety of the records and the confidentiality of the information.	<ul style="list-style-type: none"> • All health records are stored out of reach and accessible only to authorized persons, or are encrypted and available only to authorized users. See the related standard on maintenance, disclosure, and disposal of confidential information.
3. Client name or identification number is on each document in the record.	<ul style="list-style-type: none"> • The client name or identification number is found on each document in the record.
4. Entries are legible.	<ul style="list-style-type: none"> • Handwritten entries are legible. • Notes use a consistent standardized format and language that allows the reader to review care without the use of separate legend/key.
5. Entries are dated.	<ul style="list-style-type: none"> • Each entry in the record is dated. • Entries generated by an outside source (e.g., referrals, consults) are also dated when reviewed. • Notes related to client encounters or phone calls are placed in the record within 72 hours or 3 business days of occurrence.
6. Entries are initialed or signed by their author.	<ul style="list-style-type: none"> • Author identification may be a handwritten signature, unique electronic identifier, or initials. This applies to practitioners and members of the office staff who contribute to the record. • When initials are used, there is a designation of signature and status maintained in the office. • Entries generated by an outside source (e.g., referrals, consults) are also initialed or signed when reviewed.
7. Personal and biographical data are included in the record.	<ul style="list-style-type: none"> • Information necessary to identify the client and his or her insurer and to submit claims is included. • Information is included regarding client need for a language or cultural interpreter or other communication mechanisms as necessary to ensure appropriate client care. • The name of the client's primary care provider is clearly indicated in the record.
8. A. Initial history and physical examinations of new patients are performed within 12 months of a patient first seeking care or within three visits, whichever occurs first.	<ul style="list-style-type: none"> • A. Documentation for all clients includes an initial comprehensive history and physical examination performed within 12 months of the first visit or within three visits, whichever occurs first. If applicable, written evidence is created that the practitioner advised the client to return for a physical examination. The documentation of such a complete history and physical, included in the health record and done within the past 12 months by another practitioner, is acceptable. Well-child exams meet this standard.

(continues)

Table 1-4 Documentation Standards (continued)

STANDARD	PERFORMANCE MEASURES
B. Past medical history is documented and includes serious accidents, operations, and illnesses.	<ul style="list-style-type: none"> • A and B. The history and physical documentation contains pertinent information such as age, height, vital signs, past medical and behavioral health history, preventive health maintenance and risk screening, physical examination, diagnostic impression, and documentation related to the ordering of appropriate diagnostic tests, procedures, and/or medications. Self-administered client questionnaires are an acceptable way to obtain baseline past medical history and personal information. Written documentation explains gaps in information contained in the health record regarding the history and physical (e.g., poor historians, patient's inability or unwillingness to provide information).
C. Family history is documented.	<ul style="list-style-type: none"> • C. The patient record contains immediate family history or documentation that it is noncontributory, unavailable, or unknown.
D. Birth history is documented for patients aged 6 years and younger.	<ul style="list-style-type: none"> • D. Infant records should include gestational and birth history and should be age and diagnosis appropriate.
9. Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."	<ul style="list-style-type: none"> • Medication allergies or history of adverse reactions to medications are displayed in a prominent and consistent location or noted as "none" or "NKA." (Examples of where allergies may be prominently displayed include on a coversheet inside the chart, at the top of every visit page, or on a medication record in the chart.) • When applicable and known, there is documentation of the date when the allergy was first discovered, related symptoms, and previous treatments required.
10. Information regarding social history is recorded.	<ul style="list-style-type: none"> • The client record includes documentation regarding social history relevant to the purposes of the health encounter, such as sexual preferences and behaviors and use of tobacco, alcohol, or illicit drugs (or lack thereof) in clients 12 years of age and older who have been seen three or more times. • Cultural and developmental issues are clearly documented when present. • Family situation, living arrangements, and social support systems are noted. • Healthcare habits and preferences are noted, including use of alternative therapies, herbal remedies, and dietary supplements.
11. An updated problem list is maintained.	<ul style="list-style-type: none"> • A dated problem list, which summarizes the status of important client health information, such as major diagnoses, past medical and/or surgical history, and recurrent reports of symptoms, is documented and maintained. • The problem list is clearly visible and accessible. • Continuity of care between multiple practitioners in the same practice is demonstrated by documentation and review of pertinent health information.

Table 1-4 Documentation Standards (continued)

STANDARD	PERFORMANCE MEASURES
12. The client's chief complaint or the purpose of the visit is clearly documented.	<ul style="list-style-type: none"> • The client's description of symptoms or the purpose of the visit is recorded as stated by the client. • Documentation supports that the client's perceived needs and expectations were addressed. • The documented history and physical examination are relevant to the client's reason for visit. • Telephone encounters relevant to health issues are documented in the health record and reflect practitioner review, including phone triage handled by office staff, and after-hours communication handled by on-call staff.
13. Working diagnoses or clinical impressions are consistent with the health history and physical examination findings.	<ul style="list-style-type: none"> • The health history and physical examination are documented and correspond to the client's stated symptoms, purpose for seeking care, and/or ongoing care for chronic illnesses. • The documentation supports the working diagnoses or clinical impressions.
14. The midwifery action or treatment plan is consistent with diagnosis(es).	<ul style="list-style-type: none"> • Proposed treatment plans, therapies, or other regimens are documented and logically follow previously documented diagnoses and clinical impressions. • The rationale for treatment decisions appears appropriate and is substantiated by documentation in the record. • Follow-up diagnostic testing is performed at appropriate intervals for diagnoses.
15. There is evidence that risk to the client associated with any diagnostic or therapeutic procedures is addressed.	<ul style="list-style-type: none"> • The health record shows clear justification for diagnostic and therapeutic measures. • Risk related to all diagnostic and therapeutic measures is discussed with the client using accepted parameters for informed consent and clearly documented in the record.
16. Unresolved problems from previous visits are addressed in subsequent visits.	<ul style="list-style-type: none"> • Continuity of care from one visit to the next is demonstrated when documentation of a problem-oriented approach to unresolved problems from previous visits occurs in subsequent visit notes.
17. Follow-up instructions and a time frame for follow-up or the next visit are recorded as appropriate.	<ul style="list-style-type: none"> • Recommendations for the client's return to the provider's office in a specified amount of time is recorded at the time of the visit or following consultation, laboratory, or other diagnostic reports. • Follow-up is documented for clients who require periodic visits for a chronic illness and for clients who require reassessment following an episodic illness. • Client participation in the coordination of care is demonstrated through documented client education, follow-up, and return visits.

