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Review

# Precepting Challenge: Helping the Student Attain the Affective Skills of a Good Midwife

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Susan Agard Krause, CNM, MSN

Preparing students for a career in midwifery is a rewarding venture. The knowledge and techniques necessary to meet the requirements of a safe, beginning-level practitioner are familiar to experienced midwives. It is common for students to achieve learning outcomes in the classroom (actual or virtual) but struggle in the clinical setting. Other students may struggle academically but perform smoothly and comfortably when they apply knowledge and skills in the clinical setting. The cognitive and psychomotor domains of learning are represented by a student's application of knowledge and performance of skills. Affective skills of caring and professionalism are equally important. Research that describes characteristics of what is considered a *good midwife* identifies affective characteristics associated with effective midwifery practice. By attending equally to all domains of learning, the preceptor can more effectively support the student in attainment of the skills, values, and beliefs that make a *good midwife*. This article focuses on the acquisition of affective skills by students in the clinical setting. When affective skills are well developed, they require little attention, but if they are not, the recognition and remediation can be a difficult task for the preceptor. Acquisition of affective skills in the realms of caring and professionalism are necessary for midwifery practice. Effective teaching techniques and knowledge of the affective domain enhance the preceptors' ability to evaluate and remediate deficiencies.
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*Keywords:* affective domain, clinical teaching, midwifery, preceptor, precepting, midwife, student, midwifery education

## INTRODUCTION

Preparing students for a career in midwifery is a rewarding venture. As educators, in the classroom or in the clinical setting, we continuously assess the students' knowledge and skills. The acquisition of the knowledge and techniques necessary to meet the requirements of safe, beginning-level practice are familiar to experienced clinicians. But what of the development of the affective domain: the attitudes and beliefs of the midwifery profession? For the experienced clinician, these attitudes and beliefs may have been incorporated into practice long ago, and there may remain little consciousness of the process.

Many students arrive at their midwifery education with affective skills well honed by previous life and learning experiences. These skills are not midwifery specific. Moral reasoning and the quality of caring are affective competencies that are critical to effective caregiving. For many, it is the development of values and beliefs consistent with the hallmarks of midwifery[1] that brought us to this profession. The values of self-determination, empowerment, cultural humility, belief in normal physiology and nonintervention in normal processes, and the therapeutic value of human presence are integral to midwifery practice.[1] For many, midwifery did not teach us these values. We chose midwifery because we came to appreciate their importance and wished to practice a profession that honored what we valued.

When affective skills are already well developed in a student, they require little attention. But what if professional behaviors and values are lacking, even in the presence of adequate knowledge and skills? Recognizing and remediating the deficit can be a difficult task for the preceptor. The goal of this article is to help preceptors understand the affective domain, recognize the development of values and beliefs, and help guide interventions when a student exhibits deficits in affective attributes essential to midwifery practice.

## AFFECTIVE DOMAIN

The domains of learning are not specific to midwifery or nursing but are used broadly in all fields of education. Work by Benjamin Bloom and a group of educators classified goals and objectives for learning culminating in a series of publications, the first of which is the *Taxonomy of Educational Objectives: The Classification of Educational Goals, Handbook I: The Cognitive Domain*.[2] Bloom's taxonomy was further refined by Krathwohl in 1973, and *Handbook II: The Affective Domain*[3] was published. *Bloom's Taxonomy* identifies 3 areas, or domains, that encompass the learning process. These are the cognitive domains representing the knowing, the psychomotor domain or the development of skills, and the affective domain, which encompasses attitudes and beliefs.[3] The domains do not exist in isolation but are integrated. Every learning experience has aspects in all 3 domains.

Bloom's taxonomy of learning delineates categories of acquisition that a learner progresses through during the learning process. For the affective domain, these categories are receiving, responding, valuing, organizing, and internalizing values (Figure 1). To illustrate, consider the hallmark of midwifery: "recognition of birth as a normal physiologic process."[1] The student initially *receives* this concept in the classroom, where she or he is eager to learn and accepts the evidence base for the support of physiologic birth. The student may *respond* by actively participating in labor support activities to enhance

Address correspondence to Susan Agard Krause, CNM, MSN, Baystate Medical Center Midwifery Education Program, 689 Chestnut St., Springfield, MA 01199. E-mail: Susan.krause@bhs.org

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## Quick Points

- Many attributes of what is considered to be a "good midwife" are in the affective domain.
- Affective skills are often well developed in student midwives but if deficits exist identification and remediation can be less straightforward than for knowledge or skills deficiencies.
- Reflective dialogue, role modeling, simulation, and role play are effective teaching techniques that support development of affective skills.
- Skillful use of the clinical evaluation tool can reflect deficits and document growth.

progression of labor. *Value* is exhibited when the student explains to a client the rationale for awaiting spontaneous labor rather than scheduling induction of labor. The student *organizes* the experience of spontaneous labor versus induction, classifying the differences and relating the experiences. *Internalization* occurs when the student consistently acts in support of physiologic birth when working with women in labor and at the institutional level to change policies that interfere with physiologic birth.

