A Successful Model of Collaborative Practice in a University-Based Maternity Care Setting

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KEYWORDS

• Collaborative practice • Maternity care • Residency training • Medical education

KEY POINT

• Collaboration between physicians and midwives shows an integrated model of successful clinical care and medical education in an urban University hospital setting.

BACKGROUND

For years, interdisciplinary education has been described and promoted as a means to enhance collaborative care.[1] In the last 3 decades, the inclusion of midwives as staff or faculty members in academic departments of obstetrics and gynecology has become more common. Models ranging from side-by-side practices[2] to active midwifery participation in medical education[3] have developed during this time. The literature on midwives in academic medical centers describes this role development and a progressive increase in the number of participating midwives.[4–6] Our experience at the University of Maryland Medical Center provides a 15-year example of a sustainable and successful collaborative practice involving physicians and midwives. The achievements of this collaborative model are further underscored by its ability to succeed in a high-acuity setting of a regional referral academic institution located in an urban setting, serving both vulnerable and insured populations. This article describes the evolution of an integrated model of clinical care and medical education at the University of Maryland.

PRACTICE MODEL AND OUTCOMES

The University of Maryland Medical Center has provided obstetric and gynecologic care to the women of West Baltimore and the state of Maryland since the early

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1800s. In recent history, the Department of Obstetrics, Gynecology and Reproductive Sciences was established in 1956, staffed by the traditional academic physician faculty model. The department serves as a high-risk referral center for the state and the region. Midwives were recruited to the faculty at the University of Maryland Medical Center in 1996 to expand the services offered by the faculty practice and increase the exposure of the residents and medical students to normal pregnancy and birth.

From the start, the midwives were identified as part of the clinical faculty, providing care in both private and clinic settings and attending births of the women in their caseload. At first, the educational role was limited to modeling midwifery care to the residents as they participated in caring for midwifery patients during labor and birth, in their separate midwife private practices. As the midwifery presence and practice evolved, the midwifery group became increasingly integrated and integral to the clinical and academic functions of the department. The midwives continue to directly provide care for women, including a private low-risk practice, specialty clinics for human immunodeficiency virus (HIV)–positive and young adolescent women (teen clinic), and women who are at increased medical risk but are seeking midwifery care. The group also works with medical students at both preclinical and clerkship levels, is active in the didactic education of residents and midwifery students, performs deliveries with residents, and supervises new residents and medical students in obstetric triage.

Several forces moved the Obstetrics and Gynecology Department toward an integrated model of service including (1) the demands of clinical care volumes and didactic education in a high-acuity setting, (2) the midwives' desire to participate more fully in teaching roles, (3) shifts in resident duty-hour requirements, and (4) willingness of both physicians and midwives to work collegially in this environment. The labor and delivery unit is staffed by 2 faculty members at all times, an obstetrician and a midwife, who seamlessly share patient care responsibilities; this is not to say that the duties are divided equally, because their scopes of practice differ. However, the obstetrician and midwife on duty have embraced an environment of mutual respect and collegiality, such that each supports the other. The midwife is the first line in triage, supervising the interns and junior residents as they evaluate and assess pregnant patients with a host of obstetric and nonobstetric conditions. The obstetrician is thus available for consultation on complications and for surgical intervention.

Midwifery faculty members were thoughtfully recruited and selected for strong clinical experience and flexibility to work in a model in which traditional midwifery management of labor may not be appropriate or possible. The midwives are adept at identifying when physician involvement is indicated. Meanwhile, if the physician is otherwise occupied in the operating room or the emergency department, or in gynecology-service care, the midwife is able to work with the resident staff to monitor the labor unit caseload and accomplish their births.

If there is a midwife private-practice patient who has risk factors suspicious for a complicated delivery, the physician is welcome to check on the progress of the labor managed by the midwife, and to serve as backup to a colleague. The physicians also enlist the aid of the midwives when there may be a challenging second stage of labor, receiving suggestions for different approaches to pushing and midwifery techniques that might aid in achieving a successful vaginal delivery.

Throughout this collaborative model of care, the midwives are integral to, and actively participate in, the education of every level of resident. This participation includes evaluating their history-taking and physical diagnosis skills, coaching them to develop clearer and more succinct presentation skills, assessing their hands-on technical skills during births, and monitoring and expanding their leadership and teaching skills, with their progressively increasing responsibility commensurate with