(continues)

Table 1-4 Documentation Standards (continued)

STANDARD	PERFORMANCE MEASURES
17. Follow-up instructions and a time frame for follow-up or the next visit are recorded as appropriate. <i>(continued)</i>	<ul style="list-style-type: none"> Implementation of a standardized plan for follow-up contact with the client is documented for individuals with critical test values or acute conditions who do not return for care as recommended. Such a plan is described in the practice's risk management policy.
18. Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated as needed.	<ul style="list-style-type: none"> Information regarding current medications is readily apparent from a review of the record. Changes to the client's medication regimen are noted as they occur. When medications appear to remain unchanged, the record includes documentation of an annual review by the practitioner. Documentation addresses medication, herbal, or dietary supplement interactions, side effects, or adverse effects when indicated by the agent, or the individual's health status or genetic make-up.
19. Healthcare education is noted in the record and periodically updated as appropriate.	<ul style="list-style-type: none"> Education is age, developmentally, and culturally appropriate. Education may correspond directly to the reason for the visit, may pertain to specific diagnosis-related issues, may address client concerns, or may clarify recommendations. Education provided to clients, family members, or designated caregivers is documented. Examples of patient divergence from the plan of care are documented.
20. Screening and preventive care practices are offered in accordance with current recommendations from national standards-setting organizations.	<ul style="list-style-type: none"> Each record includes documentation that preventive services were ordered and performed or that the practitioner discussed preventive services with the client and the client chose to defer or refuse them. Current immunization and screening status is documented. Practitioners may document that a patient sought preventive services from another practitioner (e.g., family practitioner).
21. An immunization record is completed for clients 18 years and younger, and vaccines offered and administered to adults are documented.	<ul style="list-style-type: none"> The record includes documentation of immunizations administered from birth to present for clients 18 years and younger. When prior records are unavailable, practitioners may document that a child's parent or guardian affirmed that immunizations were administered by another practitioner and the approximate age or date the immunizations were given. For clients older than age 18, the record reflects discussion of current adult vaccine recommendations and documents any vaccine administration.

Table 1-4 Documentation Standards (continued)

STANDARD	PERFORMANCE MEASURES
22. Requests for consultation are consistent with clinical assessment/physical findings.	<ul style="list-style-type: none"> • The clinical assessment supports the decision for a referral. • Referrals are provided in a timely manner according to the severity of the patient's condition. • Referral requests and expectations are clearly documented.
23. Laboratory and diagnostic reports reflect practitioner review.	<ul style="list-style-type: none"> • Results of all laboratory tests and other diagnostics are documented in the health record. • Records demonstrate that the practitioner reviews laboratory and diagnostic reports and makes treatment decisions based on report findings. • Reports within the review period are initialed and dated by the practitioner, or another system of ensuring practitioner review is in place and clearly delineated in the practice's policies and procedures.
24. Client notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented.	<ul style="list-style-type: none"> • Clients are notified of abnormal laboratory and diagnostic results and advised of recommendations regarding follow-up or changes in treatment. • The record documents patient notification of results. A practitioner may document that the client is to call regarding results; however, the practitioner is responsible for ensuring and documenting that the client is advised of any abnormal results and recommendations for continued care.
25. There is evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.	<ul style="list-style-type: none"> • Consultation reports reflect practitioner review. • Primary care provider records include consultation reports/summaries (within 60–90 days) that correspond to specialist referrals or documentation that there was a clear attempt to obtain reports that were not received. Subsequent visit notes reflect results of the consultation as may be pertinent to ongoing client care. • Specialist records include a consultation report/summary addressed to the referral source. • When a client receives services at or through another provider, such as a hospital, emergency care, home care agency, skilled nursing facility, or behavioral health specialist, there is evidence of coordination of care through consultation reports, discharge summaries, status reports, or home health reports. The discharge summary includes the reason for admission, the treatment provided, and the instructions given to the client on discharge.

Source: Adapted from American Cancer Society, 2010; American Health Information Management Association (AHIMA), 2008; CareFirst BlueCross BlueShield, 2009; National Heart, Lung, and Blood Institute, 2011; National Institutes of Health, 2011; U.S. Preventive Services Task Force, 2011.

for follow-up care and evaluation includes relevant parameters for initiation of multidisciplinary practice when indicated or applicable.

The American College of Nurse–Midwives (ACNM, n.d.), American Association of Birth Centers (AABC, 2007), and the Midwives Alliance of North America (MANA, 2010b) all offer clinical data sets that can be used as tools to evaluate the adequacy of standardized client record forms used in midwifery practice and that contribute to a national database to document and describe midwifery care. These data sets have been developed to provide standardized and validated tools for collecting data about the care midwives provide. Midwives seeking to improve their documentation skills may also use these clinical data sets as a self-evaluation instrument by performing retrospective chart or medical record audits to determine process or documentation strengths and weaknesses and to identify areas needing improvement.

Thorough and complete documentation is concise and focused; rarely is it necessary to provide lengthy notes. Handwritten notes must be legible to the average reader. Notes may be entered on a form that provides a preset format, such as a labor flow sheet, or written on a blank sheet of paper, such as a progress note. Some notes are dictated and transcribed. All practices are moving toward the transition to computer charting.

Notes should reflect pertinent findings and the critical thinking that occurs during the care of each client. All notes should contain, at a minimum, the following information:

- Client identification: Name, date of birth, and medical record number where applicable.
- Date of service: Date and time are necessary for time-sensitive situations such as labor care or during newborn resuscitation.
- Reason for encounter: Often described in the client’s own words (e.g., “I think my water broke”) or as a simple statement (e.g., “onset of labor”).
- Client history: An expansion of the reason for the encounter, commonly known as the “chief

report” or the “history of present illness”; it includes all relevant history and subjective information provided by the client or family, including, as applicable, the review of systems, past history (chart review), family history, and social history.

- Objective findings: Includes the results of the physical examination, mental status evaluation, and/or laboratory work, ultrasound, or other testing as indicated by the history and physical. Depending on the level of access to the client’s EHR from remote locations, notes pertaining to off-site phone encounters with the client may not include these findings.
- Clinical impression: Also known as the “assessment” or “working diagnosis”; it may include several differential diagnoses under consideration pending laboratory or testing results. These findings may be documented as “primary symptoms” or “conditions” with differential diagnoses listed to validate testing and communicate anticipatory thinking.
- Midwifery plan of care: May be subdivided into several categories; it essentially outlines all diagnostic, therapeutic, and educational measures initiated at the visit, along with further actions anticipated based on potential results and specific needs of the client. The plan of care should end with a recommendation for the timing of the next visit.

Documentation as Risk Management

Exemplary midwifery practice includes understanding and implementing essential components of a risk management program to enhance midwifery care and client outcomes. Thorough documentation using a standardized format allows for objective evaluation of the care provided. Each note should be written from the objective outside observer point of view. Thorough but concise documentation is the ideal. Use of fill-in-the-blank forms or drop-down menus can be a useful way to quickly record essential information, particularly for routine encounters; a common example of

this practice is the prenatal flow sheet. These notes are best supplemented with a narrative note whenever there are unusual circumstances or findings.

The problem list is a convenient way to highlight ongoing acute or chronic problems. It should be kept in an easily seen location, thereby enabling all clinicians caring for the client to identify at a glance potential factors that may influence the care provided. Creation of and reference to such a list decreases the potential for a problem to be missed and focuses providers on important current and resolved health issues for this client. The medication list is often placed adjacent to the problem list. Risk may be reduced by reviewing and updating both lists at each visit.