The cognitive domain has categories of progressive acquisition of knowledge: remembering, understanding, applying, analyzing, evaluating, and creating[4] (Figure 2). Compared to the cognitive domain, the affective domain is underrepresented in the teaching and learning literature. Affective learning has to do with values and beliefs, but also with humility, personal insight, and professional ethics.[5] When a student can explain the birth practices that vary among cultures, she or he is demonstrating cognitive knowledge. But it is an affective skill to treat a woman in a way that respects those differences. When a student explains the midwife role in consultation, collaboration, or referral, this is knowledge. When a student participates respectfully as an equal member of a multidisciplinary team, she or he is showing affective skill.

*The Core Competencies for Basic Midwifery Practice*[1] of the American College of Nurse-Midwives (ACNM) speak to the knowledge, skills, and behaviors expected of a new practitioner. Affective skills are well represented throughout the core competencies. The hallmarks of midwifery[1] speak to the art and science of midwifery (Table 1). The concepts of advocacy, empowerment, facilitation, and promotion are critical skills for the beginning-level practitioner. "Integration of cultural humility" and the "therapeutic value of human presence" are necessary skills to develop in order to truly care for women and families.[1] The midwifery profession recognizes the importance of affective skills to the practice of new midwives. But for many preceptors, affective skills acquisition is a less familiar process than that of cognitive skills acquisition.

### A GOOD MIDWIFE

Nicholls and Webb[6] performed a systematic review of the literature in order to determine a research-based definition of what makes a *good midwife*. Thirty-three methodologically diverse papers met the inclusion criteria for this review. The most frequently cited attribute was good communication skills. Other major attributes identified were compassion,

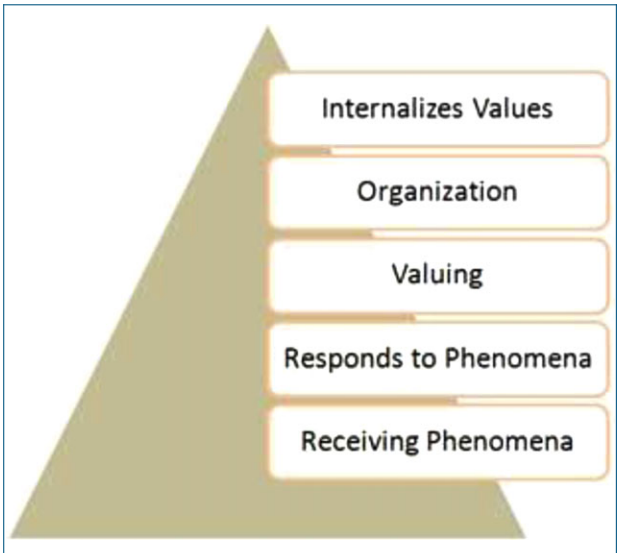


**Figure 1.** The Affective Domain.

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Clark DR. (2004). Bloom's Taxonomy of Learning Domains. Retrieved from http://nwlink.com/~donclark/hrd/bloom.html

