# My Report

**Last Modified: 03/28/2016**

## 4. How would you describe the goal of your practice as a CNM?

| Text Response |
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| Safe, affordable, family centered care. |
| To provide home birth and birth center services to families who make the choice to give birth at home or in a birth center |
| To provide safe, satisfying and personalized care to the women in my community |
| To provide the best possible primary care to women from puberty throughout the lifespan, including pregnancy, birth and the postpartum period. |
| Provide high quality, Evidenced based care to women in my community for both OB and Gyn care theought the lifespan seeking care of a CNM. |
| Wellness promotion / Illness prevention |
| I am an educational program director who trains nurse-midwifery students. My goal is that all of my students perform well, pass the classes, graduate, and successfully complete their certification examination to become CNMs |
| To provide compassionate comprehensive care to the women I serve |
| Establish a trusting relationship with my clients, provide continuity of care, follow evidence based practice and promote physiologic birth in order to achieve the safest outcomes for both mom and baby. |
| To provide comprehensive holistic care that supports client's individualized requests and preferences for care delivery that reflects and respects a women's unique needs, family structure, and personal choice. Care should encompass physical needs, psychosocial needs, cultural preferences, and educational needs. Women's mental health care is an essential tool and should be addressed at each and every patient care interaction, |
| Providing quality, evidence based care to women throughout their lifespan. |
| To give women the birth choices they desire in a hospital setting |
| Antepartum and postpartum care |
| To provide safe, evidence-based, and respectful care to women while providing each woman with the information she needs to feel empowered and to make her own autonomous decisions regarding her health. |
| expand options for women. support low intervention natural birth. |
| provide safe birth options for women in my community |
| Provide evidence-based care to women desiring low-intervention births in their homes. |
| Provide evidence-based prenatal care and family-centered postpartum care. |
| Support women and families in the birth of their choice |
| Improving the birth choices for women while offering safe and compassionate care in the hospital setting. |
| Patient-centered, minimal-intervention, research-based care that focuses on best outcomes for mother, infant and family. |
| Educate and empower women to be active participants in their healthcare through shared decision making. I endeavor to provide holistic women's health and maternity care that is individualized to the woman/family needs and is evidence based. |
| supporting women's decision making, healthy mothers/babies, provide family planning, providing full scope midwifery services |
| Provide holistic, personalized, women-centered, satisfying, evidence-based care to women and their families during pregnancy, birth, post-partum, and across the lifespan through well-woman care, family planning, preventative health care. To support physiologic birth. To improve health outcomes for women and babies by partnering with women to optimize their health and to minimize unnecessary interventions and |

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| medications. |
| Empowerment of women and families in normal birth in hospital. |
| To continue as a hospital based midwife. |
| To provide quality care to the women I serve while being sensitive to their needs. |
| I am retired |
| Safety is paramount. We strive to provide safe, evidence-based care to healthy women with low-risk pregnancies. We believe that a way to help women give birth effectively and safely, is to help them experience physiologic birth with minimal interference or manipulation. |
| Safe satisfying birth for all women |
| I would like to start a home birth practice. I am currently unable to do this due to supervision requirements and the fact that there are no physicians that I am aware of in this area who are willing to collaborate with an out of hospital provider. |
| No comment |
| to preserve and promote the option for physiologic birth in our community |
| To provide exceptional client-centered care to the families who present to triage at Sentara Princess Anne Hospital |
| Continue to provide a collaborative practice model within the military health care system. Continue with lower than national average primary cesarean section rates and the promotion of physiologic birth. |
| Helping families through the birthing process and caring for women to create health and a strong sense of self. |
| My goal is to provide compassionate and competent care to private Mennonite families in an out of hospital birth center in Dayton, VA. That means that the mother and baby are together the whole time they are at the birth center. If the mother has problems that need attention, the father is holding the baby. We have 100% breast feeding. About 2-3% subsequently supplement, due to problems with supply. |
| To provide full scope midwifery care to all women who desire it and are not high risk |
| Providing safe individualized care to Ob & Gyn patients in my care |
| Support physiologic birth. |
| provide personalized GYN care and home birth and birth center services for women within a 40 mile radius of our office. |
| I am mostly retired and as such no longer attend deliveries. This area has a few physicians who are very supportive of midwifery care and many who seem to fear us. The local CPMs vary from a few well versed practitioners to several who do their best to frighten their clients away from any other providers even in high risk situations. |
| to provide the best full scope midwifery care possible, while continuing to learn and keep current on best practices |
| Interprofessional collaboration; ability to do homebirth and maintain admission privileges |
| To offer midwifery care to all low risk women who have an interest |
| To provide the opportunity for Patients to have birth choices in a hospital setting |
| To help women have the birth they desire by educating and guiding them along the way. |
| To provide safe and holistic care to women and families choosing to have babies in the hospital setting. |
| To promote the health of mothers and babies in Virginia and to eventually practice autonomously. |
| Winding down now to retirement! |
| To bring midwifery options to my patients |
| Satisfying quality empowering care for women and the people who love them |

| Statistic | Value |
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| Total Responses | 51 |