A follow-up file or software is a useful way to track clients with problems that require future care. Although not part of the client medical record per se, such tracking comprises a significant part of the midwife's risk management plan. When notification of abnormal results is documented in the medical record, a plan must be formulated. The follow-up file system tracks whether clients return for recommended care and generates reminders to document clinician notification of clients who have not returned for care as recommended. The midwife's risk management plan should describe the follow-up process and clearly indicate the procedure for utilizing that follow-up system.

Documenting Culturally Competent Care

Midwives and other health professionals have a legal and moral obligation to provide culturally competent care (Office of Minority Health, 2010). Cultural competence is the ability to step outside of your own culture and obtain the vision and skills necessary to provide care in a context that is appropriate for the women whom you serve.

The attitudes and behaviors needed to become culturally sensitive and provide culturally competent care include a sincere interest in other cultures, the ability to communicate effectively across cultural and language barriers, and a demonstrated sense of

honor for the customs of others. On a more practical level, the ability to access interpreter services is a key behavior that is both essential and legally mandated. Each midwife is expected to obtain or to have access to information regarding specific healthcare problems that are racially or ethnically mediated. Each midwife should become familiar with historical events and cultural practices that may also affect health in the populations served. Each of these components should be addressed in the client's health record when they are applicable.

Documentation of cultural competence can include a detailed description, such as when the informed consent process is provided through an interpreter before surgery or a procedure. It may be culturally appropriate to excuse the father from the birth room or to ensure a family member is present as a chaperone during intimate examinations. Documentation of cultural indications for changes to or variations from usual care serves to validate the midwifery care provided while reinforcing the need for respect and awareness of cultural differences. Some women may belong to cultural groups characterized by very limited access or availability of health care and accept whatever care is provided. Other women can have a strong need to direct their health care and mandate their active participation in all health-related decisions. Most women fall somewhere between these two extremes.

The essential characteristic of the culturally competent midwife is an ability to embrace diversity while retaining one's sense of personal cultural identity. To do so, it may be necessary to relinquish control in select client encounters. Feelings of discomfort, failure, fear, frustration, anger, or embarrassment can serve to indicate a need for the midwife to examine her or his personal viewpoint and consider thoughtful and deliberate examination of challenging intercultural exchanges as a means to foster personal growth.

Awareness of and sensitivity to cultural practices and beliefs can enhance client satisfaction and build a trusting professional relationship. Cultural diversity encompasses a wide range of reference points, which may include social and emotional development, age,

race, religion, sexual orientation, ethnic heritage, country of origin, geographic location, and cultural beliefs and mores. Becoming culturally competent involves a certain level of interest, inquiry, and awareness of cultural differences. It involves not only sensitivity to the customs of the social groups to which the woman belongs, but also an awareness that she may not conform to the common perceptions of those groups' behaviors and beliefs.

Cultural differences can be considered cross-cultural, meaning the midwife and the client come from different ethnic or racial backgrounds, or they may be intercultural, where the midwife and the client come from similar ethnic or social backgrounds but have developed disparate views and beliefs, especially with regard to health care. Examples include the home birth midwife whose client reveals she wants access to pharmacologic pain relief for labor or the hospital-based midwife whose client calls to request an in-home examination for possible labor.

Cultural competence requires that the midwife remains open-minded, cultivates active listening and observational skills, and evaluates each woman's needs according to the environment of care with an attitude of cultural sensitivity and humility. Access to culturally competent interpreters to translate language, social customs, and mores related to women's health care is extremely helpful. Literal translation, however, does not always provide correct or accurate information. Individualizing care also involves taking into account the woman's chronologic age, her developmental stage, emotional development, sexual orientation and preferences, cultural background, and other social factors.

Developmental Considerations

Attention to developmental changes throughout a woman's life is essential to address the concerns that may be most pressing to her. The needs of adolescent women are very different from those of women of childbearing age, which are in turn different from those of the woman who is past menopause—even when each type of client presents for the same type of

visit. Midwives who frequently care for the medically underserved should remember that the effects of poverty, abuse, low self-esteem, or marginal nutrition may adversely impact a woman's developmental growth.

Adolescent Women

Young women in their teens may present at various developmental stages based on age, emotional development, ethnicity, and other social and cultural factors. Developing a mutually acceptable plan of care is frequently an issue, as authority may be challenged and the young woman seeks to explore the boundaries and limits of her situation. Parental presence and involvement may indicate support and guidance for the teen and her choices, or they may reflect the presence of dysfunctional parent–teen dynamics.

Adult Women

The adult phase of life encompasses the concerns of the young adult woman, the mid-life woman, and the gracefully aging woman. Milestone events that affect health and life obligations can include educational and occupational endeavors, development and maintenance of intimate and family relationships, and childbearing and child rearing. After the childbearing years have passed, women often experience a change of focus from reproductive health care to concerns surrounding general health and well-being. Many women celebrate the freedom of mature adulthood. They may explore new attitudes, become more adventurous, and find that their confidence flourishes. Many older women live alone, by choice or by circumstances. Women, more than men, are affected as they age by increasing poverty and diminished resources to cope with illness or disability.

Mentally Challenged Women

Women who struggle with mental challenges may require coordination of specialized services so that they are provided with appropriate reproductive health care. Intimate examinations may require extra time and patience to avoid emotional trauma, especially in the mentally challenged woman with a

history of sexual abuse. Sedation or anesthesia for intimate exams can be considered in selected cases.

Physically Challenged Women

Physically handicapped women may or may not have developmental delays depending on the cause of the physical challenge. Individual assessment is necessary to determine the client's developmental level and provide developmentally appropriate services. Examinations may be made more challenging by physical limitations, and ample time should be scheduled to allow for this possibility.

Immigrant and Refugee Women

Women raised in other countries may have culturally mediated variations in development, which may make interpretation of their developmental stages more challenging. Accessing resources to learn about cultural variations may aid in appropriate client assessment and effective coordination of services.

Socioeconomic Challenges

Various socioeconomic challenges may influence the rate and progression of a woman's physical, emotional, and social development. Additionally, a woman's health insurance status (or lack of insurance) will affect covered healthcare services and out-of-pocket expenses. Considering services that might best meet a woman's needs in the context of her socioeconomic resources is an important aspect of caring for vulnerable women.

Informed Consent

Informed consent is a specific process designed to ensure that clients receive the full, unbiased information necessary to actively participate in their healthcare decision making regarding a recommended treatment or procedure (Kuczkowski, 2005). The midwife is expected to recommend a course of action and share her or his reasoning process with the client. Client understanding of the information provided is as important as the information itself. Discussion should be carried on in layperson's terms, and client understanding should be assessed along the way.