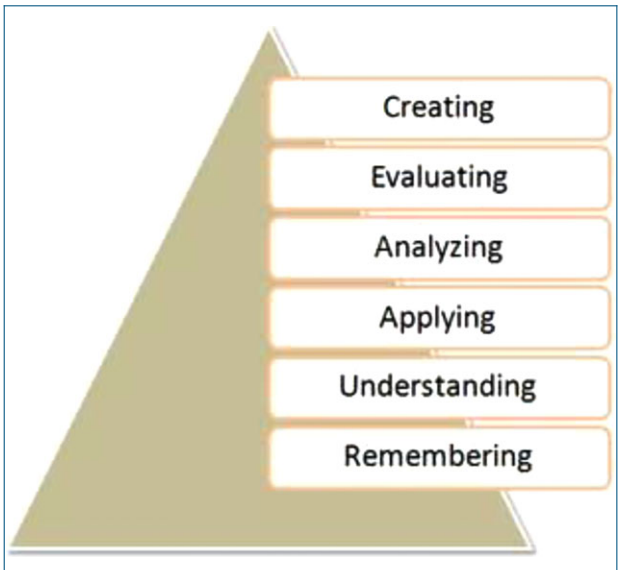


**Figure 2.** The Cognitive Domain.

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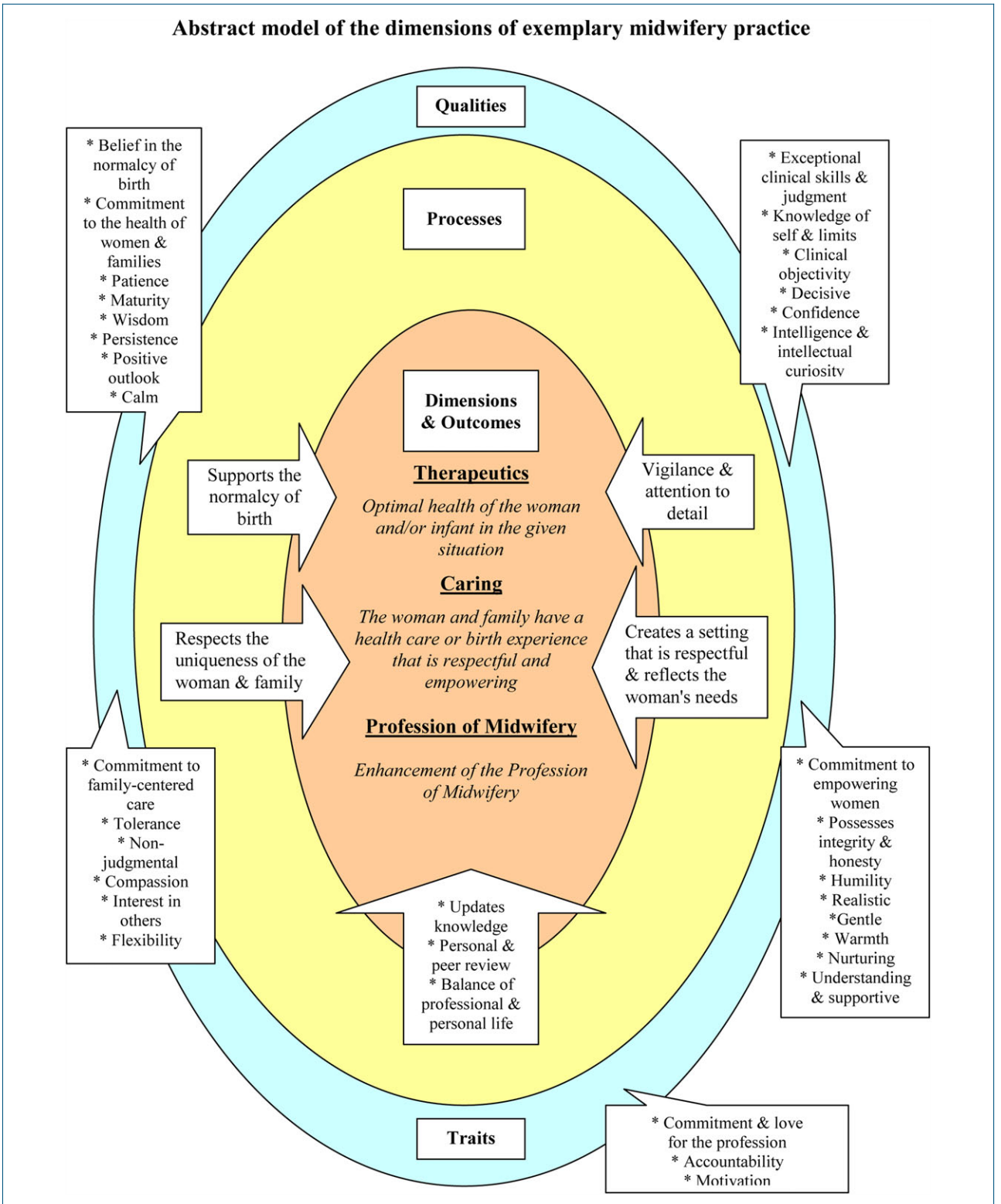


**Figure 3.** **Abstract Model of the Dimensions of Exemplary Midwifery Practice.**

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kindness, supportiveness, and demonstration of knowledge and skills. A *good midwife* was also involved in teaching and in research. A *good midwife* was acknowledged to have additional value-added factors beyond the competency demonstrated by passage of the American Midwifery Certification Board (AMCB) examination, referring to affective skills not evaluated on a standardized examination. Recognizing the identification of affective characteristics, the researchers posed the question as to "whether these attributes are present when the person starts midwifery education or whether they

**Table 1. Hallmarks of Midwifery[a]**

| The art and science of midwifery are characterized by the following hallmarks: |
|---|
| A. Recognition of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes |
| B. *Advocacy* of nonintervention in normal processes in the absence of complications |
| C. Incorporation of scientific evidence into clinical practice |
| D. *Promotion* of woman- and family-centered care |
| E. *Empowerment of women* as partners in health care |
| F. *Facilitation* of healthy family and interpersonal relationships |
| G. *Promotion* of continuity of care |
| H. Health promotion, disease prevention, and health education |
| I. Promotion of a public health care perspective |
| J. Care to vulnerable populations |
| K. *Advocacy* for informed choice, shared decision making, and the right to self-determination |
| L. Integration of *cultural humility* |
| M. Incorporation of evidence-based complementary and alternative therapies in education and practice |
| N. Skillful communication, guidance, and counseling |
| O. Therapeutic value of *human presence* |
| P. *Collaboration* with other members of the interprofessional health care team |