## 10. What has made your experiences working with physicians positive?

| Text Response |
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| Respect of our assessments. |
| Mutual respect and willingness to function on a colleagial basis |
| Mutual respect |
| When physicians treat me with respect, and let our mutual patients know that I am respected. Also, when a physician comes without my asking twice, and responds to my requests for consultation with a pleasant attitude and an attitude that indicates he/she knows we are on the same team and have the same ultimate goals for our patients. |
| When they are non-judgemental of the care provided by CNMs and are more supportive of the care we provide and our greater knowledge of the physiologic birth process. Unfortunately in my current situation, this is infrequent. |
| Mutual respect and collaboration |
| They respect me as an professional and colleague. |
| My back up physicians are readily available. I know them each well and they know me. We share the common goal of providing safe care for the mom and baby even though we sometimes see different routes to obtaining that goal. |
| Willingness to let me interact with clients without interference |
| They respect and value my skills and opinion. They are happy to allow us to take full responsibility for the care of women within our scope and happy to consult or collaborate as needed. When a full transfer of care occurs, I know their care will still be evidence based and they will be cared for with compassion and kindness. |
| There is a convenience working in a nd/CNM practice but also disadvantage as we both desire a certain group of women as our clients |
| The change in attitude from both the physicians and the organization we work for in supporting a relationship of "colleagues" not supervisors |
| I work in a collaborative group with wonderful physicians who respect women and provide true evidence based care, as well as informed consent to women. If a particular person declines a suggested intervention, the physicians respect that choice. The group with whom I practice values my education and my practice and they treat me as as partner in our work together. |
| respect for me and my client. Effective communication. clear definitions of roles and responsibilities. |
| a second opinion and surgical expertise |
| Physicians open to my assessment of the patient and situation at time of consultation. |
| Physicians who treat me as a colleague and treat patient with dignity. Physicians who view transfer from a home birth as a sometimes-necessary part of the planned home birth continuum of care--Rather than a "See, this is why you should give birth in the hospital!" mentality, it is a "I'm glad we were able to help you in this situation. It's why we're here" mentality. Simple things like a physician making eye-contacting with the transferring midwife or asking for questions or input--inclusion of the midwife in the care team (not as a decision-maker in a transfer scenario, but as a valued support person, like a kind doctor would treat a doula) |
| expertise for management antenatal referral for problems hospital liasons GYN referral site |
| Knowing I have the resources needed to provide women with the highest quality care possible. |
| When the patient's wishes are at the center of our care plan, both CNMs and physicians |

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| usually have a positive experience. Also, when our low intervention plan of care (limiting internal monitors, intermittent auscultation, delaying AROM for SROM) is reviewed with the physician and supported, the CNM feels supported in our scope of practice. |
| The OB & MFM physicians with whom we most often consult and refer understand that we are providing midwifery care to our clients - which often is different in form than the medical care they provide their patients. They provide us space (i.e. are not highly restrictive or objecting) to do this work while creating an environment of open collaboration when our clients need additional medical care. |
| they appreciate the work I do, I help train residents and interns in normal labor/delivery, many have same thoughts as I, RE: fetal monitoring |
| Accessible, easy to communicate with via texting or emailing, respectful to me as a professional, understanding of our clients' desires for low-interventions. |
| mutual respect |
| Excellent teachers |
| I appreciate it when I physician trusts my judgement, and is readily available when I need them. |
| Obstetricians have reached out to me and my patients to be available for consultation and transfer of care. Some have given their personal cell phone numbers which has been very helpful. |
| Respect for midwifery model |
| Extremely medical minded and high intervention. |
| we are an independent practice which allows us a great degree of autonomy |
| Physicians are respectful of my knowledge and experience. |
| Young, open-minded, eager to learn how to work collaboratively with CNMs |
| Their commitment to families and their willingness to learn from the women. They are courageous outliers among their peers who are only just catching up with them. |
| My collaborating physician reviews my charts (OB and GYN) and is available by phone for consultation. Our professional relationship is based on trust. I have a written agreement with a hospital CNM / MD practice for transfer of care when needed. That relationship works as it is also based on trust. It is interesting to note that as time passed, the CNM's in the transfer practice received my patients, instead of the doctors. This resulted in decreased C-sections. The C-S rate for my practice is between 3-4%. |
| Willingness to work in a collaborative relationship |
| Similar philosophy of care, similar practice styles, and commitment to positive non-interventional birth experience. |
| He respects what we do and is open to listening and improving our relationship We have only worked together X 1yr, |
| the physicians I currently work with are open-minded, practice evidenced-based care and don't seem to have issues with ego. In addition, competition for payments is not an issue. |
| The physician who backs me is supportive yet allows me autonomy. He teaches me and challenges me everyday. |
| The group I work with supports midwifery care and realises the importance of working alongside CNM philosophy to better care for families who prfer midwifery care |
| Helpful consultations and recognition of my experience |
| I have been in the same practice for 22 years and have seen some ups and downs but over-all I mad my choice to leave my home-birth practice behind and "come in to the fold" for family reasons and the wear and tear on me of the up-hill struggle of practicing my profession in a (pretty) hostile environment |
| Most are very supportive of CNMs at the Military Facility where I work. I teach/train medical students, interns and residents and collaberation is important in this aspect. I |

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| answered unsure on the question because in our community they are not at all supportive, in fact there are very few hospitals that have CNMs are currently have privileges. Most that are here are functioning as NPs with no delivery options. |
| Mutual respect |

| Statistic | Value |
|---|---|
| Total Responses | 43 |

## 11. What would you change about your collaborations with physicians?

| Text Response |
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| Nothing. |
| Remove supervision from the regs to more clearly deliniate who is responsible for care More frequent non-judgmental review of transfer of care cases More informal discussion of updates of clinical procedures |
| I would prefer that our consulting practice worked more as a group among themselves rather than as individual physicians who happen to be a group |
| I find that the business arrangements get in the way. I would work for an employer who is NOT a physician, who also employs the physicians. The conflict of interest when the physician is trying to make money to help a practice prosper, often doesn't seem in the best interests of patients. They order too many tests, and impose too many restrictions on patients in ways that impact the physician's private practice in a positive way, but don't necessarily improve patient care. I would also only work with physicians who had been educated in settings where CNMs were practicing, as these are the physicians who tend to respect us, and not just see us as physician-extenders, or "2nd year residents", as I have heard us described. |
| Have the ability for collaboration and respect that physicians have with other physicians when they collaborate and/or refer patients. Instead the relationships I have mostly encountered have been that of Junior provider, Senior resident to Junior resident etc. |
| Not a thing |
| That the relationship was voluntary and more equal to that of family doctors to OB and OB to MFM. That it wasn't regulated so that I had to be dependent on a doctors permission to practice |
| I wish that collaboration between midwives and doctors was a "2-way street" where midwives consult about high risk or complicated clients and doctors consult about normal/low risk clients. I wish that consultations/collaborations were always mutually respectful and not condescending. |
| I have little respect for physicians. I continue to feel that they consider CNMs a profession below themselves. I do not feel they use a holistic approach, nor do they advocate for the woman. I feel there decisions and advise are often based on fear of litigation. I do not think they treat CNMs as peers, not do I think they value our opinion for input. |
| I wish they valued labor support a bit more, and I wish they did not expect us to take on the higher risk patients. They respect our skills a bit too much sometimes! |
| I would love to work independent and with more respect that phycisians would give us. More as an equal |
| Most are respectful of my knowledge base and my role |
| Nothing about them but many things that they have to do because of organizational or legislative issues. My organization requires that a physician co-sign each one of my notes (despite the fact I have been in practice longer than some of my back up physicians have been in medical school or residency, much less in practice!). I am not a voting member in my hospital's OB committee and decisions are made there which impact my practice and the care my patients receive. I am allowed to sit in and comment during those meetings and my collaborating group particularly respects my input, but I should be able to vote. I would prefer to be able to admit patients to the hospital rather than having to admit under my back up physician. |
| I work in a academic environment. Sometimes I have to consult with a PGY2 or 3: I have |