Complete informed consent includes discussion of the following elements:

- Indications for the recommended procedure, medication, or treatment
- Accepted or experimental use of the proposed procedure, medication, or treatment
- Potential or anticipated benefits, actions, or effects of the proposed course of action
- Potential risks, harms, and adverse effects of the proposed course of action
- Potential risks, harms, and adverse effects of declining the proposed course of action
- Any urgency to undergoing the proposed course of action
- Alternatives to the proposed course of action, including potential effectiveness, risk, and benefit
- Client understanding of discussion, best demonstrated by the client paraphrasing information received and documented by direct quote (e.g., "You're going to try to turn my baby so she isn't butt first")
- Client choice regarding the recommendation based on participation in the informed consent process

Ideally, the midwife and client signatures will be witnessed by a third party. The informed consent process can also be used to present information on the midwife's practice; indications for consult, collaboration, or referral; and birth options or settings. It provides an opportunity for questions, discussion, and documentation of client participation in decisions.

In most cases, it is clear whether the client is competent to make her own decisions. The midwife should assess the client's ability to understand the nature of the problem, to understand the risks associated with the problem and the recommended course of action, and to communicate her decision based on that understanding.

Competent clients have the right to decline testing or treatment after going through the informed consent process. This right may be limited when the

client is pregnant and her decision affects her unborn child. The stress and pain of labor raise interesting questions regarding informed consent and competence during labor.

Components of Common Medical Notes

When documenting care provided using a standardized format, each category noted on the form should be addressed, using either appropriate details or the phrase “not applicable.” This practice serves two purposes: It maintains the expected format of the note, and it clearly indicates which clinical components the midwife included while caring for the client. Some electronic health records have automatic fill-in functions that default to a normal finding; this places the midwife in the position of being a careful editor of the client record, rather than being a careful author of the client record.

Office Visit or Progress Note

The office visit/progress note format is typically used for problem-oriented and well-woman office visits as well as for progress notes during labor and postpartum. Standardized prenatal care forms typically vary from this format; however, it becomes useful during evaluation of a problem or complication during pregnancy. Many electronic health record systems have set up their documents using the SOAP format:

- **Subjective:** Client interview, history, and record review
- **Objective:** Physical examination and diagnostic or screening test results
- **Assessment:** Differential or working diagnosis
- **Plan:** Evaluation, treatment, education, and follow-up care, including coordination of care, consultations, and/or referrals

Procedure Note

The procedure note is used to provide detailed information about a procedure such as endometrial biopsy, intrauterine device insertion, colposcopy, external cephalic version, or circumcision. This format

is appropriate to use to document a procedure regardless of location or environment of care and includes the following information:

- Procedure performed
- Indication for procedure: Include diagnosis and any relevant history of present problem
- Informed consent: Include any relevant discussion
- Anesthesia, if used
- Estimated blood loss, in milliliters; a notation of “minimal” is accepted for an estimated blood loss less than 10 mL
- Complications: Describe, along with treatment rendered and the client response to that treatment
- Technique: Describe techniques used, including instruments, anesthesia technique and amount used, sequence of events, and rationale for technique choices, when appropriate
- Findings: Describe clinical findings, specimens collected and disposition of same, and client status post procedure

Medical Consultation or Referral

The purpose of the formal consultation or referral request is to provide the consultant with adequate information about the client in advance, thereby allowing the consultant to focus on the problem or condition. Referral requests may be verbal, written (commonly in letter format), or electronic, and often include the following elements:

- Client introduction: Name, date of birth, and indication for consult or referral
- History of present problem or illness
- Type of consultation requested
- Brief client history: Allergies, medications, illnesses, surgeries, and relevant social history
- Expectation for care: Advises the consultant of any client education provided regarding the problem or illness; appropriate to advocate for the client’s preferences when stating expectations for care

Admission History and Physical Examination

The admission history and physical examination format is typically used when admitting a client to the hospital with an obstetric, gynecologic, or medical problem. However, it is also appropriate to use when admitting a client to midwifery care in labor in any environment of care. It includes the following elements:

- Admission diagnosis
- History of present condition or illness
- Past pregnancy and gynecological history
- Past medical history
- Past surgical history
- Current medications
- Allergies
- Social history
- Family history
- Review of systems
- Physical findings
- Diagnostic testing
- Client's preferences for labor and birth (birth plan)
- Midwifery plan of care
- Anticipated course of care based on current findings and maternal preferences
- Indications for consultation, collaboration, or referral
- Plan for reevaluation

Labor Progress Note

Labor progress is typically documented in a SOAP format in the progress notes. Most practitioners document labor progress in notes written every 2 to 4 hours and when notable events or changes occur, including the following elements in the note:

- Date and time: Noting the time is essential during labor
- Interval history since previous note
 - Maternal status: Labor progress, maternal well-being and activity, response to labor, emotional status, and labor preferences
 - Fetal status: Fetal well-being and means of evaluation

- Labor status: Frequency and duration of contractions, cervical status if applicable, fetal position and station, assessment of maternal and fetal well-being in relation to phase of labor, evaluation for variations or complications of labor
- Assessment: Clinical evaluation of labor phase and progress, and presence of indications for consultation, collaboration, or referral
- Plan of care: Anticipated course of action (including watchful waiting or active intervention, consultation, collaboration, or referral), discussions with client regarding course of labor, and plan for reevaluation

Birth Note

The birth note is designed to summarize the pregnancy, labor, and birth in a brief but comprehensive overview of the pregnancy and labor, including detailed information about the birth and immediate postpartum and newborn periods. A typical birth note includes the following elements:

- Brief review of prenatal course
- Admission status
- Course of labor
 - Length of each stage
 - Rupture of membranes: Time, color, and fetal heart rate
 - Maternal and fetal response during labor
 - Labor events or interventions
 - Complications and treatment
- Birth information
 - Time, date, and location
 - Route and method of birth
 - Maternal and fetal position
 - Techniques or interventions used with indication:
 - ◆ Anesthesia, type, and dose
 - ◆ Episiotomy or laceration
 - ◆ Type of suture and technique of repair if done
 - ◆ Medications if used
 - ◆ Complications and treatment, including client response

- Evaluation of placenta
- Estimated blood loss
- Maternal status post delivery
- Newborn information
 - Gender
 - Resuscitation, if indicated
 - Apgar score
 - Weight
 - Bonding
 - Feeding, voiding, and stooling
 - Newborn status post delivery

Discharge Summary

The discharge summary is an appropriate format to use after a hospital admission but may also be used for summarizing a birth center admission or home birth. It includes the following information:

- Admission diagnosis
- Discharge diagnosis
- History of present condition or illness
- Past medical history
- Past surgical history
- Current medications
- Allergies
- Social history
- Family history
- Review of systems
- Physical findings
- Diagnostic testing
- Treatments and procedures
- Hospital or postpartum course
- Complications
- Discharge medications
- Discharge instructions
- Condition on discharge
- Plan for continued care

Documentation is an essential skill for midwifery and women's health practice that should be mastered with the same care and attention given to other components of clinical practice. Meticulous documentation accurately reflects the scope and nature of midwifery care and enhances communication among health professionals who care for and about women.

The information contained within the client's medical record forms a basis for planning continued care, and continuity of care is enhanced through the interdisciplinary documentation of care and services provided. This includes communication between the midwife and the client, and between the midwife and other health professionals contributing to the client's care. Other uses of the medical record, such as internal hospital audits for quality assurance purposes and for protection of the legal interests of the client and healthcare professionals who provided care, are addressed in the next section on risk management.