[a] *Affective skills in italics*
Source: American College of Nurse-Midwives.[1] *Core Competencies for Basic Midwifery Practice*. Silver Spring, MD: American College of Nurse-Midwives; 2012.

can be developed through education, either in the classroom or in the clinical area."[6]

Kennedy's[7] qualitative phenomenological research on the essence of nurse-midwifery care examined the attributes valued by women who were cared for by nurse-midwives. The themes identified emphasized the care process that developed as a result of the midwife-client relationship and identified the social aspect of this process. From the descriptions given by women about the care they received from midwives, Kennedy identified repeated themes: feeling safe, experiencing a caring relationship, feeling respected, and feeling in charge.[7]

Kennedy's[8] further work identified 3 dimensions comprising exemplary midwifery practice: the dimensions of therapeutics, caring, and the profession.[8] In her abstract model of these dimensions (Figure 3), all 3 domains of learning are identified by midwives and women recipients of midwifery care. The cognitive domain is represented by clinical judgment and updated, current knowledge. Clinical skills are representative of the psychomotor domain. The affective skills are represented by many qualities: belief in normalcy of birth, patience, maturity, wisdom, persistence, positive outlook, calmness, compassion, tolerance, being nonjudgmental, interest in others, flexibility, knowledge of self and limits, confidence, and decisiveness.[8]

In order to support the development of traits and qualities identified in Kennedy's model, preceptors must work with students to develop skills in 2 generalized areas. The student must develop caring behaviors with clients and families that accentuate therapeutic effectiveness, consistent with Kennedy's caring dimension. And students must develop skills consistent with Kennedy's professional dimension in order to interact within a multidisciplinary team to the benefit of clients and families. Kennedy's work provides a framework that illustrates the qualities of exemplary practice, or *good midwifery*.

Ulrich examined the affective professional socialization of midwifery students, acknowledging that although professional socialization involved cognitive, psychomotor, and affective domains, there had been little studied on the socialization of midwifery students in the beliefs and values of the profession. Her qualitative study categorized themes from the stories student midwives told of the first births they attended. The 3 dimensions of caring (therapeutics, caring, and profession) identified by Kennedy were themes that emerged from this research.[9] Students were able to identify *good midwifery* within experiences in the clinical setting.

The concept that students come to midwifery school with some core midwifery attitudes and beliefs is supported by Carolan's[10] qualitative thematic analysis examining the motivation and beliefs of beginning midwifery students in Australia. Four themes emerged: personal qualities and attitudes; a belief in women and natural birth; compatible work ethic; and the possession of additional attributes such as being empathetic, caring, cheerful, friendly, patient, kind, and understanding.[10] She found that students entering midwifery education had a clearer understanding of the affective attributes of a *good midwife* but less of an understanding of the knowledge and skills required.

In summary, research illustrates the importance of affective skills to competent, caring midwifery practice. A *good midwife* is recognized as having well-developed affective skills. But how do preceptors recognize and support the development of affective skills in the clinical setting?

## WORKING WITH STUDENTS

### The Effective Preceptor

An effective preceptor supports the process of learning in the clinical setting. A number of studies have identified preceptor characteristics students have found helpful.[9–12] The work of Licqurish and Siebold[11] supports the importance of the relationship between preceptor and midwife students. They performed in-depth interviews with midwifery students in Australia that identified the therapeutic, interpersonal, and clinical characteristics of the preceptor that impacted learning. These characteristics included supportive supervision, enjoyment of the teaching role, and debriefing.[11] Ulrich's work identified the support and guidance provided by the preceptor in creating a circle of safety that enabled students to care for women. She concluded that the powerful role played by the preceptor highlights the need for training and support of clinical preceptors.[9]

In developing a preceptor preparation program for nurses, Finn and Chesser-Smyth[12] identified competencies associated with effective teaching in the clinical setting. Teaching and facilitation included assessing the learning needs in conjunction

with the student and promoting active participation in client care. Role modeling was a way to demonstrate best practices. Communication enabled continuous constructive feedback.[12] Time for a preconference before the start of a clinical session and a chance to debrief in a postconference upon the session's conclusion provide a structure for communication and feedback. The opportunity to observe the preceptor in practice should be balanced with increasing independence as the clinical skills of the student progress, and can be used in combination during interaction with clients.