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| WAY more experience than these residents in training. I think CNMs should be and should consult with attending level physicians. |
| not understanding the midwifery model: the dedication to physiologic birth: constant push for productivity |
| First and foremost, human-kindness to my clients, and secondarily to me. A brief acknowledgement to the client that, "It must be disappointing to not have had the birth you hoped for but we're going to give you great care here, too." I would love to know how to reach a place of mutual respect--we have different specialties. In case of a transfer, they are the specialist in treating this problem, and I am the specialist in my client's needs. Simple acts like being allowed into the OR to support my client demonstrates a professional respect. I have usually poured my all into this client and her labor prior to transfer and when I am suddenly cut out, not acknowledged as being present, it hurts both my client and I. |
| would like to see seniority of CNM/ years in practice allow to buy into/ be part of partnership still 2 tiered management |
| Maintaining one strategy for the plan of care. |
| I think our practice collaborates with physicians well. The only push back I receive on a regular basis is that interventions should be employed more quickly, rather than allowing more time for natural labor to take its course. Induction of labor is a good example. Very often, women are induced at 41+0 weeks (approx 30% in our practice); if the pregnancy is otherwise uncomplicated and a baby has a beautiful reactive NST, why can't a women go another 3-4 days before induction? Most often they go in to labor spontaneously with the extra time. Most of the situations that CNMs and physicians don't see eye to eye on are related to differences in our scopes of practice...it's not that we need to change how we collaborate - more so, we need to understand the foundation that each of us practices on. |
| Education for the other specialists/physicians in my community so that they know the work I do. When I refer to another provider (GI for example), I often hear from my clients and sometimes on the consult notes back that that doctor recommends they have care from OB - simply because they do not understand what we do. |
| would not change |
| less competition for normal birth |
| Nothing |
| Nothing. My current practice in the health department provides good collaboration when needed. |
| I would like more OB's to be open to taking my patients and to not feel threatened by liability. The partners in the group need to support the decision of individual OB's to work work with home birth CNM's and their patients. I need to be able to call the docs directly and get quick access during emergencies. |
| incemtivize mds to collaborate |
| As stated above, I would like to be in a completely different setting and collaborate only as needed for complicated cases. I would like to have a mutually respectful arrangement where each understands and honors the skills and expertise of the other and acts accordingly. |
| improved communication |
| Because physicians are often the employer of CNMs, they hold the reigns over our practice. If we attempt to advocate for the rights and needs of our clients, we may be perceived as a 'trouble maker." If we try to advance normal birth, it can be perceived as negative toward physicians who have high intervention rates. More autonomy, better business savvy and a direct financial benefit that physicians can clearly see would go a long way to making us more valued. |

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| Nothing at this time |
| We are unnecessarily controlled by supervisory clause. It controls too many aspects of our practice as though our profession is unreliable, child-like. It limits our income. Too many CNMs are treated like indentured servants working dangerous hours for the right reasons but for someone else's leisure and profit. |
| I strongly believe that CNM's should be the gatekeepers for Obstetrical care. We are well educated in what is normal and what is not, and what, subsequently, needs medical care. CNM's should be primary care providers for normal OB and GYN care of women. |
| More independence in terms of being able to hire another CNM |
| Nothing. They allow me great autonomy and respect my clinical judgement. |
| Make more time to meet together to discuss cases |
| More acknowledgement for our areas of expertise, such as referrals of clients to Centering Pregnancy care, matching midwives with women desiring drug-free labor/births, teaching role of residents by CNMs in normal/hands-off care.... |
| Sometimes I feel belittled and not a menber of the team. |
| Nothing. We are a strong team with great respect for each other |
| I would prefer MDs to be true consultants and avoid micromanagement of midwifery clients. |
| I would like to see a model like The Netherlands and Canada where Midwives are trained and trusted to practice their profession of rendering care to women from cradle to grave and to giving care to their infants, with a user/patient-friendly means of consultation and referral as needed. |
| More acceptance of the midwifery model of care. |
| Recognition of validity of midwifery care |

| Statistic | Value |
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| Total Responses | 42 |

## 12. If a problem arises between you and a physician, which of the following best describes the steps you would take to resolve that issue? Select ALL that apply.

| Other (please describe below) |
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| Only to supervisor if unable to resolve issue between the two of us and it affects patient care |