RISK MANAGEMENT

Risk management is a dynamic process based on assessing probabilities of untoward outcomes or events and on developing strategies to reduce or manage these events. In health care, this term is often used to refer to health risks to the client, health or professional risks to the practitioner, or financial risks to the institution or practice. Application of sound risk management principles to midwifery and women's health practice includes providing and monitoring quality health care to the women whom the midwife serves while practicing in a manner that protects the midwife from undue risk, whether it be from infectious disease, malpractice litigation, or financial insolvency. This section identifies ways to safeguard practice while providing quality care in our litigious society.

Developing a Collaborative Practice Network

Midwives do not practice in isolation. Every midwife, regardless of practice location, needs a network of contacts to help provide ongoing care and services. The collaborative practice model allows for a wide variety of professional relationships that range from informal to highly structured arrangements.

Development of professional relationships with physicians and other healthcare providers in your area begins with you. Make arrangements to meet at a convenient time and introduce yourself. Bring practice brochures or business cards so that these providers and their office staff members understand which

services you offer and how to reach you. Present yourself as a competent, skilled, professional colleague. Your goal is to initiate a relationship so that when you have a client who needs care, your credibility has been established. It is not required that you agree on philosophy of care or management styles, but it is important that you establish a good working relationship. It is also good practice to nurture your relationship with the office staff for those times when you may need them to prioritize your requests for assistance during office hours.

Determining in advance which type of consult is indicated affects which information you provide to the consultant provider. Present the consultation request in terms that advocate for the type of care you are seeking for your client. If you do not provide this direction, the physician will likely manage your client as she or he would her or his usual patients.

The AMA *Evaluation and Management Services Guidelines* state “A consultation is a type of evaluation provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem, or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem” (AMA, 2010). Forms of consultation that the midwife may use include the following types:

- **Informational:** “Just letting you know that Mrs. B is here in labor. She is a G3, P2002 at term and is at 5 cm after 1 hour of labor. The fetal heart rate is in normal range with good variability, estimated fetal weight is 7½ pounds, and I expect a spontaneous vaginal birth shortly.” In this instance, you have already established a professional relationship with a defined collaborating individual that includes notification in specific circumstances or as indicated according to your professional judgment. This may also include proactive consultation to provide information when there is potential for an emergency that may require additional support or expertise.
- **Request for information or opinion:** “Ms. K has atypical glandular cells on her most recent Pap smear. I’ve never seen this before. What do you recommend for her follow-up?” In this instance, you are looking for information from your consultant physician to guide your client’s care when you have reached the limits of your experience and knowledge. This is a good time to discuss future management of such patients and to determine your own needs for continuing education.
- **Request for evaluation:** “I’m sending Mrs. S to you for evaluation of her enlarged uterus. She is a 47-year-old G2, P2002 who has had severe menorrhagia for the past 5 months. We have discussed potential treatments, and she is interested in exploring endometrial ablation to treat her menorrhagia.” In this instance, the client has a problem that requires evaluation and treatment, but that care is not within your scope of practice. Clearly stating previous discussions, client preferences, and your expectations for care can influence the care provided to the client. The expectation is that the client will return to you for care once the problem has resolved or been treated. As this is a more formal consultation, a consult form or letter, as well as patient permission for release of supporting clinical documents, should be initiated.
- **Transfer of care:** “Mrs. R has a large lesion consistent with cervical cancer. I am transferring her to you for care of this problem.” In this instance, the client has a problem that necessitates ongoing physician management. Transfer of care means that the client is released from midwifery care and the consultant is expected to assume responsibility for her ongoing medical care. In an emergency (e.g., “Ms. P has a postpartum hemorrhage. I believe she has retained placental parts. Her EBL is currently at 1000 mL. Please come to L & D immediately.”), the nature of the problem requires immediate action on the part of the consultant. Expectations for immediate physician evaluation of a client must be

clearly stated. For those midwives who provide labor and birth care in the out-of-hospital setting, calling the labor and delivery staff, OB/GYN physician, or pediatrician on-call may be needed in addition to calling emergency medical services (EMS), 911, or the emergency room. If you have an established working relationship, a direct admission to a maternity unit prepared for your client's arrival may be possible.

- **Other multidisciplinary practice relationships:** Primary care providers commonly care for clients in the event of a general medical problem such as hypertension, diabetes, or heart disease. Although some midwives have expanded their practice to include primary care services, this care may be limited by the practice setting to treatment of acute minor conditions, such as back pain and upper respiratory infections. Many midwives initially manage selected chronic conditions, such as mild depression, and refer the patient if no improvement occurs with standard measures, or they may continue management of selected stable chronic conditions, such as asthma, and refer the patient if the condition destabilizes.

Every practitioner caring for women, regardless of her or his scope of practice, should develop a network of multidisciplinary care providers such as physicians, chiropractors, naturopaths, acupuncturists, dietitians, mental health professionals, social service personnel, clergy, support and self-help groups, local emergency services, homeless shelters, and addiction centers. This network provides the mechanism by which midwives can address the varied needs of the women who come to them for care.

A key element to providing woman-oriented care is to connect women with essential services they may not know how to access. This can include a combination of mainstream medical care, alternative or complementary modalities, and nonmedical services. The role of the midwife is to listen to women, clarify their needs, and facilitate meeting those needs in a caring and nonjudgmental manner. The foundational

philosophy of midwifery guides the care that midwives provide.

Collaborative practice connects midwives with additional health professionals who provide ongoing or specialty care outside the midwife's scope of practice. Along the way, these other specialists become aware of the services midwives offer to women and, in turn, may serve as a source of referrals to the midwifery practice. Women's health care forms a continuum that extends from home birth and alternative care, through general medical and community-based medicine and midwifery, to high-tech tertiary care and specialty services.

Collaborative practice means that a working relationship is formed between the attending midwife and the physician or other multidisciplinary care provider. Each discipline has distinct and different services to offer. Midwives function as an integral part of the healthcare system. Clear discussion of the parameters of midwifery practice within the practice location(s), practice scope guided by collaborative relationships, clinical practice agreements, and clinical options of midwifery care (including privileges) are all useful tools in evaluating whether a particular midwifery practice is appropriate for the individual client. Midwives have a responsibility to provide access to services as indicated by the individual woman's health, her preferences, and the midwife's scope of practice. Not all services are appropriate for all women. The primary goal of the collaborative relationship is accessing the best care for each client as needed. The ACNM joint statement with the American College of Obstetricians and Gynecologists includes the following assertion, which reinforces this principle:

The American College of Obstetricians and Gynecologists and ACNM believe health care is more effective when it occurs in a system that facilitates communication across health care settings and among providers. OB/GYNs and CNMs/CMs [Certified Nurse-Midwives/Certified Midwives] are experts in their respective fields of practice and are educated, trained, and licensed independent providers who may collaborate with each other based on the needs of their patient. (ACNM, 2011)

Several proactive practice habits are essential to risk management in any clinical setting. The first is quality assurance and improvement. This continuous process can be accomplished by defining clinical standards, analyzing and monitoring clinical practice and practice systems, and adjusting to reduce risk and provide quality care (American Academy of Family Physicians [AAFP], 2008). The second is clear and thoughtful documentation of the care encounter. Orderly, precise, and legible documentation of care is not only the basic tool for monitoring and evaluating a client's progress, but also the best protection against malpractice claims (Nissen, Angus, Miller, & Silverman, 2010). Lastly, a vital component of risk management is building a client–provider relationship that encompasses the qualities of trust and respect. The establishment of trust is essential if the client is to have confidence in the midwife's diagnostic and therapeutic abilities. No single approach to client relationships is appropriate for all providers; however, one common element comprises maintaining a respectful demeanor toward every client.