## Techniques That Support Affective Learning

There are a variety of effective techniques that promote affective learning.[13–18] Reflective dialogue, occurring in the classroom or in the clinical setting, allows for discussion about dilemmas, differing perspectives, or values clarification.[13] In her descriptive phenomenological study, Rees[14] interviewed senior nursing students about their use of reflective practice in response to emotionally challenging situations in the clinical setting. Paying attention to the affective domain in this way was shown to help the students understand complex and emotionally challenging situations. Feelings of anger, guilt, frustration, and sadness were acknowledged triggers for reflective activity. The role of the mentor in assisting students with the process was demonstrated.[14] In the clinical setting, a student can be asked to reflect upon her or his own practice or upon the practice of the preceptor.

If a reflective opportunity does not arise, a hypothetical situation can be used to introduce an ethical or moral conflict and to stimulate thought and discussion. This *what if* technique can be more effective than the discussions that involve asking "why didn't you . . ." or stating "you should have . . ." Challenging a student's beliefs can be an effective strategy for growth.[15]

Simulation of emergency situations has been shown to help develop the affective skills of effectively working with other team members and assuming the leadership role.[16] Role play and simulation can elicit skills from all 3 domains, but the affective domain is often the hardest for a student to act out within the structure of the classroom role play. Well-designed and well-implemented role plays that utilize debriefing and evaluation of the experience are the most effective in changing attitudes and values.[17]

Classroom teaching techniques vary in their support of affective skills acquisition. Objective structured clinical evaluations (OSCEs) have been shown to assess only knowledge and skills. Cazzell and Rodriquez[18] performed a qualitative analysis of affective skills following participation in an OSCE. The results revealed that the OSCE produced both positive and negative effects on affective learning, and the researchers concluded there was a need to include the affective domain in the development of experiential teaching strategies.[18]

## Acquiring Affective Skills

Compared to cognitive or psychomotor skills, deficits in the affective domain can be more difficult to identify and challenging to address. In the affective domain, it can be the absence of behaviors rather than an error that is revealing a deficiency. Delineating what is missing may be challenging. A preceptor's impression may be amorphous or hard to articulate. The preceptor may think the student "just doesn't seem to get it" or "doesn't trust birth." The preceptor may notice that women don't seem to like the student or that the student doesn't take feedback well. There may be a number of comments such as, "We talked about this, but nothing changed" or "This student is hard to work with." Increased familiarity with affective characteristics and skills can help the preceptor articulate the deficit and guide the student's growth.

As seen in Figure 1, the skill of receiving phenomena is the first step in acquiring an affective skill. This is an awareness that an issue exists and a willingness to attend to it. It includes motivation, or openness, to receive information. The behaviors of the student may relate to self, colleagues, or clients. A student demonstrates receiving phenomena by showing acceptance, being attentive or perceptive, or acknowledging phenomena.[3,19] Students having difficulty at this level of affective skill acquisition may have trouble listening to a preceptor's comments. They may have difficulty self-evaluating on a clinical evaluation tool. They may have trouble listening to a client's concerns or be unable to attend to those concerns because of preoccupation with another task or skill. There may be discomfort with the watchful waiting employed in the labor setting or failure to recognize that intervention is indicated.

Responding to phenomena requires active participation on the part of the student. It is the motivation to learn and to act on the received phenomena. The learner complies with suggestions, is willing to respond, and does so satisfactorily. Behaving, cooperating, contributing, observing, and discussing are behaviors consistent with responding to phenomena.[3,19] Students having difficulty in this area might have received the information shared by a client but then provide inappropriate responses to concerns expressed or provide information to a client at the inappropriate educational level. They may have heard what a preceptor tells them but be unable to act upon it. The preceptor might observe a lack of behaviors that demonstrate awareness of appropriate interprofessional or interpersonal interactions. In a situation where the student has identified the need for intervention, there may be reluctance to act.

The act of valuing occurs once the student accepts and believes in a phenomenon. The student assigns worth to the affective skill as demonstrated by incorporation into practice. Consistency between internal beliefs and demonstrated behaviors is evident to the preceptor. Stability over time and between varied situations should become evident. Accepting, believing, respecting, appreciating, and justifying are behaviors exhibited by the student who is developing value.[3,20] Student difficulties in this area might involve feeling that a client should make certain decisions or choices while stating they believe in a client's self-determination and informed decision making. Students who have trouble incorporating feedback into a change in clinical behavior are struggling with developing value. Inconsistency in management of similar situations can occur.

The higher levels of affective skill attainment, organization and characterization, are not and may not become fully developed in the beginning-level student. Organization

involves the ability to compare, relate, and synthesize values. The learner merges his or her values, resolving conflicts between beliefs and attitudes through the processes of examining, clarifying, and integrating. Characterization is the final level of affective skill attainment. The value system controls the behavior of the individual. The student is able to practice and act with consistency according to values that are integrated into the professional ethic.[3,19] Attainment of these final levels of affective skills may occur in the first years of professional practice.