## 14. What are the challenges to working with physicians; what makes it harder?

| Text Response |
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| Our clients do not have an opportunity to develop a relationship with the physician. |
| Acceptance of each other's point of view from both sides Dealing with hospital policies that put barriers in the way |
| The physicians are a very diverse group and do not always agree with each other's plans, which means that the plan may change from day to day depending on who is the consultant for that day |
| I think I answered this previously- the economic relationships, the lack of familiarity with the level of training and expertise that CNMs have, and the assumptions of the superiority of biomedicine over other evidenced based perspectives. |
| In my practice they have a different agenda and goal than I do. C/S rates exceed 50% for some providers with no accountability or shame. Practice defensive medicine and berate CNM for not practicing in this manner. Have no desire to expand their practice to include Evidence Based Medicine. |
| We are all very busy professionals. |
| That they feel they have to manage me |
| We generally all of the same goal--healthy mom and baby. As midwives we also place a large emphasis on the client's happiness and emotional health and I wish that physicians saw more value in that. Women build very strong trusting relationships with their midwives and I think doctors sometimes don't understand the importance of that. I wish that physicians placed a higher value on physiologic birth and how it impacts the health of mom and baby. |
| I do not find them accountable for their actions, I find they commonly blame their mistakes on others including staff, CNMs, and RNs. I find they have an authoritative and self-inflated image of themselves. Some, not all, I have worked with, do not feel they should explain decision to the patient and that their advice should be taken with no room for questioning or further explanation. |
| When they are loath to collaborate or take on a patient that is outside of my scope. |
| Their superiority toward us |
| When decisions are made without my input. |
| In the past, I have worked with a physician who was disrespectful to women and to me, and did not practice in an up-to-date or evidence based way. I was very frustrated because I could not practice without him ( due to constraints in legislation and the organization) so I felt at his mercy. The situation was intolerable but luckily he was asked to leave. I would have resigned and moved otherwise. The difficulty was that , with the practice model I work within, and the high risk patients our group serves, I absolutely have to have collaborating physicians who are trustworthy and respectful to women and to midwives. |
| Not all the physicians have the same clinical skills> For example, there are some physicians who will not do an instrument delivery at all...they will do a cesarean. There is a element of fear for these physicians that impacts clinical options for women. When doctors get scared they tighten the reins, put more pressure on me to get babies out, limiting time for women. |
| not understanding the midwifery model: constant push for productivity |
| The "need" is one way. I need a physician in order to work, but they have no need of me. And more than that, some think I should not even be in practice. When clients who transfer to an MD are unhappy with their care, it can further burn bridges. |

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| Physician are to tiered with power CNMs without admitting privileges power still with MDs/ we are considered less powerful as nurses |
| Approachability, especially when the unit is busy. |
| As mentioned before, it is almost always a misunderstanding of the midwifery model of care. |
| Many of them make open comments of disapproval or disagreement that is not helpful or in the spirit of collaboration. Many will make recommendations and expect that those recommendations will be followed (forgetting that we are the primary care takers/givers and that the client will make choice). I think they are unaware of what we really do or why we really do. It is difficult when they don't ask for our thought process or background on situation but assume our thought process (or disregard it altogether). |
| they do not always trust mother's to birth without intervention, some younger physicians are more apt to suggest cesarean or operative delivery - likely medical-legal cause |
| Difficult to access (hard to reach); difference in management strategies |
| Listening to what the patient wants is not a high priority for them. |
| The large group model as well as the limitations physicians face when their practice is owned by a large healthcare corporation. |
| Lack of respect |
| Physician perspective of "supervision" and their functional ability to restrict and control practice of CNMs. Differing practice philosophies cause conflict. |
| our back-up physicians are a large, busy practice and we are not always their priority |
| I am not expected to voice a difference of opinion with their recommendations for patient care. Even when there is an evidence-based best practice they haven't considered or are not comfortable with, I am expected to shut up and do what they say in some cases. If I question or present evidence to the contrary, I am seen as "uppity." |
| Rotating physicians due to military changes in duty stations Fresh out of residency No experience in working with CNMs Misunderstanding of roles/responsibilities of CNM scope of practice |
| Lack of autonomy. |
| The fee for service model of care makes TIME an element of care (BEYOND what it is for making judgements based on any OB problems observed.) In other words, decisions are (unfortunately) made based on when the doctor's shift ends as well as the actual OB problem experienced by the woman receiving care. If reimbursement is an annual salary, then allowing time for the normal differences in laboring women is more attractive. |
| The physicians preference to communicate electronically instead of face-to-face whenever there are conflicts |
| none |
| Getting to know each other and understanding their management plans |
| acknowledgement of our differing areas of expertise |
| Knowledge base Their misunderstanding of midwifery model sometimes |
| In the past I have worked with MDs who felt threatened by midwifery care. In the end most of these MDs have left OB care and not supportive of the trend for the increased midwifery presence in Americas birth arena. |
| Different MDs have different approaches to management of minor problem pregnancies; consistency and trust in the CNMs judgement are needed in my practice at times. |
| My practice has been curtailed by my decision to stay in a physician owned practice and that has been the hardest part of practicing here in Virginia for me. However, it was my decision to take a job in this setting and to not leave the job when they decided not to have me practicing full-scope any longer (no deliveries) |
| Too much of a medical model is expected. They are OK with low intervention but have |

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| low tolerence for encouraging them if not progressing. |
| Their Perspective on birth as a medical event/crisis And the unequal balance of power. |
| Mds have power over how we practice and even if we practice. |

| Statistic | Value |
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| Total Responses | 41 |

## 15. What are the facilitators to working with physicians; what makes it easier?

| Text Response |
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| We use the same physician who is familiar with our practice and our client population. |
| Openness and understanding each other's lived experience of practice |
| The fact that these physicians frequently must rely on us for back up means that there is give and take (as opposed to take and take) |
| It is easier when the physician does not feel like they are supervising my work, but collaborating. And it is easier when it is not a direct fee for service environment (not the current case in my practice, but I have been there, and it was great) |
| Little to no mechanisms in place for this to occur. Thought process amonst physicians (in my practice arena offic hospital) is that CNMs are "Junior" providers who need (and will always require) direct supervision and the "supervisor" ie MD in charge ultimately has vicarious liability for what the CNM dose. No agreement on differences in the way we practice. Their way is only correct way, since they are the MD. Etc, etc. |
| We work in close proximity to each other |
| That our OBs are generally kind and practice the best evidenced based care |
| A trusting relationship with open "2-way" communication where the midwife listens well to the doctor and the doctor listens well to the midwife. Mutual respect for the expertise of each party. An understanding that both parties care deeply about what's best for the mom and baby and an understanding that there is often more than one right way to provide safe and high quality care within the same situation. |
| I think that when physicians and CNMs are both hospital employees that the interaction is much more positive. Physicians in private practice often feel superior to all employees. I have seen them to extremely disrespectful even among their physician peers when they are in the owner/solo practice model. |
| When they have a understanding and respect for physiologic birth. |
| Not sure |
| -Regular meetings as a "team"where CNM input is valued and sought -Practice guidelines that are followed by all providers: CNMs, NPs, physicians, residents, Med students, MFMd |
| I feel really lucky because on of our physicians is a champion for midwifery practice. He believes that low risk women should be cared for the specialists in low risk birth and that midwives should be providing the majority of OB care in the US. The things that facilitate my work on a day to day basis are that we work very m, very closely together (sometimes even sharing an office while in the clinic) and that helps the physicians see me as a good person and a skilled midwife. I believe sharing our OB patients (we all see all of the patients) helps them see my value. |
| Being honest. Being responsible. following clear guidelines or evidence that you can reference with them. having communication: SBAR: situation, background, assessment and response or plan. It also helps tremendously if you have some relationship with the physician. there is then a basis of trust. |
| second opinion and surgical management |
| When clients who transfer appreciate the physician's taking part in their care, it does smooth the paths. When physicians have a respect for midwifery care (especially internationally-trained MDs) it helps. When physicians are just kind people it makes working with them easier. When transfers can be made to 24/7 coverage teams it helps because a solo-practice doctor can be unhappy to be called in for someone who is not even "their" patient--and quicker to section a client in order to get back home or to the |