Risk to the Client

Quantification of risk for an individual is a difficult task and requires careful counseling that avoids absolutes. When a client is “at risk,” it is important to specify which condition or complication she is at risk for and why, and to then give a probability of both its occurrence and its nonoccurrence. For example, if a woman undergoing amniocentesis has a 1 in 100 chance of rupture of membranes during the procedure, then she has a 99/100 chance of no rupture during the procedure. Providing women with information on *attributable risk* for a condition (the actual number of additional adverse outcomes attributable to the risk factor) can provide a balanced perspective on the condition risk (Jordan & Murphy, 2009). Using visual tools such as the Paling Palette, a visual tool that displays risk of a condition without numbers, can help women of all languages understand risk for a condition better than just stating numerical risk (Risk Communication Institute, 2011).

New data are continually being compiled and published about risks associated with race, ethnicity, genetics, lifestyle, behaviors, and other factors. By keeping abreast of new data, critically evaluating those data, and incorporating them into your knowledge base, you will then be able to provide clients with information relevant to healthcare decisions and options that are appropriate for them. Frank discussions about the relative risk of options for care should include the potential for unexpected outcomes, the unpredictability of individual response, the consequences of watchful waiting, and the impact and importance of self-determination.

Risk to the Unborn and the Newborn

Calculating risk to the unborn, and by extension to the newborn, is also difficult and fraught with emotions as parents try to make the best decisions possible on behalf of their child. Pregnant women and their families look to their midwives as skilled professionals with the ability to identify potential problems, discuss the various options open to them, involve them in decision making, and take corrective action to safeguard their babies in the womb.

How information is presented during pregnancy and women's healthcare visits may influence the client's attitude about her body, the safety of birth, the ability of the healthcare system to meet her and her baby's needs, and her ability to parent. Risk should be addressed in a realistic fashion that is supportive of women and birth and that does not undermine traditional, alternative, or mainstream medical providers. You can foster the concept that childbearing is a normal and healthy physiologic process while still addressing the fact that there are no guarantees of perfect outcomes, and that access to basic and advanced medical services is available.

Risk to the Midwife

Each midwife needs to determine what is included in her or his own individual scope of practice. Not every midwife provides every service. A scope of practice is a dynamic entity—one that changes with experience,

practice location, fatigue, staffing, and distance to specialty care, among other factors. Each midwife must manage her or his individual professional risk by constantly assessing the scope of her or his midwifery practice and determining whether it meets the midwife's needs as well as those of the community of women served.

Identification of a woman with risk factors may influence midwifery management of risk in a number of respects: It may result in a transfer of care, a consultation, or continued independent management of the woman's care. The outcome depends on the midwife's expertise and self-determined scope of practice, state laws regarding midwifery practice, and the midwife's comfort in caring for the particular risk factor in this individual, healthcare setting, community, and legal climate.

Standards of practice define the expected knowledge and behaviors of the midwife according to her education, certification, and licensure status. Midwives are held accountable to national, state, and local standards. Each midwife should maintain familiarity with the professional standards, state laws, and rules that govern her or his midwifery practice. Professional standards are defined by ACNM, MANA, and the International Confederation of Midwives (ICM). Each of these organizations requires that the midwife have knowledge of the following:

- Midwifery practice standards and recommendations
- Pathophysiology and treatment of commonly encountered conditions
- Indications for and access to medical consultation

Risk Management Plan

A risk management plan is designed to outline strategies that reduce and minimize the possibility of loss (AAFP, 2008). Such a plan is a helpful way to organize essential information about the various components needed to identify and manage risk in midwifery practice. A comprehensive and realistic midwifery practice risk management plan demonstrates that

the midwife seeks to provide care that is consistent with best practice, is cognizant of the risk involved in this profession, and has taken reasonable steps to limit that risk. It should include practice policies and procedures that address topics such as the following (Greenwald, 2004; Maine Association of Certified Nurse Midwives, 2009):

- Written practice description
- Philosophy of practice
- Location(s) of practice
- Practice guidelines and standards
- The role and scope of practice for each midwife
- Health record documentation standards
- Documentation forms that reflect care provided
- Informed consent policy and process
- Client autonomy in decision making
- Provisions for practice coverage
- Indications for consultation or referral
- Collaborative practice relationships
- Plan for transfer of care or client when indicated
- Requirements for continuing education
- Education requirements for expanded scope of practice
- Peer review and outcomes-based evaluation of care
- Review process for client or practice-related complaints or concerns
- Licensing and professional practice issues as legally defined by state or professional organization
- The nature and extent of midwifery professional liability coverage
- Malpractice claims procedures

When Bad Things Happen

Midwives vary tremendously in the amount of risk they are willing to live with on a day-to-day basis. Some may prefer to work in settings where there is a physician available at all times, whereas others may practice in isolated settings where the nearest physician is located miles away. Increased midwife autonomy may be associated with increased midwife risk, as can practicing in a setting that is antagonistic to midwives,

Table 1-5 Steps for Living with Bad Outcomes in Practice

DO'S	DON'TS
Understand the emotional nature of the events for you and your client.	Do not delay in honest communication with your client.
Continue to provide excellent midwifery care with clear concise documentation.	Do not alter the medical record; however, a late entry that is documented as such is acceptable.
Contact your risk management department and liability insurance company immediately after an occurrence or event in case a suit is filed.	Don't write any written reports or narratives of the events unless directed to do so by risk management or your liability insurance company.
Take care of yourself physically and emotionally. Avoid the emotional isolation associated with litigation by sharing your feelings.	Do not discuss the details of the event with colleagues, family, or friends.
Know that you are not alone. All midwives experience poor outcomes during a lifetime of practice; many become involved in legal proceedings in the aftermath of a poor or unexpected outcome.	

regardless of midwives' legal status as certified or licensed professionals.

Even with thorough documentation of excellent care and a healthy, actively involved client, things can still go awry. Wherever there is life, there is also the possibility of death, illness, or injury. Most midwives encounter bad outcomes in caring for their clients from time to time in the course of their careers (Guidera, McCool, Poell, & Stenson, 2007). Such a result is devastating to the client and her family, as well as to the midwife involved. Midwives' reactions after poor outcomes in practice can range from sorrow to departure from practice (Table 1-5).