## EVALUATING AFFECTIVE SKILLS

### Evaluating Clinical Performance

The clinical evaluation tool is the written documentation of a student's progress in acquiring the skills necessary for safe beginning-level practice. An effective evaluation tool reflects affective as well as cognitive and psychomotor domains. Such a tool aids the preceptor in several ways: it can contribute to student self-evaluation and awareness of progress, help to identify areas of strength and deficit, and aid in the development of a plan for improvement. In addition, the clinical tool is a vehicle of communication between preceptors and between the preceptor and education program faculty.

Developing the ability to self-evaluate and plan for continued professional growth is a skill in the affective domain. Preceptors are responsible for assisting the student in development of these professional skills by providing verbal and written feedback with the goal to improve understanding and performance. Each clinical experience provides opportunity for self-evaluation, guided by the preceptor. The preceptor's role is less about giving feedback than about helping the student identify when feedback has occurred within the clinical situation. It is less effective to give advice, ideas, opinions, plans, reflections, suggestions, or warnings. Feedback is a self-correcting mechanism, and students will often provide correction with support of self-reflection guided by the preceptor. Effective feedback enhances the student's innate ability to optimize their performance. Mahar asserts that "teaching people how to discern feedback in their work environment is comparable to installing a continuous process improvement generator in the student."[21]

The most effective feedback occurs immediately following an interaction. The more removed the feedback is from the experience, the less learning may occur. Feedback that occurs directly after an encounter can lead to learning, but if delayed may be felt as criticism and decrease the student's ability to integrate self-correcting behavior. Immediacy is not absolute time but is measured by opportunities. If a student needs remediation, it should be addressed at the first opportunity that arises. If there is not time in the moment, tagging the experience for the student by saying, "Let's remember this encounter and talk about it later," helps recall when time allows. If opportunities for feedback occurred and the feedback was not given to the student, the delayed feedback can arouse defensiveness.[21]

The feedback process is formalized on the clinical evaluation tool. The student should self-evaluate and plan for her or his growth followed by input from the preceptor. This encourages the student to self-reflect prior to receiving preceptor input. The clinical tool reflects where performance was strongest and which areas are in need of improvement. Student midwives identify the opportunity to postconference as supportive of their learning.[11] When this is not feasible, a debriefing should occur at the next available opportunity.

If an interaction with a client does not go well from the perspective of the preceptor, the first intervention should be reflection on the part of the student. For example, a preceptor and a beginning-level female student are in the office seeing a woman for a routine prenatal visit. The student asks appropriate, open-ended questions but, since the women is a little slow to respond, quickly follows with a closed-ended question. These closed-ended questions are answered, and the student obtains the information she wants to complete the visit. The preceptor recognizes that the woman was given no opportunity to express her concerns and should elicit the student's self-evaluation by asking, "How did you feel your conversation with Ms. T went?" The student may say that she collected the data needed in a timely fashion. The student demonstrated value in efficiency, and while the preceptor might agree that this is true, she or he has also identified an affective deficit in the student's lack of responding to the client's need for self-expression. A follow-up question could be, "What technique did you use to enable to Ms. T to share her concerns?" This would require the student to reflect on her practice and recognize that she did not provide this opportunity. Once the student is helped to see this, she can return to the room and frame a question that allows Ms. T to share concerns. Or the preceptor may model this for the student. In postconference, the preceptor and student could reframe the student's frequently used closed-ended questions into open-ended questions. During the next client encounter, the student should provide her own feedback and enhance her performance by adjusting her interviewing technique. This is a more effective learning technique than to simply tell the student to use open-ended questions.

### Affective Skills: The Professional Role

Functioning in the professional role requires affective skill development. An indication that the student is assuming the professional role is integration of the management process. Students can be expected to exhibit continued development as they progress through their clinical experience. One example of assuming the role of the midwife is seen when the student refers to midwives he or she works with as *we* rather than *they.* When performing an antepartum visit, for example, the beginning student might say, "Last week they recommended …" As the student assumes the professional role, he would say, "Last week, we (or I) recommended . . ." This shows that the student is assuming the provider role and becoming a member of the caregiving team.