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| office. |
| loyalty to practice  MOMs! they are our advocates outocmes- lowest c/s rates in area associated with CNM  led care for normal/ Md involvement for high risk |
| The amount of trust they have in CNM's knowledge base, experience and intuition. |
| An understanding that midwives establish a low intervention plan of care because that's our model of care; for example, if a woman comes in PROM'd, it's realistic that we will allow her expectant management without augmentation. Secondly, open communication about a plan of care is imperative. I think that when physicians understand what our plan of care is, there is always more support. It's when they're kept out of the loop when they prefer to know what's going on that clashes become imminent. |
| Having open dialogue about clients we are caring for, thought process, etc so that interactions and consults/collaboration can be truly collaborative - valuing the expertise of each of us. Our interactions with our MFM and OBs is easier because we see them often - even if we are not transferring/referring or consulting on cases. We know them and they know us. |
| having a good rapport with physicians, trust my judgement |
| Ability to easily access/communicate via texting, emailing, quick responses, mutual respect |
| We speak a common language, and there are accepted clinical guidelines to follow. |
| When they are open and friendly and willing to talk. If they make negative assumptions about midwifery care or home birth and are inaccessible, midwives and home birth families suffer. Communication and not feeling threatened by a different model of care and liability are vital. |
| Don t know |
| Mutual respect. Independent practice for CNMs would facilitate this and remove the issue of restricted practice and physician concerns about their responsibility in "supervising" CNMs. This would open up the relationship to be more collegial. |
| establishing trust and relationships over time clear practice guidelines support from administration |
| Level playing field for patient safety.  Financial arrangement where physicians see a direct monetary benefit from working with CNMs. |
| Communication Respect for each other's perspective and style of practice; willingness to explore best practice. Team work |
| Look at the military. Rank supersedes job title. Time in grade is what confers authority. |
| Clear communication about the CNM's observations, and clear communication about what she/he may wish to see as possible medical interventions helps the physician to intervene effectively.  However, the model of medical care (fee for service) is the problem.  If we continue to allow physicians to "head" the team of OB caregivers, we will never make effective change in the expensive way we deliver OB care.  If we have CNM's as gatekeepers and they are reimbursed fairly, but not based on the medical, fee for service, model, we will start of see decreased C-Section rates and decreased hospital costs and still have quality care. |
| face-to-face communication |
| Similar goals in patient care. |
| mutual respect |
| keeping patient goals front/center of care |
| Allow me autonomy and choices to manage as ling as I am being safe..even if it's not what they'd do. |
| Respect for each other, mutual understanding of birth philosophy and coming together in the middle to meet the desires and needs of expecting fanilies |
| A personal relationship with a physician makes it easier to consult. |

| |
|---|
| Frankly, the money, and the ease of not swimming up-stream doing home birth as I did for many years |
| Share alternatives and EBM supporting them. We are good, since no inductions without medical indication, not before 41 weeks. Offer TOLAC and IA |
| Mutual respect.  Similar ideology re birth, respect for women |

| Statistic | Value |
|---|---|
| Total Responses | 41 |

## 19.  What has made your experiences working with CPMs positive?

| Text Response |
|---|
| Very knowledgable and hard-working. |
| Respecting each other's point of view Learning about their informed decision process with clients |
| I haven't had any positive experiences yet (but I am hopeful) |
| We have gotten to know them personally and professionally.  They come with their patients and keep thorough records. |
| I only work with CPMs when I receive a transfer to the hospital from a CPM practice. This only happens about 2 times per year for me. I have had positive experiences because the client who was transported was safe and I was able to provided the needed services for a good birth outcome. |
| The openness to transfer when appropriate, keep accurate records. |
| Not positive in my area |
| their patients are well educated and come prepared with questions |
| Unfortunately the times I have interacted with CPM's have all been very poor judgement calls with unnecessary morbidity and at times mortality. Hence the reason for them coming into the hospital. |
| We have had very positive relationship with the CPMs in our immediate community - getting to know them and building relationship outside of transports and consults has been immensely helpful. |
| Mutual respect, sharing the midwifery model of care |
| communication |
| I only work with one CPM in VA. She is my associate midwife. There are a few others in the state that I respect and trust as having good judgment and being adequately trained. She is skilled at helping difficult labors progress and in giving safe herbal and nutritional advice. |
| good communication no hesitancy on their part to transfer patients in |
| mutual respect and sharing information |
| being open to helping clients of CPM, when our expertise is needed....such as providing Rhogam injections, treatment for UTI, etc. |
| I appreciate their passion for midwifery philosophy but I often frustrated with the risk that some high risk clients take on to have home birth. |