Allow yourself time to grieve this event with your client and on your own, but also be prepared to take practical steps that protect your ability to continue to practice and to recover emotionally. Midwives have reported that formal debriefing with a counselor, attorney, midwife partners, or morbidity and mortality committee members have been helpful strategies to promote personal and professional recovery (McCool, Guidera, Delaney, & Hakala, 2007).

Review the chart with a midwife practice partner or your physician consultant—someone with legitimate rights to access the chart and the ability to evaluate the care. Some charts are automatically reviewed for

certain key events in the hospital; for example, the occurrence of neonatal seizure or maternal death is discussed at a perinatal morbidity and mortality review. In contrast, women's health care provided in the outpatient setting may not have such a review mechanism. It is important to extract the learning value from these difficult situations while maintaining client confidentiality.

Most malpractice suits in midwifery are initiated for poor neonatal outcomes from events such as shoulder dystocia or fetal distress, misinterpretation of fetal heart rate tracings, or delay in consultation (Angelini & Greenwald, 2005). If errors were made by you or your staff, it is best to be honest and compassionate with your client in a timely fashion. You can apologize without implying guilt or blame, such as "I am sorry this complication occurred" or "I am so sorry this happened to you." Compared to the "deny and defend" stance of traditional risk management, open and honest communication with families and genuine apology when warranted can result in significant reduction in malpractice claims (Agency for Healthcare Research and Quality, 2010). Continue providing support to your client, just as you would before the event, and document your ongoing care and the client's response.

It is always appropriate to share empathy and sorrow with your client. Understand, however, that although midwives pride themselves on delivering excellent relationship-based care, this is only one of many considerations in a client's decision to take legal action.

ETHICAL MIDWIFERY PRACTICE

Ethical midwifery practice is based on a human rights framework (Thompson, 2004). This framework includes four foundational ethical principles:

1. **Autonomy:** The human right to personal independence and the capacity to make decisions and act on them
2. **Justice:** The human right to be treated fairly and with reasoned care
3. **Beneficence:** The human right to be treated with intent to do good
4. **Nonmaleficance:** The human right to be treated with intent to avoid harm, the classic "First do no harm" directive attributed to Hippocrates

These guiding ethical principles are reflected in midwifery's philosophical tenets and have also been codified specifically for midwives by several midwifery organizations, including ACNM (2004, 2008), MANA (2010a), and ICM (2008).

For these ethical principles to have any meaning, they must be a touchstone for your practice decisions. Ethical problems are not always clear-cut issues. Sometimes, it is a matter of choosing between what is right and what is easy. Ethical dilemmas are inherent in midwifery care, and they are sometimes embedded in the simple day-to-day provision of care. An example is the client who says to you, "I'll do whatever you think I should," after you provide information on genetic screening options. The reflective practitioner will examine and learn from decisions made and actions taken in the clinical setting from an ethical perspective. Midwifery is a morally important endeavor that promotes women's optimal health, and the ethics of clinical care are worthy of your continued and thoughtful consideration.

EXEMPLARY MIDWIFERY PRACTICE

Optimal midwifery care occurs when the midwife is able to support the physiologic processes of birth and well-woman care while at the same time remaining vigilant for the unexpected (Kennedy, 2000). Remaining attuned to small details that might subtly indicate a significant change in maternal, fetal, or the well-woman's status provides the midwife with the opportunity to identify problems early and initiate treatment geared toward improving outcomes promptly. Midwifery encourages care that is individualized for each woman and each birth. Patience with the birth process is a hallmark of midwifery care. Midwives' compassionate and attentive care reinforces women's belief in their ability to give birth and care for themselves. By utilizing interventions and technology only when necessary, midwives bridge the chasm between medicine and traditional healing.

Exemplary midwives demonstrate professional integrity, honesty, compassion, and understanding. They are able to communicate effectively, remain open-minded and flexible, and provide care in a nonjudgmental manner. When these attributes are coupled with excellent clinical skills, they result in attentive and thorough assessments, excellent screening and preventive health counseling processes, and infinite patience with the process of labor and birth.

Finally, midwives provide personalized care that is tailored to the individual and her present circumstances. Regardless of the clinical practice setting or the client's educational background, midwives endeavor to create an environment that engenders mutual respect and focuses primarily on meeting the needs of the woman or mother and family. Recognition of individual variation is tempered by a thorough grounding in both normal and pathologic processes. This broad scope provides the midwife with a clear view of the continuum of health and allows more accurate assessment and personalization of care.

The midwife who holds as an ideal the provision of exemplary midwifery care must actively create a balance between the professional life as a midwife and the needs and demands of the individual's personal

Box 1-3 Web Resources for Clinicians

- Review of systems form: http://www.fammed.ouhsc.edu/forms/FMC_ROS_Form.pdf
- American Cancer Society, Guidelines for the Early Detection of Cancer: http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp?sitearea=PED
- ICD-9 Codes: <http://icd9data.com/>
- Institute of Medicine: <http://www.iom.edu/Reports.aspx>
- Risk Communication Institute, Paling Palettes: http://riskcomm.com/paling_palettes.htm
- National Institutes of Health, National High Blood Pressure Education Program: <http://www.nhlbi.nih.gov/guidelines/hypertension/>
- National Institutes of Health, National Guidelines Clearinghouse: <http://www.guideline.gov/index.aspx>
- National Heart, Lung, and Blood Institute, Clinical Practice Guidelines: <http://www.nhlbi.nih.gov/guidelines/>
- U.S. Preventive Services Task Force: <http://www.ahrq.gov/clinic/epcix.htm>

life. Time off to refresh and rejuvenate is as necessary to quality practice as is ongoing professional education. Personal relationships nourish the midwife and provide emotional sustenance. All midwives must remain attentive to their own needs to bring their best to midwifery.

Midwives strive to provide exemplary midwifery and women's health care. This demands the development of excellent clinical skills and the determination and persistence to couple them with sound clinical judgment. Each midwife is called on, time and again, to make critical decisions and to act on them in a way that is appropriate for the setting in which the midwife practices while demonstrating respect and honor for the uniqueness of each woman and family in her or his care.

Exemplary midwifery practice, according to Kennedy (2000), encompasses several key concepts. One of these concepts is the basic philosophy of midwifery and its active expression through the individual midwife's clinical practice. Each midwife's philosophy of care is reflected in her or his choice and use of healing modalities, the quality of her or his caring for and about women, and her or his support for midwifery as a profession. Throughout this book, the driving philosophy is of the midwifery

philosophy articulated by the ACNM (2004) (see the feature "Philosophy of the American College of Nurse–Midwives" earlier in this chapter).

SUMMARY

Defining one's personal expression of midwifery philosophy in practice is one of the joys of midwifery. What constitutes "best care" for women, mothers, and infants is determined individually at the point of care with the woman herself, with standards of care and practice guidelines being used as guides along the way. Clinical judgment is the heart and soul of midwifery care. A mindful approach to practice reduces client and midwife risk, improves outcomes, and fosters collaborative relationships. This provides the opportunity for the exemplary midwife to rest better at night and to continue a career of service to women and their families for decades.