Another indicator of professional role development is effective consultation skills. When students are first learning to collect a database from chart review and interview, the amount of information can be large. With progressive skill and knowledge, the database is honed to become more relevant to the client's presenting complaint or reason for the visit. The preceptor can help this skill by asking a student why certain

**Table 2.** Objectives That Reflect the Affective Domain: Professional Role

| Sampling of Objectives From Clinical Evaluation Tools Clustered by Topic | Examples of Student Behaviors That Exhibit Affective Skills Deficit |
|---|---|
| Communicates/collaborates effectively with health team members, faculty, peers.[a] | Difficulties communicating with preceptor around clinical management situations. |
| Behaves and interacts as a professional with preceptor and members of the health care team.[b] | Difficulties communicating with other members of the health care team: nurses, physicians, etc. |
| Shows respect for all team members.[c] | Is disruptive, disrespectful, or antagonistic to care team members. |
| Accepts responsibility for own actions and learning.[d] | Difficulties with accepting or giving feedback, difficulties with appropriate use of clinical tool. |
| Engages in self-evaluation and uses strategies to reduce common errors.[c] | Difficulties assuming accountability. |
| Incorporates ongoing self-assessment and seeks preceptor feedback.[c] | Lacks strategies to access answers to clinical questions. |
| | Lack of consistent improvement when given feedback. |
| | Insight lacking. |
| Maintains composure under stress.[d] | Difficulty continuing care when unexpected occurs. |
| Is punctual with appropriate dress for setting.[a] | Difficulties fitting in to setting in terms of appearance. |
| | Difficulties with being punctual that may relate to time management, lack of appreciation of importance of scheduling. |
| | Does not come prepared for clinical experience. |
| Demonstrates integrity, self-direction, and the ability to evaluate self.[d] | Looks to external source as excuse for poor performance. |
| Demonstrates personal accountability.[d] | Distorts facts when recounting situations. |
| | Is argumentative. |
| | Lacks motivation or enthusiasm. |
| Fosters environment of mutual respect in all professional interactions.[c] | Talks unprofessionally about other individuals: midwives, physicians, nurses, clients. |
| Reflects on consequences of a decision prior to taking action.[c] | Difficulty following through to outcome. |
| | Moves to plan prior to complete data collection and assessment. |
| | Misinterpretation of outcome. |
| Communicates plan completely, clearly with relevant data, in oral and written form, to all relevant parties.[c] | Difficulties mastering the charting system. |
| | Disjointed verbal report, unclear, missing critical information. |
| Maintains professional boundaries.[c] | Difficulty with the differentiation between friend and practitioner. |
| | Over identifies with clients' emotional or personal needs. |
| Maintains client confidentiality.[a] | Discusses clinical experiences without protecting client privacy. |

[a] Formative Evaluation Tool Form. East Carolina University, College of Nursing, Nurse-Midwifery Concentration.
[b] Clinical Performance Evaluation. The Midwifery Institute of Philadelphia University.
[c] Formative Clinical Evaluation Form. Yale School of Midwifery/WHNP Program.
[d] Clinical Evaluation Tool. Baystate Medical Center Midwifery Education Program.

things have been included. For example, the preceptor may ask, "Is it pertinent information for this situation? Why or why not? When would that information be pertinent?" This is progressive skill development. If the need for consultation arises, students need to be given the opportunity to do the consultation and give the critical information needed to the consultant in verbal or written form. This type of experience enhances professional role development.

**Table 3.** Objectives That Reflect the Affective Domain: Caring

| Sampling of Objectives From Clinical Evaluation Tools Clustered by Topic | Examples of Student Behaviors That Exhibit Affective Skills Deficit |
|---|---|
| Sensitive to clients' needs and cues.[a]<br>Consistently elicits and deals with patients' emotional and personal problems in a sensitive and skillful manner.[b]<br>Listens in a sensitive manner.[c]<br>Appropriate and gentle physical exam.[a] | Does not pick up nonverbal or verbal cues.<br>Has difficulty anticipating client needs in predictable situations.<br>Needs to familiarize self with local vernacular.<br>Difficulty performing skills and attending to client response.<br>Ignores, misinterprets, or does not notice client response. |
| Uses appropriate interviewing/counseling techniques to facilitate client understanding.[a]<br>Explains procedures to clients.[b] | Difficulties using appropriate language for education level, appropriately simplifying English for a new language learner, working through an interpreter. |
| Provides culturally competent care.[a]<br>Uses language that is meaningful and culturally sensitive.[c] | Difficulties adapting care to accommodate different cultural aspects.<br>Limited attempt to gather information specific to client's culture, ethnicity.<br>Does not consider effect of gender/race/income level/age.<br>Unconscious bias affecting interactions. |
| Promotes clients' rights to make decisions regarding health care.[b]<br>Effectively participates in process of obtaining informed consent.[a] | Difficulties with technique of providing informed consent: incomplete pros/cons, biased presentation, inaccurate information, gives insufficient time for consideration, rushes process. |
| Performs sensitive care incorporating client's culture, values, beliefs, age, and developmental stage.[b]<br>Counsels skillfully using techniques to facilitate client understanding.[a] | Difficulties assessing client needs based on developmental stage.<br>Does not recognize/is unaware of own cultural biases.<br>Explanations not understood by client.<br>Fails to check for understanding or give opportunity for client to ask questions. |
| Prevents personal biases from interfering with care.[b]<br>Aware of biases and prevents them from interfering with care.[c] | Difficulties keeping personal feelings or opinions to themselves.<br>Reacts when a decision made by a client is contrary to their beliefs.<br>Failure to maintain objectivity. |
| Provides labor support.[a] | Trouble anticipating client needs.<br>Does not include family/partner in support.<br>Is uncomfortable remaining with the laboring woman/family. |
| Demonstrates knowledge of own boundaries of management.[c] | Performs intervention prior to reviewing with preceptor.<br>Does not recognize lack of knowledge base. |