| Statistic | Value |
|---|---|
| Total Responses | 17 |

## 20. What would you change about your collaborations with CPMs?

| Text Response |
| --- |
| nothing |
| Make access to pit, cytotec, oxygen, rhogam, IV fluids, IV ABx available on their own authority. When the only remedy for PP hemmhorrage is transport, we are endangering the health of mothers |
| I would like to see them be legally empowered to have the tools (medications, O2 etc) to practice safely in an out of hospital environment. I would appreciate it if the CPMs who accompanied their patients to the hospital did not spend so much energy telling their clients that everything done at the hospital was wrong. I would like CPMs to get help before they are in deep trouble |
| That they limited their care to low risk women: eg no breech, twins, VBAC etc |
| I wish that our hospital or our practice had an established and welcoming relationship with the CPMs. I think this would help facilitate the best care possible for moms who choose CPM births. |
| I wish we had more support from our administration for collaboration with CPMs. I feel having a solid transfer protocol is the key to a safe homebirth practice, and being able to provide care for women who risk out of homebirth without hostility is our way of supporting birthrights for all women. |
| I would like to break barriers down and I would like the CPM in my area to stop seeing us as their enemies |
| CPM patients are encouraged not to trust CNMs or MDs. CPMs are often disrespectful to medical opinion and advise patients to "refuse" medical recommendation when transferred to a hospital. There is little to no trust of CPMs by the medical community in my area. |
| Improve the communication with us while they are attending a woman who falls outside the parameters of low risk. |
| Would like to have established transport guidelines so all CPMs transferring to hospital will know what to expect and we will have more consistent idea of what to expect from them - communication is key. I would also like them to be more involved in QA - being able to evaluate as a department - OBs, CNMs, CPMs, pediatricians, nurses, Neonatologists - transport cases so that we can improve communication and care. |
| I wish they had more academic, accredited training and had preparation and license to give medications commonly needed in birth. |
| difficult to navigate our current hospital system in receiving CPM transfers |
| more honesty about what type of women qualify for out of hospital births |
| ability to cover for each other's clients |
| more collaboration, less suspicion, joining forces for care state-wide, certification by Midwifery Board |
| None. I am not really Interested in collaborative care between CNM and CPMs until the CPMs have guidelines that reflect on low risk care in the homebirth environment. |

| Statistic | Value |
| --- | --- |
| Total Responses | 16 |

## 21. If a problem arises between you and a CPM, which of the following best describes the steps you would take to resolve that issue? Select ALL that apply.

| Other (please describe below) |
| --- |
| CPMs are often "shun" from the medical community |
| I could write a complaint to the Virginia Midwives Alliance and ask for a mediator or send a complaint to NARM. |

## 23. What are the challenges to working with CPMs; what makes it harder?

| Text Response |
| --- |
| None |
| Becoming "stuck" " invested" in our own point of view - closing our minds to each other |
| Fear that I could become responsible for management that I don't feel comfortable with if I get involved clinically and communication is poor |
| The CPMs I work with demonstrate little to no respect for what can be offered in a hospital environment. They criticize the midwife and what she recommends to the patient, but I feel that it would be unprofessional to criticize her and that it would put the patient in an awkward position. I think that they forget to put the patient and the patient's needs first. They will go to great (and sometimes dangerous) lengths to avoid transporting a patient to the hospital. When a patient asks a question they ask me to step out so that they can discuss it with their client, thus excluding me from the circle of care. |
| That they don't have specific guidelines about what they can and can't take |
| I don't know the CPMs in my community very well. The laws that regulate CPMs in Virginia are a big challenge because CPMs are not allowed to administer emergency medications like Pitocin. I think that is dangerous that it is not allowed and I think the law should be changed to increase the safety of CPM home birth/birth center birth for moms. Some CPMs are willing to provide certain services at out of hospital births that myself and others I practice with consider too high risk for out of hospital birth (such as VBACs out of hospital) and this makes it challenging to find agreement, support CPMs and build better relationships between the medical system and out of hospital birth care. |
| They often have different standards of care, and can be hesitant to disclose full patient history. |
| They talk to their clients as we are the enemies And so create fear and mistrust in their clients towards any medical interventions |
| I do not feel respected as a CNM by the CPM community. Often no one wants to take a first step to repair the broken relationship between CPMs and the medical community |
| Their lack of knowledge. |
| I trust the 2 CPMs in my immediate community and a few that I have been able to meet and get to know in surrounding. There are many more that I do not know and have not had good experiences with (poor communication from CPM) and this makes it difficult because I do not know what they know or what their intentions/thought process with patient was. |
| unsure of level of expertise |
| Rating my interactions and trust level with the one CPM I work with does not represent my opinion of most other CPMs who practice in my region. I wish they had more standardized education and I think this will come eventually. |
| hospital system making transfers in awkward to navigate (not fluid) |
| the local CPMs take risks that I am not able to support |
| CPMs cannot legally order and carry medications |
| Often, CNMs have to work within constraints of hospital or practice "rules" and CPMs don't have such constraints. |
| I believe our greatest challenge is the lack of middle ground between each type of midwife. Our training is similar but not the same. |

| Statistic | Value |
|---|---|
| Total Responses | 17 |

## 24. What are the facilitators to working with CPMs; what makes it easier?

| Text Response |
|---|
| Very easy already. |
| Open communication with both the CPM and the family involved Recognizing the strengths each of us brings to a situation |
| I have had one experience where the CPM thanked me for what I had to offer to her patient, and she declined to give an answer when the patient asked her a medical question because as she told the patient "I am your support person, but this is your midwife." I think that what she did was to show respect and trust in me, thus allowing her patient to trust me without feeling disloyal. |
| Getting to know them and open communication |
| We share the same goals of having healthy moms and babies. CPMs are similar to CNMs in their respect for physiologic birth and the emotional as well as physical well being of the mom. |
| Early and open communications between providers. |
| Can't yhink |
| CPMs often have a richer knowledge of the physiologic birth and many non-medical tools to assist laboring mothers. I wish we (CNMS) could learn from them. |
| Timely communication. |
| It is so much easier to work when they call us and we can talk about the client that they may be bringing, better when they come with their clients to hospital, better when they are able to stay and help us care for the client. |
| Their independent practice free from physician supervision or collaboration makes it easy for them to set up practice and to interact with other providers. |
| giving personal cell phone numbers to each other accepting transfers without judgement |
| clear guidelines |
| joint social and CEU opportunities |
| Open dialogue within each type |

| Statistic | Value |
|---|---|
| Total Responses | 15 |

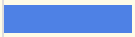
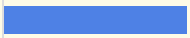
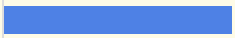
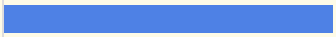
## 25. What is the scope of practice of a physician when working with a Certified Nurse Midwife (CNM)?