REFERENCES

- Agency for Healthcare Research and Quality. (2010). Full disclosure of medical errors reduces malpractice and medical claim costs for health care system. Retrieved from <http://www.innovations.ahrq.gov/content.aspx?id=2673>

- American Academy of Family Physicians (AAFP). (2008). Risk management and medical liability. Retrieved from http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/rap/curriculum/risk_management_and.Par.0001.File.tmp/Reprint281.pdf
- American Association of Birth Centers (AABC). (2007). AABC uniform data set. Retrieved from <http://www.birthcenters.org/data-collection/features.php>
- American Cancer Society. (2010). Screening recommendations. Retrieved from http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp?sitearea=PED
- American College of Nurse–Midwives (ACNM). (n.d.). ACNM datasets. Retrieved from <http://www.midwife.org/publications.cfm>
- American College of Nurse–Midwives (ACNM). (2004). *Philosophy of the American College of Nurse–Midwives*. Silver Spring, MD: Author. Retrieved from <http://www.midwife.org/philosophy.cfm>
- American College of Nurse–Midwives (ACNM). (2008). *Core competencies for basic midwifery practice*. Silver Spring, MD: Author. Retrieved from http://www.midwife.org/siteFiles/education/Core_Competencies_6_07.pdf
- American College of Nurse–Midwives (ACNM). (2011). *Joint statement of practice relations between obstetrician-gynecologists and certified nurse midwives*. Silver Spring, MD: Author. Retrieved from <http://www.midwife.org/ACNM/files/ccLibraryFiles>
- American Health Information Management Association (AHIMA). (2008). Quality data and documentation for EHRs in physician practice. Retrieved from http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_039546.hcsp?dDocName=bok1_039546
- American Medical Association (AMA). (2010). *Current procedural terminology*. Chicago, IL: Author. Retrieved from <http://www.ama-assn.org/ama1/pub/upload/mm/362/cpt-consultation-services.pdf>
- American Medical Association (AMA). (2011). CPT. Retrieved from <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml>
- Angelini, D., & Greenwald, L. (2005). Closed claims analysis of 65 medical malpractice cases involving nurse–midwives. *Journal of Midwifery & Women's Health*, 50, 454–460.
- CareFirst BlueCross BlueShield. (2009). Medical record documentation standards. Retrieved from <http://www.carefirst.com/providers/attachments/BOK5129.pdf>
- Centers for Medicare & Medicaid Services (CMS). (2010a). Electronic health records at a glance. Retrieved from <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3788&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>
- Centers for Medicare & Medicaid Services (CMS). (2010b). Evaluation and management services guide. Retrieved from https://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf
- Centers for Medicare & Medicaid Services (CMS). (2010c). The ICD-10 transition: An introduction. Retrieved from <http://www.cms.gov/ICD10/Downloads/ICD10IntroFactSheet20100409.pdf>
- Farley, C. L. (2005). Midwifery's research heritage: A Delphi survey of midwife scholars. *Journal of Midwifery & Women's Health*, 50, 122–128.
- Greenwald, L. (Ed.). (2004). *Perspectives on clinical risk management*. Boston, MA: Risk Management Publications, ProMutual Group.
- Guidera, M., McCool, W., Poell, J., & Stenson, M. (2007). What to do if you are named in a lawsuit: The professional liability handbook. In *Professional liability resource packet*. Silver Spring, MD: American College of Nurse–Midwives. Retrieved from http://www.midwife.org/professional_liability.cfm
- ICD9Data.com. (2012). Free 2012 ICD-9 medical coding data. Retrieved from <http://www.icd9data.com/>
- International Confederation of Midwives (ICM). (2008). International code of ethics for midwives. Retrieved from <http://www.internationalmidwives.org/Documentation/CoreDocuments/tabid/322/Default.aspx>
- Jordan, R., & Murphy, P. (2009). Risk assessment and risk distortion: Finding the balance. *Journal of Midwifery & Women's Health*, 54(3), 192–200.
- Kennedy, H. P. (2000). A model of exemplary midwifery practice: Results of a Delphi study. *Journal of Midwifery & Women's Health*, 45, 4–19.
- Knoche, A., Selzer, C., & Smolley, K. (2008). Methods of stimulating the onset of labor: An exploration of maternal satisfaction. *Journal of Midwifery & Women's Health*, 53, 381–387.
- Kuczkowski, K. M. (2005). Context and process of informed consent for labor analgesia: A legal standard or an enhancement of peripartum care? *Journal of Midwifery & Women's Health*, 50, 65–66.
- Lothian, J. A. (2004). Do not disturb: The importance of privacy in labor. *Journal of Perinatology Education*, 13, 4–6. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1595201>
- Lydon-Rochelle, M. T., Hodnett, E., Renfrew, M. J., & Lumley, J. (2003). A systematic approach for midwifery students: How to consider evidence-based research

- findings. *Journal of Midwifery & Women's Health*, 48(4), 273–277.
- Maine Association of Certified Nurse Midwives. (2009). Certified nurse–midwifery practice in Maine: An initiative to implement standard procedures and practices allowing hospital admission by CNM's of maternity patients. Retrieved from www.mainemidwives.org/2009%20Initiative%20Final%2009-09.pdf
- McCool, W., Guidera, M., Delaney, E., & Hakala, S. (2007). The role of litigation in the professional practice of midwives in the United States: Results from a nationwide survey of certified nurse–midwives/certified midwives. *Journal of Midwifery & Women's Health*, 52(5), 458–464.
- Midwives Alliance of North America. (2010a). MANA statement of values and ethics. Retrieved from <http://mana.org/valuesethics.html>
- Midwives Alliance of North America. (MANA). (2010b). MANA statistics project. Retrieved from https://www.manastats.org/help_public_about
- National Heart, Lung, and Blood Institute. (2011). Clinical practice guidelines. Retrieved from <http://www.nhlbi.nih.gov/guidelines/>
- National Institutes of Health. (2011). National Guidelines Clearinghouse. Retrieved from <http://www.guideline.gov/index.aspx>
- Nissen, K., Angus, S., Miller, W., & Silverman, A. (2010). Teaching risk management: Addressing ACGME core competencies. *Journal of Graduate Medical Education*, 2(4), 589–594.
- Office of Minority Health (OMH). (2010). Think cultural health. Retrieved from <https://www.thinkculturalhealth.hhs.gov/>
- Risk Communication Institute. (2011). The Paling Palettes. Retrieved from http://riskcomm.com/paling_palettes.htm
- Sackett, D. L., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (1997). *Evidence-based medicine: How to practice and teach EBM*. New York, NY: Churchill Livingstone.
- Schon, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.
- Thompson, J. B. (2004). A human rights framework for midwifery care. *Journal of Midwifery & Women's Health*, 49, 175–181.
- Tillett, J. (2009). Developing guidelines and maintaining quality in antenatal care. *Journal of Midwifery & Women's Health*, 54, 238–240.
- U.S. Preventive Services Task Force. (2011). Topic index A–Z. Retrieved from <http://www.uspreventiveservices-taskforce.org/uspsttopics.htm>