[a] Clinical Evaluation Tool. Baystate Medical Center Midwifery Education Program.
[b] Formative Clinical Evaluation Form. Yale School of Midwifery/WHNP Program.
[c] Formative Evaluation Tool Form. East Carolina University, College of Nursing, Nurse-Midwifery Concentration.

Table 2 lists a sampling of clinical objectives that reflects the affective domain, concentrating on acquisition of the professional role. Communication skills, appropriate dress and mannerisms, behavior toward others, accountability, and time management are a few of the examples of areas to be assessed. Table 2 also gives examples of difficulties a student might exhibit if he or she is having difficulties developing these affective skills.

### Affective Skills: Caring Behaviors

Many of the caring attributes are already present in new students. Some areas of assessment involve providing culturally competent care, which involves cognitive and affective skills. See Table 3 for examples of objectives reflecting the affective domain and possible behaviors exhibited by students that might be indicative of trouble with this skill.

A relevant hallmark of midwifery is "advocacy for informed choice, shared decision making, and the right to self-determination."[1] At the receiving level of the affective domain, the student would listen to what the client had to say during a prenatal visit. At the responding level, the student would enter into dialogue with the client, asking further clarifying questions and obtaining more information. Value would be demonstrated by the student formulating an evidence-based plan to address the complaint. Organization would be evidenced by implementation of the plan, and characterization would be accepting the client's decision to make an alternate choice.

### Affective Skills: Diversity and Equity

The preceptor should help the student pay attention to racial, economic, educational, and cultural differences between student and client. These differences can impact the student's learning and interfere with good communication and support. The hallmarks of midwifery speak of "integration of cultural humility," a task that may need the support of a skillful preceptor.[1] When a midwifery practice is expecting a student, providing information about the client population served and any unique characteristics can be helpful for the student's preparation. If a practice has acquired resources that have been helpful, sharing these with the student will enhance preparedness.

Midwives believe that there is link between diverse workforce and improved outcomes of care[22] and ACNM is committed to achieving equity in health care for women and in the midwifery workforce. Individual education programs may address this concern through admissions and student support. However, the percentage of midwives and student midwives of color remains small, with only modest increases in recent years. Foster asks, "What can each of us do to individually build the diverse and inclusive workforce we seek?"[23] An integral part of increasing a diverse workforce may lie with precepting in the clinical setting and consideration of precepting skills that enhance the success of a more inclusive population of student midwives.

Outcomes from the ACNM Diversification and Inclusion Task Force included identification of characteristics consistent with white culture that permeate the organization and shared cultural practices illustrative of white culture regularly employed within ACNM. Some examples are binary thinking in terms of good or bad and right or wrong; norms of communication that emphasize politeness and avoidance of conflict; a tendency to notice what is wrong rather than what is right; rationality with a focus on logical, linear thinking; and the view that emotionality is irrational.[22] These are characteristics that can be seen in the clinical setting, and it is possible that the precepting techniques utilized are not equally supportive of all students.

We know that clinical learning plays a significant role in the education of new midwives and that affective learning is integrally incorporated. Cultural and ethnic differences exist within the midwifery student body and appreciation of these differences is an affective skill. There may be underappreciated differences in communication and learning styles. Affective skills of preceptors and of students may play a vital role in creating a midwife workforce that is more widely inclusive and diverse. Much work is needed to clarify the effect of diversity on learning and precepting in the clinical setting.

## CONCLUSION

In midwifery clinical education, assessment is focused on the acquisition of knowledge and skills necessary to be a safe, beginning-level practitioner. The affective skills necessary to be a competent and caring midwife should not be taken for granted, nor should acquisition of the professional role. By attending equally to all domains of learning, the preceptor can more effectively support the student in attainment of the skills, values, and beliefs that make a *good midwife*.

## AUTHOR

Susan Agard Krause, CNM, MSN, is currently the Director of the Baystate Medical Center Midwifery Education Program and practices with Baystate Midwifery and Women's Health in Springfield, Massachusetts. She has been in full-scope practice and in midwifery education for 25 years.

## CONFLICT OF INTEREST

The author has no conflicts of interest to disclose.

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