| Text Response |
| --- |
| collaboration with complications of pregnancy or in the event of a transfer to hospital |
| I don't understand this question |
| Consultant |
| The physician is there to consult, collaborate or accept referrals from the CNM, to provide gynecological, primary and obstetrical care for our patients that is beyond the scope of the CNM practice. |
| Not sure how to answer this... Ideally the Physician should be utilized for resource when needed for collaboration, alternate skill set (surgery, 4th degree repair, etc) that is outside of CNM scope, referrals for patients that are high risk and outside of CNM care. |
| OB/GYNs have a high degree of skill and knowledge for abnormal Gyn patient needs and High Risk obstetrics, and Women's surgical needs. Much less skilled in low risk prgnacies and physiologic birth. |
| Consultation &/or surgery |
| to be available for consultation, collaboration and referral |
| Depends on where you work. The actual definition is we work in collaboration, consultation and referral |
| The physician should be available for consultation and referral as needed. The physician should understand that some cases will only require a brief consult whereas others may require a full transfer of care from CNM to MD. |
| Physicians should be available for consultation, and possible surgical intervention when requested. When a midwife works within her/his scope of practice, regular physician involvement in not needed. Consultation services and surgical management are the roles of the physicians. In most cases, I feel that CNMs are able to continue competent care, much like when an OB co-manages patients with a perinatologist. |
| Collaboration and consultation for patients with high risk situations, while being available for full transfer of care when appropriate. |
| Not sure what this question means |
| Antenatal, postpartum, gyn |
| I am not sure I understand the question. Each of us has our own scope of practice whether we work with another type of provider or not. If a woman has a high risk complication (hypertension or A2GDM, for instance), or needs an intervention I can't provide as it is out of my scope of practice (forceps or cesarean section), I call in my consulting physician. In some cases, our scope overlaps. In some cases, they consult with me (a low risk woman who is struggling with an unmediated labor is what comes to mind, or someone who needs more psychological support). |
| The physician is my consultant and collaborating colleague. The physician may also be my referral source for women who risk out of midwifery care. They provide Medical and surgical intervention when needed. |
| OBGYN |
| In some cases, they are evaluating a patient with a medical condition complicating pregnancy and their scope is to make recommendations to me, as the primary provider. In other cases, as in an intrapartum transfer, I am referring the client to them and they are taking fully over her care. |
| in our model/ CNMs are first call and MDs see high risk or call as needed for problems. |
| I don't undestand what you are asking. Are asking about my scope of practice or the physician's scope of practice? The scope of practice is delineated by the privileges |

| |
|---|
| agreed upon by you and the facility and by the professional college of the practitioner. |
| The same as when not working with a CNM; scope of practice doesn't ever change. It's always about best practice for the patient - not limiting scope of practice of either provider. |
| In our practice, the physicians we collaborate (according to ACNM definition), consult, and refer to are in a separate, private practice. They are available for consultation as we need and as the client's condition dictates. They provide recommendations, will see client for formal consultation, or will assume care if we or they feel a client needs to transfer care to them. Physician scope will vary by state law and the business arrangement. In VA, they are required to supervise our care as "patient care team lead physician". We do this in our practice by working together to care for our high risk clients. |
| consultation, referral, collaboration of care |
| (I'm not sure I understand this question.) |
| Back up |
| They co-manage some patients who are more high risk maternity patients. They handle high risk pregnancies completely, like insulin-dependent diabetics. They are available for operative deliveries. They are surgeons for gyn conditions. |
| Consultation and collaboration and commitment to accept transfers of care when a patient becomes too high risk for my scope. |
| Hard to define |
| I don't understand this question. |
| Collaboration. |
| to be available as indicated by practice guidelines and the CNM's clinical discretion to assist or assume care of medically complex clients outside the scope of practice of the CNM |
| I don't understand this question and what it is asking I would hope the scope is as a consultant and not a boss, but it rarely happens this way. |
| To serve as a consultant; collaborative partner and to co-manage more complicated patients. |
| Consultation, collaboration, availability for emergencies on short notice. |
| To care for medically complicated OB and GYN patients. |
| working in a collaborative practive |
| Collaborative |
| Their scope of practice is irrespective of working with a CNM; it includes the full range of obstetrical and gynecologic care. |
| has to be mutually agreed upon |
| to provide care that patient needs that is outside the scope of the midwife, such as operative deliveries, high risk care, repair of 4th degree lacerations... |
| Collaborates when need and assumes care when too high risk for my CNM scope |
| Collaboration |
| Collaborative. Not supervisory |
| Depends on the physician. Some give the CNM plenty of latitude to the full scope of practice and others want to be more involved |
| My understanding is that our roles are different - they care for high risk/complicated patients and I care for well women. In real life, at least here in Virginia, it is difficult to tell any difference in the roles except for the fact that CNMs do not perform C/Ss |
| Collaberative when requested |
| Depends upon the MDs & midwife and the politics of the health organization |

| Statistic | Value |
|---|---|
| Total Responses | 46 |

## 28. Which of the following are areas of conflict when collaborating with a physician? Select all that apply.

| # | Answer | | Response | % |
|---|---|---|---|---|
| 1 | Fetal monitoring |  | 14 | 27% |
| 2 | Safety of home births |  | 23 | 44% |
| 3 | C-section rate |  | 20 | 38% |
| 4 | Prescribing privileges |  | 8 | 15% |
| 5 | Liability concerns |  | 25 | 48% |
| 6 | Existing fee structures |  | 14 | 27% |
| 7 | Preserving the "normalcy" of birth |  | 36 | 69% |
| 8 | Autonomy |  | 25 | 48% |
| 9 | Other (please describe below) |  | 9 | 17% |
| 10 | None |  | 7 | 13% |

| Other (please describe below) |
|---|
| procedures that are done to make money for the practice, and are not indicated |
| these are all potential areas of conflict and I experience most but not all of them |
| TRial of Labor |
| scope of midwifery practice: thinking midwives can take care of high risk situations or things that aren't "normal" |
| transfer of medical issues |
| No cases in 2015 |
| Inability to practice to the level of my training and competency |
| Respect |
| Frequency ofvaginal exams/ interpretation of "progress" in labor |

| Statistic | Value |
|---|---|
| Min Value | 1 |
| Max Value | 10 |
| Total Responses | 52 |

## 29. Which of the following are areas of conflict when collaborating with a Certified Professional Midwife (CPM)? Select all that apply.

| # | Answer | | Response | % |
|---|---|---|---|---|
| 1 | Fetal monitoring | | 8 | 15% |
| 2 | Safety of home births | | 23 | 44% |
| 3 | C-section rate | | 3 | 6% |
| 4 | Prescribing privileges | | 10 | 19% |
| 5 | Liability concerns | | 16 | 31% |
| 6 | Existing fee structures | | 3 | 6% |
| 7 | Preserving the "normalcy" of birth | | 4 | 8% |
| 8 | Autonomy | | 9 | 17% |
| 9 | Other (please describe below) | | 16 | 31% |
| 10 | None | | 13 | 25% |

| Other (please describe below) |
| --- |
| mutual respect |
| The CPMs I am familiar with choose dogma over protocol, and do not refer appropriately, they make all midwives look dangerous, and they do not cooperate with the health care system to deliver appropriate care. They do not risk patient out of their practices when they should. They do not speak of CNMs or physicians with respect for our practice. |
| I don't collaborate closely enough with CPMs to answer, I only receive occasional transfers from them. |
| N/A as don't have contact with CPMs |
| I have found I often disagree with the information they provide the women they serve and I strongly disagree with home birth after cesarean section. We provideVBAC, they ought to refer those women to a hospital based practice so the women can labor in a safer way. |
| I'm slower to refer clients to CPMs when I am unsure about the standards of care that will be used. I think there are some CPMs in our area that do not reserve home birth for low risk women and I fear that it hurts the cause. |
| do not collaborate with CPMs. pt may transfer to homebirth |
| Calling the CNM for consult in a timely manner. |
| I don't have enough experience in working with CPMs to comment. |
| May disagree with risk status of certain pregnancies in home birth setting |
| Inadequate training for many VA CPMs and sometimes the CPMs set up independent practices too soon after becoming midwives. They need to be mentored first. |
| No cases in 2015 |
| N/A |
| Differences in interpreting 'informed consent' |
| Not applicable |
| N/A |

## 34. What would make it more likely that you would comply with recommendations from the Virginia Affiliate of ACNM?

| Text Response |
| --- |
| Get information in short, easy to read, bullet points. |
| It really depends on the issue |
| If they seemed to improve my ability to provide the best possible care for women in our community. |
| If I agreed with them and if they were based in evidence and if they allowed CNMs to practice to the full extent of their scope of practice. |
| As long as I agree with the recommendations and see the benefit then I would comply. |
| Because the VA ACNM is made up of midwives with autonomy and experience in practice, I would respect their recommendations as long as they were evidenced-based. I feel APNs are more likely to use evidenced-based practices than our physician counterparts. |
| References for literature supporting the recommendations |
| Na |
| Depends on what the recommendation pertains to: practice, collaboration, other |
| If the recommendation was in alignment with the recommendations of my collaborating physicians. That relationship is vital to my practice here and I will preserve it whenever possible. |
| It makes sense, it improves outcomes, it increases access for women, and there is evidence to support it. |
| My collaborating physician being okay with it. |
| If they were evidence based and aimed at improving birth experience and outcomes for women. If they were recommendations made by providers with home birth experience. |
| comply with recommendations of ACNM but unsure how that is different for the VA affiliate |
| Excellent publications that are brief, research based and pointed in discussion to specific topics (i.e. something that can be read in less than 10 minutes, with good research to back it, and easily disseminated among our provider team meetings). |
| group practice - others in the group agree to the recommendations |
| Compelling evidence |
| If they are made by consensus of the whole affiliate. |
| Evidence based recommendations are always a priority. |
| I comply based on the evidence |
| If I feel that they are evidence based and allow for autonomy of patients and the rights of the individual to make informed decisions. |
| . |
| Don't understand the question. Recommendation being unknown to me, I cannot say in advance. |
| Anything that would make communication better between CNM's and CPM's and MD's would be a good thing. |
| If I agree with them. |
| I agree with the recommendation |
| Evidenced based practice guidelines |
| I comply with the standards set forth by ACNM and their recommendations and position statements. |
| The 25 hour day! |

| |
|---|
| Need more information to make informed decision. |
| Evidence/ research |

| Statistic | Value |
|---|---|
| Total Responses | 31 |

## 35. What would make it less likely that you would comply with recommendations from the Virginia Affiliate of ACNM?

| Text Response |
| --- |
| Too frequent or time consuming correspondence. |
| If I had evidence that showed there was a reason to consider some alternative |
| It really depends on the issue |
| If they made recommendations that would compromise the health and well-being of women in our community. |
| If they preserved the supervisory status of the physician over the CNM |
| If the recommendations were not compatible with recommendations by the National office of ACNM or if they did not fit with my goals as a midwife (as stated in one of the early questions). |
| I would not be non-compliant, but would have concerns if the recommendations were not supported by research. In my experience, the guidelines of any professional group may be a bit stricter than some professionals agree with, but I think it is important that we adhere to these guidelines. For example, if the professional organization agreed that home births for VBACs were acceptable practice, I myself would not feel comfortable with that and would refer them to a different midwife after I reviewed my concerns and the research-based recommendations. |
| Na |
| Practice recommendations that have strong evidence to the contrary or those that violate my conscience or faith |
| If the recommendations were counter to evidence based practice. |
| if it not validated by research. |
| My collaborating physician "prohibiting" me following the recommendations or withdrawing his/her support if I choose to practice per recommendations. |
| If the recommendations were aimed at pleasing ACOG rather than serving women. |
| Long publications... |
| same as above |
| If they were just coming from the national office of ACNM with no changes made for the climate in Virginia. |
| If too unwieldy a burden to a home birth practice with small budget and no support staff. |
| Evidence available |
| Restrictive practice recommendations limiting patient autonomy and the ability to make informed decisions. Recommendations that are not based on good evidence and/or influenced by pressure from medical community. |
| If recommendations are unsupported in both research and practice. |
| See above. |
| Any further medicalization of normal birth would greatly distress me. |
| Mandatory support for home births. |
| If it increases my liability. |
| I disagreed with the recommendation |
| If the VA affiliate made suggestions outside of what the national office Recommends |
| If the recommendations were not based on evidence currently available |
| Need more information to make informed decision. |
| Research findings |

| Statistic | Value |
| --- | --- |
| Total Responses | 29 |